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”Competent persons who can treat you with competence, as simple as that” - An interview study with transgender people on their experiences of meeting health care professionals

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Background Transgender people face prejudice and discrimination world-wide. Little is known of their experiences in sexual health promoting settings.

Aim With a focus on sexual health and rights, this study describes how transgender people experience meetings with health care professionals.

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Method Within a descriptive design, 20 persons aged 18-74 and identifying as transgender and non-binary were interviewed. The results were analysed with constructivist Grounded Theory.

Results Disrespect among health care professionals is the core category connected to the experiences in the result; transgender people experience estrangement, expectations and eviction in different sexual health-promoting settings.

Conclusion Transgender knowledge needs to be increased in general, in both specialized transgender health care and many other health care settings, in order to prevent transgender peoples' experiences of estrangement. Moreover, an increased knowledge of, and respect for, sexual health and rights is needed to prevent transgender peoples' exposure to gender binary, cis- and heteronormative expectations. In addition, access to sexual health care is essential following gender confirmatory care as well in order to avoid transgender peoples' experiences of eviction from the health care system.

Relevance to clinical practice Nurses have an important role to play in striving for equity and justice within health care. This study describes how health care professionals appear to be disrespectful and suggestions of how this can be avoided are made.

Keywords Access to sexual health care, Discrimination, Health care professionals, Heteronormative, Non-binary people, Sexual health and rights, Transgender people

Introduction

Sexual health is as a fundamental part of general health. To have your sexual rights respected can be described as the means to an end, where sexual health is an end. In a recent report the World Health Organization, WHO, states that transgender and gender variant people worldwide do not get their sexual rights respected, and are continuously exposed to

stigmatization, discrimination and legal, economic, and social marginalization and exclusion (World Health Organization, 2015). This discrimination also appears to take place within settings where nurses are involved. In a comparative study on being transgender in Europe, including 28 countries, data from 6, 579 respondents were analyzed. More than half of the participants stated that they had been discriminated against during the last year, and one of five noted that this discrimination had taken place within a health or social care setting (European Union Agency for Fundamental Rights 2014). Consequently, in a recent meta-synthesis of qualitative research on the lived experiences of transgender people, the authors stress the need for health care providers and health promoters to support transgender people (Moolchaem et al., 2015).

This paper presents findings from an interview study with transgender and non-binary people in one European country, Sweden. The main focus of the study was sexual health. However, many informants shared experiences of meeting health care professionals and other professionals in different sexual health-promoting settings. These experiences will be presented. Suggestions of practical use for nurses will be given, on how to respect the sexual rights of transgender and non-binary people and thus provide person-centered care.

Background

Transgender people

The unifying term “transgender” is not unproblematic, nor accepted by all. The term can however be less stigmatizing than a psychiatric diagnosis that often is a prerequisite to access gender-confirmative care. This pathologization of a lived experience, where a person is ascribed a psychiatric diagnosis that defines them as deviant from the binary gender norm is seen as offensive to some transgender people (Krieg, 2013; Moser, 2014). In this paper, the term transgender will be used throughout, as a description of an individual whose gender

identity or gender expression partly or always differs from the norm of the gender ascribed to them at birth. This also includes individuals who identify as non-binary, that is as neither female nor male, or both.

Transgender research is a rapidly growing area, and “transgender subjects are increasingly understood to constitute populations to be researched and from whom data can be collected and analyzed in the name of rendering them visible, promoting their health, conferring them with rights, and marketing to their needs” (Stryker & Aizura, 2013, p.5). Research concerning transgender people and health tend to have a medical perspective. A current example of this is to be found in the abstract book from the World Professional Association for Transgender Health, WPATH, summarizing the latest global conference on transgender health (World Professional Association for Transgender Health, 2014). The lion’s share of the abstracts describes quantitative studies mainly on transsexual people and different medical aspects of gender confirming care, and access to and quality of this care. How transgender people experience health care has been investigated, and experiences of navigating the health care system through four sub-processes were seen among the 25 informants: moving forward, doing due diligence, finding loopholes and making it work (Roller et al., 2015). When “moving forward,” informants decide to actively seek out health care professionals that could assist them with their specific needs in a non-discriminatory fashion instead of turning to any health care professional. The sub-process of “doing due diligence” is characterized by experiences of being persistent in finding out what health care one needs or wants. “Finding loopholes” describes informants’ experiences of negotiating different health care systems and dodging barriers in order to have their health care needs met. Lastly, “making it work” describes the sub-process of getting one’s health care needs met over a longer period of time (ibid.). The study contributes valuable knowledge of how

