How do healthcare professionals make sense of the barriers and facilitators to care for transgender women living with HIV?

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Acknowledgements

> "*We are survivors. The rest of the world may assume we are weak and fragile because of our feminine inclinations, but in reality, living with other people's relentless misogynistic bullshit has made us tenacious bad-asses*."
>
> — Julia Serano, Trans Activist and Writer.

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To my father Mike who was unfortunately never able to see me pursue my career, thank you for being a source of inspiration, resilience, and strength. I am grateful to you for instilling a sense of morality and determination in me. You are deeply missed.

Finally, this thesis is dedicated to all the trans women living with HIV. Both society and the healthcare profession need to do better and take more accountability in providing trans-inclusive care and celebrating gender diversity. I hope this research is one of the many small steps in the right direction.

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1. Lay Summary

Introduction: Transgender or ‘trans’ is an umbrella term to describe people whose gender differs from their sex assigned at birth. The term ‘sex’ refers to the physical characteristics and differences between people and can be described as male, female or intersex. A person’s sex is defined at birth and can be described as their ‘natal sex’. By contrast, gender refers to a socially defined set of norms, behaviours, and roles which can vary country to country and change over time. People may describe their gender as woman, man, or non-binary which describes someone who may not view themselves as either a man or woman. There are also lots of other descriptions of gender and it is important to recognise that gender may be fluid and is not fixed. Therefore, a transgender woman is somebody who was assigned as male at birth but whose gender is a woman. They may have gone through various changes such as medical, legal, social, or physical processes. However, there is no set requirement to go through any of these and it is up to the individual.

Human Immunodeficiency Virus (HIV) is a virus that attacks the body’s immune system and can lead to infections and other health complications. The outcomes for people with HIV are better than they were historically and can now be managed with antiretroviral therapy (ART). If people with HIV take this medication regularly, it will help them to stay healthy and prevent the virus from being passed onto other people.

Both people living with HIV and who are transgender face a lot of discrimination and unfair treatment. It is likely that people who are diagnosed with HIV and are transgender women may experience further difficulties engaging with healthcare and getting appropriate treatment. This study set out to investigate this group of people and to try and improve their experiences of healthcare.

Systematic Review

Background: A systematic review refers to a methodical and carefully planned out literature search of research into a specific area or topic. The findings are then analysed, and a judgement is made about the quality of the available evidence. It was important to search the literature regarding transgender women's perspectives of accessing HIV care to evaluate their experiences of services, and to direct future research efforts. It is known that transgender women are more likely to experience barriers in accessing healthcare and experience prejudice and discrimination.

What did I do? Qualitative research, which deals with non-numerical data, and may be collected through interviews or focus groups, is important. It allows researchers to gain in-depth understandings of individual experiences which might otherwise be ignored. Thus, this review focussed on transgender women living with HIV who accessed healthcare related to their diagnosis. A total of 7,085 articles were screened for relevance before 29 global studies were included in the review.

What did I find? Ten different themes were conceptualised to describe the experiences of transgender women's HIV care. Different forms of stigma were frequently reported which had implications for the way in which transgender women may engage in HIV testing and treatment services. Positive relationships with staff were important to trans people, as was viewing professionals as compassionate and validating, which appeared to help women attend healthcare services. Negatively held attitudes from staff increased self-reported experiences of prejudice and discrimination. Trans women reported concerns about specific aspects of care related to their gender and may be concerned that HIV medication interacts with the efficacy of their hormones.

Conclusion: Improved professional training of gender-specific needs and trans-inclusive care is likely to improve health outcomes for this group. Future research could explore training initiatives to reduce stigma and improve engagement in healthcare.

Empirical Study

Background: An empirical study refers to novel data being collected. Prior research shows that transgender women living with HIV experience multiple barriers to care and often do not view their clinicians as competent and knowledgeable. Very little research has been conducted into healthcare professionals' perspectives on trans women who are living with HIV.

In the UK, it is not known how many trans women there are because of problems with recording this population due to institutional stigma. Although recent efforts have been made to change this, very little information exists regarding this group. As healthcare professionals exhibit power over trans women and are likely making decisions that impact their wellbeing, additional knowledge about clinicians is required.

What did I do? I interviewed seven healthcare professionals in London and Brighton who work with transgender women who are living with HIV. I asked them about their views on providing healthcare for this group, what their experiences were, and what they thought needed improving. The research was approved by the University which meant it was safe to carry out.

What did I find? I found 7 major themes that were important:

1. *Connecting with the patient:* Participants put themselves in the patients' shoes, were welcoming, and spent appropriate time with patients to help facilitate positive and trusting relationships.
2. *Identifying the needs of trans women:* Participants recognised that trans women may need to be provided with special care due to their gender and that all trans women are different.
3. *Making sense of healthcare systems*: Participants found that gender and HIV healthcare services were often complicated which made it difficult for both patient and professional to get the outcome that they would like.
4. *The 'ripple effect'*: This described how professionals saw that trans women with HIV often had difficult lives and other aspects may make HIV care more difficult. This included factors such as housing, finances, drug use and sex work.
5. *Insufficient professional knowledge*: Participants identified that they often had a lack of knowledge in providing care to trans women. Sometimes they were worried about getting it wrong and used the patient to educate themselves.
6. *Unhelpful perspectives and the limits of 'knowledge'*: Participants highlighted that harmful attitudes about trans women are held not only across society in general, but sometimes by healthcare professionals too. They also witnessed that trans women may blame themselves for this.
7. *Finding solutions to improved care*: Participants discussed ways to make care better for trans women with HIV. This included providing holistic care, speaking to patients

about what they would like to see services do, and improving training for professionals.

Conclusion: Healthcare professionals, overall, had a good understanding of the healthcare provision for trans women with HIV. However, they identified barriers that may impact on trans women engaging with them. This includes a lack of training, unhelpful attitudes, and not enough specialist knowledge. Providing better training for professionals and integrated gender and HIV care may help improve the health outcomes for trans women.

Integration, Impact, and Dissemination plan. This section compared the results of both the systematic review and empirical study, and suggested future research aims. Both studies shared similarities in that they jointly recognised sufficient and insufficient examples of healthcare for transgender women living with HIV. The results of this study could be shared with relevant service users, charities, and organisations who may be impacted by the study and published in relevant academic journals. For example, the British HIV Association and World Professional Association for Transgender Health are currently revising some of their guidelines and a summary of the findings is intended to be shared with them. It is hoped that the study findings will lead to improved attitudes and knowledge among clinicians, which will result in better experiences of care for trans women living with HIV.

2. A Systematic Review of Transgender Women's experiences of HIV related care.

Abstract

Literature has shown that globally there is a higher prevalence of HIV infection among transgender women than cisgender women, however, data on UK prevalence is scarce. The combination of living with HIV and being of a minority gender identity mean that inequitable access to certain societal spaces, including healthcare services, may be heightened. In the UK, little is known about the perspectives of transgender women living with HIV (TGWLH). One international systematic review in relation to transgender HIV care was identified but was not specific to transgender women. Thus, the objective of this systematic review was to investigate the experiences of accessing healthcare services among TGWLH.

PubMed and PsycInfo databases were searched using terms concerning 'transgender women', HIV, 'healthcare' and 'experiences' for qualitative papers. After screening 7085 papers, 29 full-text papers were included in the review. Their eligibility was appraised by the primary author and a 20% sample was validated by a second reviewer. A narrative synthesis was informed by Popay's (1998's) framework on systematic reviews. Included papers were from the US, Central/South America, and South- East Asia. No papers were located from the United Kingdom or Europe. Ten themes were identified: (1) *Enacted and anticipated stigma*, (2) *Positive relationships with staff,* (3) *Gender-affirming vs non-gender affirming care,* (4) *Challenging environments,* (5) *Testing and diagnosis,* (6) *Linkage to care,* (7) *Experiences of ART,* (8) *Facilitating access to care,* (9) *Structural and individual barriers to care,* (10) *Resilience and recommendations for improved care.*

Results suggest that gender-affirming care is a likely facilitator to engagement with HIV services, whereas prejudice and discrimination acts as likely barriers. Trans-inclusivity within services may improve engagement at all stages of the care continuum. Improved training of gender-specific needs and trans-inclusive care is likely to improve health related disparities.

Introduction

The term transgender encompasses a wide range of people who find that their experiences differ from conventual expressions of gender (Ellis et al., 2015). Transgender or ‘trans’ refers to those who identify differently from the sex (male/female) that they were assigned at birth, whereas the term cisgender or ‘cis’ describes people whose gender identity aligns with their sex assigned at birth (Kirwan et al., 2021). Transgender people have historically been conflated with sexual minorities such as lesbian, gay, or men who have sex with men in the research literature (MSM) (Giblon & Bauer, 2017), resulting in a chronic invisibility of the population. In the United Kingdom it is unclear how many trans people there are, but the Government Equalities Office (2018) provides a wide estimate of around 200,000 – 500,000. The results of the 2021 census due to be released Autumn 2022 will likely provide more clarity on population figures where respondents have been asked for the first time to record both their gender identity and sex assigned at birth (Office for National Statistics, 2022).

Human immunodeficiency virus (HIV) is an infection that targets the immune system and increases vulnerability to fungal and bacterial infections and some cancers (World Health Organization, 2019). Effective use of Antiretroviral Therapy (ART) for the treatment of HIV results in an undetectable viral load which cannot be transmitted to others (Eisinger et al., 2019). Despite this, adherence to ART has been found to be lower among transgender women (Sevelius et al., 2019). Transgender people are more likely than cisgender people to experience high rates of chronic conditions, such as HIV, and mental health comorbidities (Abramovich, 2020; Ellis et al., 2015).

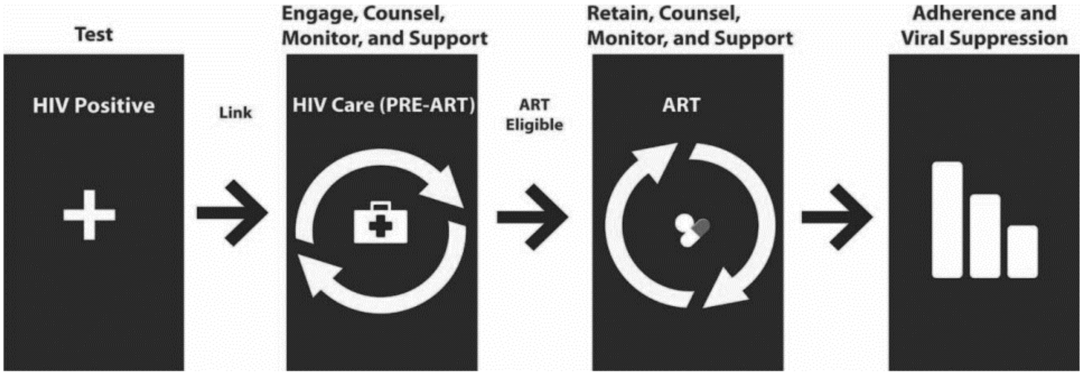
In England, transgender people report mixed experiences of primary care health services, with some citing affirmative and compassionate care, whilst others finding clinicians to be inexperienced and unfamiliar with transgender specific issues (Wright et al., 2021). Trans women are a key, yet under-researched, population in the HIV epidemic (Jaspal, 2020) where there has also been little, if any attention given to epidemiological data into transgender people living with HIV. Although estimates of global HIV among TGWLH are 19.1% (Baral et al., 2013), UK data remains unclear. Cohort data derived from both clinician and self-reported gender identity records that 140 trans women recently accessed HIV care in the UK, equating to a lower prevalence rate than international figures (Kirwan et al., 2021). Conversely, other figures suggest the rate of HIV among trans women to be as high as 4.8% (Day et al., 2021). However, given that trans women are not accurately recorded in official figures until now (ONS, 2022), and undiagnosed cases of HIV may exist (Jaspal, 2020; Williams et al., 2016), the true UK prevalence rate of HIV cannot be confidently established.

Barriers to Care

The HIV care cascade, or continuum of care (CoC, see Figure 1) is a well-established model describing diagnosis, linkage to care, retention in care, adherence to ART and viral suppression. (Gardner et al., 2011; Kay et al.,2016; McNairy & El-Sadr,2012). The framework denotes the different steps a person is required to sequentially pass through to be virally suppressed and to not transmit HIV to others (Mugavro et al., 2013). In order to achieve the treatment care cascade, barriers and social contexts at each stage should be considered (McNairy & El-Sadr, 2012). Existing international research finds TGWLH are more likely to be at risk of poorer outcomes due to challenges in engaging and accessing care at all stages of the HIV care continuum with suboptimal rates of viral suppression (Jalil et al., 2017; Jaspal et al., 2018).

Figure 1

Cascade of care



Note. Model produced by McNairy & El-Sadr (2012)

Transgender women, in general, face multiple barriers to accessing effective healthcare. These include a lack of knowledge and cultural competence in transgender specific care among healthcare professionals, discrimination, and socioeconomic barriers (Safer et al, 2016; Schneiders, 2014). Additionally, navigating healthcare services can be difficult. Trans women may need to attend multiple clinics for a variety of different needs such sexual health, HIV, hormone therapy, and mental health services, leading to dissatisfaction (Everhart et al., 2021). To help facilitate HIV testing and treatment, services that are trans-sensitive, respectful, and culturally congruent may reduce patients’ feelings of judgement and discrimination and encourage ART adherence (Melendez & Pinto, 2009; Schneiders, 2014).

Stigma in Healthcare

In addition to the barriers that trans women face when accessing HIV-related care, HIV stigma is identified as a substantial barrier to HIV prevention and treatment interventions (Earnshaw & Chaudoir, 2009). HIV stigma can take different forms such as internalised, anticipated, and enacted (Earnshaw et al.,2013). Internalised stigma relates to negative feelings and beliefs associated with HIV and applying them to the self. Anticipated HIV stigma concerns expectations of discrimination or stereotyping because of one’s HIV, and enacted HIV stigma involves prejudicial and discriminatory behaviour (Earnshaw & Chaudoir, 2019). In England, trans people with HIV are more likely to report negative comments about their HIV status, non-consensual disclosure of HIV status to another healthcare professional and being given appointments at times that are not chosen by them compared to cisgender patients (Hibbert et al., 2018; Public Health England, 2020).

Adherence to Antiretroviral Therapy

Inadequate care and experiences of discrimination are not the only barriers to successful health management. Some trans women take antiretroviral therapy (ART) and hormone therapy (HT) differently than prescribed due to concerns over medication interactions (Braun et al., 2017). This therefore could put women at risk of deleterious health outcomes. To improve uptake and adherence to ART, transgender-friendly practices are required to understand interactions between hormones and ART

(Sevelius et al., 2014; Williamson, 2010) and a holistic approach to service provision encompassing HIV and transgender specific care, and general healthcare has been suggested (Melendez & Pinto, 2009).

Mental Health and Trans People

Public Health England recently established that trans people with HIV have lower levels of life satisfaction and poorer health outcomes compared to cisgender people and are more likely to be described as economically inactive (PHE, 2020). Suicidal ideation among trans people is found to be higher, often due to a complex array of factors (McNeil et al., 2017). Correspondingly, trans people with HIV are more likely to be under psychiatric care in England, than cisgender people (Kirwan et al., 2021) and to experience depression (Kalichman et al., 2017). Twenty percent of trans people with HIV rated themselves as severely depressed or anxious, and more likely to have an additional long-term condition (67%) or diagnosed mental health disorder (53%) than cisgender people with HIV (PHE, 2020). These figures are based on critically small samples in the UK (n= 39) so generalisable conclusions are unable to be made.

Existing Systematic Research

A manual search of systematic reviews relating to the HIV care of transgender people revealed only one paper (Fontanari et al., 2019) which resulted in the inclusion of 63 studies. Findings demonstrate that worldwide, transgender people are not sufficiently engaged in each stage of the HIV CoC and results suggest that transgender women exhibit the lowest adherence rates to ART compared to cisgender men and women. This is a comprehensive global review, evidencing some of the health inequities among transgender people living with HIV. However, the review was limited to quantitative research; this will exclude the ‘lived experience’ of individuals where qualitative methodologies are likely best for exploring a depth of insight and breadth of experience (Chapman et al., 2015). Honouring the expertise that arise from lived experience is important, especially in the context of transgender women who live through challenging circumstances (Everhart et al., 2021). Furthermore, the review focussed on both HIV-positive and HIV-negative individuals and trans men, women, and non-binary populations. Arguably, these represent numerous heterogeneous populations which may prompt the need for separate examination when investigating experiential processes.

Rationale

The increased likelihood of TGWLH experiencing mental health problems and having difficulties in accessing care appropriate for their needs warrants further investigation. This, coupled with existing data often being quantitative in nature and not centralising trans women’s experiences justifies the need to provide a qualitative and up to date review in this area**.**

This systematic review is intended to collate and summarise the findings exploring perspectives of trans women who are accessing and receiving HIV related care. The review maps onto one of the World Health Organisation’s research priorities which is improving knowledge of suitable HIV prevention, treatment, and care options for transgender people (WHO, 2015). Because there are different aspects to analyse regarding trans women’s experiences, the review will categorise experiences broken down by the HIV continuum of care, linkage and engagement in care, ART adherence, and HIV viral suppression.

The review aims to make research evidence accessible whilst identifying potential gaps in the literature and unearthing recommendations for future research in this area. It may help to inform clinical practice by identifying what is clinically useful, but also unhelpful to this population when seeking care.

Objectives

The review aimed to answer the following questions:

1. How do transgender women living with HIV experience healthcare related to their diagnosis?

2. How do trans women's experiences map onto the continuum of care?

Method

The systematic review was conducted according to the 'PRISMA' (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) statement (Moher et al., 2015) and were also registered on the International Prospective Register of Systematic Reviews (CRD42022303768).

Eligibility Criteria

For inclusion in the review, studies were required to meet the following criteria:

a) Sampled transgender women who were HIV positive as the sole or significant population under study
b) Expressing views related to HIV care (including HIV treatment, preexposure-prophylaxis, ART adherence, barriers/facilitators to engagement in healthcare)
c) Generated qualitative data regarding the attitudes and lived experiences of participants accessing HIV care
d) Written in English
e) Limited to participants 18 years and above

Exclusion criteria

Excluded studies were those that were: largely biomedical in nature and did not include significant data relating to healthcare views or experiences of participants; the reviewer was unable to determine the HIV status or gender identity of relevant results; and did not present any results concerning transgender women's HIV related care experiences.

Source of Information & Search Strategy

Systematic literature searches were conducted using the electronic databases PsycInfo, and PubMed (Medline) were searched up to and including 13 August 2021 with no particular start date. The search was limited to peer-reviewed research with unpublished or ‘grey’ literature omitted from the review.

A title and abstract search were conducted in PubMed with search terms relating to “*transgender woman”, “HIV”* and “*healthcare*” and “*experience”*. Boolean operators ‘OR’, ‘AND’ were used to combine and exclude key words in the search. Truncations were denoted with an asterisk to allow for multiple variations of the root word to be searched (see Appendix B for full list of search terms).

The search terms used were informed and adapted by prior systematic reviews corresponding to the research area (Baral et al., 2013; Fontanari et al., 2019). Whilst it is recognised that previous data has at times conflated men who have sex with men (MSM), with the transgender population, the term ‘MSM’ was not used because it yielded too many results.

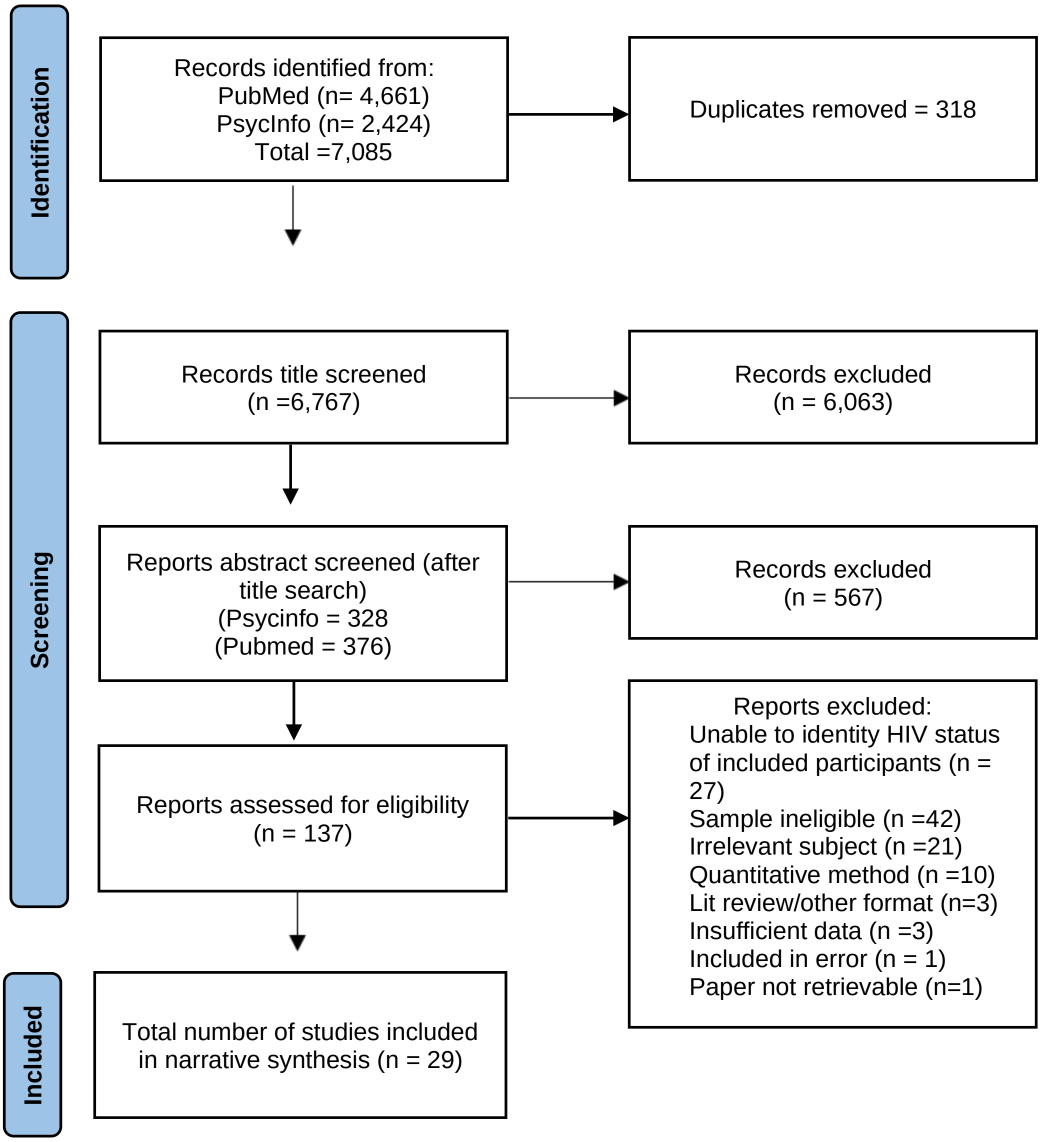
Study Selection & Data Extraction

All inclusion and exclusion criteria were applied to the papers yielded in the search. The original search returned 7,085 articles (see figure 2 for PRISMA flowchart). After 318 duplicates were removed using Endnote, 6,767 articles remained. First titles and then abstracts were screened separately to ensure accuracy. This led to the exclusion of 6,063 papers. 137 potentially relevant articles were read in full. After this, 29 studies met the inclusion criteria and were included in the review.

To assist in methodological rigour when assessing for eligibility, a secondary reviewer (a final year clinical psychology doctorate trainee) screened 20% of papers at the full text stage to judge for eligibility and demonstrate reliability. The papers the second reviewer examined were decided by assigning each paper a number and randomising the papers using Research Randomizer (https://www.randomizer.org/). The first twenty percent of the randomised sample were shared with second reviewer to critically appraise. The level of agreement was very good ($k = 1$, $p<0.000$) indicating that there was a high strength of agreement between the two raters and the application of the inclusion criteria can be judged to have strong interrater reliability. The final papers included in the review were extracted into a study characteristics table detailing the author, year of publication, methodology, sampling strategy, sample size, and key findings.

Figure 2

Adapted from PRISMA Flow Chart Page et al., (2021)



Quality Assessment

Two critical appraisal tools were used to assess quality and methodological rigour among the studies; the Critical Appraisal Skills Programme (CASP; 2018) qualitative checklist and the Standard Quality Assessment Criteria (SQAC) by Kmet et al. (2004). The Kmet tool has been used in a systematic review which included transgender individuals living with HIV (Perazzo et al., 2017) and the CASP has been commonly used with this population (Aylagas-Crespillo et al., 2018; Hamilton et al., 2020). Both the CASP and SQAC tool had 10 criteria each, thus each of the 29 studies were given a score out of 10 for each tool (see Table 1). If a criterion was only partially met, a score of 0.5 would be granted, with a full score of 1 if the item had been fulfilled. In terms of assessing overall study quality, the closer the score to 10, the higher the methodological robustness a study had (see Appendix C&D for a full itemised list of study ratings).

Table 1

Overview of Quality Assessment Tools

Critical Appraisal Skills Programme (CASP)	**Standard Quality Assessment Criteria (SQAC)**
Did the study demonstrate the following?	
(1) Clear research aims	(1) Question/objective sufficiently described
(2) Appropriate qualitative methodology	(2) Study design evident and appropriate
(3) A research design appropriate to address the aims of the research	(3) Clear study context
(4) Appropriate recruitment strategy for the research aims	(4) Study design evident and appropriate
(5) Data collected in a way that addressed the research issue	(5) Sampling strategy justified
(6) Adequately considered the relationship between the researcher and participant	(6) Data collection methods described and systematic
(7) Taken ethical issues into consideration	(7) Impact of personal characteristics and methods used on data obtained

(8) Rigorous data analysis	(8) Conclusions supported by the results
(9) Clear statement of findings	(9) Use of verification procedures
(10) The value of the research	(10) Data analysis clearly described and systematic

Yes = 1, Partial =0.5, No = 0

Data Synthesis

The qualitative results sections of included papers were narratively synthesised as informed by Popay et al. (2006), and key findings presented in table form with results discussed accordingly. An increasing number of qualitative articles examining the lived experiences of transgender people warrants the need to review, integrate and synthesise study findings to provide an overall clearer picture of trans person's lived experiences (Moolchaem et al., 2015). A qualitative evidence synthesis (QES) requires that reviewers identify and extract evidence from studies; categorise evidence; and combine identified categories to develop synthesized findings (Noyes et al., 2013). Popay et al.'s (1998, 2006) guidance on conducting a narrative synthesis to systematic reviews was followed, with multiple elements comprising the analysis. Popay et al.'s (1998) original guidance suggested developing a theoretical model for intervention studies. Since none of the included studies were an intervention, this could not be adhered to. Instead, the conceptual frameworks that the articles used were considered as part of the analysis. Resultingly the key stages of the narrative synthesis were *developing a preliminary synthesis, exploring relationships between the studies,* and *assessing the robustness of the synthesis:*

1. ***Developing a preliminary synthesis:*** Here, various synthesis tools and techniques were decided on as part of the analysis.

