

LGBT report peer review comment response

1. Christine Burns

Location	Comment	Response
Exec summ	I thought the Treasury has placed L+G as at least 5% of the population during the regulatory impact assessment of the Civil Partnership Bill. SORRY – I see you addressed this at p13!	No action.
Exec summ	Did you include http://www.symposium.com/ijt/index.htm ? This is significant as much of the trans related stuff has not always been published in places that the medical databases have picked up. Hence this is why you often encounter reports citing research that is often well out of date (pre 1990 in some instances).	No this was not searched (as I didn't know about this one). However I just looked through and there is no UK based general health.
p.4	Terminology? Do you mean Primary Care Trust? Also I question the ratio. The North West region has a population of 6.8 million served by 24 PCTs. This would make the average PCT catchment 283,333.	This part has now been removed.
p.4	60 million? Should you not be doing these calculations on adult numbers though – especially for sexual orientation, where the need differential is only likely to arise once self identification takes place.	England is ~ 50 million whereas GB is ~60 million. Also, some people know they are Lesbian and gay by the time they are 11 and some trans people know much earlier.
p.4	You also need to factor less urban settings such as Brighton or Blackpool.	We just don't have any data to factor this in accurately.

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p.5	<p>No. See “Trans: A practical guide for the NHS”. The 5,000 figure is based on applying the prevalence ratio of 1:11,900 to the ADULT population. It is also supported by Government polling of agencies such as DWP for gendered name changes. The figure doesn’t include transgender. Indeed the Dutch research on which the prevalence figure is based relates specifically to people who went all the way through surgical gender reassignment. Therefore the figure is not a predictor of the numbers of transsexual people who haven’t yet come forward for help. It doesn’t include transsexual people who don’t have genital surgery. Overall, in fact, it leaves out more need areas than it includes!</p> <p>The GRC process gives us a separate and more useful predictor of the incidence of cases completing permanent transition with medical support. The steady state rate of GRC applications is 25 per month (300 per year – so this is a good proxy for the number of transsexual people getting to the two year stage of transition with a gender specialist. Separately, figures obtained from the principal clinics suggest there are around 1,000 fresh cases presenting every year now for evaluation/support. The disparities between these numbers underline why a simple figure like “5,000” can be profoundly misleading – especially in terms of budgeting for annual referral arrangements in the average PCT.</p>	Wording now changed to reflect your comment.
p.5	<p>This may be a particular issue for trans. In countries with no public health care service and little employment protection, trans people are forced into the sex trade to survive and finance treatment. Generally this is not such an issue in the UK. Therefore the risk profiles are significantly different.</p>	No action taken.
p.8	Do you need to explain this term for the reader?	Now explained in section 2.1.2.

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p.19	I hate to raise this but it would be valuable to consider whether the age distribution in these studies matches the age distribution for the general population in that year. The reason I mention that is because it has been suggested that the HIV/AIDS issue results in a lower proportion of gay men (in particular) surviving to the ages where longstanding illnesses start to become more significant. Alternatively, if not death rates, is there a general problem of finding it much harder to survey older gay and lesbian people because of a retained desire to not be identified as such?	This is discussed in section 5.2.2 – limitations of the review.
p.25	Do you mean “ideation”?	Yes (!)
p.35	This prompts me to ask the wider question as to the existence of convenience sampling in ALL the LGB research you’ve examined. How do the researchers locate their LGB subjects? Is it a comparable approach to that used in the whole population studies?	No it isn’t – discussed in section 5.2.2 – limitations of the review.
p.36	See my previous remark. If the samples are biased by a tendency towards younger people of clubbing age (because of convenience factors in participant selection) is there a risk that all these studies may be flawed by a tendency to report consequently higher levels of risk behaviour?	Yes – see response above.
p.36	Could you point out somewhere that the pattern of alcohol risk factors is likely to be different among trans people. LGB folk generally have more of a social culture since sexual activity depends on meeting people. By contrast trans people tend to be less likely to drink in group social settings and more likely to drink at home or alone, where measures are not controlled for instance. The risks may be just as high but the pattern of drinking is liable to turn out to be different.	I agree with your comment but unfortunately we don’t have any evidence to back it.