transgender people experience health care, and gender-confirming care in particular. Sexual health care is, however, not specifically addressed.

Transgender people and sexual health

In this paper, sexual health is seen as a holistic experience of physical, emotional, mental and social wellbeing, not merely the absence of disease, dysfunction or impairment (World Health Organization, 2015). On the conceptual level, reproductive health is seen as part of sexual health, not a separated area or concept. Wierckx et al. (2011) state that although sexual health following gender-confirming care is a significant area, it is not adequately addressed by professionals. Studies examining quality of life and health-related quality of life among transgender people exist (Motmans et al., 2012; Pitts et al., 2009). But in the standardized self-report instruments used, the holistic concept of sexual health is not addressed. Aspects of sexual health have also been investigated in studies regarding results of gender confirmatory care. But again, standardized self-report instruments were used, and the focus was on post-operative sexual function rather than sexual health as well-being (Costantino et al., 2013; Weyers et al., 2009). Transgender people globally have been described as having an over-risk of contracting HIV or other sexually transmitted infections, in particular, transsexual male to female (Baral et al., 2013). At the same time, others warrant that HIV preventive programs or actions must acknowledge the heterogeneity among transgender people, and that it is hazardous to make assumptions on what sexual risk-taking exists, or does not exist, in this group (Bauer et al., 2012). Studies with a qualitative approach, focusing on transgender people and their experiences of holistic sexual health, have not been found.

Nursing and transgender sexual health

Sexual health among transgender people is an understudied field in nursing research as well. Furthermore it brings together two concepts and research areas – sexual health and transgender health – that in themselves have been reported as connected to invisibility, lack

of knowledge, prejudice and bias within nursing education and practice (Arikan et al., 2015; Carabez et al., 2015; Lim, Johnson & Eliason, 2015; Merryfeather & Bruce, 2014; Zunner & Grace, 2012).

Against this background a search for transgender peoples' own descriptions of sexual health is important. In 2015, an interview study on transgender peoples' experiences of sexual health was conducted on behalf of the Public Health Agency of Sweden (forthcoming). Experiences and factors of importance for sexual health among transgender people in different ages, life phases and social circumstances were examined. The informants' stories were rich in experiences from meeting professionals, primarily health care professionals, including nurses. These narratives will be presented in this paper and contain valuable input on how nurses, and other health care professionals, can provide transgender people with non-discriminating person-centered sexual health care in accordance with international ethics and laws (International Council of Nurses, 2012; World Health Organization, 2015).

Aim

To describe transgender peoples' experiences of meeting sexual health care professionals.

Methods

Theoretical underpinnings, preconceptions and ethical considerations

The lived experience of sexual health in the contemporary society is central in this study.

With a social constructivist approach, an understanding of different aspects connected to sexual health were sought. The chosen perspective means that the stories the research participants chose to share, and the interpretation of them, is seen as a contextual construction. Throughout the study, the human rather than the gendered person has been important, a humanistic rather than a transgender political approach. Moreover, the study has a public health approach where sexual health is seen as an important public health goal, and a

human right for all. Nevertheless, an awareness exists that transgender politics is important, especially from a human rights perspective. The study refrains from psychologizing or pathologizing; to understand why and how someone is transgender has not been of importance. This position is not only a methodological choice but also a statement of support for the ongoing discussion on pathologization within the transgender politics (Krieg, 2013; Moser, 2014). The researcher's preconception and position can be summarized as an outsider's perspective, with no experience of working with transgender people, however sexological competence and experience in conducting sexual health research.