   These were *tabulating the data, assessment of quality* and *transforming the data into themes*.

2. ***Exploring relationships between the studies:*** Relationships between the studies were considered as were any divergence and convergence between the studies and compared to the wider literature base.
3. ***Assessing robustness of the synthesis:*** Assessing study quality using two critical appraisal checklists was used to enhance robustness. The methods used, context, population and sample characteristics were also commented upon in the discussion and provided further background to the utility of the synthesis.

Results

Characteristics of the included studies

Across the 29 studies, data was collected from 341 transgender women living with HIV. One paper (Teh, 2008) documented experiential data from TGWLH, but it was unclear how many were living with HIV so were not counted in the overall total. The age of the samples ranged from 15-69. Included studies had a range of ethnicities, predominately Caucasian and African American. A few studies only included one ethnic group. Hines et al (2019), Fauk et al., (2019) and Auerbach et al., (2021) all had related or companion papers using the same data set and were not counted twice in the study characteristics.

Included studies were undertaken in the US (n = 13), Central or South America (n = 4), South/ Southeast Asia (n = 5), Canada (n = 5) and South Africa (n = 2). None of the included studies were UK based, and no qualitative studies of TGWLH from the UK were located in the search. Income classifications of each country were determined by the World Bank (2022) and integrated into the table of characteristics. All 29 studies recruited participants from a community setting - either from HIV clinics, community-based organisations (CBOs) or non-governmental organisations (NGOs). The most common method of data collection was semi-structured interview (n = 17) and focus groups (n =8), with some studies using a combination of both. Methods of analysis were all qualitative, employing phenomenological, content analysis, case comparative narrative analysis, thematic analysis, grounded theory, and framework analysis. The characteristics of included studies are displayed in Table 1. Not all studies included complete information such as age or ethnicity of participant. Occasionally this information could not be discerned and thus were not reported in the table. Some studies or transcripts had components which were translated into English (Biello et al., 2016, de Villiers et al., 2020; Fauk et al., 2020; Fauk et al., 2019; Teh, 2008; Maiorana et al., 2021; Melendez & Pinto et al, 2009; Restar et al., 2019; Sevelius et al., 2019; Sevelius et al., 2014)

Study Quality

The included studies were appraised using the two study tools (CASP; SQAC). Table 3 illustrates assessment of study quality, with studies being of high quality (n=25), moderate quality (n=3) and low-moderate quality (n=1). Broadly, the most common reasons for a lower study quality were due to poor reflexivity of the researcher, no consideration between researcher and participant, poor description of ethical considerations, and occasionally a lack of data support the conclusions. Teh’s (2008) study was overall the lowest quality study among the results, and this was due to a lack of reporting in the methodology, analysis, and a dearth of participant quotes. Some of the disparity in study quality may be due to different requirements of reporting between journals, which would be difficult to assess.

The breakdown of each criterion and individual scores for the critical appraisal tools are displayed Appendix C and D.

Table 2

Overall Ratings and Quality of Critically Appraised Studies

Author	CASP total	SQAC total	Mean Average	Overall quality
Auerbach et al (2020)	0.65	0.65	0.65	Moderate
Auerbach et al (2021)	0.65	0.7	0.675	Moderate
Barrington et al., (2016)	0.9	0.9	0.9	High
Biello et al., (2019)	0.9	0.9	0.9	High
Bockting (1998)	0.75	0.7	0.725	Moderate
Chakrapani et al., (2011)	0.9	0.9	0.9	High
Daniels et al., (2019)	0.9	0.9	0.9	High
de Villiers et al., (2020)	0.95	0.95	0.95	High
Fauk et al., (2020)	0.9	0.9	0.9	High
Fauk et al (2019)	1	1	1	High
Harper et al., (2019a)	0.9	0.95	0.925	High
Harper et al., (2019b)	0.9	0.8	0.85	High
Hines et al., (2017)	0.9	0.9	0.9	High
Hines et al., (2020)	1	1	1	High
Hines et al., (2019)	0.9	0.9	0.9	High
Lacombe-Duncan et al., (2019a)	0.9	0.9	0.9	High

Lacombe-Duncan et al., (2019b)	0.85	0.85	0.85	High
Lacombe-Duncan et al., (2020)	0.9	0.9	0.9	High
Maiorana et al., (2021)	0.85	0.85	0.85	High
Melendez & Pinto (2009)	0.85	0.85	0.85	High
Munro et al., (2017)	0.9	0.95	0.925	High
Remien et al., (2015)	0.85	0.8	0.825	High
Restar et al., (2019)	1	0.95	0.975	High
Schilder et al., (2001)	0.85	0.85	0.85	High
Sevelius et al., (2014)	0.95	0.95	0.95	High
Sevelius et al., (2019)	1	0.9	0.95	High
Silva et al., (2020)	0.85	0.85	0.85	High
Teh (2008)	0.6	0.4	0.5	Low-Moderate
Wilson et al., (2020)	0.9	0.85	0.875	High

Table 3

Data Extraction & Study Characteristics

Author(s), year	**Context and Country**	**Study aim(s)**	**Design** **Method of Analysis**	**Sample and Sampling**	**Results and findings**	**Recommendations for future practice/research**
Auerbach et al., 2020	Local agencies providing HIV care in and around San Francisco, USA High-income	To explore barriers and facilitators to inclusion of trans women in HIV services traditionally designed for cis women	Cross-sectional, semi-structured, focus groups and interviews Method of analysis unclear	38 women living with HIV (10 trans, 25 cis, 3 as 'other') participated in focus group Purposive sample	Positives of all-women HIV clinic spaces included reduction in isolation; learning from other women; gender affirmation; and trauma-informed care. Challenges include a perceived risk of rejection or harassment if cis women display misperceptions of trans women, which may prevent them from seeking care.	Both cis and trans women recommended adaptations in the physical environment to allow for gender inclusion, increasing trans visibility in a variety of settings, and engaging all women in planning and evaluation of services
Auerbach et al., 2021	As above High-income	Identifying strategies for developing an inclusive all-women HIV care environment	As above	As above	Specific strategies for implementing all-women HIV care were identified including trans visibility and representation education and training, clinic environment	Practical Requirements and Implementation Strategy framework discussed which was generated from trauma-informed care

					considerations and safety and gender affirmation.	
Barrington et al., (2016)	Guatemala City, Guatemala Upper-middle income	Describing the factors that influence diagnosis, linkage, and retention in care among MSM and transgender women	In-depth interviews using a semi-structured guide Maxwell and Miller’s theory of Qualitative Analysis (2008)	11 TW (mean age 41, range 23-70) and 15 MSM with HIV	Fear of discrimination, delayed HIV testing, diagnosis acceptance and linkage to care.	Support systems for early testing and linkage to care need to be improved. Stigma must be addressed at all levels to reduce fear and improve care access
Biello et al., (2019)	Rio de Janeiro, Brazil Upper-middle income	To better understand barriers and facilitators to ART adherence and possible difference between cisgender and transgender youth.	Semi structured focus group discussions Content Analysis	24 adolescents aged 15-24 with HIV. MSM (n=10), TW (n = 8) mean age 22.3 SD 2.3Purposive sampling	Content analysis found barriers and facilitators to ART adherence such as low knowledge, side effects, substance use, stigma from partners and healthcare providers, and structural barriers (e.g., transportation and medication access)	Future development of an ART adherence intervention organised around identity and social networks may improve outcomes
Bockting et al., (1998)	Minneapolis, USA High-income	Needs assessment of HIV prevention	Focus group Content analysis	19 of 26 invited transgender individuals took part in a focus group – including 4 transgender people	TW specific risk factors for HIV and community involvement strategies were identified.	Education of healthcare professionals regarding transgender identity and support services for TW are needed

				with HIV/AIDS (Mean age 32.8, SD 5.9); Caucasian Ethnicity Sample recruited from community organisations and adverts	Negative invasive healthcare experiences were documented.	
Chakrapani et al., (2011)	Chennai, India Low-middle income	Exploring barriers to ART access among Kothi's (MSM) and Aravani (TW)	Semi-structured in-depth focus group Framework analysis	Aravani (n =17), Kothi's (n=17) mean age 33 Purposive sampling	Interrelated barriers to ART were found at the individual, healthcare-system and family/social level	A national policy and action are required to address barriers to ART access for marginalised groups.
Daniels et al., (2019)	Rural Mpumalanga, South Africa Low income	Understanding factors that influence ART adherence	Semi-structured focus group discussions Constant comparative analysis	TW (n=4), MSM (n = 16) with HIV Convenience sampling	Few participants had optimal ART adherence. Medical mistrust due to different interpretations of HIV and its cure. Desire for a relationship a determinant of ART adherence.	HIV disclosure and relationship skill-building interventions are required to improve the effectiveness of universal testing and treatment.

					Different perspectives on disclosure influence adherence	
De Villiers et al., (2020)	Western Cape, South Africa Upper-middle income	Exploration of anticipated, experiences and internalised stigma affected accessing HIV services	Longitudinal semi-structured interviews Case-comparative narrative analysis approach	8 participants (TW = 1, ‘femgay’ = 3, Gay/ MSM = 3, uncategorised = 1) Living with HIV (n = 4) Purposive sampling	TGW experience anticipated, enacted, and internalised stigma relating to HIV and gender. Additional barriers to care intersecting with stigma are low socioeconomic status, marginalised jobs, drug use and a history of crime Inconsistent uptake of ART linked to stigma	Further research could be longitudinal and investigate intersectional stigma. Social support networks are important in counteracting stigma and future studies should explore developing resilience.
Fauk et al., (2020)	City of Yogyakarta, Indonesia Low-Middle Income	Exploring factors relating to ART adherence	Face to face in-depth interviews Thematic analysis	*29 Waria* (TW) Mean age = 44, range 32-57 Purposive and snowball sampling	Varying individual, social and structural factors such as social influences, fatigue, viewing self as healthy or poor finances contributed to varying levels of ART adherence.	There is a need for development of HIV/AIDS related health support systems where healthcare professionals have better training and have lower levels of judgement.
Fauk et al., (2019)	As above	Factors associated with accessing HIV/AIDS related	As above	As above	Availability of services, ease of access and comfort felt by participants were common	Approachable, affordable, and appropriate healthcare

	Low-Middle Income	healthcare services			themes. Positive relationships with professionals facilitated access for TW.	services are needed to meet the needs of TW with HIV.
Harper et al., (2019a)	14 cities across US High-income	An examination of the barriers that transgender youth face at different stages of the CoC	Semi-structured in-depth interviews Phenomenological framework enquiry analysis	66 Gender diverse youth with HIV (TW = 32) Purposive sampling	Within all CoC stages barriers to care were found e.g., negative provider interactions, societal oppression and difficulties with service access.	Future research should examine resilience processes demonstrated by gender diverse youth. Ensuring respect in clinic interactions is vital to affirming gender identity and promoting good healthcare experiences.
Harper et al., (2019b)	As above High-income	Examining factors of psychological resilience among the CoC	As above	As above	Despite HIV related stigma and transphobia, young TW display psychological resilience.	Public health interventions at individual, community, and systems levels to bolster resilience with TW should be considered.
Hines et al., (2017)	Metropolitan area in Central Indiana, USA High-income	Describing factors influencing testing and entry to HIV care among TW	In-depth interview	18 TW aged 21-60 Cultural backgrounds were African American (n=10),	Information support, confidentiality, avoidance of stigmatising practices, and direct personal referrals facilitate earlier access to healthcare.	More longitudinal research is required to allow a more robust description of how trans women

			Qualitative descriptive method/ content analysis	White (n=4), multiracial (n=2), 1 = Latina, 1 = Native American		experience early stages CoC.
Hines, et al., (2019)	As above High-income	To explore the healthcare experiences of TGWLH	As above	As above	Four themes were identified: 1) clinician types (*clinicians who get me* vs *clinicians who don't get me*) 2) unmet health and educational needs 3) system-level barriers to healthcare access and 4) recommendations for improving quality of healthcare.	Participant led recommendations for improved care included gender specific training for clinicians, adapted medical documentation, employment of TW staff and gender affirmation.
Hines et al., (2020)	As above High-income	To generate a theoretical stage model describing transgender women's coping strategies after an HIV diagnosis	As above Grounded Theory	As above	Dynamic stages relating to HIV diagnosis were hypothesised 1) Having the world come crashing down 2) Shutting out the world 3) Living in the dark 4) reconstructing the world.	Transgender women may withdraw from care and avoid initiating or adherence to ART/HIV care. Clinicians should focus on helping TGWLH to accept their new diagnosis, guidance on disclosure and psychological support.

Lacombe-Duncan et al., (2019a)	Multiple Provinces in Canada High-income	To explore TW's engagement in HIV care and to describe barriers and facilitators to care along the CoC and understand attrition	Convergent parallel mixed method design; qualitative part semi-structured interviews Framework analysis	TW (n=11) 8 living with HIV. Age range 20s-60s Multiple ethnicities Purposive sampling	Complexity of trans women's experiences shape their engagement in different parts of CoC. Physical health, wellbeing, multiple stigmas (e.g., HIV related and transphobia) and life circumstance impact on engagement in care.	Future studies should explore how multiple forms of stigma impact engagement in HIV care.
Lacombe-Duncan et al., (2019b)	As above	Describing barriers and facilitators to medical transition for TGWLH	As above	As above	Varied transition experiences, affected by community norms & expectations, 'passing' as a TW and class privilege, HIV seropositivity and structural barriers.	Gender-affirming care competency of HIV settings need to be increased, alongside increasing HIV competency and challenging HIV-related stigma in healthcare settings where TGWLH. may need to access medical transition.
Lacombe-Duncan et al., (2020)	As above	To explore resilience exhibited by TW in response to stigma in healthcare	As above	As above	Three overarching themes identified: 1) resilient responses to stigma in healthcare, 2) motivations, benefits and consequences of responding 3) recommendations for	Receiving meaningful feedback from TW and hiring/supporting TW in positions of power could improve services.

					systemic change e.g., trans inclusion in service delivery.	
Maiorana et al., (2021)	Metropolitan settings, US High-income	Qualitative findings from a multi-site evaluation of interventions designed to improve engagement in HIV care for TW	Cross-sectional in-depth interviews Framework analysis	31 TW, 20 TW of colour (TWOC) (average age 44) and 36 staff members (project coordinators/ deliverers of interventions)	Addressing unmet health needs, facilitating engagement in HIV care, improving health literacy & helping to navigate the healthcare system were some of the valued roles of interventions.	Culturally responsive and gender affirming services is critical to address health disparities among TW and TWOC.
Melendez & Pinto (2009)	Low-income area of New York, US High-income country	Exploring concerns and needs of TW surrounding HIV prevention and primary care	Cross-sectional in-depth interviews	20 TW (4 HIV+) Mean age 30.7 years (SD =9.8)	3 key themes arose a) identity issues and tensions with gay communities b) holistic approach of services c) transgender focussed services	Community based services can be valuable for TW and for HIV prevention
Munro et al., (2017)	Ontario, Canada High-income	Dynamics of healthcare utilisation among TW living with HIV was explored	Semi-structured in-depth interviews Grounded theory	HIV+ TW (n=14) Average age 40 (range 30-58) Service providers (n=10)	TW highlighted discrimination, denial of service, lack of staff training and unwelcoming environments.	Specific training relating to transgender needs is essential to make services accessible.

Remien et al., (2015)	New York, US High-income	Barriers and facilitators to HIV care among vulnerable populations	Qualitative interviews Thematic analysis	80 participants with HIV (TW = 20, African American = 20, MSM = 20, previous incarcerated = 20) Convenience sample	Multiple barriers to HIV care exist, including unemployment, social and economic marginalisation, mental illness, substance use, medical mistrust.	Strong communication, coordinated services, and peer navigation are important for vulnerable population's accessing HIV services.
Restar et al., (2019)	Manila, Philippines Lower-middle income	Examination of views and experiences of ART and Feminising hormone treatment and incorporation of gender affirming care	Semi-structured interviews Phenomenological Approach	TGWLH (n= 9, average age 25, SD 3.1) and HIV-providers (n = 15) Purposive recruitment & snowball sampling	TW who experienced gender-affirmative care were more likely to take ART and FHT concurrently.	Future research needs to elucidate gender-affirmative care with HIV services.
Schilder et al., (2001)	Vancouver, Canada High-income	Characterising the relationship between identity and healthcare experiences	Structured focus groups and interviews	47 PLWH (TW = 10) Purposive sampling	Culturally competent providers were associated with care-seeking and ART adherence	Improving deficits in knowledge, access and practice will improve adherence to ART in gender minority groups
Sevelius et al., (2014)	San Francisco, US	To examine culturally unique barriers and	Focus groups and in-depth-interviews	TW (n=58)	Gender affirmation and integrated care in HIV care	A theoretical model of gender affirming care was theorised as a

	High-income	facilitators to retention in care.	Template analysis	Interviews (n=20), Focus groups (n = 38) Age range 20-69 Purposive and Snowball Sampling	increases retention and engagement with services.	powerful model of healthcare empowerment.
Sevelius et al., (2019)	Rio de Janeiro, Brazil Upper-middle income	TW's perspectives on HIV prevention approaches	Focus group Content Analysis	36 TW (15 TW HIV+) Sampling frame not reported/unclear	Anticipated and experienced HIV/gender-related stigma was linked to avoidance of testing, accessing services and HIV disclosure.	Programmes and interventions that use a gender-affirming approach were preferred to reduce stigma and discrimination in health services.
da Silva et al., (2020)	Recife, Brazil Upper-middle income	Exploring vulnerability in young TW with HIV	Semi-structured interviews "Qualitative, descriptive, explorative study"	6 TW (average 21.6 years) Convenience sampling	Engaging in sex work may increase levels of stigma for TGWLH. A lack of knowledge among young TW may mean difficulties in HIV care.	Young TW and their health workers may be unprepared for providing comprehensive care.
Teh (2008)	Major towns in Malaysia Upper-middle income	Identify social and behavioural problems that contribute to HIV/AIDS, assess access to knowledge and	In-depth interviews Unclear methodology	*Mak Nyah* (TW =15) Number HIV+ unknown Convenience sampling	Negative interactions with clinicians and harassment from authorities were common among the sample. Poor instructions regarding hormone use and HIV disclosure impact on sex	HIV prevention efforts are needed, NGOs are needed, and care facilitated by TGWLH themselves would help facilitate engagement.

		resources, identify barriers to prevention programmes			work may influence engagement in care.	
Wilson et al., (2013)	San Francisco, US High-income	Exploring barriers and facilitators to care among HIV+ trans women.	Semi-structured in-depth interviews Purposive sampling	10 African American TW (age range 28-55 years) Thematic content analysis	Gender-related stigma and medical mistrust were key barriers to accessing care.	Instrumental, institutional and emotional support may facilitate access to HIV care

Narrative Synthesis

The stages of analysis as informed by Popay et al.'s (1998) guidance led to the development of overarching themes to describe the experiences of TW accessing HIV related care. Ten interrelated themes were discovered through analysis of the data: (1) *Enacted and anticipated stigma,* (2) *Positive relationships with staff,* (3) *Gender-affirming vs non-gender affirming care,* (4) *Challenging environments,* (5) *Testing and diagnosis,* (6) *Linkage to care,* (7) *Experiences of ART,* (8) *Facilitating access to care,* (9) *Structural and individual barriers to care,* (10) *Resilience and recommendations for improved care*.

Theme 1: Enacted and Anticipated Stigma

Different stigma mechanisms were present throughout many of the included studies. Enacted stigma demonstrates the degree to which individuals living with HIV experience prejudice or discrimination due to their diagnosis (Earnshaw & Chaudoir, 2009). For trans women, they may experience interpersonal, individual, and structural forms of stigma (White-Hughto et al., 2015). These forms of stigma were evidenced across multiple health care encounters (Barrington et al, 2016; Biello et al., 2019; Chakrapani et al., 2011; Harper et al.,2019a; Teh, 2008).

Enacted stigma experiences in health settings included being stared at, pointed at, and watched by other patients and clinic staff, which was noted to likely impact retention in care (Barrington et al., 2016). Other participants found that other staff groups such as security guards working in hospital settings were discriminatory towards TW due to laughing and being stared at (Harper et al., 2019a). Being refused care was another form of enacted stigma, with some women reporting that they had been refused feminising procedures due to their HIV status (Munro et al., 2017). A TW who was referred to a psychiatrist for support in coping with her HIV diagnosis was refused care, and the doctor reported: "*I've not dealt with anybody like this before*" (Hines et al., 2019, p.87).

One participant described feeling very dehumanised as a result of their HIV treatment: "*.the HIV treatment in the hospital… I don't like the way they treat me because I was like an alien. It's embarrassing when they stand around whispering*" (Lacombe-Duncan et al., 2019a, p.317).

The intersection of stigma for trans people with HIV was often further compounded by being a member of a marginalised ethnicity. Trans women experienced discrimination due to being trans, HIV positive, and as a person of colour (Maiorana et al., 2021; Munro et al., 2017). Other TW of colour were concerned about travelling to clinic appointments on public transport for fear of harassment or violence (Wilson et al., 2013).

Some trans women also felt that professionals homogenised them into one discriminated group:

> "*You're a prostitute, that's the stigma that is attached to every single transgendered person. They see us all the same, dirty, HIV-positive, addicts, bad people. Taboo! Stay away from them*" (Schilder et al., 2001, p.1651).

Whilst some individuals felt able to challenge negative attitudes from staff (Barrington et al., 2016; da Silva et al., 2020) this was not a common theme, and some TW felt that they may be banned from services if they complained (Munro et al., 2017).

Anticipated stigma was present where individuals were concerned how they would be treated if they received an HIV positive diagnosis (Barrington et al., 2016). Some participants who were HIV positive were fearful how clinicians would treat them and whether this would impact on hormone or gender affirming therapy, and predicted negative interactions from staff (Bockting et al., 1998; Chakrapani et al., 2011; Munro et al., 2017). Some participants reported that HIV seropositivity was a barrier to undergoing gender-affirming surgery (Lacombe-Duncan et al., 2019b), indicating a form of enacted stigma at the intersect of their HIV diagnosis and gender identity.

Being supported to attend clinic appointments from a peer-coordinator or supporter was found to reduce anticipated stigma and build up confidence until TW could attend clinics alone (Maiorana et al., 2021). However, others who had the opportunity to be supported by trans peer-workers expressed concerns that their information or HIV status may not be treated in confidence (Sevelius et al., 2014). Similarly, others had concerns regarding social competition with other trans women in terms of physical appearance, which also created distrust (Wilson et al., 2013).

Subtheme: Degrading experiences

Although highly pervasive and negative attitudes from staff have been previously discussed as a form of enacted stigma, there were several experiences that TW reported which stood out as particularly traumatising, inhuman, and degrading. One earlier study discussed how one participant was treated by professionals who had limited knowledge around TW with HIV:

> “*The young interns and residents come in and won’t touch you unless they have a pair of gloves on. They are scared to death.”* (Bockting et al., 1998, p.519).

Another person described how invasive and undignified clinicians had been when being treated as a TW with pneumonia:

> “*When I was in the hospital, every single doctor wanted to look at my genitals. And after the third one I said ‘What are you doing? I have pneumonia. You cannot look at my genitals anymore!’*” (Bockting et al., 1998, p.519).

Theme 2: Positive relationships with staff

Although many participants described distressing and unhelpful attitudes or experiences from staff, many were also able to highlight positive and appropriate clinically helpful relationships with staff.

Staff who were open and understanding of patient gender identity was important (de Villiers et al., 2019) and having trusting relationships with staff meant that participants felt comfortable enough to contact staff to rearrange appointments without fear of a negative reaction (Barrington et al., 2016). Those who trusted their medical team were found to listen to advice around medication:

> *“The doctor advised me to continue taking ARVs regularly and on time…We know each other very well since I was diagnosed so I listen to his advice*” (Fauk et al., 2020, p.119).

Participants who deemed their clinicians as nice, friendly, and supportive found it easier to ask for help (Fauk et al., 2019). Respect and affirmation of gender identity, transition and expression helped individuals feel welcomed and accepted (Harper et al.,2019b). Some described their HIV care team as "*trans-sensitive*" to describe the authenticity of "*true*" caring as opposed to just doing a job (Wilson et al., 2013, p. 10). Participants who identified similarities in life experiences between service user and service provider helped to build rapport and enhance a willingness to discuss personal issues (Maiorana et al., 2021).

A coordinator who navigated access between service providers and service receivers were positively appraised by TW who viewed them as supportive and as a useful advocate on their behalf when they could not attend appointments (Fauk et al., 2019). Similarly, relationships that felt authentic and informal akin to family bonds appeared to be a powerful form of support:

> *"Like I said, I love y'all* [staff at clinic]. *Like, like y'all is like my second home. Y'all is my aunts, my mom, you know. All of y'all play a big part of my life, even from the secretary downstairs…"* (Harper et al.,2019b, p.58).

Approachable and supportive staff were a strong theme with some TW saying, "*it is a family kind of environment*" (Maiorana et al., 2021, p.75). Informal relationships with staff appeared to facilitate engagement and retention in care and were strongly valued by participants (Lacombe-Duncan et al., 2019b). Additionally, if trans women worked as healthcare providers this was also considered important (Sevelius et al., 2019) and likely influenced retention in care.

Support in attending appointments was valued by transgender women. Participants described it as helpful when staff contacted them offering transport or support to attend health appointments (Maiorani et al., 2021). Similarly, persistence from health care providers was also valued by participants and helped with starting treatment:

> "*They kept calling me and calling me* [to start treatment]. *The pressure helped the denial stage end… so they started me on the* [HIV] *regimen*" (Hines et al., 2017, p.11).

Theme 3: Gender affirming versus non-gender affirming care

Throughout the included studies, gender affirmation was an important framework, which could be conceptualised as "*interpersonal, interactive processes whereby a person receives social recognition and support for their gender identity and expression*" (Sevelius et al., 2019 p.3). Affirming women's gender was a pervasive theme throughout most of the included studies. This was a term that was different across the studies, and it took on different meanings for individuals. Some women argued that being labelled as 'transgender' was problematic:

> "*I hate the word transgender and I do not like being categorised. I am a woman and that's it, period. …Instead of a trans girl here and a cis girl there… if you put them together, then you're a women-serving clinic*" (Trans woman, Auerbach et al., 2020 p.5).