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p.38	Again I think it is valuable to explain to the reader that there is likely to be a very different pattern of drug use in trans people. The recreational drugs found in clubs are likely to be far less prevalent but we know absolutely nothing about whether isolated trans people use other drugs in the same way as alcohol to escape their situation.	See comment above.
p.51	It would be nice to have a table so that the percentages can be more readily compared.	This is now being done.
p.51	<p>I think you would need to distinguish episodes of exogenous depression arising from external factors particular to the transition period or not “passing” from spontaneously arising depression long after transition.</p> <p>Note that since this is a section about health experiences it may be worth pointing out the national studies I referred you to (Whittle et al and the work by the London SCG / AIAU) are both capable of being broken down to regional level so that figures COULD be extracted for West Midlands. In any case I recall that the representation by gender and age of the WM participants was comparable to the overall proportions, so results can be inferred. It would be nice to try and refer to some trans research in this area, in spite of the fact that there is none specific to WM, as the results are significant.</p>	<p>I agree but we have no information on this.</p> <p>The Whittle survey you refer to is listed in appendix 3. There was no information I could obtain that was includable according to the inclusion criteria.</p>
p.52	General practitioners?	No there was also teachers, practitioners seemed like the best generic term.
p.73	I recommend that you explain here the criminal law implications of improperly disclosing the background of a trans patient with a GRC. No research is needed to support such a statement; it’s simply a fact that health staff may be reported to the police and prosecuted under section 22 of the Gender Recognition Act for disclosure without consent. See the NHS trans guide for a more detailed explanation.	This has now gone into Section 4 with all the other legal material.

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p.73	Certainly for trans people too.	Agree but this is reporting the results of the systematic review and no trans research was includable.
p.74	Same goes for the substantial volume of DH/NHS resources now available re gender identity.	See comment above.
p.77	Note that gender reassignment is already part of the public sector gender equality duty. The intent in the new Equality Bill is to clarify this further and extend the definitions to cover a wider variety of people	This section has been rewritten.
p.78	You may wish to note that the likely trans population of each English region is estimated to be in the region of 500-550 people. (Essentially 10-11% of the 5,000 figure. This puts a sample of seven people (who were probably a convenience sample anyway) into clear perspective.	The extra bit added to the epidemiology section brings this point out.
p.82	The same goes for trans related research too.	I agree.
p.83	Again I would be grateful if you would refer to the available trans experience surveys even if only to explain that they were not included because they're not peer reviewed, published in a journal or broken down specifically for the WM area. The point is that although I appreciate the purpose of the study being to look at WM research, the audience need to know that there is at least SOMETHING they can refer to as indicative findings to tackle the trans evidence void.	This is now mentioned in section 5.2.2
p.83	Could you consider a rider to make that point for trans?	Now added - This is particularly true where no information was available, such as for trans health.
p.84	The lack of a previous baseline to compare will also impair the ability to draw any conclusions about improvement.	Agree – now added.
p.84	Do you mean adult men, young adults? (18-65) or all adults (18-death).	All adults.

Location	Comment	Response
p.85	The figure also suggests that action directed at reducing self harm in the LGB population specifically would have a disproportionate effect on reducing the overall statistic. Remember that the 2.4% figure is inclusive of the LGBT population. If you addressed self harm in LGBT it would reduce the overall numbers by 62.5%! A case, if ever, for targeted actions.	Agree - sentence added.
p.86	Consider rephrasing.	“Ever” removed.
p.88	And (separately) trans people. A relevant question because it is often erroneously asserted that lots of trans people regret their treatment and go on to be suicidal, whereas the available evidence suggests that the risk is significant in untreated gender Dysphoria but then diminishes markedly following treatment. What we don't know is the incidence of non-transition related to mental health issues post transition.	Separate bullet point added.
p.88	Similar question re trans people – possibly exacerbated by issues relating to use of public sports centre facilities.	Sentence added.
p.89	I don't know how you could deal with this but there is a string of related questions for trans people which you cannot ask here because the methodology prevents you from considering the research the points to the problems. Is it possible to include a paragraph to make that point in some way? Otherwise, although you put a very important trans issue first in your list, there is a risk of readers coming away with no awareness of the specific health issues relating to (for example) self medication by trans people, or the effects of the high rate of people reporting being refused healthcare by GPs.	I have put some of this in anyway because I think it needs to be there.