To conduct a study with transgender people on sexual health includes, on the one hand, a risk of cementing stereotypes, or, on the other hand, to further categorize or marginalize those who might already have these experiences. A stereotype that can easily be reinforced is that the transgender experience is primarily about sexuality, which it is not. It mainly concerns gender identity. The risk of further marginalization encompasses what can easily occur when people are grouped together in research; variations and heterogeneities may be lost. Apart from focusing people in sometimes marginalized positions, the study concerns sexuality, a subject that for many is private. No reimbursement was given to the participants. Instead, the opportunity to discuss aspects of your life with someone interested in them was regarded as potentially beneficial. A participatory approach has also been applied. A public transgender person, experienced in transgender- and sexual political activism, was contacted and read the ethical application as well as the results in different stages. This was part of an ambition to conduct research not about, but with, those concerned. The study was approved at the regional ethical review board in Lund, Sweden. Participants were informed in writing and orally on the right to withdraw from participation at any time. Oral consent was received, but not any personal information that made identification possible.

Design and data collection

Transgender peoples' experiences were sought, consequently qualitative interviews were conducted, within a descriptive design. A diverse sample was wanted, with the purpose of illustrating variations as well as similarities. Study information was spread through two non-governmental organizations: an organization whose members identify as transgender, and through a sexual political organization. In addition, five key persons who are active within sexual activist organizations or working within gender-confirming health care were asked to spread information of the study in their respective networks. A person interested in participating was asked to contact the interviewer (the author), via email or phone. Inclusion criteria were to be 18 years or older, to identify as transgender, and be willing to share thoughts on sexual health.

During four months, December 2014 to March 2015, twenty interviews were conducted. The informant chose the way to be interviewed; in a meeting (n9), over Skype (n6), over the phone (n1), or in writing (n1). The interviews had a narrative rather than interrogating character; the informant was asked to develop hir thoughts on sexual health, not answer a battery of questions. Informed consent to audio record was gained, and the interviews lasted between forty-five minutes and three and a half hours, on average, one and a half hours.

Analysis

Constructivist Grounded Theory was used. This implies an inductive, systematic and comparative approach, suitable in a study with the purpose to concretize and theorize themes important to people in their everyday life (Bryant & Charmaz, 2010; Charmaz, 2010). Initial knowledge of the research questions was sought, and the analysis started after the first interview. During the following interviews similar, but also varying, experiences were pursued. Generalizable knowledge was not the aim, but nuanced descriptions. When twenty

persons had been interviewed a subjective assessment was made on saturation (Bryant & Charmaz, 2010; Charmaz, 2010), since the results mirrored the informants' experiences well enough, and data collection ended. In order to further strengthen the findings, a research seminar was held where a first draft was presented. Invited and present were participants from different transgender communities as well as sexual political communities, professionals within specialized transgender care and within public health focusing on sexual health as well as sexuality researchers and policy makers. The fifteen seminar participants gave valuable comments, mainly suggestions on how to clarify the presentation of the findings.

The twenty study participants constitute a heterogeneous group, although they all have certain things in common. One of them is experiences from interacting with different health care professionals, mainly sexual health care professionals. Among the professionals mentioned are specialists within specialized transgender care such as counsellors, endocrinologists, nurses, psychologists, psychiatrists and surgeons. Different professionals from outpatient care are also mentioned: midwives, nurses and physicians in primary health care clinics or clinics focusing sexual health such as youth clinics, STI-clinics or gynecological clinics. Moreover, counselling professionals within the municipality and the church are mentioned, as well as teachers. Disrespect among health care professionals is the core category connected to the processes in the result; transgender people experience *estrangement*, *expectations* and *eviction* in different sexual health-promoting settings. The results section is divided into these three themes, but initially a thick description of the informants will be given. This is motivated by a wish to emphasize the heterogeneity among transgender people.