Accounts of clinicians being uninformed, uninterested, aloof, or uncomfortable with transgender identities and bodies were identified and acted as a deterrent to engagement with care (Hines et al., 2019). Furthermore, it was found that being "dead-named" which refers to the incorrect use of a transgender person's natal name (Sinclair-Palm, 2017) was experienced by some of the participants when engaging with professionals:

> "*One day I arrived dressed* [as a woman] … *and they call me by my* [legal] *name and it made me feel bad and it was in front of all the people waiting in the hospital.* (Barrington et al., 2016, p. 1754)

Misgendering from healthcare professionals was a common occurrence cited by TW (Hines et al., 2019; Lacombe-Duncan et al.,2019a; Lacombe-Duncan et al., 2020; Schilder et al., 2001; Sevelius et al., 2014). Further reports of staff being reluctant to use preferred names until TW were aligned with legal documentation were also found (Hines et al., 2019). Chakrapani et al (2011) found that TW participants reported that they had sometimes been admitted to male hospital wards despite living as female.

Among those who had been gendered correctly by staff, it was sometimes described as a new experience:

> "*So, it's actually only new, in the past year or less that I've not been misgendered by* [healthcare system]" (Lacombe-Duncan et al., 2019a, p.317).

Participants also perceived that they received different care that was not 'usual':

> "*He* [doctor] *did everything, but not like usual. You know how the doctor puts the thing* [stethoscope] *on you and listens? He wouldn't touch here* (indicating her breast/chest area). *It was weird. Afterwards I never went to that doctor again*" (Hines et al., 2019).

This excerpt displays the sense that TGWLH may receive unexpected differences in their medical consultations.

Theme 4: Challenging Environments

Linked to experiences of discrimination and non-affirming care were the physical clinic environments that TW had to navigate as part of their care**.** All-inclusive gendered spaces could sometimes be felt as unwelcoming for some trans women. For instance, one participant stated their experiences of using gender inclusive toilet facilities:

> *"I have seen some women fly out of there and go to the front desk and say there's a man in there; you know?"* (Auerbach et al., 2021, p.336)

Participants expressed concern over the physical clinic space itself and how it was a stressful and stigmatising space for individuals (Bockting et al., 1998; de Villiers et al., 2020). It was highlighted that some participants had extreme concern about anonymity and seeing people whom they knew (Wilson et al., 2013; Harper et al., 2019a). One person described:

> "*Walking through this door, and from that elevator to the first floor all the way to the lobby like this is the death walk ride…I was worried someone would see me and know what I am here for*" (Harper et al., 2019a, p.40).

Other participants had a different experience and felt that doctors looked after them, one citing that they did not need to wait and could go straight to the doctor's consultation room (Fauk et al., 2019, p.8). By contrast other TW noted that in the clinics they accessed, severe wait times impeded on their ability to use care:

> "*The waiting time, you would be in there all day and if you have a job, you just can't be gone all day and it's just like it was just awful so I left….*" (Harper et al., 2019a p.38).

> "*The first time I see* [healthcare professional] *I wait for five hours to meet him. So, I decide to leave*" (Lacombe-Duncan et al., 2019a, p.318).

In addition to uncomfortable clinic spaces and long waiting times was a confusing system characterised by multiple clinic locations for different services with competing opening hours (Harper et al., 2019a). Also fragmented health services not providing joined up HIV and hormonal or post-operative care was problematic (Hines et al., 2019). Some participants plainly acknowledged the complexity of health systems: "*health services are complicated*" (da Silva, p.4), which echoed the convoluted and difficult structures that a dual identity of HIV and being trans meant individuals had to navigate.

Sub-theme: Shared spaces

Shared spaces with other clinic users were addressed by participants in a minority of studies. Being in a group of both cis and trans women with no cis men was identified by some participants as reducing the shame of having an HIV diagnosis (Biello et al., 2019). A preference from transgender women to share group spaces with cisgender women was advocated by some:

> "*I would feel powerful and supportive being in a room with cisgendered women and trans women because…sometimes some men could be assholes …. I really don't like being in a clinic with men. I really don't*" (Auerbach et al., 2020, p 3-4).

Although some of the included studies demonstrated a sense from participants that services or clinic spaces shared with cis women may be beneficial, others identified concerns that sharing clinic spaces with women could mean a "*higher judgement level* *of whether or not you can consider yourself a woman*" (Auerbach et al., 2020, p4). Similarly, some participants perceived that cisgender women were given privileged treatment:

> "*When* [patients] *come to get ART, 'normal' women will be given ART and seen early. But when they* [pharmacists] *see people like us, there is laziness and they will say, 'Wait for some time, I will give you ART. Let the crowd go first*'" (Chakrapani et al., 2011, p.4).

In addition to considering cis and trans inclusivity, shared peer-support spaces with people without an HIV diagnosis were seen as important because it could reduce segregation:

> "*If you separated meetings for HIV positive and HIV negative*, [people will say], *'look, the positives are leaving the room'. I don't think that's cool* (Sevelius et al., 2019 p.9).

Theme 5: Testing and diagnosis

Testing and diagnosis of HIV were common experiences that arose across a majority of the included studies. Some participants avoided getting tested due to previous transphobia in healthcare (Sevelius et al., 2014). Out of those that initiated their own testing, it was found that the tested because they were sick or were testing as prevention (Barrington et al., 2016; Hines et al., 2017; Teh, 2008). Others described that testing did not feel inclusive for trans women and was predominately targeted towards gay men (Sevelius et al., 2014).

It was highlighted in another study that some women were not aware that HIV testing was being conducted on them (Barrington et al., 2016) and some of those diagnosed before 2006 were handed the results in an envelope by a doctor without further explanation (Barrington et al., 2016). Others evidenced that there was a lack of support around testing, especially before the 1990's:

> "*There weren't support groups or lectures or pre-test counselling, none of that existed. The word HIV didn't exist*" (Barrington et al., 2016 p.1751, trans woman, diagnosed in 1986).

Two participants were found to have a forced HIV test when they were incarcerated for prostitution (Hines et al., 2017; Sevelius et al., 2014) highlighting a similar lack of consent. Those with an HIV diagnosis were vilified and demonised, especially in prison in the early 1990's:

> "*There were these huge, red signs that said medical deadlock on them, and everybody knew that these people were HIV positive*." (Hines et al., 2017 p.9).

It was also emphasised that testing was felt by some as non-confidential and difficult to access because clinic rooms were hidden away, leading to one participant describing the process as '*embarrassing.*' (Bockting et al., 1998, p.517).

A lack of compassion and awareness as to the emotional impact of an HIV diagnosis was demonstrated by some staff. One TW described their negative experience of doctors:

> *"…They're very bland. Like they're just non-emotional, very non-emotional… It was never, uh, um sympathy or concern or anything like that,*

> *you know, how you feelin'* [sic]? *It was nothin'* [sic] *like that. It was just like OK, you're positive. We're going to send this to the lab, get your viral load and take it to the doctor*…. (Harper et al., 2019a, p.38).

After a diagnosis, it was found that some participants did not trust their clinicians, as evidenced by one participant who was told her CD4 count was higher than it was (Wilson et al., 2015).

Subtheme: Adjusting to a diagnosis

Individuals who had supportive clinicians and were explained that with appropriate care their health condition would be manageable. This explanation and support from staff appeared to make it easier to adjust to the diagnosis:

> "*The doctor* [started] *talking to me and telling me that having HIV doesn't mean I'm going to die soon….and then I just started going to get my treatment, my mood started changing and I started accepting what I had*" (Hines et al., 2017, p.8)

Conversely, others were described as being shocked and "*in denial*" that they were incredibly reluctant to seek support from healthcare services (Hines et al., 2017, p.9). This was likely to link to misinformation, discussed later on.

Theme 6: Linkage to care

Linkage to care was an important topic that arose in several papers (Barrington et al., 2016; Fauk et al., 2019; Hines et al., 2017; Lacombe-Duncan et al., 2019a). Experiences of being linked to care differed across different countries and contexts. In Indonesia, participants found that they were easily linked into counselling, viral load, CD4 checks, ART, and other health tests (Fauk et al.,2019), however this differed in other countries. The amount of time after an HIV diagnosis before individuals were linked into care was not a common topic of exploration, however one paper found that most participants were linked into care within three months of diagnosis and a direct referral was more helpful than participants contacting providers themselves (Hines et al., 2017). Other studies found that it took some TW several years to initiate HIV care (Lacombe-Duncan et al., 2019a). Delays in entering to care after diagnosis were cited because of fear of involuntary HIV disclosure and deteriorating mental health as being a barrier to accessing care (Barrington et al., 2016). Similarly, usage of drugs and alcohol impeded effective entry to care (Hines et al., 2017).

One transgender woman cited fear of medical treatment itself as being the main reason for not accessing care: "*I'm afraid of taking fucking medicine… what is going to do to me… is* [it] *going to make me sick*?" (Barrington et al., 2016, p.1752).

Theme 7: Experiences of ART

Experiences of taking antiretroviral medication varied across studies and contexts. Some trans women noted that ART medication shortages meant that their medication regime had been delayed (Biello et al., 2019), whereas others found ART supplies to be plentiful and not an obstacle to adherence (Fauk et al., 2020). Similarly, free of charge ART was seen as a motivator to take the medication as prescribed (Fauk et al., 2020). Some TW anticipated stigma from being prescribed ART medication by professionals which meant they were occasionally less likely to adhere to medication regimes (de Villiers et al., 2019). Other participants displayed a form of medication fatigue, whereby continued doctor's appointments meant individuals may have not got round to rearranging new prescriptions (Lacombe-Duncan et al., 2019a). It was found that TW who were linked to care by other TW in community-based organisations may have been helpful in initiating them to ART (Chakrapani et al., 2011).

In some settings, accessing ART was perceived as humiliating and undignified:

> "*Now our life has become worse than that of a dog. Why should we lose our respect to get this medicine? Instead, I would rather die.*" (Chakrapani et al, 2011, p.4)

Other participants demonstrated medical mistrust around pharmaceutical industries and suggested that there was a cure for HIV, but this was not being facilitated due to economical undesirability (Daniels et al., 2019). This then resulted in questioning if ART was a cure or not and if TW were being prescribed "*the ART that leads to a cure"* (Daniels et al., 2019, p.2852). Some individuals reported other misinformed attitudes such as believing the combination of ART and hormone therapies could cause cancers (Munro et al., 2017). Despite misinformed attitudes of ART in some papers, other studies acknowledged that participants believed ART was beneficial to them and so they listened to prescribing doctors (Fauk et al., 2020; Fauk et al., 2019).

Past health complications were also an identified reason affecting future adherence with antiretrovirals:

> “*The last time I got sick and was admitted to the hospital, a doctor told me that my life remained one week. That was because I was physically very weak*”. (Fauk et al., 2020, p. 118)

The fear of becoming so unwell again was a motivator for some participants to strictly adhere to their ART regime. However, the fear of dying from HIV medications due to witnessing a family member die was also cited as a concern (Schilder et al., 2001). Concerns over drug-drug interactions between feminising hormones and ART were a common barrier to ART initiation (Lacombe-Duncan et al., 2019a; Melendez & Pinto, 2009; Sevelius et al., 2014). Some side effects of ART were noted, but in one study the benefits outweighed the negatives as long-term health was valued above inconvenient drug effects (Fauk et al., 2020). However, Lacombe-Duncan et al., (2019a) found that side effects were enough to deter some women from taking ART. A related study suggested that TGWLH experienced drug-interactions before their ART was switched to a different drug, causing them to feel that they had lost time over their hormonal transition:

> *...I changed ARVs* [antiretroviral therapy] *that are a bit more complimenting to HRT. ’Cause before my medications negatively impacted the effects of HRT...Because I noticed a change as soon as I changed my meds...So for me I feel a lot of the progress I would have had from HRT, that ship has sailed...And nobody talked about it.* (Lacombe-Duncan et al., 2019b, p.5)

A gender-affirming rhetoric whereby hormones and ART could be taken together appeared to help facilitate engagement in care. (Restar et al., 2019). Respect and sensitivity to trans issues were also seen by participants as gender-affirming (Sevelius et al., 2014). Non-affirming rhetoric, where ART was prioritised over and above hormone therapy and condemned trans women taking their hormones, discouraged gender affirmation. One participant relayed their understanding of what healthcare providers had communicated to them: "*So, you want to look feminine okay. You look feminine, but you will die. Is this okay to you?"* (Restar, 2019, p10)

In one study, interviewees reported that some healthcare staff had withheld feminising hormones until their CD4 count had increased (Sevelius et al., 2014), forcing participants to make an extremely difficult choice between two forms of healthcare.

Theme 8: Facilitating access to care

Assertive engagement with patients and good accessibility to appointments were important and made individuals feel valued, thus encouraging retention in care:

> "*You know when you are working five to six days a week… and working at night, it's kind of impossible to make it. But you guys never close the door. You never forget about me. You guys will call and check with me…."* (Harper et al., 2019b, p.58).

Accessing peer-support spaces was an acceptable and useful way to find relevant information and receive support if individuals needed help with collecting medication: "*We (transgender women) share information among us, including about our HIV treatment, especially in our regular meetings."* (Fauk et al., 2020, p. 118).

Being offered regular information and focus group sessions with NGOs or community services were a further motivator to accessing relevant services. These sessions were viewed as helpful and were found to encourage individuals to engage in positive health behaviours (Fauk et al., 2019).

Moreso, integrated care was found to be important across many of the studies. Some participants highlighted:

“*Here… everything flows together. I don’t have to go on five different buses to try and get two problems solved. My needs get met*.” (Mairona et al., 2021, p.77).

“*Before I came here, it was like I was a traveling idiot”* (Melendez & Pinto, 2009 p.7).

Services that offered holistic care and provided a rounded approach to both HIV and trans health issues were welcomed by participants. Integrated care providing hormone therapy alongside HIV care was valued by many (Melendez & Pinto, 2009; Munro et al., 2017; Sevelius et al., 2014; Wilson et al., 2013). Additionally, support from project coordinators to attend appointments or information sessions were met with positive responses.

Theme 9: Structural and Individual Barriers to care

Both individual and structural factors which impacted the ability of transgender women to engage in care were noted, even though they were not directly about the care experience.

Lack of economic resources limited access to transportation meaning travelling to healthcare appointments or collecting ART was problematic (Barrington et al., 2016; Fauk et al., 2020; Harper et al., 2019a; Lacombe-Duncan et al., 2019a). Those who lived closer to hospitals or clinics found this beneficial as it reduced transportation costs or fear of discrimination in public, and some even moved closer to healthcare facilities (Fauk et al., 2019; Lacombe-Duncan et al., 2019b; Wilson et al., 2013).

Those living in rural areas were further disadvantaged as clinics were more common in urban areas (Munro et al., 2017).

Unemployment or job discrimination were noted as further blocks to engagement in care (Bockting et al., 1998) and in some countries problems with lapsed insurance meant that prescriptions were sometimes missed (Harper et al., 2019a). A lack of economic opportunities was linked to inclusion in sex work. This occasionally led to TW not taking medication due to concerns of clients noticing their HIV status, fearing for their safety or potential side effects interfering with sex work (Biello et al., 2019):

"*I'm afraid of a lot of things if I just take it on the street, understand? There are lots of* [sex workers] . . . *and if I take it and end up feeling weird, if I get hit with a bottle, or whatever it may be, something . . ."* (p.118)

Being homeless or having insecure housing was described as impacting the ability for TW to attend medical appointments due to competing needs such as shelter or access to food being prioritised (Harper et al., 2019; Remien et al., 2015; Sevelius et al., 2014).

Similar to structurally determined barriers to accessing care, individual factors existed that were relevant when considering how and why individuals may access people's care. This included use of alcohol and drugs (Sevelius et al., 2014) which linked to concerns about interactions of ART medication with drugs or alcohol, meaning that transwomen may be prevented from taking their medication when using substances. (Biello et al., 2019).

Misinformation among TGWLH was also present, and it was observed that a conflation between AIDS and HIV existed, as well as difficulty in obtaining HIV information (Biello et al., 2019) and a perception that some individuals were at low risk of HIV (Chakrapani et al., 2011). The desire for trans women to have a relationship was also found to be a potential barrier where they did not wish for potential or new partners to find out about their HIV status (Daniels et al., 2019).

Subtheme: Knowledge and information

Both knowledge held by service users and service providers appeared important in influencing the degree to which participants were retained in care. Staff not being trained in trans-specific healthcare was not necessarily problematic in itself, as one participant found: "*I inherited a doctor who was a god-send. He knew nothing about me or transgender women, but he took it upon himself to learn.*" (Hines et al., 2019, p. 85)

Receiving information from competent providers was important for educating patients about their HIV. As one participant described, being given comprehensive explanations and a choice over their treatment was a transformational experience:

"*My HIV doctor gave me a lot of education. She explained the virus to me, explained the medications, the different medications, which was my choice, they explained, you know, everything, so, it, that, that really helped me out as well and they made it comfortable and now when somebody asks me about HIV, I can explain it to them the same way my doctor explained it to me because it really opened my eyes*" (Harper et al., 2019b, p.58).

Healthcare providers were seen as “competent” by TW if they had appropriate knowledge on issues affecting both HIV and trans health issues (Lacombe-Duncan et al., 2019a; Schilder et al., 2001). Transgender women found it important that healthcare professionals were knowledgeable about the complexities of HIV-positive TW who were transitioning (Remien et al., 2015). This knowledge promoted engagement in care and affirmed participants’ identities. Conversely, some primary care doctors were found to be uninformed about HIV and transgender issues. Some clinicians appeared to find it difficult to differentiate between rashes and HIV symptoms, or to understand that transgender woman could be on ART and take hormones (Teh, 2008).

Theme 10: resilience and recommendations for improved care

Navigating healthcare services and the continuum of care was often shrouded in difficulty, negative interactions, and unwelcoming experiences. Harper et al. (2019b) characterised psychological resilience in gender diverse populations as important to accessing care. They highlighted that various intrapersonal assets such as health awareness, HIV acceptance, health motivation, and health responsibility were all important in facilitating access and engagement in HIV care. Accessing care itself was noted as a form of personal resilience and commitment to staying well. Personal strength and self-reliance were drawn upon, especially when being impacted by discrimination and structural barriers (Remien et al., 2015). Coping with stigma was found to likely increase the ability that TW could access HIV care, and social-support networks and intimate relationships were important (Daniels et al., 2019; de Villiers et al., 2020).

Interviewees in Hines et al.’s (2019) study identified that improved training for clinicians, tailored services for trans women, adapted medical documentation, improved interpersonal communication and empathy, employment of TW staff, normalising experiences of care and gender affirmation were all essential to improved care.

Discussion

To the author’s knowledge, this was the first systematic review to exclusively focus on the qualitative experiences of transgender women (TW) living with HIV and engaging with related care from studies around the world. Across 29 studies comprising 341 participants, there were a broad range of different experiences which were aggregated into ten different themes. The identified themes related to varying barriers and facilitators across the continuum of care, underscored by frequent challenges interacting with staff and services, and difficulty in navigating complex environments. Positive relationships with staff were also present as a prominent theme across the studies and the appraisal of services and healthcare professionals as compassionate and validating appeared to encourage retention and engagement in care. Individual and structural barriers to care were further identified as an adjunctive theme which appeared to mediate the extent to which TW could engage in services.

The studies themselves ranged in publication between 1998 and 2021 and were of moderate to high quality, as critically evaluated by two appraisal tools; the CASP and the Standard Quality Assessment Criteria (SQAC; Kmet et al., 2004) tool. The most consistent and common reason papers were scored lower across the two tools was due to a lack of reflexivity, a lack of consideration of the relationship between researcher and participant, and, occasionally, a poor description of ethical considerations. It is relevant that none of the included papers were published in qualitative specific journals, thus the lack of focus on reflexivity may have been due to constraints of the journal published in rather than a shortcoming of the study itself.

The review was solely focussed on qualitative studies, a particular strength as it ensures the lived experiences and valuable narratives from the affected population were heard. However, social desirability bias (SDB) whereby individuals consciously or unconsciously present themselves in a desirable manner (Paulhus, 1984) is likely to affect these studies. SDB has been found to impact on the reporting of sexual behaviour in HIV (Chillag et al., 2009) thus may have led to more favourable responses from participants.

Negative experiences when accessing care

It was clear from all the studies included in the review, that transgender women living with HIV face an inordinate amount of prejudice and discrimination when accessing healthcare services. Enacted and anticipated stigmas were a prevalent theme across all the studies with some individuals citing being refused treatment due to their dual trans and HIV status (Hines et al., 2019) or feeling that they were being treated like an '*alien*' (Lacombe-Duncan et al., 2019a). It was evident that some women felt homogenised into a single group that were prejudiced against and felt they were purveyed as unfavourable people to provide healthcare to due to their marginalised gender identity and HIV status. These findings link to a well-established literature base describing experienced or anticipated stigma from individuals living with HIV.

Earnshaw et al. (2013) found that among cisgender males and females, enacted and anticipated stigma was associated with a greater likelihood of chronic illness comorbidity, and lower CD4 counts. Similarly, internalised HIV stigma was found to have the strongest associations with health and well-being, relating to lower acceptance of and greater helplessness regarding the diagnosis.

Participants reported varied experiences of HIV care which differed in its quality and acceptability across the continuum of care. It was difficult to identify similarities between the studies given the small sample sizes, distinct settings, and heterogeneity in participant experiences. Although participants consistently reported negative experiences of healthcare and HIV support across the studies, they also cited positive interactions with providers and gender-affirming care which appeared to motivate engagement in care. This is corroborated in the literature where straightforward adaptations made to clinical practice such as using trans-inclusive and culturally competent language, and creating trans-inclusive environments are likely to reduce health related disparities (Abeln & Love, 2019; Lightfoot et al., 2021).

Testing and Diagnosis

HIV testing and diagnosis were prevalent themes across around one quarter of included studies. Overall, transphobia, forced testing, and a lack of compassion among staff were cited as common experiences. This links to existing reviews in the field which demonstrate that prejudiced attitudes, discrimination, and anticipated stigma are common factors experienced by cisgender individuals undergoing HIV testing (Chesney & Smith, 1999; Gwadz et al., 2018).

Medication Adherence

Approximately one third of included studies discussed participants' views of ART. National health services providing free medication supported regular adherence; yet repeated appointments to refine dosage, or suspiciousness of the drugs themselves hindered medication adherence. Combined care which synthesised both ART and feminising hormone therapy or other gender-affirming care was indicative of facilitating access to care. This links to other research where adherence to ART has been found to differ from cis women and men, and trans women have been found to have lower adherence levels regardless of whether TW were taking oestrogen (Baguso et al., 2016). These findings are similar to the current review, yet some participants expressed a preference of integrated hormone and ART therapy (Restar et al., 2019) and conversely some were deterred from taking ART due to a fear of drug-interactions with hormone treatment (Lacombe-Duncan et al., 2019a; Melendez & Pinto, 2009; Sevelius et al., 2014).

Medication adherence is further complicated by other interrelated factors, including race and ethnicity. It has been suggested that Black and Latina TGWLH experience multiple levels of adversity and, specifically, a lack of gender-affirmatory care has been associated with treatment interruptions (Rosen et al., 2019). The included studies evidenced the complex factors which impact availability and willingness to engage in care but were unable to be further broken down by race or ethnicity. Although many of the studies reported on ethnicity, this was unable to be identified from individual participants in the included quotes, making it unfeasible to draw conclusions about the experiences of marginalised ethnicities and TGWLH.

Individuals who trusted their care team were more motivated to be adherent with their medication (Fauk et al., 2020) whereas some questioned the authenticity of pharmaceutical industries and considered the deleterious side effects of ART itself (Daniels et al., 2019; Munro et al., 2017; Schilder et al., 2001). Medical mistrust is highlighted in the literature among this population, with the acknowledgement of no one universally agreed definition applying to describe the term (D'Avanzo et al., 2019). However, it is reported to occur among trans communities who are already discriminated against due to other identities such as belonging to an ethnic minority group (Daniels et al., 2019; D'Avanzo et al., 2019). The existing literature has mainly focussed on medical mistrust among people of colour but recognises that more research of trans women's experiences is key (Jaiswal, 2019).

Cross-country comparisons

The studies included in the review present data from nine different countries worldwide. A global meta-analysis investigating HIV prevalence among trans women included data on fifteen studies and found that the infection burden is significantly higher among this population (Baral et al., 2013). The authors did not find any significant differences in the prevalence rates between high-income and low-income countries but acknowledged that data was lacking in other countries. Similarly, the current review collated data from high-income countries, notably the USA and Canada, upper-middle income countries (Brazil, Malaysia; South Africa, Guatemala) and lower-middle income countries (Philippines, Indonesia, India). Differences in income may translate to diversity in the provision of healthcare services and thus make it difficult to compare studies both cross-nationally and within countries where there may be economic variations.

It was notable that no studies from the UK were included in the review. This was especially relevant given the reviewing team were UK based and sought to ascertain whether any specific UK research existed. Notwithstanding this, prior research finds that some LGBT service users report inappropriate care and heteronormativity from health and social care staff in the UK (Hunt et al., 2019) so it could be that UK trans participants report similar experiences to those reported globally.

Strengths and Limitations of the review

One limitation of the review is that only two databases were searched: PubMed and PsycInfo. A large number of results were found when searching PubMed exclusively (n = 4,661), and when PsycInfo was searched together this totalled 7,085 articles. Due to there being only one primary reviewer for the study, it was decided that no further databases could be searched. Given that systematic reviews require large amounts of time and human resource (Borah et al., 2017) it was deemed appropriate that two databases for 7,000 articles was appropriate. Further, reference lists were not checked for additional studies due to resource limitations. However, no cut-off date in the search was used, with papers from any timeframe eligible for inclusion in the study. The earliest included study in the review was 1998, suggesting that most of the relevant research has only been published in the last twenty-five years or so. This is perhaps in line with the historic conflation in the literature of MSM with TGWLH (Giblon & Bauer, 2017) meaning this group has been historically invisible and therefore may have partially accounted for a reduced number of available studies.

Although a synthesis of the results has been presented which report similarities across studies, differences between countries and cultural context will likely impact on the validity of the results. Transgender people consistently have poorer health indicators across low, middle, and high- income settings (Reisner et al., 2016) which may mean some experiences of healthcare could be similar despite varied economical infrastructures. Other studies find that countries that are categorised as less geopolitically progressive contribute to increased gender marginalisation and therefore higher levels of depression and anxiety among transgender people (DuBois & Juster, 2022). Trans specific healthcare may be provided under national health services or insurance in parts of Europe or Latin America, whereas in some locations of Asia and Africa it may be unavailable or sometimes illegal (Berredo et al., 2018). Other nations may criminalise transgender people based on their gender identity (UNAIDS, 2022), and reduced access to healthcare, increased poverty and HIV prevalence in some regions can explain inequities among TGWLH people of colour and migrants (Poteat et al., 2016).