2. Justin Varney

Location	Comment	Response
NB This peer review is handwritten and straightforward changes have not been listed here		
Exec summ	Needs to be more crunchy, from what you've said should recommend: - routine monitoring of s/o across HES - inclusion of s/o and g/I monitoring in all research (pop based) - target research in to specific causal relationship	This section now completely rewritten to make clearer about requirements needed.
p.3	Rephrase around disclosure and fear of discrimination – there is research on this I think and methodology is important.	Rephrased, NB The aim of the background sections is solely to give sufficient information so that the reader can understand the rest of the review.
p.5	Might be worth reporting % BME in census or disability estimated.	See comment above, no BME/disability research was included.
p.5	US did urban prevalence study over 10 cities which said higher in urban centres.	UK added.
p.6	Dutch study on prevalence.	Section now reworded.
p.7	This needs to be in the aims section.	Not in the rigid format of REP reports.
p.9	Might need to justify more (about excluding HIV research) as there might have been transfer of messages.	Justification sentence added to end of section 2.2.
p.17	Wondered about the reviews done for civil partnership?	The only civil partnership review I know of was for prevalence, rather than health. Nothing else came up in the searches.
p.18	Need footnote to define (impact factor).	Now done.
p.20	Interesting given HIV is a disability.	Now put into background section that MSM with HIV/AIDS comprise approximately 0.02% of the gay male population.
p.20	Is this about access or health?	Its about health service use really.
p.21	This is very significant and needs to be flagged (2% cancer rate).	Yes but the sample is very small and convenience, so we really don't know how accurate.
p.22	What does this mean (GHQ scoring system).	General explanation of questionnaire measures now in section 2.2 explanation of outcome measures.

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p.54	Link to target in national sexual health strategy.	This is now in the discussion section.
p.67	Concept of social norm for health risk.	No action taken.
p.83	Lots of maternity repeating same message?	This section now edited.
p.86	Legislation and policy framework – rephrase and link to NHS constitution.	This section now rewritten, including NHS Act. However, the heading is fixed for REP reports.
p.88	Can you compare to BME or disability.	Relevant BME literature now inserted.
p.89	Might be an artefact because need assistance so are investigated.	So are the heterosexual women comparison group
p.92	(strength of team) not sure if relevant but might be for local politics	I think this is important for credibility.
p.96	May be worth referencing Bolton’s targeted resource.	There is another one in Glasgow and the Audre Lord clinic, but I think we need to concentrate on the West Midlands and general NHS services for this.
p.98	Might be better to cluster there 1, epid/PH research 2, prevention/screening, 3, treatment intervention 4, outcomes 5, causality	The order it was in was driven by the results section, now clustered into themes.

3. Ruth Garside

Location	Comment	Response
	<p>Thanks very much for giving me the chance to see this – I enjoyed reading it!</p> <p>As a general point, the title suggests that you will be comparing LGBT health in the W. Midlands to that in the UK, but in fact a lot of your comparison in Section 3.23 compare LGBT (from WM or the UK as a whole) to the general population. This may need justifying? Although, I do think it is reasonable as there is so little health data from any source for the LGBT population. You may need to make some statement for the qual stuff about whether or not you are assuming that the findings are transferable from other UK locations to the W. Midlands.</p>	<p>Thanks for reading! I have generally tried to make the changes you have suggested. I think they are all good points but, in a few cases where changes haven't been made that was more in consideration of the report recipients. They will not be particularly knowledgeable about methods of qualitative review and I considered that some of the detail might act to confuse rather than clarify issues.</p> <p>Inserted at the end of section 3.2.5: Since limited qualitative data was available from West Midlands surveys, discussion of qualitative findings relates to all UK studies. It was considered that findings would be reasonably generalisable to the West Midlands area.</p>
	<p>Also, it is quite difficult to get a picture of what's going on in the effectiveness review because there are so many different outcomes etc. Some summary statements in each section about what the data says (or doesn't say) would be helpful.</p>	<p>Not sure if you are talking about qualitative results but, as another reviewer commented that it would be useful, a table has been inserted to summarise qualitative findings (table 44 p.79)</p>
<p>p.11 (& p.139, Table 54)</p>	<p>Quality assessment tool – the Wallace criteria doesn't have the “+” “-“ scores – these are from NICE – not sure if you want to include them, (I wouldn't!) especially as there doesn't, at first glance, seem to be that much difference in criteria in Table 54 between those you've given + and those given -) if you do, you should probably say in the methods how you made the decision to give a positive of negative grade.</p>	<p>Removed + and – scores</p>