Results

The informants

Ages, ethnicities, places of residence, educations, employments and identities

Twenty persons with transgender experiences participated. To maintain confidentiality they are presented at an aggregated level. Names, many of them gender neutral, have been replaced, and exposing events have been changed. Pronouns are used according to how the informant used it, and when the informant identified as non-binary or when not known, the gender neutral pronoun *hir* is used. In the quotes, the informant's initials and the interviewer's (XX) are used. The words of the informants are also present in the text, in *italics*.

The informants are 18 -75 years old, with an average age of 35 and a median age of 30. The younger are often in the beginning, or in the middle of an evaluation and treatment process at one of the six national gender identity clinics. These teams and this process will henceforth be called specialized transgender care. The median-aged informants have in common that it often, but not always, has passed five to ten years since they were in specialized transgender care. Among the older ones, different experiences are found. Some are, although relatively old, in the beginning of a gender-confirmatory process. Others were in this care setting nearly twenty years ago. The different ages are also connected to different ways of speaking about sexuality. The younger ones have a more straightforward vocabulary, often with a human rights connotation.

A majority are born and raised in Sweden, a few have another north or middle European background. A fourth live in one of three largest cities in Sweden, half in another city, and the last fourth in a smaller city or rural area (less than 10,000 inhabitants). The places of residence have a vast geographical spread, from the very south to the north of the country. Most informants have finished high school, and many have a university degree.

Most work or study, a few receive livelihood support due to psychiatric ill health and yet another few are searching for an employment. Among those who work or study, most are open about their transgender identity or experience at the work place or at the educational facility.

When the participants are asked about how they gender identify, a great variety occurs. Many use different descriptions in different situations: transgender woman / transgender girl / MtF / woman / girl (n8), transgender man / transgender boy / FtM / man / boy (n7), and non-binary (n5), sometimes non-binary transgender. Again, an age-related difference is seen. Those who identify as non-binary are most often younger. Among the older participants it is more common to not want to use the prefix trans at all, they identify as women or men. A few others choose to use the acronyms FtX (Female to X) or MtX (Male to X) about themselves and others, and say that the X is inclusive towards all bodies, and individuals. The letter X encompasses those who have chosen to not alter the bodies or genitals they were born with, but in other ways have chosen to transition from the gender woman to the gender man, or vice versa. With a binary gender perspective, this can mean a woman with a penis or a man with a vagina. The acronyms FtX and MtX also encompasses individuals who identify as non-binary. A handful have chosen not to have a genital surgery but in many other ways, for instance hormonal and juridical, made a transition from the gender they were ascribed at birth. Many say that they are open about their transgender identity or experience in most situations when the question of gender identity is actualized. Depending on the situation they choose to present themselves with or without the prefix trans. A few live with their transgender experience completely hidden, expect for a few chosen close ones.

Sexual orientations and current relations

The question of sexual orientation or preference were posed as an open question. It was not inquired whether the informant identified as bi-, homo- or hetero sexual or other, but with whom the informant prefers to have sex. Most say they prefer having sex with someone of the gender or sex they themselves identify with. A few, mostly but not only those identifying as non-binary, say that the gender or sex of the person they have sex with is irrelevant. Others prefer having sex with someone they describe as being of the opposite gender or sex. A couple of the informants use the categories bi- homo- and heterosexual, others do not. The sexual orientation becomes more complicated to explain for those who identify as non-binary. Some of them dissociate themselves from the binary gender norm, and say that they are sexually interested in individuals, not their sex or gender. The binary gender norm, and the categories bi- homo- and heterosexual, is problematic for an individual identifying as non-binary. Indy says that using the traditional categories (bi-, homo- heterosexual) is problematic for hir:

If we find a better wording it will help us all. For some it is really practical to have a solid and narrow language. But, it is like, I definitely think that more people than us transgender experience this as problematic.

Most informants have ongoing sexual relations with one or more partner. A few say that they, at the time, *only have self-care*, that is masturbation, and a few state that they are not sexually active at all. Some are married and live with a partner, others live together with a partner and some live on their own.