In terms of the global response to HIV, clinical management of the disease in developing countries has historically been associated with limited access to ART, treatment discontinuation, and premature mortality (Wood et al., 2003). The United Nations AIDS targets of 90-90-90 which seeks to diagnose 90% of HIV, provide ART to 90% of people living with HIV and achieve viral suppression in 90% of people was set as a goal to be accomplished by 2020 (United Nations General Assembly, 2016). However, large variability exists between countries in achieving these targets. A study of 60 countries found that 79% (CI 67–92%) of HIV positive people knew their HIV status, 78% (CI 69–82%) were accessing treatment and 86% (CI 72–92%) of people accessing treatment had achieved viral suppression (Marsh et al., 2019).

This variability in care provision across nations can mean challenges in interpreting the results of the review. This study did not seek to directly compare a homogenous sample, but rather sought to present the findings of lived experiences of healthcare, therefore rendering the direct comparability of findings not of pivotal importance.

However, caution should be applied when interpreting the results due to multifaceted and disparate healthcare services between countries in the provision of HIV and transgender affirming care. A further limitation was that many studies initially appeared relevant to the research question as they included transgender and cisgender women with and without HIV. However, numerous studies had to be excluded because it was either impossible to determine the number of transwomen living with HIV in the sample, or the quotes and data provided in the results did not inform the reader who was or was not a TGWLH. Similarly, the mean ages of the participants involved in the studies were predominately thirty to forty years old. There is an aging population of trans adults experiencing transphobic practices from health professionals in the UK, indicating the need to improve staff knowledge and attitudes into gender diversity across the life course (Willis et al., 2020). Due to time constraints and a small reviewing team, it was not possible to contact each author of these studies to obtain specific demographic information about the samples.

A further strength is that the review followed the protocol guidelines of PRISMA-P (Moher et al., 2015). This guidance ensured that a pre-defined methodological approach helped to provide consistency within the research team and across appraisal and analysis of the studies.

The search strategy was limited to English papers, yet at least eleven studies included in the review had been translated from other languages where the participant's first language was not English. It was important to include these relevant studies and samples within the narrative synthesis, however translation of language itself can be seen as an interpretive act, meaning that understandings can be lost in the process (Van Nes et al., 2010).

The review exclusively focused on qualitative studies given it was a review to synthesise TGW's experiences of accessing HIV care. At least ten studies were excluded on the basis that they used a quantitative methodology. It could have been that these papers may have denoted relevant quantitative data about TGWLH, but which did not amount to experiential information.

Transferability of results

All the included studies recruited participants who were engaging in HIV support services in some form. A few of the studies recruited through using peer-workers or community-based representatives and not directly through an HIV clinic. This means that all participants were engaged in HIV support and care to a certain degree. Additionally, those motivated to take part in research may demonstrate a different narrative to those not willing to take part. The articles included small sample sizes, recurrently translated into English from multiple different countries. Thus, the extent that the findings can be applied to other settings or countries was constrained by the above.

Situatedness with theoretical models

The primary framework running throughout the review is that of gender-affirming or trans-affirming care. This philosophy of practice is conceptualised as comprising different aspects including the use of appropriate and inclusive language, trans clinical competence, affirming physical spaces and documentation (Lightfoot et al., 2021). Similarly, the concept of trans erasure, whereby trans voices are systematically minimised or not included due to cisnormativity (Bauer et al., 2009) is also vital to contextualise the studies included in the review.

Clinical, research, and policy implications

The findings of this review can be used to inform clinical practice when working with trans women who are accessing HIV services. The results suggest that healthcare professionals must reflect on the treatment and care they provide to trans communities, to ensure they are providers of gender sensitive and affirmative care. Global research finds that LGBT structured training programmes for healthcare professionals are a growing yet severely lacking field (Sekoni et al., 2017). Trans specific training is most sought out by those already providing transgender care in a clinical setting (Stryker et al., 2020), suggesting the need for earlier exposure to this population and an earlier provision of trans specific training. This is echoed by a recent study finding a significant variation in the amount and breadth of LGBT content in UK medical schools (Tollemache et al., 2021). The Royal College of Psychiatrists recognise the need for improved care for this group and the provision of professional education events (RCP, 2018). The Royal College of Nursing also recognises that trans and non-binary people are at higher risk of prejudice and discrimination and have produced a clinical professional resource to help educate their workforce (RCN, 2020).

Previous interventions to improve trans patient-centred care have shown initial promise through the provision of experiential learning opportunities in clinical practice (MacKinnon et al., 2016; McCave et al., 2019). Thus, training programmes could specifically aim to reduce prejudice and discrimination in this group through improving professional attitudes, fostering encouraging attitudes from staff, and delivering trans-specific care under a gender-affirming framework. Covid-19 has been found to impact the quality of gender-affirming care, highlighting the need for increased access to gender affirming resources and telehealth/digital health provision (Jarrett et al., 2020). Two studies in the review also found that being supported to attend appointments from a peer-coordinator increased attendance of appointments. (Fauk et al., 2019; Maiorana et al., 2021). Thus, provisions to support trans women with attending relevant appointments may be a valuable asset that overall improves engagement with care.

Several research implications arose from the current review. Firstly, it is pertinent that no included studies were conducted in the UK. This is important since the reviewer was UK based and drew upon UK legal and policy frameworks to orientate the review. Thus, it continues to stand true that there is a dearth of qualitative and experiential research of TGWLH in the UK. Consequently, studies which examine the perspectives of this group and the extent of gender affirming and holistic care are urgently required. Although many of the studies described experiences which could be understood as enacted or anticipated stigma, little focus was given to understanding the internalised stigma of TGWLH. Future research could examine beliefs about the self to ascertain the extent it may impact on an individuals' motivation to engage with care.

Improved qualitative methodologies in future studies with an increased focus on reflexivity and acknowledgement of bias is also particularly important when the research landscape continues to be dominated by cisgendered heteronormative voices.

Conclusion

This systematic review narratively analysed the experiences of transgender women accessing HIV care from around the globe. The interpretation provided a synthesis of the experiences of TGWLH and found that gender-affirming care is a likely facilitator to engagement with services. Negatively held attitudes from staff act as a likely barrier to care and increase the self-reported experiences of prejudice and discrimination. These factors have implications for testing, diagnosis, linkage to care and adherence to ART medication. Improved training of gender-specific needs and trans-inclusive care is likely to improve health related disparities.

3. How do healthcare professionals make sense of the barriers and facilitators to care for transgender women living with HIV?

Abstract

Prior research demonstrates that transgender women living with HIV (TGWLH) may face unique barriers to gender-affirming HIV care resulting in reduced engagement across all stages of the continuum of care (CoC). In the UK, TGWLH have been largely ignored in the research literature, and inferences about their care likely have been made from the wider global literature. TGWLH often report prejudiced and hostile attitudes from healthcare professionals, and little is known about how clinicians view this patient group. Seven semi-structured interviews with Consultant Physicians (n=6) and a Clinical Nurse Specialist (n= 1) working in urban UK Sexual Health and HIV services were conducted. Interpretive Phenomenological Analysis found seven interrelated themes relating to their experiences of care provision: (1) Connecting with the patient, (2) Identifying the needs of trans women, (3) Making sense of healthcare systems, (4) The 'ripple effect', (5) Acknowledging insufficient professional knowledge, (6) Unhelpful perspective and the limits of 'knowledge', and (7) Finding solutions to improve care.

The findings suggest that professionals had an adequate level of knowledge regarding gender inclusive care for TGWLH but expressed concerns at a lack of mandatory and routine training for working with this patient group. Harmful societal, institutional, and internalised attitudes were considered a barrier to care. Intersectional identities among TGWLH, and fears surrounding interactions between hormone therapy and

ART were cited as a further impediment to care. Appropriate knowledge and the ability to foster positive patient-professional relationships with specific knowledge in providing trans-competent care were important. Future research should seek to corroborate the findings from TGWLH to establish if their experiences map onto the views of professionals. Different types of training on gender-affirming and trans-inclusive care would be useful for all healthcare professionals who work regularly or infrequently with transgender women accessing HIV services. This would have implications for reducing anti-trans and HIV-related stigma whilst improving the quality of care in multiple healthcare settings.

Introduction

The World Health Organisation recognises transgender populations as a priority in HIV treatment efforts, and recommends addressing social, legal, and environmental enablers to HIV transmission, as well as measures to reduce discrimination within healthcare (WHO, 2015). In the UK, HIV-related stigma has reduced since the introduction of antiretroviral therapy (ART) meant that HIV became perceived as a manageable condition (Hedge et al., 2021). Despite this, at least 40% of those sampled living with HIV in the UK report at least one form of discrimination in healthcare settings (Wiginton et al., 2021), indicating that HIV-related stigma remains a continued problem.

Overall, transgender people engaging with healthcare services report various negative experiences. Hostility when disclosing their transgender status to medical professionals, mistrust of professionals, prior negative experiences of discrimination, and the low provision of transgender specific services all act as barriers to healthcare access (Bradford et al., 2013). Pervasive misinformation about trans people further breeds prejudice and discrimination which is associated with deleterious health and wellbeing outcomes (Winter et al., 2016). This synthesis of anticipated, enacted, perceived, and internalised stigma among TGWLH are likely to impact individuals at testing, diagnosis, linkage, engagement, and retention of engagement in HIV care.

Transgender women and healthcare interactions

There has been minimal research into TGWLH in the UK. This has resulted in unclear estimates of HIV prevalence rates as transgender women have not been counted in census data (Jaspal et al., 2018). However, some recent data suggests that 4.8% of trans and non-binary people may have an HIV diagnosis (Day et al., 2021). Trans people are more likely to attend a sexual health clinic, have poorer health, greater psychological distress, and lower satisfaction with life than cisgender people (Hibbert et al., 2018; Hibbert et al., 2020).

In experiences of general healthcare, transgender women have reported that they often do not feel heard and understood by clinicians (Hines et al., 2019). It is known that having positive relationships with care providers can help increase engagement in care for transgender women living with HIV (Auerbach et al., 2020; Baguso et al., 2016; Bockting et al., 2020; Sevelius et al., 2021). Transgender or nonbinary individuals report higher levels of their gender not being taken seriously by healthcare professionals (Markovic et al., 2021). They are more likely to delay or avoid seeking healthcare due to fear of prejudice from professionals or a lack of confidence in the services offered (Restar et al., 2020; Smiley at al., 2017). Trans women who face additional intersecting systems of oppression, such as being a woman of colour, may face higher rates of trans and race-related stigma (Hudson et al., 2019).

Resultantly, gender-affirming care and healthcare empowerment have both been cited as important factors for engagement in care and viral suppression (Sevelius et al, 2021a). However, professionals may not know how to manage gender-affirming care alongside HIV care (Bockting et al., 2020) which may lead to a reduced engagement in care. Given that data shows that TGWLH can achieve comparable viral suppression to cisgender counterparts (Poteat et al., 2020), optimisation of the care experience is vital.

Knowledge & Attitudes of Clinicians

Transgender women have highlighted concerns in finding clinicians who are experienced in transgender health (Hines et al., 2019), and a lack of knowledge among professionals and inadequate contact with people who are diagnosed with HIV may be associated with higher rates of HIV-related stigma (Davtyan et al., 2017). Thus, ensuring appropriate competences for healthcare professionals working with transgender people may be an important facilitator to care (Bockting et al., 2020),

Clinicians working with patients diagnosed with HIV may be more likely to exhibit HIV-related stigma if they do not work in settings where appropriate training is implemented (Stringer et al., 2016). Individual characteristics of healthcare professionals may be associated with a higher incidence of HIV-related stigma, such as white ethnicity (Stringer et al., 2016) and may also be driven by historically misinformed interpretations of HIV (Davtyan et al., 2017).

Very little specific research is available on the views of healthcare providers delivering care to transgender women, either with or without HIV. Healthcare professionals have been found to minimise the risk of HIV acquisition among transgender populations (Kimani et al., 2021), but do not demonstrate any differences in knowledge or attitude between professions (Kanamori & Cornelius-White, 2016). Most recently, perceptions and conceptualisations of gender affirming healthcare from healthcare professionals working with TGWLH in the US have been investigated. Lacombe-Duncan et al. (2022) interviewed eight clinicians regarding their perceptions and conceptualisations of healthcare among TGWLH. Multiple perspectives were identified, including the presence of gender-based violence, concerns about feminising hormones, gendered caregiving expectations and anti-trans and HIV-related stigma.

Improving Care

Prior literature has made suggestions to the improvement of care for transgender women. These include improved education for clinicians, adapted medical forms; enhanced interpersonal communication; employing transgender staff, and gender affirmation (Hines et al., 2019). Behaviour change strategies co-facilitated by people living with HIV have shown promising results in reducing HIV-stigma, fear, and improving attitudes among professionals (Nyblade et al., 2018). Basic training relating to terminology surrounding sex and gender, and discussions surrounding gender-inclusive practices have advanced professional knowledge towards trans women too (Allison et al., 2019).

Brief training interventions targeted at health and social care providers have shown promise in improving knowledge, attitudes, and competence when treating TGWLH

(Lacombe-Duncan, 2021b). Technology and social media efforts are becoming more popular, and have been recommended to provide accurate HIV information, medication reminders, and to establish an affiliation with other TGWLH (Holloway et al., 2020; Poteat et al., 2019). Recommendations regarding the avoidance of conflating gender with sex, promoting gender-affirming medical care, and addressing structural barriers to HIV care (Lacombe-Duncan et al., 2022) may be useful in the improvement of HIV related care for trans women.

Impact on the cascade of care

The healthcare experiences of transgender women may have significant implications on their ability to engage at different stages within the continuum of care[1] (CoC). When applied to TGWLH, individuals demonstrate lower rates of receiving care, adherence to ART and poorer HIV suppression than their cisgender counterparts (Kalichman et al., 2017; Lacombe-Duncan et al., 2019). Pre-exposure Prophylaxis (PrEP) refers to medication which is taken to reduce the likelihood of acquiring HIV infection (Centre for Disease Control & Prevention, 2022). Trans-inclusive healthcare providers have been associated with PrEP uptake and adherence among transgender women (Sevelius et al., 2015; Sevelius et al., 2016). Yet, professionals may have less confidence and knowledge when delivering PrEP to trans women (Kimani et al., 2021). Concerns about drug-drug interactions, specifically with hormone use, may be a further barrier to PrEP use (Deutsch et al., 2015).

Overall, being linked into health care is associated with viral suppression among TGWLH (Jalil et al., 2017). However, transgender women are less likely than

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[1] Please see the introduction in the systematic review for an explanation of the continuum of care.

cisgender men or women to know their CD4 cell count and viral load (Kalichman et al., 2017) meaning TGWLH may not be able to make informed decisions about their care. In terms of ART adherence, among TGWLH who are taking hormones, there are lower odds of being on ART than among those who do not use hormones (Baguso et al., 2019). Transgender women receiving ART report significantly lower levels of positive interactions with healthcare professionals as compared to other genders (Sevelius et al., 2010). Since ART is vital for achieving viral suppression and can assist in prevention of HIV transmission (Cohen et al., 2016), it is crucial to maximise effective and gender affirming healthcare encounters to encourage ART adherence.

Theoretical Framework and Conceptual Models

An adapted identity process theory has been applied to transgender women living with HIV. Jaspal et al. (2018a) hypothesise that both structural violence and direct violence can threaten identity, and result in maladaptive coping. Structural violence refers to the way in social institutions may prevent people from meeting their basic needs (Lee, 2019) and may be particularly pertinent in relation to transgender people. One of the maladaptive coping strategies suggested by Jaspal et al. (2018a) is disengagement with care services. However, the provision of and access to gender affirmative services can offer essential support when confronted with adversity. Thus, understanding what may enable individuals to access care, or feel supported to access care will be useful in promoting adaptive coping strategies in the face of an HIV diagnosis.

Another useful theory is the situated-Information, Motivation, Behavioural Skills Model of Care Initiation and Maintenance (sIMB-CIM). This theorises the ways in which adults living with chronic medical conditions may initiate and engage with care (Amico, 2011). Here the model has been applied to HIV care and posits that information received by the person and motivational processes both influence behavioural skills and the outcome of the illness. It situates itself in the context of social-environmental constraints, such as limited resources and structural difficulties. Although this model has been applied to HIV, it has not been used with transgender women living with HIV, who represent an additional complexity of healthcare needs.

A final theoretical model which may inform healthcare interactions is Poteat et al.'s (2013) model of managing uncertainty and establishing authority. It is posited that existing structural or institutional stigma limit the opportunities for training of healthcare professionals, leaving them unequipped to effectively manage healthcare encounters. Both patient and professional may approach healthcare interactions with uncertainty which challenges the traditional framework where the medical provider is expected to have appropriate knowledge to be able to deliver care.

Study Rationale

Transgender women living with HIV have been a particularly neglected population for research efforts in the UK (Jaspal et al., 2018). Additionally, the views of healthcare professionals working with this population have often been overlooked (Lacombe-Duncan et al., 2022), which is important given their power and influence over patients (Poteat et al., 2013).

It is demonstrated by the literature that gender-affirming, and empowering healthcare are important components in promoting health outcomes among TGWLH (Lacombe-Duncan et al., 2019; Sevelius et al., 2019). This highlights the need to investigate the extent that health care professionals themselves are providing these facets of care. Additionally, inequitable access at different states along the continuum of care have been emphasised (Baguso et al., 2019; Jalil et al., 2017; Kalichman et al., 2017), indicating that clinician's perspectives on the different barriers and facilitators to care need to be understood.

Research Aim

Correspondingly, the aim of the current study is to make sense of how healthcare professionals view the barriers and facilitators to healthcare for transgender women living with HIV in the UK.

Methodology

Design

A cross-sectional qualitative design was used, within an Interpretive Phenomenological Approach (IPA; Smith & Shinebourne, 2012). Semi-structured empathetic interviews were employed and were analysed using the latest guidelines (Smith, Flowers & Larkin, 2022).

Participants

A total of seven participants (see Table 4) were recruited, an appropriate sample size for an IPA thesis (Smith et al., 2022). Interviewees had a mean number of 11.9 years working with transgender women living with HIV. Additionally, the median number of TGWLH worked with annually was N = 7. None of the participants had received any formal training in transgender healthcare as part of their core training.

Table 2

Individual Level variables	Participants interviewed (n= 7) N
Gender	
Transgender Woman	1
Cisgender Woman	4
Cisgender Man	2
Pronouns	
She/her	4
He/Him	2
Not specified	1
Does not use pronouns	1
Age Bracket	
26-35	2
46-55	5
Ethnic Group	
Mixed/Multiple Ethnic Group	3
White British/Other	4
Profession	
Consultant in HIV medicine/Sexual Health/Infectious disease/Endocrinology	5
Specialist Registrar in HIV medicine/Sexual Health	1
HIV Community Nurse	1
Length of time working with TGWLH	
1-5 years	3
10 years +	1
20 years +	3
Number of TGWLH worked with in last 12 months	
1-5	3
5-10	1
10-15	1
20-25	1
25-30	1

Inclusion and exclusion criteria

Inclusion criteria:

a) English speaking aged over 18 years and living/working in the UK,

b) Any healthcare professional who had worked with at least one trans woman/ transfeminine individual within the last year whose gender is different to their sex assigned at birth and who has a diagnosis of HIV.

Exclusion criteria:

a) Their risk to self or others was deemed too severe to take part in the study, as assessed by the researcher,

b) Unable to demonstrate capacity or provide informed consent.

Procedures

A purposive sampling and snowball approach were employed where multiple NHS HIV and Sexual Health services were directly approached asking for their interest to take part in the study. The research team had prior links with clinicians due to previous discussions regarding TGWLH (see section 4, ‘reflections on recruitment’ for further information) and were approached initially via email. Clinicians across multiple trusts London and Brighton were provided with specific details about the study (see Appendix E). All participants were recruited from Brighton or London HIV and Sexual Health Services. Participants were provided with an information sheet and consent form (see Appendix F & G), with the opportunity to ask any questions.

Participants were informed about how their data would be used, and that they could withdraw from or terminate the study at any time.

Data collection

Prior to the interview, participants completed a demographic questionnaire (see Appendix H). Characteristics including age, ethnicity, professional background, and number of patients worked with were collected to help contextualise the background of the participants (see Table 4). Semi-structured interviews were conducted remotely using a private and unique Zoom link with a randomly generated password. Interviews lasted between 45 and 90 minutes and were all conducted by the primary author.

At the end of the interview, participants were given the opportunity to reflect on their experience and were offered a list of support services, which was declined. No participants demonstrated any evidence of significant distress or discomfort.

Interview guide

The original interview guide was developed in collaboration with the primary author, academic and field supervisors as well as two Experts by Experience (EbEs) living with HIV or identifying as trans. The EbEs were consulted to comment on key participant documentation including the participant information sheet, interview schedule, consent form, and demographic questionnaire. Changes to wording and around the use of language were helpful to encourage the use of inclusive and affirming language. The academic supervisor supplied feedback on interview transcripts which further shaped the approach of the interviews. Although the topic changed from interviewing TGWLH to professionals (see section 4, 'reflections on recruitment), much of the content remained highly relevant. Interviews were then adapted to question professionals and sought to explore participant's perspectives of HIV care among TGWLH and asked questions such as *"what is your knowledge around medication adherence among this group?"* and "*to what degree do you think is HIV care and gender-affirming care integrated?"*. The full interview guide is displayed in Appendix I.

Remuneration

All service users involved in the study were entitled to a small payment for their time. Experts by experience were provided with a £25 voucher in exchange for their feedback and document changes. Interview participants were also provided with a one-off £10 voucher for their time and sharing of experiences.

Epistemological considerations

Phenomenology

Phenomenological approaches are concerned with how people experience the world during particular contexts at particular times (Willig, 2013). IPA makes sense of how people experience their world as they reflect on the importance of an event, and it involves a 'double hermeneutic'. This is concerned with the researcher making sense of another person making sense of their own world (Smith et al., 2022). A positivist approach employing quantitative methodology would likely denote "*reductionist or* *associationistic assumptions*" (Spinelli, 2005, p.33) and thus may not capture the experiences of participants so richly.

Thus, IPA is suitable for examining healthcare professionals' experiences of providing care, which is a unique and highly personal event, and necessitates the need to be explored and understood from the perspective of the participant.

The study employed a feminist approach to implementing IPA, which whilst emphasising women's experiences and voices, recognises that patriarchy continues to exist within different elements of the research domain (Clifford et al., 2018). This fits well with conducting research regarding gender diversity, where feminist scholarship in some parts of the world has been interwoven with trans activism, sexuality, and queer studies (Macleod et al., 2014). Moreover, feminist standpoint epistemology places women at the core of the research and uses women's "concrete experiences" to build a true and accurate representation of their experiences (Brooks, 2011) and in this way is adjunct to the aims of IPA.

Reflexive Statement

This research itself was borne out of the rejection of a gender critical (GC) standpoint which ostensibly appears trans-inclusive yet harbours a strong hatred towards transgender populations. Researchers or scholars who label themselves as GC often advocate a stronghold over women's spaces for cisgender women while excluding trans women (Zanghellini, 2020). These perspectives are erasing the voices of trans women who are weaponised as being potentially dangerous or harmful to cisgender women.

The primary investigator vehemently rejects this so-called gender critical stance and denies that feminism can be labelled as so when it subjugates the realities of trans lives. Instead, the IPA approach intends to understand the realities of individuals and make sense of the phenomenon they experience (Smith, 2009), which is in line with transgender affirming and inclusionary care.

Sampling

A purposive sampling approach was employed with the intention of a homogenous sample, an important factor in IPA so convergence and divergence can be examined (Smith et al., 2009). The purpose of phenomenological projects is to understand the detailed meanings and processes individuals ascribe to themselves and their experiences (Hesse-Biber & Leavy, 2012; Smith et al.,2009). Thus, it was inappropriate for the sample size to be large since this would prevent the comprehensive analysis of participant's realities. It is recommended for professional doctorates that between four and ten interviews is an appropriate range (Smith et al., 2022), thus this approach was adopted, with one interview conducted per participant.

Analysis

Quality standards

In any type of qualitative research, credibility, authenticity, criticality, and integrity are considered primary criteria to be adhered to when measuring validity (Whittemore et al., 2001). Credibility and authenticity were demonstrated by ensuring that an accurate representation and interpretation of the data was made. This was managed through multiple reading and re-reading of transcripts and themes in an attempt not to deviate too far away from the original meaning. Themes were also regularly discussed and reconsidered with the primary supervisor. Criticality and integrity refer to paying particular attention to the assumptions and biases of the researcher (Whittemore et al., 2001). Biases and assumptions were considered in annotated notes and throughout the interaction with participants as well as considering the context within which they recruited, namely NHS services in different geographical and socioeconomic locations.. Efforts were made to conduct member checks (See Appendix N) to ensure participant perspectives were understood and represented correctly.

Transcription

All interviews were audio-recorded and transcribed verbatim by the primary researcher. The supervisor gave constructive comments on multiple aspects of the interview. This included observing that the phrasing of questions that were potentially leading, closed-ended, or not sufficiently reflexive and by providing suggestions for improvement. The supervisor further provided feedback regarding potential lines of inquiry and exploration during the interviews and how attending to the affect or emotion of the participants may be useful.

Analytical Process

The data analysis was conducted by the primary author. The analytical process was informed by IPA guidelines and supervisory feedback. The interview data was analysed in accordance with general guidelines for IPA which acknowledges that rigid rules do not exist (Pietkiewicz & Smith, 2014; Smith et al., 2009). These are concerned with the following three processes:

1. *Multiple reading and making notes*

   Initially the transcripts were read and listened to multiple times. Notes were made regarding the interviewer's perspective and reflections of the interview. Differences and privileges between interviewer and interviewee were considered, particularly regarding an inherent power differential.

2. *Transforming notes into Participant Experiential Themes (PETs)*

   Here the notes were translated into emergent themes. For instance, questions were asked around experiences of healthcare, so themes arose which related to individuals' appraisals of these, and how they made sense and meaning of their realities.

3. Seeking relationships and developing Group Experiential Themes (GETs)

Next, themes were considered from a convergent and divergent perspective, examining what was similar and what was different in people's experiences and interpretations. This differed due to varying sociocultural backgrounds, demographics, and professional qualification and experience.