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p.12	<p>The description of what you did to analyse the findings is very sparse - were the findings synthesised or summarized across studies? Once we get to the results section it appears that you have summarized the health related areas discussed by the papers and then produced a thematic analysis which identifies and synthesises barriers to good healthcare under a series of sub-themes.</p>	<p>More detail given (p.12).</p>
	<p>Where do these thematic headers come from? Are they taken from the included literature or introduced by the research team? How did you decide which to use? For example, are the concepts of items such as “conferred and internalized homophobia” described in the papers? If not, when did you decide to use them – prior to reading the papers, or through reading the papers? If so, did they all use this terminology or have you assumed that some papers are talking about this, even if it is labelled another way in the papers itself (i.e. you have “translated” the findings of one paper into those of another as in meta-ethnography?). If not, how did you come to use this terminology, and how did you apply these terms and interpretive tools to understand the literature?</p>	<p>Themes were derived from the included literature, identified by reading all studies. Studies were then re-read to retrieve all data relevant to those themes.</p> <p>Described p.12: Qualitative information on experiences of LGB healthcare from the point of view of patients and professionals was extracted. Synthesis was conducted using an approach similar to meta-ethnography but involving both first order concepts (expressions of participants) and second order concepts (interpretations or explanations by researchers of included studies) in thematic analysis. Themes were identified by reading the included studies. Papers were re-read and relevant concepts were grouped into these themes narrative discussion. Synthesis was undertaken by a researcher who has no particular theoretical approach to qualitative research or LGB health. Data extraction and thematic synthesis was conducted by one reviewer. Another reviewer read papers and checked findings for consistency.</p>

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	<p>You might find it helpful to distinguish between first order concepts (the words of the participants that are used to interpret their experiences), second order concepts (the interpretations of these by the primary researchers) and your interpretations as reviewers (3rd order interpretations – see (Britten et al. 2002;Campbell et al. 2003). Have you organized your analysis by interpreting the primary data, or by interpreting/ synthesising the existing interpretations of the findings?</p>	<p>Both primary data and interpretations of findings were used. Details given (see p.12).</p>
	<p>How many people undertook the analysis? If more than one, how did you collaborate to analyse the findings and to produce the synthesis?</p>	<p>One (p.11).</p>
	<p>Meaning of the last sentence on p.12 is unclear. Does it mean that you didn't have an extraction sheet? How did you code the findings that were extracted?</p>	<p>Didn't use a formal extraction sheet. Findings were highlighted as relevant to certain themes on the papers themselves as went through. A record was made of the concepts identified. Themes were then developed by reviewing the concepts. Once themes had been generated, papers were re-read and all data relevant to each theme was directly entered into a word document.</p>
<p>p.62 3rd para</p>	<p>You say that the studies used qualitative techniques to collect and analyse data but only report the data collection methods – what methods of analysis did they use? Did any claim recognized philosophical approaches (IPA, grounded theory etc)? Also, what, if any, use of theory was there? Also, the status of self completed questionnaires as qualitative research may be equivocal especially, I suspect, where 307 participants are involved! I assume you mean that there were open questions on a survey – but how were they analysed?</p>	<p>Methods of data analysis and theory of approach have been inserted in table 43 p.56.</p>

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p.62	It might be helpful to discuss the focus of the included papers and how you approached this in the analysis. For example, some are very focused – on treatment of homosexuality since the 50s, or homophobic bullying on schools - whilst a number of others are more clearly similar – about experiences of healthcare among LGBT. How did you approach these differences in the analysis? Did it cause any difficulties? Did all contribute to the synthesis? Did some contribute more than others? Did it mean that some findings were not included in the synthesis because they did not have much overlap with your interests? Etc.	See bottom p.54. The source of each first or second order concept was stated to give transparency but data from different sources was not treated differently in the analysis. Some papers contributed a lot more data to the review than others. If findings were not relevant to the review i.e. did not address LGB health, they were not included and, where a theme was only identified from one source or weakly identified, this was not always included.
p.65	Are these speculations about the impact of the sexuality of the researcher based on your interpretations or do these come from the primary research authors? It's not clear here. Is this the only or main concern of reflexivity?	Where researchers are explicit about their sexuality, this is noted in quality assessment (table 57). In most cases it is not and these speculations come from own interpretations.
	It could be argued that, as review of qualitative research is also an interpretive endeavour, some reflexive practice from the <i>review</i> authors is also good practice....what ideological perspective do you bring to the review? How might this “bias” your interpretation?	p.12 has stated that no particular ideological perspective. But I suppose will always have a perspective of some sort!