Expectations on participating

At the beginning of every interview the informant was asked what made hir contact the researcher, and about expectations on their participation. One common explanation is that sexual health is an important area. Pete's motivation to participate is that:

There is a lot of research on different surgical procedures, on how organs function, and the appearance of them, cosmetically, but there is very little on sexual function, on what the sex life looks like.

Some say that they participate for their own sake, as a possibility to put words to their thoughts. Many say that research regarding transgender people is important, no matter what it covers and that all new knowledge is needed. It is described as important to participate, and share knowledge. Kim says that *being silent is over, society must change*. Charlotte describes, with a laugh, herself as *an insufferable source of knowledge*, and that one of her main reasons to participate *is to make people less afraid*. In sum, the individuals participating constitute a heterogeneous group. However, they share similar experiences of estrangement, expectations and eviction when meeting health care professionals.

Estrangement

Many informants tell of a feeling of being *a live teaching material* or *a dictionary* and of how tiresome it is to *at all times be the one who teaches in your everyday life*. This *differentness*, to be regarded as *a monkey in a cage* appears to be very strenuous. It is wearing to have to come out at (as transgender) all the time, even when meeting professionals since *you don't come out once, you don't come out twice, you don't come out five times, you come out seven hundred and fifty thousand times, in all new situations*. Experiences of being questioned by professionals are common. This can take place outside the health care system, like *when the masseur asked me if I was a victim of some kind of catastrophe*, in reference to the informants' thorax scars. Within the health care system many professionals pose different questions, saying they want to learn more. Sometimes professionals ask to see body parts that are not relevant to the on-going health issue the informant is seeking assistance for. This lack of knowledge appears to exist also in so called LGBT-friendly clinics. Although one of the

informants had asked not to be given comments on hir genital organ, the examining physician burst out in comments on how well the hormones were effecting the genital organ. The informant thinks it was a misplaced attempt to empower hir. Some say that being at a LGBT-friendly clinic is not a guarantee, and that *there is a fear among the L, G and B to include T, that LGB might lose credibility*, that the cis-gender and heteronormative majorities in society do not want *another group to take into account*.

Experiences of not being treated well lead to an unwillingness or fear to seek out health care assistance. Informants say they postpone or choose not to seek help. One informant who just moved to a new city describe how difficult it is to find a clinic to trust, and calls out for some *usual manners and decent behavior* among health care professionals. Hir also describes a situation where hir wanted counselling in connection to the death of a close relative. The counsellor kept focusing on the transgender experience and not the current bereavement. Similarly, another informant says that hir chose not to seek the support of a psychiatric consultant when feeling depressed due to a period of unemployment since *they would only bring up and question why I had not gone the whole way with the operations, and stuff like that*. Informants who identify as non-binary experiences that the health care professionals gives them a gender, and that their non-binary body is *an anomaly to health care*, a body that brings unwanted attention to itself. Others say that they do not mention their non-binary identity, in order to protect themselves, and from fear of being ill-treated. Love explains:

L: A situation that can be very tough is going to the youth clinic. There is no place where they assume your gender as much as there. The language used there, assumes to a hundred percent that you are a woman.

XX: Like a walking uterus?

L: Yeah, exactly (laughs). Yes, and I believe that especially youth clinics, or those who speak to persons about sexuality, are places where gender is an issue. Those are the ones that need to learn more, if it is to be a better experience to visit them. To get a test, check out your health or whatever.

Experiences of being questioned when wanting a referral to specialized transgender care are also present. For instance a physician asked an informant with female gender ascribed at birth:

"Don't you think that your wish to become a man is really about you being lesbian?" And I had such a hard time to understand, I hadn't even said if I found women sexually attractive or not, and still he drew that conclusion.

Some informants have been denied counselling support by professionals with the rationale that the informants' way of living their life was against the professional's moral values. For instance, one informant tell of how hir and hir's partner wanted relational counselling but after the first contact the counsellor broke the alliance referring to moral impediment. In addition, the school setting is described as in need of more knowledge. One of the younger informants say:

It is so important to get knowledge into sex education at school, because they teach according to the hetero, and cis norm. Yes, it is difficult for a transgender person to get a good picture of what sexual health can be. And, you know, I got so cross, and spoke to the teacher afterwards. And, well, I don't know, hir didn't have any good answers or explanations, but said that yes it is difficult to not teach according to the hetero norm if you are a hetero, and not according to the cis norm if you are cis.