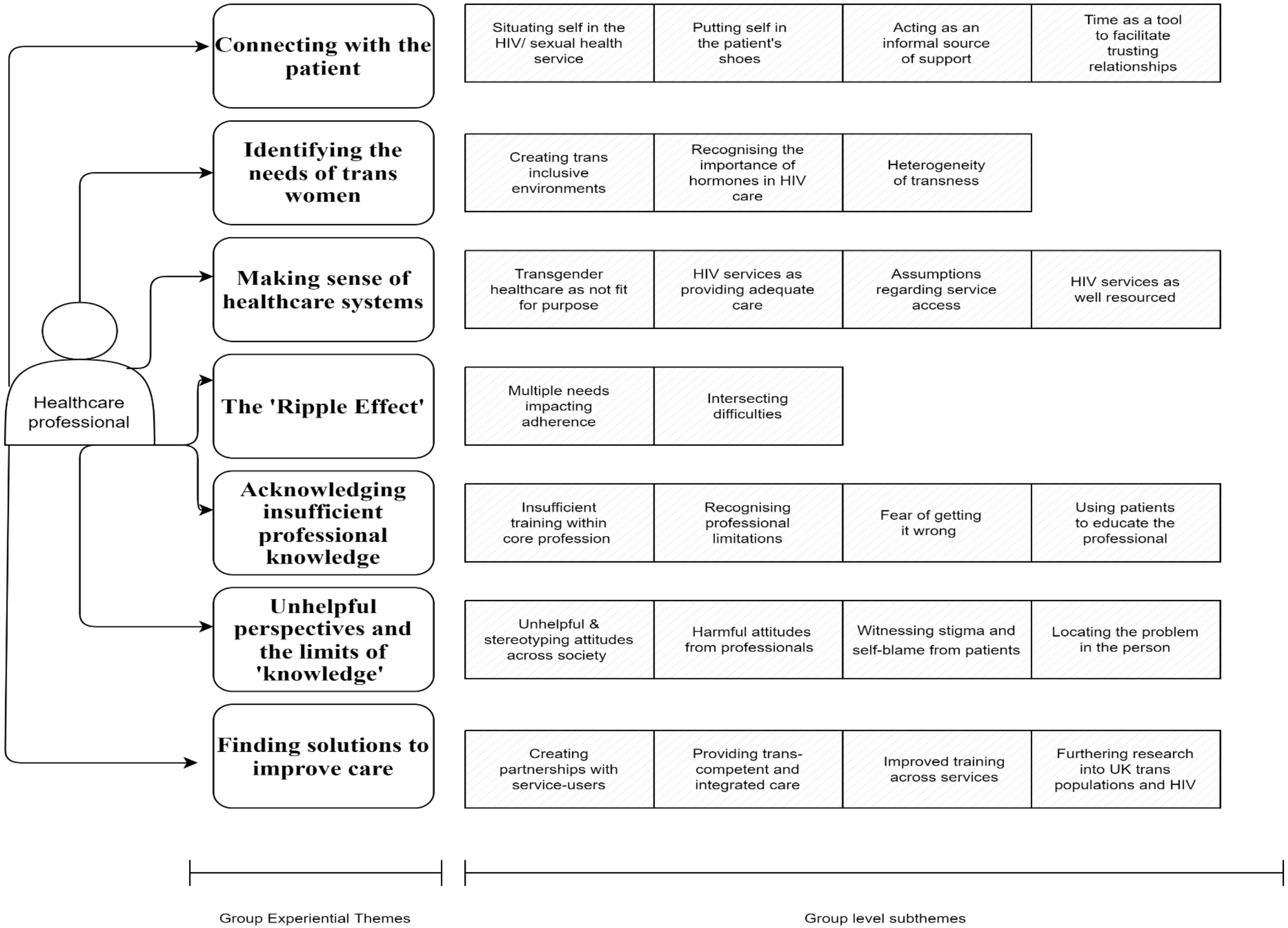
Ethical considerations

Prior to the commencement of data collection, Royal Holloway, University of London provided ethical approval ensuring that the study was safe to be conducted (see Appendix J). Given the interviews involved potentially sensitive topics, it was important that potential harms were considered carefully. The risk of harm was managed through a detailed informed consent procedure, assessment of capacity and reminder that the participant could withdraw from the interview at any time. The British Psychological Society's code of research ethics was consulted (Oates et al., 2021) to encourage ethical practice. At the end of the interview, participants were given an opportunity to provide feedback. Supervision was received from an academic supervisor who has extensive research and clinical experience in the subject of HIV.

Results

Seven interrelated, yet distinct, group-experiential themes (GETs) arose from the semi-structured interviews (see Figure 3). These were comprised of group-level subthemes which evidenced the multiple perspectives and experiences of professionals' views. Group Experiential Themes (GET) are described below and illustrated by the corresponding subthemes therein. An example coded transcript of exploratory comments, and experiential themes are displayed in appendices K-M.

Figure 3



Participant experiential themes

Adapted from Pagnini et al., (2018)

Group Experiential Theme 1: Connecting with the patient

Participants spoke about a range of different processes to describe the way in which professionals demonstrated situatedness with their clients. Through various cognitive and behavioural processes, professionals appeared to draw on a selection of methods to further increase and positively strengthen their clinical relationships with their patients.

Situating the self within the HIV/Sexual Health Service

Participants spoke about their journey of coming to work in the field of HIV. It was a common theme that professionals spoke about being accepted and welcomed in working in sexual health and HIV services. For instance, Sarah stated "*people are open and friendly and non-judgemental"* when speaking about the colleagues she worked with early in her career. Moreover, Zahra spoke of how there was a moment where she felt that she finally believed she was working in the right place:

"….it never kind of felt like I found a tribe, people that I could really gel with and work with until I decided to go back to sexual health." (Zahra)

Similarly, Vincent shared this belief stating **"***I'll never forget that sense of, oh my gosh, I found my tribe. I found the people that I get on with and it's okay for me to be me."* This was a theme across multiple participants working in different teams reflecting on the inclusivity of services.

Putting yourself in the patient's shoes

Linked to an inclusive workplace was the idea that professionals mentalised what it may be like to live as a trans women with HIV:

"*…And safe spaces, even simple things like male and female toilets and all the controversies around that. I can't imagine being a trans person and coming into hospital and then just doing something straightforward, like using the toilet because there isn't one that is suitable for them or one that they would feel comfortable using."* (Amy)

Amy's use of "*I can't imagine*" suggests she perceives an extreme difficulty in the ability of trans people to use gendered hospital facilities, but also sees it as unfeasible to fully recognise the challenge of being a trans person in this setting.

Likewise, Sarah began to envisage what it would be like to live as a trans women by saying *"I can only imagine or try and empathize with what that must be like about having to jump through all those hoops just to access something [*healthcare*] that's fundamental to who you are."* This suggested a difference to Amy's perception as Sarah possibly found it easier to imagine a person's difficulty and distress.

Liam specifically reflected on his own experiences reporting that "*I've been stigmatised over my life for different reasons and been part of minority, so I know how that feels"*, suggesting he used his own experiences of being marginalised to connect with the adversities of others. Thus, by participants situating themselves as the patient, or drawing on their own experiences of adversity this appeared to elicit empathy and therefore humanise the patient.

Acting as an informal source of support

Professionals further spoke about how being approachable and reliable was important in clinical practice:

“…. it’s a funny way of saying it, but like you've got their back, like you, you're there to support them and whatever they decide because they're in charge of their health, you're there to kind of help them and guide them and support them and have their back when things get difficult” (Amy)

The idea that Amy has “*got their back*” suggests a relaxed style of support, almost akin to that of a friend. One consultant medic likened their professional role to friendship itself stating *“I am their friend more than their doctor in those circumstances and listen”* (Daniela). Correspondingly Vincent said,“*all my patients call me [*first name*], I wouldn't expect anything else*”. These comments suggest the role of the professional as being viewed partly a friend who provides unreserved support.

Time as a tool to facilitate trusting relationships

Some clinicians observed that the period spent with patients was conducive to a positive and effective alliance. Amy noted that “*we are lucky in that we have a very long therapeutic relationship with our patients”* Moreover, another reported *“because they are under our care for years for years, they are the most stable patients in the long-term follow up. I think that they feel accepted and treated equally”* (Adelle).

These statements suggest the temporal nature of a clinician and patient relationship, indicating that the length of time a person is seen in clinic may promote a better outcome according to the view of the professional. Likewise, Sarah’s comment suggests that a longer relationship with a patient allows for a holistic view of the person: “*then I think over time, you get to know someone, what their family setup is, what their home setup is, what their job is”* (Sarah).

Group Experiential Theme 2: Identifying the needs of trans women

Another pertinent theme that arose from the interviews was clinicians frequently identified the clinical and psychosocial needs of trans women under their care. This was characterised through a range of different subthemes:

Creating trans inclusive environments

Here, participants considered the different elements that characterised a trans inclusive and competent clinic environment. It was implied that this related to all aspects across the continuum of care with one participant remarking:

"I think offering an environment where trans women feel safe when they test. Safe not only within the experience of testing, but also, if they test positive, they know that they are accepted and supported." (Daniela)

The idea of women feeling safe when they accessed care was echoed by the idea of decreasing discomfort: "*usual things like the toilets and the pronouns and how you call somebody from the waiting room and…things that might make people feel more or less uncomfortable at this space."* (Amy)

Adaptations in the healthcare environment were appraised by professionals as being crucial to increasing acceptability and suitability of trans women's care. Amy's statement regarding use of pronouns was mirrored by another clinician who purported that "*asking people about their gender and including trans, you know, male or female and including trans males or trans females, you know, being explicit*" (Zahra). Liam deliberated "*I don't think people understand how important it is to the person who is asking for those pronouns to be used and what effect it could have on them*". These remarks suggest a comprehension around trans-competent care but indicate that maybe not all clinicians understand the necessity to use pronouns. Similarly, another clinician raised the problem of accurately recording gender diversity:

"I do believe that there is a lack still of coding...In our clinical system there is no option for trans women…So sometimes you can't even identify the person sitting in front of you as a trans woman, and maybe this could have an impact on the type of the care that this person receives. But on the other side, it can make things, you know, non-judgmental. Nevertheless, I do think it should be coded." (Adelle)

Adelle's statement suggests that she positions the non-recognition of gender diversity as resulting in less disparaging attitudes, however a lack of accurate recording of gender could result in adversely affected care.

Other ways of formulating trans-inclusive environments were the appreciation that all staff had a responsibility to provide positive interactions, and this was not solely limited to clinicians, as noted by Vincent:

"We have one receptionist…She's unbelievable. I don't know how she does it. She just makes everybody feel special and she's infamous for it in the city I think." (Vincent)

Recognising the importance of hormones in HIV care

All participants spoke about the use of hormone therapy to support with transition among their transgender clients. There was a general understanding that not all patients used hormones and it was dependent on the preferences of the individual. Interviewees described how that among those who did take hormones, it was a very important aspect of their healthcare:

"…*And the hormones are very much almost like a lifeline, the thing keeping you afloat.*" (Zahra)

"It seems when I'm talking to people about HIV, it seems it's a less of a priority…. what we end up talking about a lot is about their hormone treatment. It seems to me like that's the most important thing" (Sarah)

Clinicians understood how patients often placed hormone care as central to their healthcare, sometimes above HIV. Participants further considered that there may be an interaction between ART and hormonal therapy which could negatively affect their ART adherence:

"If we think about what happened in the past, that those sort of messages started to get out and actually people then stop taking their antiretrovirals so adherence to their treatment that was affected…" (Zahra)

"*The major concern of trans populations, like 'when I start this therapy, is this going to affect my hormones?' because this is like the focus of, it's their focus."* (Adelle)

These statements suggest participants conceptualised trans women as anxious of the interaction between ART and hormonal therapy. One participant cited that holistic care may be one way of addressing this:

"There are data in the literature that shows that… HIV clinic[s] *that deliver care to people who are trans, if they also are able to prescribe hormones, they increase the retention to care."* (Daniela)

Heterogeneity of transness

This subtheme saw clinicians verbalising the heterogeneity and diversity among the trans population. For instance, Daniela reported that *"There's not one trans woman, they're all different. People are all different"*. This suggests an appreciation of the individuality of her trans patients within her cohort. Similarly, Zahra spoke of the importance of comparing patients to individuals in a clinician's life:

"When you see people, as you, as your friend, as your partner or as your child or, you know, whatever, neighbour or someone like that, you see people outside of that medical context, then you see that person as a human being" (Zahra)

Zahra's comments suggest that by professionals imagining trans women outside of a medical setting it is easier to see a '*human being'* who is more relatable as an individual similar to a friend or family member rather than one homogenous group.

Group Experiential Theme 3: Making Sense of Healthcare Systems

This theme portrayed how professionals theorised the advantages and challenges of HIV care for trans women and broadly incorporated perspectives around how transgender healthcare is currently ineffective, under resourced and not continually trans-competent.

Transgender healthcare as not fit for purpose

This subtheme suggested there was an awareness from participants that the current services in place were not effective:

"But I've been brainwashed almost. You know what I mean? I would bet if you talk like this to a GP [regarding providing more time to a trans patient], *they just look at you and say, 'But I have 500 patients to see this week and prescriptions to do. What are you talking about?' I think that's where the kind of problem is."* (Daniela)

Daniela's posits that primary care services are overstretched and unlikely to provide longer consultations to patients. She suggests that she is '*brainwashed*' implying a disconnect between how she believes services should be, compared with the reality. Similarly, another participant recognised further difficulties in healthcare:

"The Swiss cheese model that led to this point. One of those huge factors is that there is no alternative provision that works. There is no working system for gender care." (Sarah)

The '*Swiss cheese model'* suggests a perception by Sarah that there is ineffective care and no appropriate system in place.

Navigating gender competent healthcare services

A related but distinct subtheme was the view from interviewees regarding how difficult it was for both patients and professionals to navigate through different services to ensure effective care:

"You need your HIV care, so you come and have your bloods done, then you see me, then I prescribe it, then I'll write to your GP and the system just works like that. It feels like women, they have to take it on themselves to get their blood tests done and then get someone to interpret those blood tests and then communicate that to their GP and get that prescription, and then follow up that prescription when it's not come through…" (Sarah)

Sarah's comments imply her perception of a fragmented trans-inclusive service, highlighting the backwards and forwards between patient and clinicians to obtain correct medication for a patient. Her use of '*they have to take it on themselves'* suggests an unfair expectation on patients to circumnavigate through different barriers and receive appropriate care. Equally, Daniela stated similar struggles:

“The waiting time at the [gender identity service] *is forever, so that is a real challenge. I have faced this a few times with some of my patients where you try to help them, you do the referral a year later, they're still waiting…. It increases anxiety, depression, fear, loneliness, isolation...”* (Daniela)

The waiting time to receive specialist gender care may contribute to emotional difficulties and seclusion among patients. Daniela’s comments suggest frustration on the part of the professional who made the referral by stating that ‘*they’re <u>still</u> waiting.*’

Assumptions regarding service access

Although participants noted the distinct and individualised care that trans women required, they also held views regarding their trans patients and the extent to which they are able to access particular services or appointments:

“If you or I had an abscess we would have to go to a doctor, be seen, get treatment, go pick the prescription up. But she won't do any of that. She, she won't go and see anyone…” (Liam)

Liam’s comments suggest a different view of himself and the interviewer compared to one of his patients. He uses the term ‘*she won’t’*, highlighting that he views she may be making a choice not to engage with appropriate care. Another comment which appeared to diverge from previously held views was that of Adelle who stated the following when discussing barriers to service use:

"They have the same issues that any other person living with the HIV would have you know. Like problems with phone lines not working, but nothing specific to trans women." (Adelle)

Adelle's statement suggests she believes that when accessing services, trans women *'have the same issues'* and homogenises this group with others accessing HIV care and implies there are no specific difficulties among trans women regarding care access.

Appraising HIV services as providing adequate care

Even though participants considered that specific care relating to gender healthcare needs were under resourced, some participants thought of HIV services themselves as being generally proficient in providing care:

"*HIV is still a very, a very well-resourced disease area, and I think that's because of the health inequalities that are seen in our patient population."* (Amy)

Amy regards HIV as a disease which is appropriately resourced, she views that this could be due to disparities in this group, however it is unclear what these inequalities may be. Relating to this Daniela formulated the differences between the UK and European care:

"*The relationship with sex is culturally completely different than the rest of Europe. The application of this knowledge into HIV is one of the reasons why we are so good and so open-minded, and so open to diversity, and that I think allows us to run services that are accessible and that's why we have so low lost to follow-up, including trans people."* (Daniela)

Daniela comprehends HIV care in the UK as being culturally different to other countries due to her perspective of increased societal openness to diversity. She therefore attributes this as meaning that more trans people are engaged and retained in care.

Group Experiential Theme 4: The ‘ripple effect’

This theme employed the language a participant used who described the ‘*ripple effect’* to explain the range of interrelated difficulties a patient may face which could have negative implications.

Multiple needs impacting ART adherence

Participants described various needs and complexity that affected the ability of trans women to take their HIV medication:

“*It's just an unachievable goal, dealing with whatever it is in their lives that's causing them issues is obviously the first priority before you can then get them to take their tablets seriously.”* (Amy)

Although not referencing specific difficulties, Amy emphasised that patients who have opposing needs may not take their ART as prescribed and her comment suggests that she perceives medication as a professional goal for patients to adhere to. Similarly, Liam described an array of requirements which may impede an individual’s ability to reliably take their medication:

“*I've been dealing with, you know, housing and engaging her with the trans GP and but then I guess you've got to...think, well if none of those is being dealt with then... she's unlikely to keep her engagement up and adherence. So, things have a ripple effect. And that's kind of a lot of what we do in our job isn't directly about their* *adherence. It's kind of making sure everything else is in place so that doesn't impact their adherence." (*Liam)

Intersecting difficulties

This theme recognised the overlapping psychosocial and systemic issues trans women may face. For instance, Amy remarked that individuals may have '*significant trauma'* even before being diagnosed with HIV. Liam stated that one patient he saw had mental health problems, drug dependency, was facing eviction and appraised the woman as having "*a lot on her plate*". Correspondingly another participant discussed "*holistic*" issues for the population:

"*Also, it's important, …to think about over holistic well-being issues for people living with HIV. I guess that's particularly pertinent with transgender women who can really struggle with issues around depression, mental health, suicidality, and just feeling that they're* [not] *fitting into society.*" (Vincent)

This demonstrates Vincent's view of trans women as contending with psychological difficulties and struggling to feel an included part of society. His use of "*particularly pertinent*" suggests that for him, this population may have to cope more frequently with obstacles in addition to being HIV positive.

Another participant also considered the interconnectedness of trans women's lives:

"All of these things could disadvantage a person in this setting for example. I think they all come from the stigma of being or society's stigma that puts on trans women. That's why trans women do more sex work or have higher rates of mental health diagnoses or substance misuse. Alongside that, then comes increased risk of

HIV…where you…have very little power as a member of such a marginalized group that society shuns…" (Sarah)

Sarah's statement suggests a degree of certainty in the population through her use of '*that's why*' and '*then comes'* when describing mental health and HIV risk. This suggests the participant has a causal understanding of the reason why women engage in sex work or experience psychological distress or use drugs is due to stigma.

Likewise, Zahra describes stigma due the duality of belonging to a gender minority and having an HIV infection:

"*And it's the there's an intersectionality between the stigma associated with living with HIV and stigma associated with being trans and those two, you know are quite a potent mix*."

(Zahra)

This implies that by being concurrently trans and living with HIV, individuals may face further stigma. The use of the term '*potent mix*' suggests how powerful and difficult it may be.

Group Experiential Theme 5: Acknowledging Insufficient Professional Knowledge

This theme describes the realisation that professionals may not continually have correct knowledge and understanding of this patient group due to poor professional training and often inaccurate knowledge.

Insufficient training within core profession

Here, most participants acknowledged there was a lack of trans specific training, both for HIV and other health issues either when they were completing their medical or nursing training and throughout their professional career.

One participant stated that her training was non-existent which prompted her to develop and provide trans specific training herself (Zahra). Another interviewee explained:

"*.... It was not part of my medical school education. It was just something that I learned on the job, I guess, seeing patients in clinic... there's a lot of movie portrayals of transgender women with HIV and their experiences of living with HIV and also communicating and navigating health systems...more than you ever get in any curricular*." (Vincent)

Vincent concludes that there is a significant absence of appropriate training. For him the training is so inadequate that popular culture has provided a greater level of knowledge. This is mirrored by Amy who described that she had felt *'very ill equipped'* to provide appropriate support to trans women.

Recognising professional limitations

This subtheme characterised how some participants felt comfortable in the limits of their professional knowledge:

"I think clinicians, as a whole, have got a lot better at saying, actually, I don't know a lot about that. I'm going to read about and we'll get back to you. And that's certainly what I say to people now." (Amy)

Here Amy presents as feeling comfortable with uncertainty and makes effort to build on her knowledge before returning to the patient with a more informed view.

Similarly, Daniela explained '*there is nothing wrong in being humble and honest'* when explaining it is acceptable to communicate to a patient the parameters of one's knowledge.

Fear of getting it wrong

A related yet contrasting subtheme related to some professional's concerns about being 'wrong' in their clinical interactions with trans women who lived with HIV:

"*I'm scared that I might miss… some of the issues or symptoms if I miss the fact the person in front of me is a trans woman or a trans man."* (Adelle)

This participant explained their worry regarding omitting certain tests such as prostate, cervical or breast cancer screening that was typically gender specific.

A related worry was exemplified by concerns over interpreting test results:

"*I'm not 100% confident in how to interpret these blood results. I hope I'm doing the right thing. Also, I don't want to get in trouble with the GMC for doing something wrong*." (Sarah).

Sarah explained her fear that she may get in trouble with her professional regulatory body for providing incorrect care. This shows the extent of Sarah's worries of causing inadvertent harm which could suggest this could affect the medical care she provides.

Using patients to educate the professional

Drawing on the patient's knowledge to inform the professional was an emergent theme:

"I saw a patient yesterday and I was intrigued by the hormones, so I just asked her, you know, what's that one for? What's that one for?" (Liam)

This evokes a sense of Liam’s curiosity about a trans women’s hormonal medication and his unapologetic approach to questioning the patient. Another participant suggested this process was potentially problematic:

“*I think a lot, a lot of us as trans people have had to go in with information to educate our GPs, to educate our doctors.*” (Zahra)

Zahra’s comment draws on her lived experience of being forced to educate health professionals and it evoked a sense of frustration in her tone. This suggests that it is an unwelcome experience for her as a patient to educate the professional.

Group Experiential Theme 6: Unhelpful Perspectives and the limits of ‘knowledge’

Participants generally recognised unconstructive comments and beliefs that were held by society, within their service, their professional self and within patients themselves. The term ‘knowledge’ was used to suggest that knowledge is socially constructed, and one person’s truth may differ from another.

Unhelpful and stereotyping attitudes across society

This was a prevalent subtheme which contextualised participant’s observations of the problematic widely held views of trans people:

“Changing society is very difficult. We think we're making headwind and we get Trump and we get Johnson so actually now our politics is becoming more right-wing than it was 20 years ago. These things are always going to pop up, aren't they? People who live in the shadows, in minority, in marginalized parts of society are always going to suffer when that happens.” (Vincent)

This statement suggests that the participant views governing political systems as a barrier to inclusive care of trans women. The perception that '*politics is becoming more right-wing'* is formulated by the participant to mean that when this occurs trans women continue to endure difficulties. Comparable statements indicated "*many people still have very, very, very strongly held incorrect beliefs about HIV*" (Amy) and "*there's just lots of pockets of society like that that need challenging*" (Liam) suggesting an acknowledgment of widespread prejudicial views.

It was acknowledged by some interviewees that such stigmatising views led to an uproar in the media such as, '*headlines about trans women in female spaces and all this nonsense' (*Sarah) or "*in the press that there's this just this ramping up of the hysteria around trans women using women's toilets*" (Zahra).

Harmful attitudes from professionals

Participants further recognised problematic attitudes from professionals working in the field which resulted in some inequitable and questionable views:

"*But in the health care system, there is a morbid interest... in the details that are outside of their clinical care…. Is there a penis or is there a vagina basically, it's like it is a big thing for everybody including my SpRs, my junior doctors…*" (Adelle)

A '*morbid interest'* represents a controversial and intrusive view of trans patients where there is an undue focus on genitalia. The participant remarks how in her experience, all spectrums of the medical profession have expressed this view, suggesting an element of surprise. A related statement suggests that a trans person seeking care may be asked about unrelated aspects of their gender:

"V*arious people have recognized this phenomenon afterwards, where this trans woman goes into A&E with a broken arm and gets asked about, "What hormones are you on? How might they be contributing?"* (Sarah)

Witnessing stigma and self-blame from patients

Participants remarked on the internalised and anticipated stigma that some patients may experience:

"*I think it's partly external stigma that they experience from other people, but I think it's probably a little bit of internal stigma as well, potentially from HIV itself. A lot of people directly link their actions to the development of HIV as well. Usually incorrectly, but that's the link that they make in the head…. And that's true for people I've met who have been trans as well."* (Amy)

Amy's comment suggests she perceives an internalised sense of blame whereby patients may link past traumas to potentially influencing their behaviour and HIV acquisition. She recognises that there is prejudice from outside the individual, but the statement '*directly link their actions'* and '*incorrectly*' suggests an erroneously causal inference is made by patients, which is likely to be a form of internalised stigma towards the self. A related view was also that patients may anticipate stigma from healthcare interactions: "…. *they might have experienced negative experiences within healthcare already, and so fearful that that happens again*" (Daniela). She further explained: "*someone that might experience an internalised stigma, you need to spend more time to make sure that you comfort them, you support them, and you answer their needs…"* (Daniela). This statement implies Daniela's awareness of patients who may self-blame and how crucial it is to ensure clinicians are supportive and take their time during clinic appointments. Participants recognised resources which allowed clinicians to provide adequate support was believed to be an important factor in reducing internalised stigma.

Locating the problem in the person

Professionals occasionally situated the patient's difficulties within the person as opposed to using language which understood the structural barriers and inequalities around a person. For instance, Adelle used the phrase "*chaotic lifestyle*" to describe the impact on a person's adherence. Similarly, Liam described: "*and then there are some that I can't imagine will ever be discharged because they're so dysfunctional*" indicating he views the person is "*dysfunctional*" as opposed to considering any external factors meaning they may require ongoing care.

Group Experiential Theme 7: Finding solutions to improve care

The final overarching theme described explicit suggestions that interviewees made regarding improved care for trans women. The suggestions fell under different subthemes relating to creating partnerships, increasing training, providing competent care, and drawing on the resources of others.

Creating partnerships with service users

Professionals identified the value of developing partnerships with service users to improve services:

"*What we can do is provide a really open environment for people to constantly reflect on how our service looks…take on negative feedback from patients about what happens to them in that clinical environment and change that.*" (Vincent)

By creating transparency and an openness with patients this was seen by professionals as a key strategy to improve on the efficacy and acceptability of services. Similarly, the idea that service users '*hold our feet to the fire'* (Zahra) denoted that being held accountable was important to improving care and how clinicians can '*make the service better*'(Zahra).