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	I would also suggest that the language of “bias” and “unbiased” is not that helpful in this context, since all people come with their own agenda, there is no one objective answer – it’s about perspective, orientation and/or focus and how open and thoughtful people are about this in the write up. The criteria are quite different to quantitative research. In addition, there is a long (legitimate) tradition of “emancipatory” or advocacy research within qualitative research – identifying and articulating marginalised voices to emphasise their particular needs. Within this context, emphasizing where systems or people are, rather than are not, homophobic (for example) is completely legitimate. The language used to articulate this - “at the mercy of” the researcher, sounds very distrustful – do you mean to be so?	Removed these terms (p.58).
p.66	“sources of bias and confusion”? Do you mean it confuses you? - Not sure that this is an appropriate term!	Removed (p.58).
p.66	Are all the health behaviours you discuss perceived as relevant to both gay men and lesbians? Who identified these – health professionals or LGBT community?	Identified by research of LGBT individuals. For most, but not all of the behaviours mentioned studies had been done in both men and women.
p.66 3.2.6	You say that you are “summarizing” the literature – is this right? i.e. you have summarised all the findings in all papers without trying to synthesise them or understand them in relation to each other or interpret the findings?	Replaced with ‘brings together’.

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	<p>Again, it is not clear whether the focus on barriers to healthcare is your imposed focus and thematic organizer, or if this comes from the primary research. Similarly for the list on p.67. I would also have thought that it is important to identify areas of agreement and disagreement between key areas identified by LGBT and the health professionals.</p>	<p>The focus comes from the primary literature identified from reading the papers.</p> <p>By the headings, whether the discussion relates to patients/professionals has been added (p.60-61 and p.73)</p> <p>The table in appendix 7 may help as it shows which studies contributed to which themes.</p>
Section 3.2.6.2	<p>Throughout his section, it would be helpful to be totally clear about who and what is being quoted – participants vs. author quote is not clear in a number of places; if the study is of health professionals vs. LGBT; man vs. women – there may be others. This may mean reassigning labels since “respondent 9” for example isn’t informative outside the primary study. It may also be helpful to summarise which studies contributed to a theme at the beginning of the section – for example whether studies among lesbians, gay men and health professionals all identified the same theme. Alternatively, it may be possible to do a table showing which studies contributed to which themes.</p>	<p>To try to make it clearer I have added (p.59-60): “In the text, <i>“Italics”</i> are used to identify concepts from study participants and ‘single quotation marks’ identify concepts of study authors.”</p> <p>Made change to make the identity of the respondent clearer.</p> <p>Table with studies included for each theme has been added in appendix 7.</p>
	<p>In addition, there are no ref numbers in table 42 making it difficult to cross reference between reported study findings and the aim, date, location etc. of the studies</p>	<p>Added.</p>
p.68-70	<p>Most of the stuff reported about conferred homophobia relates to a historic study. It may be helpful to consider the impact and relevance of this to current practice more clearly. Alternatively, should it be excluded? - Particularly as you excluded studies published post-2000 presumably as the expressed views were likely to be dated?</p>	<p>Although these studies relate to historical events, views expressed are current and so considered relevant.</p>