One of the few informants who has not had any contact with the specialized transgender care shares experiences from psychiatric care where hir had a counselling contact due to psychiatric ill health. When hir has tried to bring up a non-binary identity hir feels that it has not been of interest to the professional. Hir, and others who identify as non-binary say that they sense a view that a non-binary gender identity is something political, that it is seen as an opinion, not an identity. This is experienced as an obstacle when seeking health care, especially gender-confirmatory special care. The solution, says one of the informants, is to

fool the system, and seek help as a traditional transgender person. Even within specialized transgender-care teams, lack of knowledge is present. One of the informants say:

The counsellor said that “Well, you girls you usually want to remove your breasts, and all that with FtM and this and that, well, well, I can’t keep all these concepts in my head.” A professional person sitting there and...should do the job? It would be as if a cardiologist would say, well, a pacemaker, a cardiac flutter, well, well, it’s not that important.

Lack of knowledge among professionals appears to be common, and something that most informants have experienced. Especially within non-trans-specialized health care. This lack of knowledge seems to lead to transgender people being asked questions, as well as being questioned. A process of estrangement due to lack of knowledge appears.

Expectations

Almost all informants have experiences from a specialized transgender-care setting - the six existing clinics in Sweden - occur in their stories. Their experiences varies from being ongoing to up to twenty years back. Most say that they are content with the care given, as a whole, although it puts them in an exposed position: *you are in a very vulnerable position, because these people want what is best for you, at the same time they hold all the keys that will, well, let you begin your life.* But, experiences of being seen as the person the specialized gender-confirmatory care wants you to be, not who you are, are common. Many describe a feeling of having to fit into a certain template, to fulfill certain diagnostic criteria and to go through a process with an expected outcome (to go from a woman to a man, or vice versa), *that it felt as if I had to fit into the pattern in order to get help, even though the people I met were very good.*

Apart from these experiences, many tell of heteronormative expectations within the specialized transgender care, such that professionals also make normative assumptions. One counsellor at a clinic questioned why an informant ascribed male sex at birth would want a

vagina, the comment from my counsellor says it all, the counsellor asked me: "But, if you don't fancy guys, why do you want a pussy?" Others say they avoided mentioning certain things during the process at the clinic, for instance sexual orientation. When thinking back, they say that they would have acted differently today. Tom does not remember whether there were any specific questions regarding sexual orientation, but remembers gender binary, cis and heteronormative expectations:

T: The options were black or white. What I could choose when I grew up was to be either a man, or a woman. If you didn't fit into one you must be the other. I think I would have been very careful about what to disclose. If I would have identified as gay, I would have been careful, to express that.

XX: You felt you had to adhere to a norm?

T: Yes, and I had been told, before, that, or at least as I interpreted it, that, well, this is where you learn to be a man. Well, okay, then I have to walk like this, sit like this, talk like this. If I had entered that investigation now, I would have had a totally different, a totally different knowledge with me.

Ronnie's experiences from a specialized transgender care clinic were only a few years back, and she says that she chose not to disclose her sexual orientation at that time. She kept her partner for many years hidden:

Those who were correcting their genitals to female should have a boyfriend, those who would correct their genitals to male should have a girlfriend, to fit into their template, to their guidelines, to their criterion.

Others say that to be bisexual, or poly-amorous (to have more than one relation at a time) are details not disclosed during the investigation out of fear of *complicating things for the health care*. Those who identify as non-binary have other difficulties, e.g. to account for their health care needs since they risk not fitting into the linear demands of transgender care. Love, for instance, says:

A non-binary person makes new demands on health care, the outcomes are unclear. Maybe it is necessary to stop regarding it as if this person shall become something specific, and instead look at what this person needs in order to feel good?