Multiple participants acknowledged that peer support for patients was important to retention in care; '*I think meeting other people with HIV helps'* (Liam). Daniela shared a similar sentiment stating '*I think there is peer support. People can support each other'* when discussing adjustment to an HIV diagnosis, suggesting that other people with lived experience have an important role to play in coping with the diagnosis. Moreover, one participant raised the idea of *'acceptance'* by a community:

"*I think acceptance by the community is a huge part of it, whatever community that you are part of."* (Sarah)

Providing trans-competent and integrated care

In addition to service user involvement and co-production, the idea of advancing current guidelines and providing equitable care was significant to many interviewees:

"*So, I think it would be amazing to have the guidance of trans HIV services and trans health incorporated in both BHIVA and European Medical Agency Guidelines.*" (Adelle)

The idea of providing specific guidelines was comparably important to the notion '*special care'*:

"*So, I think that and you know what, what I want to say is that's the really big thing I want health care providers to know that, you know, you're dealing with a minoritized, a stigmatised population that you have to take special care of. You know, equality isn't good enough, providing the same care to everybody isn't good enough…*" (Zahra)

Zahra's perception is that equal care of the same standard for everyone is not akin to individualised or bespoke care for a marginalised group. Sensitive care that is tailored to an individual's needs could also be linked to the notion of providing combined care across both trans healthcare and HIV services:

"*The integrated care may increase motivation to attend services and deliver better care, so I think there should be a choice. I think it's a very good idea.*" (Daniela)

Improved training across services

To support with enabling trans-competent and excellence in care, the need for further training of healthcare professionals was discussed. One participant explained training should take place with repercussions for discriminatory behaviour:

"*Make sure that there is formal training for clinicians around… sexual orientation and gender. Also, make sure that people are aware that kind of behaviour is never going to be tolerated and the people should not be allowed to get away with that kind of prejudice behaviour.*" (Vincent)

This suggests Vincent's stance on prejudice and how he believes it should not be tolerated in professional settings. Another participant raised the need for not only training in specialist care, but widening the knowledge of primary care clinicians:

"*...Make sure that we train everybody. Not only sexual health, and so, you know where, of course, it's optimal, but also other areas of the country and so on. GPs, I think primary care is really important*." (Daniela)

Furthering research into UK trans populations and HIV

Some participants discussed the limits of research into trans women and HIV:

"*There are definitely studies showing that around the world that the trans population because of many things is more prone to being infected with HIV than the non-trans population. But it depends you know, we can't generalise."* (Adelle)

Consequently, Adelle is questioning the generalisability of these research findings in the UK and whether trans people are more at risk of HIV infection. Similarly, another participant stated:

"*It's basically an established fact that trans women are at high risk of HIV globally, but when you look into the evidence behind that, we just don't have much evidence for anything to do with trans people, because we don't even know how many trans women there are in the UK. How do we know whether they're at higher risk of HIV or not?"* (Sarah)

Discussion

This study explored healthcare professionals' perspectives of the barriers and facilitators to care among trans women living with HIV. Seven clinicians comprising of six physicians and one nurse took part in interviews exploring their experiences of working with this patient group. Seven group experiential themes (GETs) were identified, and twenty-five subthemes were conceptualised which defined the GETs. The findings were displayed in a schematic representation of themes as discussed previously (Figure 4).

Overview of Findings

Strengthening clinician-patient relationships

All participants reflected on the degree to which they relate and empathise with their patients who are transgender women living with HIV (TGWLH). Cognitive and behavioural processes such as imagining oneself as the patient, and behavioural pursuits such as being approachable and friendly, or being patient and giving time to support effective clinical interactions were important and may be translated into an advanced understanding and empathy towards the patient. These findings are in direct comparison to the phenomenon of dehumanization in health-related settings. Dehumanization in medical settings can be viewed as impersonal care, reduced empathy and support, and an overreliance on efficiency and standardisation of care (Haslam, 2006). Dehumanization in health settings may deny human uniqueness, and the use of dehumanizing metaphors about individuals can have negative consequences in terms of the provision of patient centred care (Diniz et al., 2019). By contrast, empathy is considered a key component to quality healthcare delivery (Irving & Dickson, 2004) and may allow for eliciting enhanced therapeutic change where patients feel more comfortable to express their concerns (Moudatsou et al., 2020). Among trans women specifically, it has been reported that those who felt heard and understood by healthcare professionals were more likely to trust their clinicians and continue to engage in care (Hines et al., 2019).

Recognising transgender-specific needs

Each participant identified the specific nature and sensitivity that trans women require when accessing healthcare. This was principally characterised by recognising the need for a welcoming and inclusive environment where all staff are proficient in working with gender diversity. In this sense, gender affirming care can be defined as: “interpersonal, interactive processes whereby a person receives social recognition and support for their gender identity and expression” (Sevelius et al., 2019, p3). Ensuring appropriate pronoun-use and recording gender accurately were also seen as important factors. This finding relates to research documenting that healthcare professionals working with TGWLH understand the importance of gender-affirming care (Lacombe-Duncan et al., 2022). Similarly, the current findings complement previous recommendations which suggest important modifications to standard care such as appropriate recording of sex assigned at birth and gender identity on record forms (Hines et al., 2019; Reisner et al., 2016). Using non-stigmatising, non-pathologising language, respecting current gender identity, and using chosen names or pronouns is also highly valued (Bouman et al., 2017; Pampati et al., 2021). Similarly, gender-affirming care at all stages of the HIV continuum is important to TGWLH (Sevelius et al., 2014). Different types of gender affirmation exist, encompassing four dimensions;

social, psychological, medical, and legal (Reisner et al., 2016), indicting the need for clinicians to understand the different ways they can provide a gender affirming framework of healthcare.

The findings of the current study diverge from the findings of recent UK research exploring the knowledge of professionals working in sexual health. It has been found that conflation of ‘transgender’ with homosexuality and confusion over what it may mean to patients who are trans are evident among the service providers (Lefkowitz & Mannell, 2017). This finding could be partly explained due to a larger sample and wider geographical area than the current study. Similarly, transgender people have reported that professionals often have a narrow view of defining transgender individuals which is determined by their understanding of a binary system and what it means to be male or female (Ellis et al., 2015). The participants included in the study did not fully explain how they defined the term transgender. This would have been a useful indicator to see how healthcare professionals make sense of gender itself.

All participants involved in the current study recognised the important yet varied nature of hormone therapy for some transgender women accessing care. This finding has been replicated where transition-related care may be prioritised over HIV care and has been shown to lead to fears about drug interactions impacting on ART adherence (Sevelius et al., 2014). However, for other TGWLH, oestrogen therapy did not affect adherence to ART (Baguso et al., 2016). Thus, the impact of hormone therapy is unique and wide-ranging, and likely to affect individuals to different degrees when engaging with HIV treatment. In the current study, some participants discussed that integrated HIV and gender-affirming care can increase retention in care, and that GPs should be more competent to prescribe hormones. This finding is in line with recommendations from the World Professional Association for Transgender Health (WPATH, 2012) who strongly advocate the need for primary care clinicians to prescribe hormones.

Complex nature of healthcare systems

Participants highlighted that transgender care was not fit for purpose and viewed primary care services as overstretched, impacting on the ability to provide appropriate care to TGWLH. Similarly, other respondents described how navigating healthcare services to obtain adequate HIV or gender care was often complex and timely both for professional and patient. Clinicians remarked on the need to contend with complex referrals or patchy provision from GP services. Further, longer waiting times to be seen at gender identity clinics were acknowledged as adversely affecting patient mental health. These findings are supported by prior research suggesting fragmented or disrupted HIV and gender care (Maiorona et al., 2021) and delays in accessing gender identity services in the UK may contribute to poor mental health and minority stress (Ellis et al., 2015).

The World Health Organization document the need for holistic care as TGWLH have needs beyond that of solely HIV treatment (WHO, 2015). Similarly, healthcare professionals have previously remarked that there is a lack of trans-specific services and organisations (Lacombe-Duncan et al., 2020) and recommendations have been made for integrated hormonal therapy and ART in primary care settings (Sevelius et al., 2014). This suggests that integrating trans-competent care into varied healthcare settings is a global requirement.

Multiple needs and intersecting difficulties

All participants spoke about interrelated needs of their patients and the likely adverse outcomes due to intersectional and marginalised identities. One participant acknowledged that one of his clients struggled with housing and how this had a possible impact on ART adherence. This relates to the complex nature of health disparities among this group, where housing instability has been found to be associated with poorer HIV treatment outcomes for TGWLH (Santos et al., 2014). Correspondingly, prior research highlighting being of an ethnic minority, co-morbid health difficulties, unstable income, drug/substance use, sex work, and concerns over personal safety mean the complexity of daily life can negatively impact ART adherence (Lacombe-Duncan et al., 2020; Maiorana et al., 2021; Sevelius et al., 2014). Other participants recognised that multiple identities (i.e., sexuality, gender, health, ethnicity) of their patients may contribute to multiple forms of discrimination. Intersectional stigma is a term that is used to describe this process and may have a deleterious effect on psychological wellbeing and related health behaviours (Turan et al., 2019).

Insufficient professional knowledge

Participants recognised limited professional knowledge and insufficient training for transgender health and related HIV needs. They also expressed a fear of delivering care that was below appropriate standards. This key finding is mirrored with research conducted outside of the UK where Lacombe-Duncan et al. (2020) found that trans women often described healthcare providers as having a lack of knowledge of trans women’s issues. Two participants discussed the role of educating professionals as falling on the burden of the patient. This is comparable to research highlighting that

TGWLH often must educate themselves or clinicians regarding hormones through consulting the internet or from other trans women (Sevelius et al., 2014; Poteat et al., 2013). This elucidates a need for further accurate training for healthcare professionals to share correct information with their patients.

This finding can also be supported by a previous study regarding the extent of transgender-specific health needs being incorporated into medical education. Although this systematic review was conducted in North America, it was found that transgender medical education was lacking and contributes to the creation of health inequities among the transgender community (Dubin et al., 2018). Conversely, it has been suggested that transphobia itself predicts clinician knowledge of trans people as it may act as a barrier to successful learning (Stroumsa et al., 2019). The sample in the existing study was of seven healthcare professionals working in HIV and transgender specific clinics, thus may have been more motivated to engage in training needs around this population. It is therefore important to be aware of the motivations of clinicians outside of this group who may be less aware or exposed to gender diversity. Notwithstanding this, a brief educational intervention has been found to be effective for medical students' attitudes and knowledge of transgender patients (Click et al., 2020), and training has repeatedly been recommended for clinicians to reduce health disparities (Hines et al., 2019).

Discrimination and prejudicial attitudes towards trans women living with HIV

Within the sample there was clear evidence to suggest that healthcare professionals recognised the presence of different types of internalised, anticipated, and enacted stigma experienced by this patient group. This finding is supported by evidence which has found that service providers have identified the presence of hostile experiences when trans women access care (Lacombe-Duncan et al., 2019; Poteat et al., 2013). Most recently research has seen healthcare professionals identify stigma and discrimination as barriers to accessing healthcare among TGWLH (Lacombe-Duncan et al., 2022). Enacted, anticipated, and structural stigma have all been suggested to affect trans people across different domains (White Hughto et al., 2015). Enacted stigma has been found to be positively associated with psychological distress in transgender people (Bockting et al., 2013) pointing to the need for interventions to reduce harmful attitudes perpetuated by wider society and professionals themselves.

Within the sample, participants identified discriminatory views around transgender women both at a political, and service level. Some UK governmental polices appear to subscribe to a form of structural stigma where one group (cisgender) is prioritised over another (transgender) (White Hughto et al., 2015). For instance, recent efforts to ban supposed ‘conversion therapy’ were passed by parliament, but only for lesbian, gay and bisexuals – transgender people were deliberately omitted (Dyer, 2022), and it remains that married people who are transgender must obtain their spouse’s consent when seeking gender recognition (Marriage Act, 2013, Section 12). Furthermore, some academics posit that those who argue against trans-rights are being radicalised, yet the UK authorities hold ambivalence as it is framed as an ideological as opposed to a violent debate (McLean, 2021). Thus, transphobic discourse remains embedded into the policy and frameworks of the UK.

Identifying solutions to improved care

All themes in the present study were related to the importance of improving care and clinical outcomes among this group. Participants explicitly highlighted the need to create trusting partnerships and collaboration with service users; increased training among professionals and a need to reduce prejudicial views. This finding can be linked to recent research stating the need for individual, social, and organisational level initiatives to increase representative services and diversity, as well as building supportive-care networks for trans women (Lacombe-Duncan et al., 2022). Some participants specifically discussed the importance of peer support as important for engagement in care or acceptance with their diagnosis. It has been found this may help with retention in care (Hines et al., 2019) and peer coordinators supporting with attending health appointments are valued by TGWLH (Fauk et al., 2019).

All participants acknowledged the need for future care to be gender affirming and culturally competent for trans women. Healthcare professionals and trans women themselves are likely to be battling against cisnormativity in health settings. Informational and institutional erasure can be understood to occur where training, curricula, policy, documentation, and related practices are based on the assumptions of cisgenderism which limits inclusive practices for trans people (Bauer et al., 2009). Although the current study recognised the need for trans appropriate care, there is a requirement for continued improvement to push back against cisnormative assumptions at the individual and system level.

Application to wider healthcare

The findings from this study may be applicable outside of HIV care. The academic literature recognises that trans people's health beyond mental health and HIV has been largely ignored (Rich et al., 2020), and published research on chronic illnesses among transgender people appears to be sparse. A global review of studies examining the general health of transgender people found it to be the least researched aspect in the global burden of disease (Reisner et al., 2016), and further gaps exist in age-related conditions, inflammatory diseases, and the burden of chronic illnesses (Rich et al., 2020).

Like clinicians in the current study, primary care physicians have shown a lack of professional knowledge in hormone therapy, endocrinology, gender-affirming surgical options and social issues (Soled et al., 2022). Although professionals who were interviewed often articulated they worked for a comprehensive HIV and Sexual Health service, sexual healthcare has often been inadequate due to longstanding inseparability from MSM populations (Winter at al., 2016). In other settings, literature shows that trans people may receive unnecessary questioning about their gender when accessing healthcare regarding other issues such as flu, respiratory tract infections, or when attending A&E (Chisolm-Straker, 2017; Wagner et al., 2016). Moreover, other studies find that healthcare professionals in Emergency Departments have shown that incorrect pronoun use by staff is exacerbated by patient documentation which exclude transgender identities (Allison et al., 2021). Insensitive questioning in general or acute healthcare may differ from the knowledge or HIV or Sexual Health specialists in the current study, who may have increased exposure and knowledge around transgender populations.

Transgender men may also be disadvantaged by healthcare systems. For instance, transgender men who are pregnant receive poorer care than cisgender counterparts (Winter et al., 2016). Transgender men who have reproductive organs are not receiving the same level of preventative care or screening as cisgender women due to their invisibility, putting them at risk of gynaecological cancers (Gatos, 2018). Those assigned male at birth and who are trans or non-binary who receive urological care consistently report misgendering, and the requirement for knowledgeable and culturally competent providers (Chung et al., 2021). Age may be a noteworthy factor too, in that the aging transgender population may be reluctant to access healthcare, due to prior negative experiences and fear of judgement (Fredriksen-Goldsen, 2014).

Thus, the necessity for developing trans-specific and intersecting healthcare provision is therefore not isolated to HIV care, and rather continues to expand into general healthcare provision too. Insufficient knowledge among some professionals included in this study concerning trans care is not specific to the specialism of HIV (Safer, 2021), and is widespread across healthcare encounters, indicating the urgent need for improved gender diverse healthcare training.

Strengths and Limitations

A major strength of the study is that there has been a significant lack of research concerning healthcare and trans women living with HIV in the UK Although TGWLH were not direct participants, they represent a key beneficiary, and this research seeks to provide some contribution to the extensive gap in the literature.

Tong et al.’s (2007) guidelines of consolidated criteria for reporting qualitative research (COREQ) were adhered to. This ensured considerations such as the participant-researcher relationship were considered and confirmed that components of the study design were adequately reported. It is posited that use of the COREQ may increase transparency and allow for simpler critical appraisal of this empirical research (refer to appendix P).

A limitation was that no participants provided feedback on the themes despite requested to do so. The participants were all busy professionals working in HIV and sexual health clinics, so it is understandable that they were unable to provide timely feedback. However, a particular strength was that the findings were shared with the participants and two experts by experience were consulted to provide their feedback, one being a Trans Activist and another being a Clinical Psychologist working with the client group. They provided specific comments on their reflections of the recruitment difficulties in the original project, their views and understanding on the themes and how dissemination to a wider audience may be appropriate (see Appendix O for further details). Similarly, credibility was enhanced through regular debriefings with the internal supervisor, and multiple analysed transcripts were critiqued, which enhanced critical reflexivity and refined the researcher’s interview skills.

One limitation was that all the participants included in the study were working in urban or semi-urban clinic locations. Their experiences were likely to be only related to TGWLH who had better access to city centre locations, whereas those who live rurally may have different experiences or impeded access to care (Koch & Knutson, 2016). The sample itself predominately comprised of cisgender women and men which likely denotes a cisgender interpretation of transgender experiences. Despite this, there were three individuals who described themselves as belonging to the LGBTQ+ community and thus resonated with themes of stigma, suggesting some sexual and gender diversity. Another constraint was that all but one of the sample were medics and so represented a very specific set of experiences. IPA, however, favours a homogenous sample to support with depth of understanding (Smith et al., 2022); yet this appears to be at a trade off with the transferability of the findings. Furthermore, the interviewees were largely trans-affirming in their views, and different results could be yielded if individuals working in other medical specialities or geographical locations were consulted.

Theoretical Implications

Two theoretical models can be used to illustrate the current study. The Behavioural Model of Health Services Use (Andersen, 1995) suggest different aspects of the healthcare system and external environment influence population characteristics which in turn impact health behaviour and outcomes. Applied to HIV, system, clinic, and provider factors alongside the external environment are seen as important barriers or facilitators to care (Holtzman et al., 2015). Although not explicitly applied to TGWLH, Anderson’s behavioural model could be used to suggest that colocation of HIV and gender specialist services, trans-inclusive policies, and strong relationships with professionals, all might go some way to facilitating access and retention in care.

Additionally, the situated-Information Motivation Behavioural Skills model of Care Initiation and Maintenance (sIMB-CIM) suggests that accurate information, personal and social motivations, and behavioural skills influence engagement with healthcare (Amico et al., 2011). Applied to the current study, it is hypothesised that TGWLH who have to access differing services for their HIV and gender-affirming care will impact on a patient’s ability in successfully navigating systems of care (e.g., HIV/ Sexual Health services, Gender Identity Clinics, Primary Care). Furthermore, misinformation regarding trans-specific healthcare from providers may act as barriers to care engagement, whereas accurate information on treatment, adjustment and systems of care will likely support TGWLH’s ability to seek care at different stages of the care continuum.

Research Implications

Further studies exploring the experiences of transgender women themselves would be necessary to corroborate their experiences with the views of healthcare professionals. However, given that TGWLH may be distrusting of professionals (Daniels et al., 2019), appropriate resources and time would be required to develop trusting and authentic relationships with the trans community to allow for effective recruitment.

Future training of healthcare professionals working with gender diversity is necessary, and preliminary interventions show promising results (Click et al., 2019), highlighting the possibility of future studies measuring attitudinal, behavioural, and knowledge-based change. This research has solely focussed on binary transgender identities and evidence confirms that non-binary trans identities also report poorer mental health than cisgender populations (Jones et al., 2019); hence this population should also be incorporated into future studies.

Clinical and Practice Implications

Transferability to clinical settings can be inferred from the study findings. Firstly, allowing appropriate time in clinic appointments to facilitate trusting and positive patient-clinician relationships would be prudent. Secondly, paying particular attention to patient names, preferred pronouns and gender identity is the essential bedrock of trans-inclusive care. Additionally, recognising the likelihood that patients will have experienced a range of prejudice and discrimination across societal settings prompts the need for appropriate mental health screening or assessment. Similarly, clinicians are required to be aware of the impact of waiting times for specialist gender identity care may have on the emotional wellbeing of patients. All these components are likely made more complex by the presence of intersectional identities, making it essential that professionals recognise the heterogeneity and individualised nature of TGWLH. Finally, healthcare trusts and services would benefit from integrating mandatory training on transgender healthcare to increase acceptability and knowledge of this patient group.

Concluding Remarks

This study highlighted a moderately homogenous group of professional views among clinicians working with trans women living with HIV. The study findings largely replicated previous non-UK research investigating health care professionals' attitudes (Lacombe-Duncan et al., 2019; Lacombe-Duncan et al., 2022) and points to several future implications intended to improve health outcomes for this population, specifically around the requirement of improved training and initiatives to advance trans-inclusive care.

4. Integration, Impact, and Dissemination

Integration

The overall aim of this project was to explore the barriers and facilitators to care among transgender women living with HIV (TGWLH). This was achieved by: (1) a systematic review investigating TGWLH and their experiences of HIV related care, and (2) an empirical study exploring healthcare professional's view of care provision and associated barriers and care among TGWLH. The following summarises how the systematic review and empirical study can be synthesised. A self-critical reflection and appraisal of the thesis is also discussed below.

The systematic review was the only known review of its kind investigating global qualitative experiences of healthcare among TGWLH. Originally, the systematic review was intended to be a logical foundation to the empirical project. The original empirical project was intended to interview TGLWH, but this was changed to interview healthcare professionals themselves due to a variety of unforeseen complications (see '*reflections on recruitment'* section for further details). Twenty-nine studies were narratively synthesised from the review to present a range of different findings. No UK studies based on the inclusion criteria were identified in the systematic review. Results highlighted that TGWLH often reported enacted and anticipated stigma from healthcare providers including degrading or dehumanising experiences. This aligned with the empirical study which found that clinicians recognised far reaching discrimination at different levels of society and witnessed degrading treatment from others towards TGWLH in healthcare.

The review found that positive care interactions, such as being heard and understood or viewing their care team as specifically sensitive to trans-care, were important to TGWLH. The empirical study saw that professionals actively tried to create positive interactions with patients and made deliberate efforts to connect with patients. Likewise, the review highlighted that gender un-affirming environments were problematic to TGWLH and were a deterrent to care engagement. Similarly, studies found that for some TGWLH shared clinic spaces with cis women or MSM were beneficial, whereas others identified concerns over being negatively judged in all-inclusive spaces. Although participants spoke about trans-inclusive environments in the empirical study, there was often a lack of specificity or tangible examples. Similarly, the findings appear to diverge from the review in that there was little appreciation about shared environments with other genders, but this could have been because some of the participants were actively working in specific trans clinics. In the review, themes were uncovered regarding covert or forced HIV testing. This differed from the empirical piece which did not have any disclosures from participants regarding unethical care, possibly due to social desirability bias, or implicit bias which professionals may be unaware of (Mayfield et al., 2017).

Structural and intersectional barriers to care were discussed in both studies, with more emphasis in the review on racial discrimination. Both acknowledged the importance of hormonal therapy for TGWLH and recognised that this was sometimes a conflicting priority among those taking antiretroviral medication due to fears of drug interactions. In the review, assertive engagement was found to be important where creative ways of reaching marginalised groups were valued. By contrast, the empirical study only included one participant who appreciated the need for assertive engagement by visiting patients in the community. Conversely, one medic completely denied that there were any problems for TGWLH in accessing services, citing that busy telephone lines affecting all patients was likely to be the only difficulty. Linked with this, the review found that flexibility in clinic appointment times was helpful, but this was not highlighted by participants in the empirical study. Finally, an overwhelming theme running throughout both pieces was the consistent requirement for healthcare professionals to have accurate and competent training for trans healthcare needs. The review evidenced that if healthcare professionals are educated about trans healthcare needs, patients feel empowered to engage with their care and their trust in clinicians increases.

The overall differences between the systematic review and empirical study could be explained by multiple factors. Firstly, the review concerned TGWLH directly, whereas the empirical study interviewed healthcare professionals. As such, it is expected that different experiences and perceptions would emerge. Secondly, although both qualitative, the empirical study employed interpretive phenomenological analysis (Smith et al., 2022), whereas none of the studies included in the review specifically used IPA. This likely potentially allowed for the emergence of different results and themes due to the specific emphasis on a participant's experience of a particular phenomenon. Moreover, the studies in the review were subject to the effects of earlier publication dates, a wide geographical span across multiple countries, and were influenced by differing legal and socio-political frameworks within each nation. As such it is difficult to accurately compare the findings between the review and with the empirical study itself.

Reflections on recruitment

Initially the empirical study set out to directly interview transgender women living with HIV regarding their experiences of engaging in healthcare related to their diagnosis. An extensive number of clinicians working in HIV and sexual health were contacted about the feasibility of using their service or organisation as a recruitment site. Due to a low response rate and a lack of suitable participants accessing identified services, only two sites agreed to support recruitment after enquiries were made with over fifteen services. One of the organisations indicated they were agreeable to collaborating in the research and assured the researcher that they were able to identify sufficient participants to be able to take part in the study. Unfortunately, this site disengaged from the study and did not identify any willing participants. A further site identified three eligible participants who were spoken to in clinic by a professional, but upon contact with the researcher they did not respond (n=2) or cited poor mental health as a barrier to taking part (n=1).

The difficulty in finding recruitment sites willing to support with recruitment was also underscored by the recurrent need to submit amendments to the NHS research ethics sub-committees. This was due to continued efforts to widen the inclusion criteria to recruit via social media, and throughout Europe. A separate project was considered to interview women accessing sexual health services without a diagnosis of HIV. However due to time constraints, these ethical amendments were not able to be executed.

Due to these delays and because no participants had formally agreed to take part, it was decided that interviewing healthcare professionals working with the population may be a more viable option. Personally, this was a difficult realisation to contend with and due to the prior efforts in drafting a research protocol, applying for, and obtaining NHS ethical approval and drafting of relevant sections of the thesis, it caused disappointment in myself as a researcher. However, it is important to contextualise myself as a researcher and as ‘outsider’ wishing to investigate marginalised populations who needs to embed themselves within the community under study. Prior research finds that efforts to recruit gender diverse participants may be increased through partnering with gender diverse investigators or research staff (Asquith et al., 2021), and trans women working in the field were original collaborators on the study. When consulting with the EbE and service user for consultation, it was suggested that TGWLH may be cautious of taking part in research due to previous negative experiences (see Appendix O for further details).

Furthermore, remote recruitment may have inadvertently thwarted the enrolment of trans women to the study as they did not get to meet the researcher in person before the interview. In-person recruitment may help achieve a sense of collaboration and empowerment for transgender participants (Tebbe & Budge, 2016) and not having face to face interactions may have been problematic. Alongside attempts to facilitate the original project, the systematic review was conducted concurrently. This was helpful in that it influenced my understanding of the literature and thus shaped the interview questions. However, in some ways it may have narrowed the focus of the interviews where I had been motivated by the prior evidence base.