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	In addition, given the focus of the review, there are distinctions to be drawn here, and in the following sections, between the impact of a homophobic culture generally (?and its impact on health) and the way that this is explicitly expressed in people’s experiences of healthcare.	In this review, concepts relating to expression of homophobia in the healthcare setting were found but no information relating the impact of the generally homophobic culture on health was identified. Drawing distinctions maybe useful but, since the latter type of evidence was not found, it was felt that distinction between these might act to confuse readers rather than clarify.
p.70	Middle paragraph - is the interpretation of the GPs language as homophobic yours or the primary study authors? It isn’t clear.	My interpretation. Study author interpretations are always in ‘quotations’ or referred to as author interpretations.
p.71	“in the body of qual. research...” is this your interpretation of the findings and /or quotes, or is it found in the literature itself (note as well that although you say “in the body of” all the quotes used are form a single study).	It is my interpretation. Changed to “in one study”.
p.72	Following on from the comments above, is it you or the authors of the papers that are making the distinction between homophobia and heterosexism? It would be useful to identify where the use here has come from.	I have made the distinction. But it is made commonly by other researchers in this area.
p.74/5	It’s not clear to me why the stuff about inappropriate behaviour is here rather than in the homophobia section? You may well have a rationale that just needs outlining more clearly.	Yes, to a certain extent I agree that this fits in the homophobia section. The emphasis is slightly different though – not only having homophobic attitudes but when doctors etc do not give proper treatment/act in a non-professional way.
p.79 2 nd para	– again – I think that this is <i>your</i> interpretation of the findings but these needs to be made clear.	Yes, it is my interpretation but that should be made clearer by the bit added on bottom page 59-60 (In the text, “ <i>Italics...</i> ”).

Location	Comment	Response
p.82	“suggestion that confidentiality not always maintained” in 1 st sentence paragraph 3 but many examples quoted are about perceptions or fears, rather than an actual breach?	Yes, have changed to: “Participants in some studies had concerns about confidentiality in relation to their sexual orientation”.
Minor points	There are some odd page breaks where Word has done its weird thing of attaching cross references to breaks in the figure/table label.	Yes we’ve tried to tackle this – ongoing problem.
p.V. 1st para	– “trans” in full in the abstract or put in the Glossary?	This is explained in section 2.1.2.
p.V 3rd para	“circulated for comment” – to whom?	Now changed to “NHS and academic colleagues for comments”.
p.V	Methods says non-peer reviewed research was excluded but results mentioned that unpublished research was included – unclear here although I know that this is explained in greater detail in the review body (p.6-7) – it would be helpful to have some more explanation here is space.	Now reads “Included were West Midlands surveys, systematic reviews with UK studies and peer reviewed and published UK quantitative and qualitative primary studies on LGBT people reporting any physical and mental health outcomes, health behaviours and experience of healthcare”.
p.V	Results section – there may not be room, but some indication of the research designs and focus would be helpful here?	These are in Appendix 5.
p.1 2.1.1	Typo “.”	I’m sorry but I can’t find it.
p.3	It’s not clear what a “category 2” ONS ques is.	Footnote now added to explain.
p.13	No description of how the qualitative research will be presented, only quantitative.	This is given in section 3.2.5 onwards, now mentioned on p12.
p.20	Last sentence – would be helpful to repeat the % of LGB people taking medication here.	There was a general difficulty of whether to repeat tables in the text or include general population data in tables. In the end, the latter has been chosen.

Location	Comment	Response
p.20	Sentence beginning “equivalent rates...” Is problematic – not clear which “categories” are referred to as so many different measures in Table 6.	Equivalent removed.
	Also is it true that rates of very good or good health are lower in the LGB population than the general? 74% general pop vs. 79.3% women in excellent or good health in Prescription for change, “very good or good” 86.2% WSM, 81.7% WSMW and 87.8% WSW in Mercer et al 2007?	Wording changed to difficult to determine.
p.28 Table 15	There are big differences in lifetime suicide attempts between men and women – worth highlighting in the text?	There is high heterogeneity in the men’s so I decided not.
p.28	May be useful to reiterate that the published papers are UK based?	Rivers now is a new paragraph to distinguish from the systematic review.
p.31 Table 17	The write up & title around this are about infertility but reports acnes, hirsutism etc as well. A bit misleading – I assume acne isn’t a cause of infertility!	Now inserted - With regard to baseline characteristics of the two samples.
p.61	Break down the number of papers with gay men and women here?	This is in table 43.
p.68	Your comment “the direct physical abuse...” etc. seems to suggest that the other treatments described might be acceptable!	We are unclear how you interpreted the sentence that way so it has not been changed.
p.85	– typo third line “that” instead of “than”.	Changed.

Britten, N., Campbell, R., Pope, C., Donovan, J., & Morgan, M. 2002, "Using meta-ethnography to synthesise qualitative research: a worked example", *J Health Serv Res Policy*, vol. 7, no. 4, pp. 209-215.

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. 2003, "Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care", *Social Science and Medicine*, vol. 56, pp. 671-684.