Some say that they have been through gender-confirmatory special care but kept their non-binary identities hidden. In line with this, many say that transgender and gender-variant people often have to fight the health care system, and that *care is normative, health care doesn't always give us what we want and we have to deal with the health care, and the ideas that the health care has of our bodies*. In contrast, others problematize that maybe this is not the case in all specialized transgender-care teams, that *they are professionals, humans, who understand that variations are more common than what fit into the juridical, or into norms*.

When informants meet professionals within specialized transgender-care, sexual health does not seem to be important. Many say that sexuality has, or had, no or a very small place in this care setting. Magdalena says:

M: Nobody has ever discussed it, no one from the gender identity team. All the psychologists, psychiatrics that I have spoken to. I have talked to a looooooot of therapists. But, no one has ever asked me anything about sexuality. Or touched on the subject at all. Nobody has ever asked. And still, I have been there with my partner. But still, no one has never ever asked us what it like, how our sexual life works. Never. They just say: "You are so sweet together, you seem so, it all seems to function so well". But the truth is, and I can tell you here and now, that I am probably the most sexually frustrated person on earth. I long for an orgasm (laughs). See, I could pay a million to have an orgasm. Honestly. I miss that part of my life.

XX: So, something important is missing?

M: Yeeeee.

Pete says that he has experienced difficulties when talking to his physician within specialized transgender-care about a changed orgasm experience following a genital operation. He had to find help, and counselling at a different clinic, not specialized in transgender health.

The informants' experiences from the specialized transgender-care settings include normative expectations from the caregivers regarding gender binarity, gender and sexual orientation or preference. Also, a lack of focus on sexual health is described. A process of gender binary, cis- and heteronormative expectations appear.

Eviction

After receiving specialized transgender-care, many describe experiences of suddenly being on your own, with a new body to relate to. Tom says that the future is unclear, it has not been discussed within specialized transgender-care:

What happens afterwards, what happens when you are medically and clinically finished and have come out on the other side? I can't just go to the bar to pick someone up without explaining, I can't bring someone home without explaining what you see is not what you get.

What Tom describes, that the specialized transgender care suddenly ends, is seen as problematic by many. When procedures that have been agreed upon are made, the health care contact ends. Although the feeling of having passed through the process of gender-confirmatory care is described as a strongly positive one, there is uncertainty regarding one's new sexual identity or one's new sexual body and its' functions. What is missing is professional help to address that *there may be sexual difficulties even after the investigation and treatment, you don't have the moon and the stars as promised, when it is all over*. Also, the lack of access to counselling where one lives is mentioned:

Support to dare live in the new, but you don't get that. Within a year a total reorientation of the body has taken place. If you could only get the question: "How are you feeling, how is everything going?" Questions about now, and the future.

Access to reproductive health care is also mentioned as important. Informants who have a wish to become a parent discussed this, and they were very unsure of the future access to maternal care. Gabriel, who still has his uterus, says:

I have not been sterilized. That is an active decision, to keep it, because I do want children, and since I am interested in men. If you are two guys you cannot have a child, biologically, that is difficult, but I don't have any problems considering it and....to be pregnant that is. For me, I can consider it, I see no troubles, the way I know my body and my identity. I wouldn't feel sick being pregnant. But I am very, I would be very worried concerning how I would be treated, within health care, and in society at large. It feels very, how shall I put it, unconventional.

The informants also point out that even bodies that are altered or gender-confirmed may need access to screening related to the gender assigned at birth, for instance gynecologic pap smear, prostate screening or mammography. This can however be problematic. If the gender the person has is contrary, for instance a transgender woman with a prostate gland, it can evoke unwanted attention. The importance of clinics where transgender and gender-variant people can visit and be treated without prejudice, and easily accessible written information on transgender sexual health, is also mentioned. Pete says:

What is missing is all that concerns the everyday health, like going to have a test, how to get a good gynecologist. How do you get that, not all that which is exotic and only about transgender people, but all the other stuff, the stuff that everybody needs?

Informants who have received the specialized transgender care they wanted and needed describe feelings of suddenly being on their own, with a lack of access to different forms of health care. A process characterized as eviction appears.