Self-reflection and development of the topic

I am a 31-year-old white British cisgender heterosexual and able-bodied woman who does not live with a diagnosis of HIV. I am a trainee clinical psychologist who has nine years' experience working in psychological and clinical health settings but limited experience of working with gender minorities. The inspiration for the project was borne out of my understanding of feminism. Over the years, I found myself engaging with theories which attempt to describe and explain gender. To me, the patriarchy is a system which oppresses and subjugates minorities who differ from white cisgender heterosexual males to retain power. Related to this, I believe that certain political structures maintain patriarchal ideals and traditional gender views, most notably through right-wing idealism.

Whilst I have the privilege to feel relatively comfortable with my own expression of gender as a cis woman, I have lived experience of the micro-aggressions and misogyny faced by cis women which prompts a very small insight into considering the violence and abuse more marginalised groups may face, such as TGWLH. When starting to consider the health inequalities for trans people, I came to realise that the UK continues to broadly maintain trans-exclusionary beliefs in line with harmful media rhetoric and discriminatory policies upheld by a right-wing ideal. This, coupled with prejudice and discrimination that those living with HIV face, indicated a requirement to explore healthcare among TGWLH in the UK.

It is vital to acknowledge that the research is interpreted through this lens of experience which relates to the 'double-hermeneutic' in IPA research (Smith et al., 2022). Therefore, I, as the primary researcher am making sense of an individual making sense of their own experiences. Additionally, I am making sense of interviewees' experiences who are making sense of patient experiences. Consequently, I considered the situatedness to TGWLH and acknowledged my inherent freedom and privileges. After the interview, ultimately the interviewer was able to separate from the oppression and marginalised dual identity of a chronic health condition and minoritized gender identity, whereas the population under indirect study are not.

Reflections on the interview process

Most of the healthcare professionals interviewed were senior clinicians working in HIV or sexual health services. This represented an interesting dynamic, and at times I felt I was in a position of less power than the participant. However, to reduce power differentials in qualitative inquiry, acts of disclosure and authenticity between researcher and participant may be useful (Karnieli-Millet et al., 2009). This was done in an appropriate sense, such as discussing the researcher's career background and hopes for the impact of the research. Some of this appeared to help to create a dialogue which ultimately fostered an effective rapport. Nevertheless, despite the attempt to reduce power differentials, I observed that on occasion it seemed difficult to interrupt interviewees, and to probe more about their emotions. I noticed that I felt more at ease with interviewees who were more aligned to my age bracket, whereas those who were older and had more clinical experience than me likely contributed to some silence on my part. The participants who differed in age, gender, and ethnicity to me may too have perceived a barrier and may not have been able to express themselves as willingly due to out-group and in-group dynamics.

Moreover, due to my views as a feminist left-wing individual it may have been that I unconsciously interpreted aspects that were more aligned with my beliefs. Thus, another researcher with a different epistemology and political alignment will have likely generated different findings.

Design of the research

Service users were consulted at various stages of the study. At the development stage of the original project, which was designed to interview trans women directly, both a trans woman with HIV and a cis woman with HIV were both consulted. They provided feedback on the participant documentation where they gave a valuable contribution in terms of ensuring inclusive and non-stigmatising language and suggestions of the ordering of questions. Their feedback was adapted to be used for the creation of the participant documentation for professionals, however it is acknowledged that the research project changed to interview professionals. Thus, not all the EbE feedback may have been relevant for the empirical study.

Analysis of results

At the results and analysis stage of the project, a transgender author and activist was consulted along with a psychologist working in the field of sexual health/HIV and a gender identity service. They provided feedback and consultation on the recruitment procedure, experiential themes, and methods of dissemination. However, it can be construed that service users were not involved in all stages of the research and development process, and consultation may represent a form of tokenism (Tritter & McCallum, 2006). Resultingly, future projects of this ilk should seek to include key participant groups at all stages of the research process. Quality throughout the analysis of results was maintained through role playing an interview with the academic supervisor to place myself in the role of the interviewer. Similarly, the supervisor provided feedback on unannotated, annotated, and coded transcripts allowing myself to improve my interpretations and analytic comments.

Impact and Dissemination

Potential Beneficiaries

Given that there is a critical lack of research in the UK into TGWLH and their care it is hoped that this research will impact a range of beneficiaries including transgender women with and without HIV who access sexual health/HIV services, clinicians, charities, the academic community, and policymakers.

Transgender Women

Both the systematic review and the empirical study highlighted examples of good healthcare interactions through the provision of trans-competent and culturally sensitive care. The studies recognised problematic attitudes from healthcare providers and wider society, as well as a lack of appropriate training to improve clinical knowledge and reduce problematic attitudes. Transgender-specific health knowledge regarding hormonal therapy and ART was frequently cited as important across both studies and healthcare professionals demonstrated such an awareness. TGWLH will likely benefit from appropriate knowledge regarding the interactions between ART and hormonal therapy so they can make informed decisions about their treatment. Collecting routine information from TGWLH when they access services may be useful. For instance, patients could be invited to complete a brief feedback form after healthcare appointments querying how trans-inclusive, they found their consultations to be.

The study findings have implications for transgender women who are not living with an HIV diagnosis but who will benefit from improved gender-affirming care and competent clinician knowledge.

Clinicians

The findings from both the systematic review and the empirical study may have a positive effect on healthcare professionals working in HIV and sexual health services by:

1. Ensuring clinicians use gender-affirming language such as preferred names and pronouns.
2. Reminding professionals that TGWLH may have concerns about healthcare workers due to previous negative experiences, thus clinicians will need to ensure longer consultations and appointments to help facilitate trust.

3. For all clinicians to take responsibility to address discriminatory or transphobic attitudes from staff or professionals.
4. To be aware of the heterogeneity of transness and that overlapping or intersectional identifies may increase the barriers to care of some TGWLH.

This may not be solely applicable to services who work either directly with transgender women or those diagnosed with HIV. Wider healthcare services may also benefit from increased knowledge around transgender people and gender diversity. Several organisations provide foundational training to businesses and services to address this gap such as CliniQ (https://cliniq.org.uk), Gendered Intelligence (https://genderedintelligence.co.uk/) and the Diversity Trust (https://www.diversitytrust.org.uk/) .A summary of the study findings could be shared and linking up with these organisations may generate discussions regarding widening access to training.

Additionally, the participants in this study spoke about the need for trans-inclusive care but did not describe comprehensively or tangibly what this was. The formation of an accepted definition in the UK would set a benchmark of what is required in terms of services being culturally competent and trans-sensitive which should be a collaborative approach from professionals, policymakers, and service users.

General Practitioners

This study also suggests that primary care services need to provide better care to trans people with or without HIV. Policy documents from the Royal College of General

Practitioners suggest that GPs are '*required to show the same level of support, dignity, respect and sensitivity*' (RCGP, 2019, p.8) to trans patients as cis patients. However, it is less clear about how doctors should go about doing this. A suggestion would be to explicitly mandate transgender healthcare training into guidelines, encourage appropriate collaboration with transgender patients or advocates, and create a document summarising the practicality of how GPs can be gender inclusive during every consultation.

Academic Community

The study may influence future directions for research. Ways to engage with TGWLH are essential for meaningful co-production and recruitment in research. Crucially, future data should be gathered through interviewing trans women directly to garner specific details on their perspectives of care provision in the UK, and to provide related recommendations to enhance healthcare experiences.

Policymakers

The British HIV Association (BHIVA) produce guidelines on the prescribing of ART. They have drafted an updated version which is open to consultation and have included a section on transgender people (BHIVA, 2022). Findings from the current study could be communicated to encourage appropriate clinician understanding of the value of hormone therapy to TGWLH. Similarly, the London Assembly Health Committee (2022) recently published recommendations into improving healthcare for transgender

Londoners. The current study maps onto some of these recommendations including improving NHS IT systems to record trans status in an accurate way, commissioning research of trans people, a review of medical training and curricula to include LGBT training as compulsory, and developing a consultative group to assess commissioning and review policies. The London Assembly have existing channels to communicate professional feedback, and a summary of the review and empirical study could be provided.

International efforts into providing standards of care for transgender people have been developed. The World Professional Association for Transgender Health has published guidelines into improving the quality of evidence-based health care for trans people (WPATH, 2012). They are currently producing an 8th edition which has a new section on competency, training, and education (WPATH, 2022). It could be that the results of the current study are communicated by providing a summary of the findings to add weight to the need for specific professional training in universities and healthcare care services.

Mental Health Services

The current study acknowledges professionals' views of stigma and aligns with studies that find stigma contributes to minority stress, low mood, and associated psychological distress (Bocking et al., 2022). The all-party parliamentary group (APPG) on HIV and AIDS highlight the connection between HIV and mental health, and the associated stigma it causes (APPG, 2020). A related report by the National Aids Trust (NAT) finds that primary care mental health services are often ineffective for people living with HIV (NAT, 2021). Consequently, stakeholders in the provision of primary care mental health could be consulted regarding the importance of mental health for TGWLH.

Additionally, the requirement to understand trans and gender diversity is not included in the standards for accreditation for clinical psychology (BPS, 2019). Thus, the findings of the current study could be shared with the BPS to assist in putting forward a case for psychologists to be more knowledgeable on gender-affirming and trans-inclusive care.

Dissemination

It is of key importance to communicate the findings back to the community this research intends to benefit. Research produced for academic qualifications is not often shared with trans communities themselves (Tebbe & Budge, 2016), yet sharing research findings with trans populations one of the main guidelines and considerations when conducting transgender health research (Adams et al., 2017).

It is intended that key findings will be shared with service users who the research mostly impacts (i.e., trans women with HIV). This would be written in lay language to ensure acceptability of the material. This would help to ascertain what service users consider most useful or helpful, and how it maps onto their own experiences of engaging in care before being used to inform guidelines. Lay findings could be shared with third sector and peer-organisations such as the UK community advisory board of HIV treatment advocates. Likewise, liaison with the Gender Identity and Research

Education Society (GIRES) to establish the most effective ways to disseminate researching findings to trans people may be beneficial.

Broadly, the findings of the systematic review and empirical study are planned to be published in a peer-reviewed journal such as AIDS & Behaviour or the International Journal of Transgender Health. The findings may be shared to Special Interest Groups (SIGs) such as the British Psychological Society's HIV and AIDS SIG. The aim of this would be to engage HIV and sexual health professionals in the discourse of transgender identity and to increase their awareness around the need for transgender specific and culturally competent care. Similarly, researchers in the field could become aware of the study's findings which may be used to add to the evidence base surrounding TGWH.

For clinicians, the findings of the study are planned to be shared with specific sexual health and HIV services, and arrangements have been made to disseminate them to two London services. This may enable clinicians to become more aware of transgender relevant issues in clinical care. It is possible that this could situate professionals to being more aware of pronoun use and appropriate language, as well as more practical issues such as the importance of hormone therapy in women who may be transitioning.

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Appendices

Appendix A: Systematic Review Protocol

Title

Transgender women's experiences of HIV related care

Registration

CRD42022303768

Authors

Charlotte Gould

2nd Reviewer

[Redacted]

Objective

The systematically summarise the literature of transgender women's experiences of HIV related care.

Method

A systematic review to be conducted according to the 'PRISMA' (preferred reporting items for systematic reviews and meta-analysis) statement (Moher et al., 2009). Two databases (PsycInfo and Pubmed) will be searched. Results will be removed for duplicates in Endnote before being title, abstract and full paper searched and included on the following criteria:

Eligibility Criteria

f) HIV positive diagnosis
g) The study samples transgender or transfeminine populations engaging with services related to HIV care (including HIV treatment, PrEP, ART adherence, barriers, or facilitators to engagement in healthcare)
h) Involved data regarding the opinion/attitudes/beliefs/experiences of participants surrounding their health care or service input
i) Be an empirical article generating quantitative or qualitative data

d) Transgender women were either the sole population under study or formed part of the population under study

e) Were studies written in English and;

f) Limited to adults aged 18 years and above

Exclusion Criteria

Studies to be excluded are those that are;

a) largely biomedical in nature and do include views or qualitative data from participants,

b) have an unclear or indistinct methodology which means critical appraisal could not take place,

c) does not present any results concerning transgender women's HIV related care experiences

Search Strategy

The search strategy comprises searching for terms relating to 'HIV', 'Transgender woman', 'experiences' and 'healthcare'. See Appendix 1 for a full list of terms.

Selection Process

One reviewer (CG) will search information sources independently and assess identified studies for inclusion in the abstract screen. Two reviewers (CG/redacted) will review abstracts, and full title searches to reach an agreement for inclusion. Agreement will be reached when both reviewers have a consensus that the study meets the inclusion criteria.

Data collection process

Data will be extracted and populated into a summary table describing relevant study characteristics.

Risk of bias in individual studies

Data will be critically appraised using two critical appraisal tools, the Critical Appraisal Skills Programme Checklist (CASP) and the Standard Quality Assessment Criteria for Evluating Primary Research Papers (Kmet, Cook, & Lee, 2004). Scores from both tools will be aggregated to give an overall picture of which studies have a higher methodological rigor.

Synthesis

A meta-analysis will not be possible due to the expected heterogeneity of the included data. Papers will be narratively synthesised and key findings presented in table form.

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Appendix B: Systematic Review Search Terms

Transgender women

transgender* OR "transgender wom*" OR "trans wom*" non-binary OR non-conforming OR genderqueer OR ‘assigned male at birth’ OR ‘designated male at birth’ OR ‘travesty’ OR ‘koti’ OR ‘hijra’ OR ‘MTF’ OR ‘male to female transgender’ OR ‘transsexual’ OR transvest* OR “mahuvahine” OR “mahu” OR “waria” OR katoey OR “cross dresser” OR “bantut” OR “nadleehi” OR “berdache” OR “xanith” OR “genderqueer” OR “gender queer” OR “FTM” OR “MTF” or "MSM" or "men who have sex with men"

AND

Experience

Experience* OR Satisf* OR Aspect* OR View* OR Perception* OR Perceive* OR Attitude* OR Belief* OR Evaluat* OR Value* OR Prefer* OR Choice* OR Opinion* OR Understanding* OR Knowledge* OR Judgement* OR inclus* OR Concern* or Barrier* or Engag* or Facilitator or Access*

AND

Healthcare

Care OR Healthcare OR Service* OR Provider* OR Support* OR Peer* OR org* OR health OR Medicaid OR Medicare OR health care OR “Health Care Systems” OR “Health Care System” OR Treatment OR NHS or "National Health Service" OR Clinic OR "specialist unit"

AND

HIV

HIV OR "HIV infections" OR 'human immunodeficiency virus'

Appendix C: Critical Appraisal Skills Programme (CASP) for Qualitative studies

Author	Clear research aims?	Is Qual Method the right methodology?	Appropriate research design?	Appropriate recruitment strategy?	Research issue addressed by collected data?	Relationship between researcher and participant considered?	Consideration of ethical issues?	Rigorous Data Analysis?	Clear statement of findings?	Value of research?	Total
Auerbach et al (2020)	Yes	Yes	Yes	Yes	Yes	No	Partially	No	Yes	Yes	0.65
Auerbach et al (2021)	Yes	Yes	Yes	Yes	Yes	No	Partially	No	Yes	Yes	0.65
Barrington et al., (2016)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Biello et al., (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Bockting (1998)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Partial	Yes	0.75
Chakrapani et al., (2011)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Daniels et al., (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
de Villiers et al., (2020)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	0.95
Fauk et al., (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Fauk et al (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	1
Harper et al., (2019a)	Yes	Yes	Yes	Yes	Yes	No	Yes	yes	Yes	yes	0.9
Harper et al., (2019b)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Hines et al., (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Hines et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	1
Hines et al., (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Lacombe-Duncan et al., (2019a)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Lacombe-Duncan et al., (2019b)	Yes	Yes	Yes	Yes	Yes	No	Partially	Yes	Yes	Yes	0.85
Lacombe-Duncan et al., (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9

Maiorana et al., (2021)	Yes	Yes	Yes	Yes	Yes	No	Partially	Yes	Yes	Yes	0.85
Melendez & Pinto (2009)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Partial	Yes	0.85
Munro et al., (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9
Remien et al., (2015)	Yes	Yes	Partial	Yes	Yes	No	Yes	Yes	Yes	Yes	0.85
Restar et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	1
Schilder et al., (2001)	Yes	Yes	Yes	Yes	Yes	Partially	No	Yes	Yes	Yes	0.85
Sevelius et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	1
Sevelius et al., (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	0.95
Silva et al., (2020)	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Partial	Yes	0.85
Teh (2008)	Yes	Yes	Yes	Yes	Partial	No	No	No	Partial	Yes	0.6
Wilson et al., (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	0.9

Appendix D: **Standard Quality Assessment Criteria (SQAC)**

Author	**1.:Question/ Objective sufficiently described?**	**2.Appropriate Study design?**	**3. Clear study context ?**	**4.Theoretical framework ?**	**5. Relevant sampling strategy?**	**6. Systematic & Clear data collection methods**	**7. Data analysis clearly described?**	**8. Use of verification procedures?**	**9. Conclusions supported by results?**	**10. Reflexivity of the account?**	**Total**
Auerbach et al (2020)	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Partial	No	0.65
Auerbach et al (2021)	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	0.7
Barrington et al., (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
Biello et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
Bockting (1998)	Yes	Yes	Yes	Yes	Yes	Yes	Partial	No	Partial	No	0.7
Chakrapani et al., (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
Daniels et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
de Villiers et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	0.95
Fauk et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
Fauk et al (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	1
Harper et al., (2019a)	yes	Yes	yes	Yes	yes	yes	yes	Yes	Yes	Partial	0.95
Harper et al., (2019b)	Yes	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	No	0.8
Hines et al., (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
Hines et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	1
Hines et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9

Lacombe-Duncan et al., (2019a)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	0.9
Lacombe-Duncan et al., (2019b)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	No	0.85
Lacombe-Duncan et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	yes	No	0.9
Maiorana et al., (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	No	0.85
Melendez & Pinto (2009)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	No	0.85
Munro et al., (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	0.95
Remien et al., (2015)	Yes	Yes	Partial	Yes	Yes	Yes	Yes	Partial	Yes	No	0.8
Restar et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	0.95
Schilder et al., (2001)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Partial	0.85
Sevelius et al., (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	0.9
Sevelius et al., (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	0.95
Silva et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	Partial	Partial	0.85
Teh (2008)	Partial	Partial	Partial	Yes	Yes	No	No	No	Partial	No	0.4
Wilson et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	No	0.85

Appendix E: Recruitment Email to Clinicians

From: Gould, Charlotte (2019) <Charlotte.Gould.2019@live.rhul.ac.uk>
Sent: 05 April 2022 11:40
To: [REDACTED]
Subject: RE: Assistance required for project interviewing trans women living with HIV

Dear [Redacted]

I hope you do not mind me contacting you directly further to [Redacted] email below.

I am a trainee clinical psychologist employed by the NHS and training at Royal Holloway University conducting some research into trans women living with HIV. I am now looking for professionals to interview who have worked with transgender women with an HIV diagnosis in the last year. This to hear their views about engagement and facilitators/barriers to care among this group.

Is it please possible that you could be so kind to share the attached information with any professionals who may be eligible to be interviewed, and would yourself kindly consider being interviewed? All interviews are anonymous and confidential. A small voucher will be provided in exchange for the time of the interviewee.

Very best wishes

Charlotte

Charlotte Gould (she/her)

Trainee Clinical Psychologist

Royal Holloway University of London

Email: charlotte.gould.2019@live.rhul.ac.uk

Appendix F: Participant Information Sheet

Participant Information Sheet

Healthcare professionals' perspectives on barriers and facilitators to care for trans women diagnosed with HIV.

You are being asked to take part in a research study investigating the perspectives of healthcare professionals who work with trans women living with HIV.

Research team: Charlotte Gould (she/her), Trainee Clinical Psychologist at Royal Holloway University of London (RHUL), supervised by Dr Michael Evangeli (he/him), Reader in Clinical Psychology, RHUL and Dr Kate Nambiar (she/her), Speciality Doctor in Sexual Health and HIV Medicine.

Thank you for your interest in the research study. Please read the following information carefully:

What is the study about?

The aim of this project is to hear more about knowledge and attitudes involved in the care and treatment of trans women living with HIV. We know that trans women are more likely to experience prejudice and discrimination which may have an impact on accessing care. We think it would be useful to investigate the knowledge and attitudes held by healthcare professionals regarding trans-inclusive care, and how they conceptualise the barriers and facilitators to care.

We hope that the findings will be used to inform or improve HIV services for trans women.

Who can take part in the study?

You have been invited to take part in the study as you are a healthcare professional or practitioner who is working with transgender women living with HIV. To be eligible to take part in the study you must meet all of the following criteria:

1) A professional working with HIV positive trans women for one year or over.

2) English speaking and registered to work in the UK.

3) Aged 18 years and over.

What will the study involve?

If you decided to take part, you will be invited to attend an interview where you will be asked about your experiences of working with trans women living with HIV. This interview will take place remotely at a time convenient to you. The interview will last approximately 60 minutes and will be audio recorded. The researcher will ask you about your experiences of providing care or support to trans women. You will also be asked a basic questionnaire which asks for information about you (age, ethnicity etc…) and basic information about your professional status.

Is it confidential?

Yes. Your information and responses will be kept completely confidential unless you tell us something that indicates you or someone else is at a significant risk of harm. We will attempt to discuss this with you before telling anyone else. All data will be stored in a password-protected database that only the research team will have access to. After the data has been transcribed and given an anonymous ID, your data will not be able to be deleted as your data will not be able to be linked back to you.

Only the lead researcher (Charlotte Gould) will have access to the interview recording and transcribe the data which will be deleted after it has been transcribed and written up. The transcribed interview will be anonymised which means the information you will provide will be unable to be identified as belonging to you. Additionally, your questionnaire answers will also be stored anonymously meaning you cannot be identified. Because this study is part of a doctoral thesis in clinical psychology, examiners can ask to view the transcripts. These will be anonymised and you will not be able to be identified.

We will ask you to provide an email address to be sent a summary of the study findings and for you to check that we have understood your responses correctly. This part is optional and if you choose to provide this information, your email addresses will be stored in a password protected file on an encrypted USB drive.

Do I have to take part?

Taking part in the research is completely voluntary and you may withdraw from the study at any time, without giving a reason.

What are the risks of taking part?

We do not think there are any particular risks associated with taking part in the research, however we acknowledge that talking about your experiences of working with a vulnerable population may be difficult. If you feel worried or distressed during the study, please let the researcher know. You can also ask to stop the interview or take a break at any time.

What are the benefits of taking part?

You may find it a positive experience to know that your knowledge is informing research which would go on to help other people. In recognition of your time and expertise a small token of a £10 voucher will be provided.

What will happen to the results of the study?

The research will be submitted in partial fulfilment of a doctorate degree in Clinical Psychology. We aim to publish its results in a peer-reviewed journal and at conferences. The published data will be anonymised, and no participants will be identified.

Who is organising and funding the research?

The research is being led by Charlotte Gould and is being funded and sponsored by Royal Holloway, University of London (RHUL), as part of the doctorate programme in Clinical Psychology. This study has been reviewed and approved in accordance with the College Research Ethics Committee at RHUL. This means the research has been deemed as safe to go ahead, any risks have been considered and kept to a minimum, and that it is completely voluntary whether you decide to take part or not.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have if it has been transcribed.
- We need to manage your records in specific ways for the research to be reliable. This means that we won’t be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- by asking one of the research team
- by sending an email to Charlotte Gould on charlotte.gould.2019@live.rhul.ac.uk or
- by ringing us on 01784 414012
- or contacting dataprotection@royalholloway.ac.uk

How will my data be stored?

Your data is going to be collected and stored in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. We do not intend for the raw study data to be accessed beyond this specific research study and no anonymised or confidential information will be shared with other people outside of the study, in the future. Your raw data will be kept by the research team for up to a maximum of 10 years or until it is no longer needed for the purposes of research. If you choose to withdraw from the study after you have been interviewed, you have 1 month from the interview date to let the interviewer know. After this time, your data will have been transcribed and anonymised so it will not be possible to remove your interview data. All other personal information will be deleted immediately, however, such as your email address.

There is a possibility that the study will be audited by independent bodies, to verify that the research has been carried out in accordance with NHS Health Research Authority protocol and in lines with the GDPR and Data Protection Act 2018. They may have access to the consent forms, transcripts, and questionnaire data if they want to audit the data, but it remains anonymous.

Who is the data controller for this project?

Royal Holloway, University of London, are the Data Controller for this project. They have responsibility for the protection of any personal information collected for this study and to ensure that itis used properly. The Data Controller has legal accountabilities to ensure that this study is compliant with the GDPR and Data Protection Act 2018.Your rights to access, change or move your consent forms and questionnaire/interview data are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate.

Who should you contact with questions or concerns?

The main person to contact for this project is Charlotte Gould, Trainee Clinical Psychologist as the Department of Clinical Psychology, Royal Holloway University of London (RHUL). You can get in touch in the following ways if you have any questions about the research at any time.

- Email: Charlotte Gould charlotte.gould.2019@live.rhul.ac.uk
- Phone: 01784 414012 (this is an answering machine - please say your message is for Charlotte Gould, leave a message clearly stating your name and phone number.)
- You can also contact the supervisor of the project, Dr Michael Evangeli (Michael.evangeli@rhul.ac.uk)

What if I want to complain?

If you are unhappy with any part of the study, please contact Charlotte Gould or the study supervisor, Dr Michael Evangeli, using the details above. Alternatively, you can contact the RHUL ethics committee at ethics@rhul.ac.uk. If you wish to complain about how your data is being used, you should contact the research team in the first instance. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer. If you are not happy with their response you can complain to the Information Commissioner’s Office (www.ico.org.uk or 0303 123 1113).

Thank you very much for taking the time to read the information sheet. If you are happy to participate, please complete the consent form on the next page.

Appendix G: Consent form

Healthcare professionals' perspectives on barriers and facilitators to care for trans women diagnosed with HIV: consent form

Name of researcher: Charlotte Gould, Trainee Clinical Psychologist, (she/her).

Research Participant - please read the following statements and indicate your response to each statement.

I confirm that have read and understood the information sheet about this study.	Yes/No
I agree to participate in this study	Yes/No
I have had the opportunity to ask questions about this study	Yes/No
I understand my participation in this study is voluntary	Yes/No
I understand that my participation in the study is entirely voluntary and I can withdraw my permission at any time without giving a reason and without my medical care or legal rights being affected.	Yes/No
I give permission for the interview to be audio-recorded and transcribed anonymously for the purpose of the research project.	Yes/No
I agree to having my anonymous quotations used in the write up of this study.	Yes/No
I understand that after my interview has been transcribed and written up for inclusion in the final report, that it will not be able to be removed from the study.	Yes/No
I understand that if the lead researcher (Charlotte Gould) is significantly concerned that serious risk of harm to myself or someone else may occur or has occurred then they may have to escalate this.	Yes/No

Participant signature………………………………………………….. Participant Name …………………………………………………..

Date ………………………….

Please note that this Consent form will be stored separately from the responses you provide.

If you have any concerns about this research, please email ethics@rhul.ac.uk.

Appendix H: Demographic Questionnaire

Demographic Questionnaire

Healthcare professionals' perspectives on barriers and facilitators to care for trans women diagnosed with HIV

Please answer the following questions. All data will be stored anonymously and confidentially as described in the participant information sheet.

1. What are your pronouns? (e.g she/her, they/them)

2. What is your gender?
    a. Cisgender
    b. Transgender
    c. Other
    d. Prefer not to respond
    e. Other (please specify)__________

3. What is your age bracket?

    a. 18-25
    b. 26-35
    c. 36-45
    d. 46-55
    e. 56-65
    f. 65+

4. Please specify your ethnicity:

    a. Asian or Asian British
    b. Black, Black British, Caribbean, or African
    c. Mixed or multiple ethnic groups
    d. White
    e. Other ethnic group

5. What is your profession?
6. What type of service do you work in?

7. How long have you worked in the HIV field?

8. How long have you provided care to TW with HIV?

9. How are TW with HIV referred to you?

10. How many TW with HIV do you work with annually?

11. What ages of patients do you see (across all populations)

Appendix I: Interview Guide

Interview Guide

Healthcare professionals' perspectives on barriers and facilitators to care for trans women diagnosed with HIV

1. **How did you come to work in the field of HIV?**
   (prompts- what influenced you, what were the messages around HIV when you were growing up? What the messages around trans people growing up?)

2. **What training have you had specifically around trans women living with HIV?**
   (prompts – professional training, training specific to HIV, gender-affirming training?)

3. **Can you tell me a bit about your clinical work or role involves with this population of women so far?** (prompts – any involvement with testing/diagnosis, ART, hormonal care?)

4. **What is your understanding of trans-inclusive care?**
   (Prompts – does your service provide this? What needs to change?)

5. **What are your thoughts on HIV prevention among trans women?**
   (Prompts – why do TW get tested, what about PrEP use?)

6. **How do women respond and cope when receiving an HIV diagnosis?**

7. **What can you say about adjusting to an HIV diagnosis?**

8. **What do you think it means to have a chronic health condition and be a trans woman?**
   (prompts – any change in identity, wellbeing, what people do?)

9. **Can you talk about the retention in care in this group?**
   (prompts – how do people engage with professionals/ medication etc…?)

10. **To what degree do you think is HIV care and gender-affirming care integrated?**

11. **What do you think is the impact of HIV or being trans is on this population's mental health or wellbeing ?**

12. **What are some of the challenges that this population may have to face?**

13. **What aspects of HIV care do you think work well and what does not work so well?**

14. **What do you find most rewarding and challenging about working with this population?**

<u>Thank you for answering the questions. Do you have anything else you would like to add that has not yet been spoken about?</u>

Appendix J: University Ethics Approval

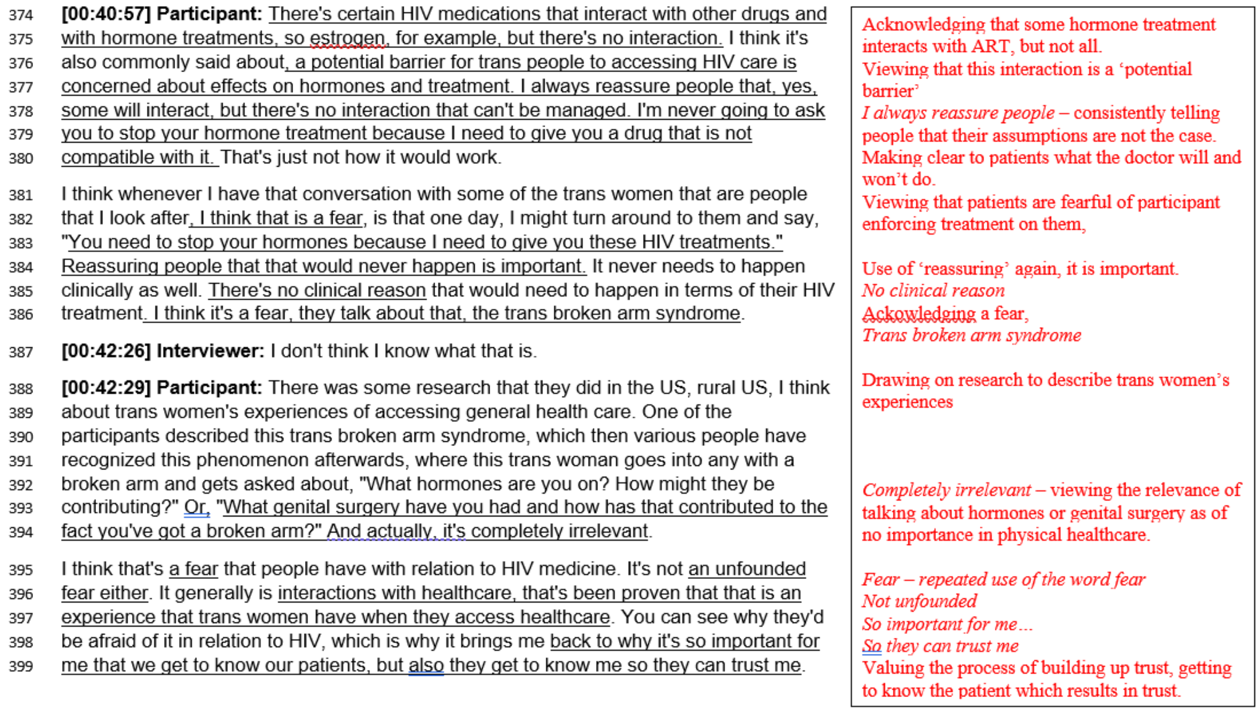
From: Ethics Application System <ethics@rhul.ac.uk>
Sent: 10 March 2022 09:15
To: Gould, Charlotte (2019) <Charlotte.Gould.2019@live.rhul.ac.uk>; Evangeli, Michael <Michael.Evangeli@rhul.ac.uk>; Ethics <Ethics@rhul.ac.uk>
Subject: Result of your application to the Research Ethics Committee (application ID 3123)

PI: Dr Michael Evangeli
Project title: Healthcare professionals' attitudes towards trans women diagnosed with HIV.

REC ProjectID: 3123

Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

Appendix K: Example exploratory comments of transcript



[00:40:57] Participant: There's certain HIV medications that interact with other drugs and with hormone treatments, so estrogen, for example, but there's no interaction. I think it's also commonly said about, a potential barrier for trans people to accessing HIV care is concerned about effects on hormones and treatment. I always reassure people that, yes, some will interact, but there's no interaction that can't be managed. I'm never going to ask you to stop your hormone treatment because I need to give you a drug that is not compatible with it. That's just not how it would work.

I think whenever I have that conversation with some of the trans women that are people that I look after, I think that is a fear, is that one day, I might turn around to them and say, "You need to stop your hormones because I need to give you these HIV treatments." Reassuring people that that would never happen is important. It never needs to happen clinically as well. There's no clinical reason that would need to happen in terms of their HIV treatment. I think it's a fear, they talk about that, the trans broken arm syndrome.

[00:42:26] Interviewer: I don't think I know what that is.

[00:42:29] Participant: There was some research that they did in the US, rural US, I think about trans women's experiences of accessing general health care. One of the participants described this trans broken arm syndrome, which then various people have recognized this phenomenon afterwards, where this trans woman goes into any with a broken arm and gets asked about, "What hormones are you on? How might they be contributing?" Or, "What genital surgery have you had and how has that contributed to the fact you've got a broken arm?" And actually, it's completely irrelevant.

I think that's a fear that people have with relation to HIV medicine. It's not an unfounded fear either. It generally is interactions with healthcare, that's been proven that that is an experience that trans women have when they access healthcare. You can see why they'd be afraid of it in relation to HIV, which is why it brings me back to why it's so important for me that we get to know our patients, but also they get to know me so they can trust me.

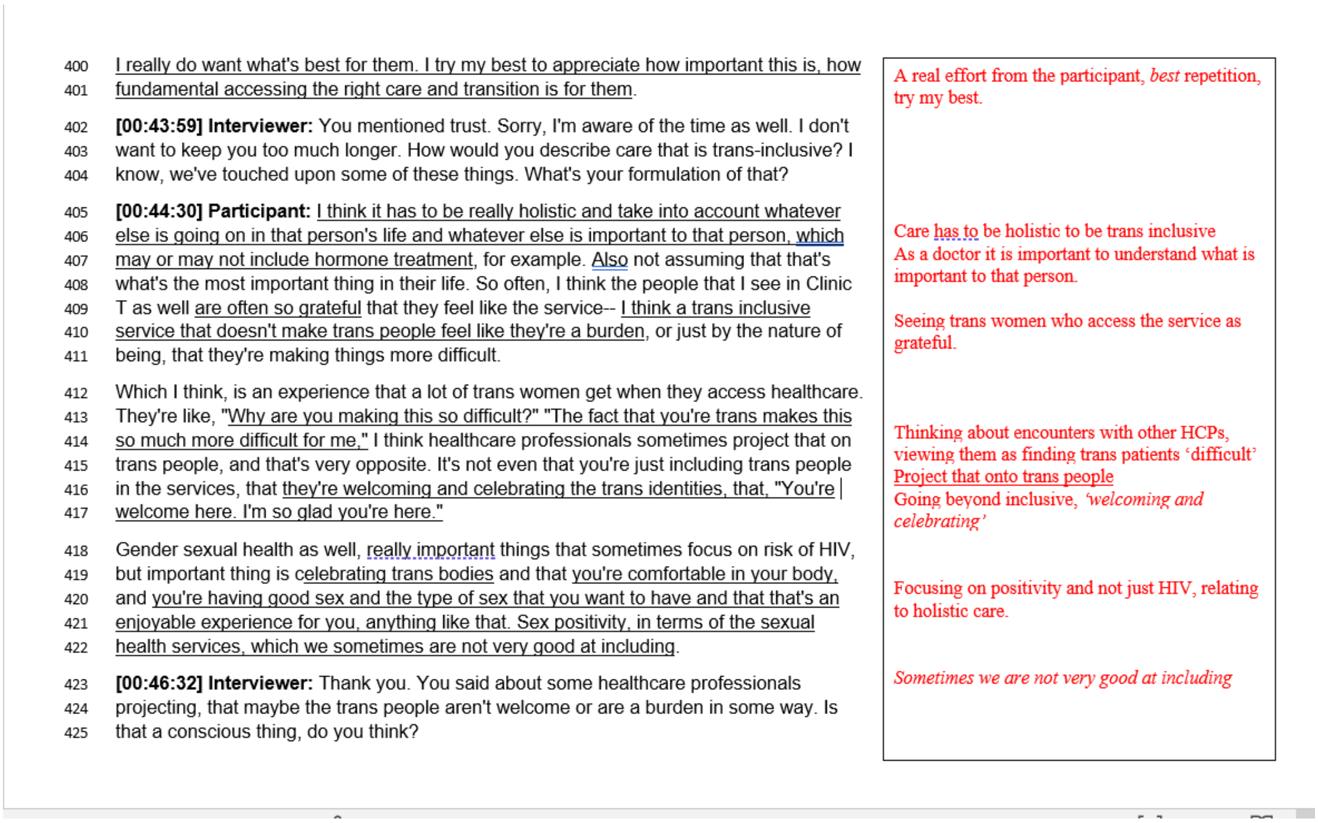
Acknowledging that some hormone treatment interacts with ART, but not all.
Viewing that this interaction is a 'potential barrier'
I always reassure people – consistently telling people that their assumptions are not the case.
Making clear to patients what the doctor will and won't do.
Viewing that patients are fearful of participant enforcing treatment on them,

Use of 'reassuring' again, it is important.
No clinical reason
Acknowledging a fear,
Trans broken arm syndrome

Drawing on research to describe trans women's experiences

Completely irrelevant – viewing the relevance of talking about hormones or genital surgery as of no importance in physical healthcare.

Fear – repeated use of the word fear
Not unfounded
So important for me…
So they can trust me
Valuing the process of building up trust, getting to know the patient which results in trust.



I really do want what's best for them. I try my best to appreciate how important this is, how fundamental accessing the right care and transition is for them.

[00:43:59] Interviewer: You mentioned trust. Sorry, I'm aware of the time as well. I don't want to keep you too much longer. How would you describe care that is trans-inclusive? I know, we've touched upon some of these things. What's your formulation of that?

[00:44:30] Participant: I think it has to be really holistic and take into account whatever else is going on in that person's life and whatever else is important to that person, which may or may not include hormone treatment, for example. Also not assuming that that's what's the most important thing in their life. So often, I think the people that I see in Clinic T as well are often so grateful that they feel like the service-- I think a trans inclusive service that doesn't make trans people feel like they're a burden, or just by the nature of being, that they're making things more difficult.

Which I think, is an experience that a lot of trans women get when they access healthcare. They're like, "Why are you making this so difficult?" "The fact that you're trans makes this so much more difficult for me," I think healthcare professionals sometimes project that on trans people, and that's very opposite. It's not even that you're just including trans people in the services, that they're welcoming and celebrating the trans identities, that, "You're welcome here. I'm so glad you're here."

Gender sexual health as well, really important things that sometimes focus on risk of HIV, but important thing is celebrating trans bodies and that you're comfortable in your body, and you're having good sex and the type of sex that you want to have and that's an enjoyable experience for you, anything like that. Sex positivity, in terms of the sexual health services, which we sometimes are not very good at including.

[00:46:32] Interviewer: Thank you. You said about some healthcare professionals projecting, that maybe the trans people aren't welcome or are a burden in some way. Is that a conscious thing, do you think?

A real effort from the participant, *best* repetition, try my best.

Care has to be holistic to be trans inclusive
As a doctor it is important to understand what is important to that person.

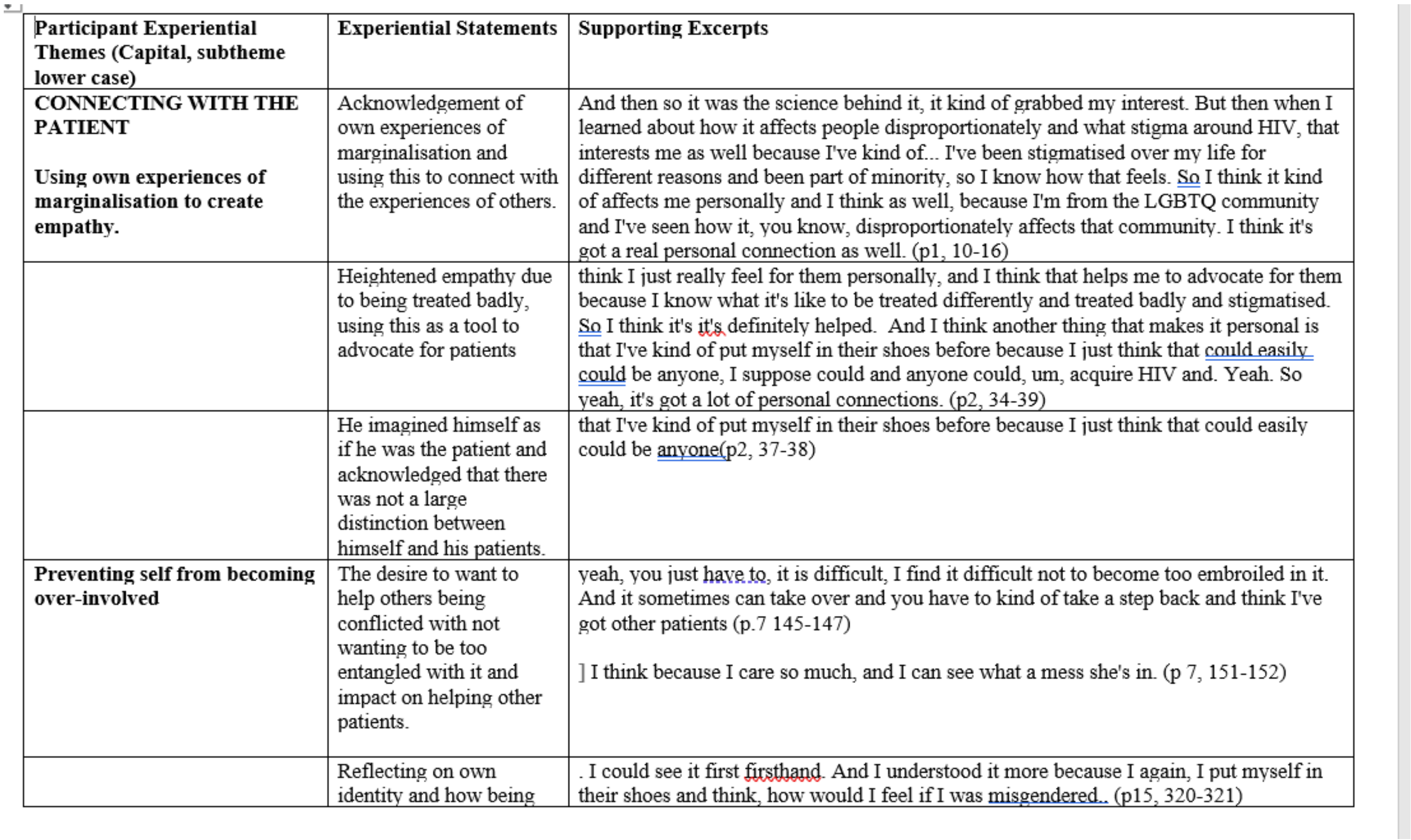
Seeing trans women who access the service as grateful.

Thinking about encounters with other HCPs, viewing them as finding trans patients 'difficult'
Project that onto trans people
Going beyond inclusive, *'welcoming and celebrating'*

Focusing on positivity and not just HIV, relating to holistic care.

Sometimes we are not very good at including

Appendix L: Example Participant Experiential Themes & Experiential Statements



Participant Experiential Themes (Capital, subtheme lower case)	Experiential Statements	Supporting Excerpts
CONNECTING WITH THE PATIENT **Using own experiences of marginalisation to create empathy.**	Acknowledgement of own experiences of marginalisation and using this to connect with the experiences of others.	And then so it was the science behind it, it kind of grabbed my interest. But then when I learned about how it affects people disproportionately and what stigma around HIV, that interests me as well because I've kind of... I've been stigmatised over my life for different reasons and been part of minority, so I know how that feels. So I think it kind of affects me personally and I think as well, because I'm from the LGBTQ community and I've seen how it, you know, disproportionately affects that community. I think it's got a real personal connection as well. (p1, 10-16)
	Heightened empathy due to being treated badly, using this as a tool to advocate for patients	think I just really feel for them personally, and I think that helps me to advocate for them because I know what it's like to be treated differently and treated badly and stigmatised. So I think it's it's definitely helped. And I think another thing that makes it personal is that I've kind of put myself in their shoes before because I just think that could easily could be anyone, I suppose could and anyone could, um, acquire HIV and. Yeah. So yeah, it's got a lot of personal connections. (p2, 34-39)
	He imagined himself as if he was the patient and acknowledged that there was not a large distinction between himself and his patients.	that I've kind of put myself in their shoes before because I just think that could easily could be anyone(p2, 37-38)
Preventing self from becoming over-involved	The desire to want to help others being conflicted with not wanting to be too entangled with it and impact on helping other patients.	yeah, you just have to, it is difficult, I find it difficult not to become too embroiled in it. And it sometimes can take over and you have to kind of take a step back and think I've got other patients (p.7 145-147)] I think because I care so much, and I can see what a mess she's in. (p 7, 151-152)
	Reflecting on own identity and how being	. I could see it first firsthand. And I understood it more because I again, I put myself in their shoes and think, how would I feel if I was misgendered.. (p15, 320-321)

Appendix M: Example Group Experiential Themes

GROUP EXPERIENTIAL THEMES IN BOLD **Group level subthemes** Supporting excerpts
1.CONNECTING WITH THE PATIENT **Situating self within the HIV / sexual health service** Yes, I was thinking about in terms of what drew me to start with the colleagues predominantly, people are open and friendly and non-judgmental, but I really like the patients as well (Sarah, p2) It was kind of, it never kind of felt right and it never kind of felt like I found a tribe, people that I could really gel with and work with until I decided to go back to sexual health. And then it really all just like, Oh yes, this is a great, great, great place to be (Zahra, p2) I'll never forget that sense of, oh my gosh, I found my tribe. I found the people that I get on with and it's okay for me to be me. That was what struck me and also the overwhelming friendliness of people working in sexual health clinics, which it's always been like that, to be honest. (Vincent, p.1) **Putting yourself in the patient's shoes** I've been stigmatised over my life for different reasons and been part of minority, so I know how that feels. So I think it kind of affects me personally and I think as well, because I'm from the LGBTQ community and I've seen how it, you know, disproportionately affects that community (Liam, p1) I've kind of put myself in their shoes before because I just think that could easily could be anyone, (Liam p2) "…And safe spaces, even simple things like male and female toilets and all the controversies around that. I can't imagine being a trans person and coming into hospital and then just doing something straightforward, like using the toilet because there isn't one that is suitable for them or one that they would feel comfortable using." (Amy, p.9) I'm trans, visibly trans and I think that, you know, we are at a point now, where trust of cisgender clinicians isn't, is, still has a long way to go (Zahra, p 25)

Appendix N: Member Checks

From: Gould, Charlotte (2019) <Charlotte.Gould.2019@live.rhul.ac.uk>
Sent:
To: Redacted
Subject: Request for feedback on interview themes

Dear participant

Thank you for your time and expertise in recently taking part in an interview regarding your clinical experiences relating to providing care for transgender women living with HIV.

It would be really helpful if you were able to provide feedback on the themes that have arisen for the project.

A table of themes is attached documenting the main findings of the study across all the participants. Please are you able consider the following:

1) Do these findings make sense to you?
2) Do they resonate with your own clinical practice
3) Do you have any recommendations in how the findings could be improved?
4) How do you consider these findings are best placed to be shared with the population it impact (i.e. trans women living with HIV)?

I understand you are all very busy with other commitments and may not be able to comment. Any feedback on the themes or recommendations for improvement is sincerely appreciated.

Very best wishes

Charlotte Gould

Trainee Clinical Psychologist

Charlotte Gould (she/her)

Trainee Clinical Psychologist

Royal Holloway University of London

Email: charlotte.gould.2019@live.rhul.ac.uk

Appendix O: Expert by Experience (EbE) feedback

Research component	Trans activist/ Expert by Experience consultation comments	Clinical Psychologist working in HIV service comments
Recruitment difficulties for original project	• Eligible participants may have felt they were 'revealing self' and disclosing sensitive parts of their identities • TGWLH may take part in multiple research projects and therefore may be deterred from taking part in this one • They could be described as having other difficulties alongside living with HIV which may make it hard to engage with research. • The notion of participants being 'hard to reach' is a fallacy, instead researchers need to integrate themselves in the communities and find appropriate ways to make themselves accessible instead of placing blame in the participants. • Participants need to know that they are valued and integrated into study designs to be involved with research.	• There is likely an apprehension and understandable resistance from TGWLH taking part in research. • Some TGWLH may have had negative experiences of healthcare and poor information handling of GPs and hospital settings as well as deadnaming which will likely further discourage individuals from taking part in research. • Engaging with the population is important and establishing links with the community prior to the study is also important.
Empirical study themes	• Many of the themes resonated with the EbE and made sense e.g. connecting with the patient. • Recognised that clinicians should mould to the patient group, not the contrary. • Trans needs to be recognised in clinic spaces more, much literature has been observed as resonating for gay males/MSM but not trans people. • Vast HIV stigma remains, incorrect notion of a 'broken body' has long been held.	• The necessity to engaging with the patient is important, especially for TGWLH, it can take a long time to build up trust with someone and garner rapport. • Uncertainty in the profession over what trans-inclusive environments look like, it is nebulous. • Specialist pilot services have been developed to partially address concerns over drug interactions with hormones., ART and recreational drugs.

	- Cisnormative assumptions of clinicians need to be recognised. - Trans-inclusivity is not appropriately defined, and problematic across settings. - The ripple effect theme → suggested that these are not transient circles bur rather static, concentric circles where the cisgender heterosexual white man is placed in the middle and the further one moves away the harder it is for individuals to access care.	- No specific SIG for transgender people, it comes under BPS sexualities group. - The 'ripple effect' is similar to the 'life cycles model' (systemic model). - Observations of healthcare professionals making assumptions about transition, e.g. medics presuming that all trans people will take hormones. - Clinicians may see TGW as problematic which patients may then internalise and needlessly apologise to clinicians for minor aspects, e.g. rearranging appointments.
Dissemination and Impact	To consider dissemination/linking in with relevant charities e.g. Sophia Forum and named researchers Future studies should embed themselves in the communities or services which provide care to TGWLH to adapt and provide appropriate study. Researchers to co-produce and co-create research with vulnerable communities and to allow voices to be heard. To create meaningful links with trans communities and those living with HIV especially those who are marginalised (e.g. black trans sex workers) To be part of the conversation of improving services and creating trans-inclusive and gender-affirming literature and information in healthcare settings	To consider speaking to relevant transgender health and HIV services, such as the one the psychologist is involved with. To share information at relevant conferences to engage with academics and clinicians, e.g. British Association for Sexual Health and HIV (BASHH) and NAZ (BAME-led sexual health agency).

Appendix P: COREQ checklist

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

No. Item	**Guide questions/description**	**Reported on Page #**
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	p.88
2. Credentials	What were the researcher’s credentials? E.g. PhD, MD	p.131
3. Occupation	What was their occupation at the time of the study?	p.131
4. Gender	Was the researcher male or female?	p.131
5. Experience and training	What experience or training did the researcher have?	p.131
Relationship with participants		p.132/33
6. Relationship established	Was a relationship established prior to study commencement?	p.132
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p.132
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p.131/33
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p.84 & 89/90
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p.87 & 91
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	p.87
12. Sample size	How many participants were in the study?	p.85
13. Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
Setting		
14. Setting of data collection	Where was the data collected? e.g. home,	p.87

	clinic, workplace	
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	N/A
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	p.85/86
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p.88
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	p.88
20. Field notes	Were field notes made during and/or after the interview or focus group?	N/A
21. Duration	What was the duration of the inter views or focus group?	p.88
22. Data saturation	Was data saturation discussed?	N/A
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	p.92
25. Description of the coding tree	Did authors provide a description of the coding tree?	p.95
26. Derivation of themes	Were themes identified in advance or derived from the data?	p.92/93
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	p.91
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	p.95-111
30. Data and findings consistent	Was there consistency between the data presented and the findings?	p.95-111
31. Clarity of major themes	Were major themes clearly presented in the findings?	p.95-111
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	p.95-111