Discussion

The purpose of this paper was to describe how transgender people experience meetings with sexual health care professionals. The results point at processes that are described and interpreted as estrangement, expectations and eviction. The estrangement is connected to lack of knowledge among professionals. The expectations are connected to gender binarity, cis- and heteronormativity among professionals, and the eviction to a lack of access to health care. Based on this, transgender knowledge needs to be raised in general, in specialized transgender care and all other health care settings. Moreover, an increased knowledge of, and

respect for, sexual health and rights is needed, especially LGBT health and rights. Regarding sexual orientation or preference, professionals must focus on sexual preferences and experiences, not on what category of sexual identity or orientation the person is supposed to fit into (van Anders, 2015). This may liberate sexual minorities and the assumption that sexual identity automatically equals or has its' departing point in gender (trans, non-binary or cis) or preference (bi, homo or hetero), can be avoided (ibid.). The informants also pointed out the necessity of continued access to sexual health care following gender-confirmatory care, for instance, counselling and sexual and reproductive health care, including screening.

It is a global human right to decide your sexuality and reproduction, and be able to have a safe and satisfactory sexual life free from, coercion, violence and discrimination (Harrison & Engdahl, 2013; World Health Organization, 2015). For transgender and gender-variant people in this study, it appears to be a continued challenge. This is worrisome since gender-confirmatory care has been offered in Sweden for more than sixty years (Dhejne et al., 2014). It also highlights that in countries where transgender sexual health and rights are not recognized or respected, neither on a societal nor a legal level, transgender people are likely facing even more discrimination when meeting health care professionals.

The experiences of estrangement, expectations and eviction that are seen in the result are interpreted to all have the same core component: disrespect. This disrespect leads to discriminatory treatment, a discrimination that may have its' cause in stereotypical attitudes leading to prejudice among health care professionals. Attitudes among cis-gendered people have been studied. Cis-gendered people see transgendered people as having the gender they were ascribed at birth and a heterosexual orientation matching that gender, regardless of how transgender people present themselves, in addition, they pitied transgender people (Gazzola & Morrisson, 2014). Attitudes among heterosexual men and women toward transgender people are strongly correlated to attitudes to lesbian, gay and bisexual people, though

attitudes toward transgender people are less favourable (Norton & Herek, 2013). This prejudice may be present when a health care professional meets a transgender person. Further research is needed on what happens when a cis-gendered person meets a transgender person, especially in a professional setting, and why. Efforts that counteract these constructions that turn into discrimination are essential.

Study strengths and weaknesses

Despite a self-selected sampling procedure, a great variation of participants was achieved regarding age, gender identities, place of residence, education, employment, sexual orientation, and current relations as well as on expectations on participating in the study. It is a weakness that only a few with other ethnic background than Swedish participated. How ethnicity, culture or race can intersect with the transgender experience is not seen in the results. Individuals identifying as transvestites, Dragqueens or Dragkings are also missing, and those who do not want gender-confirming care but still identify as transgender are underrepresented. It is therefore not possible to say that the result is varied enough to mirror all transgender experiences. However, it is regarded as varied enough to provide knowledge of how transgender people in one European country experience meetings with health care professionals, so that the findings may be transferable to similar settings.

Relevance to clinical practice

Transgender people in this study tell of experiences of disrespected sexual rights in different health-promoting settings where nurses are working. This is in line with a review of 17 studies regarding nurses' attitudes towards lesbian, gay, bisexual and transgender patients that found evidence of negative attitudes in every study examined (Dorsen, 2012). Nurses have an important role to play in striving for equity and justice within health care, and to be

transgender-competent, to respect transgender peoples' gender identities and sexual orientations and to facilitate access to care, are ways to fulfill these obligations. The results in the present paper can be of use in this vital enterprise, assisted and underscored by research-based recommendations and policy documents as well as international ethics and laws (International Council of Nurses, 2012; Lim, Brown & Justin Kim, 2014; World Health Organization, 2015). With the experiences of the informants in the present study as a departing point, a way forward will be suggested. A nurse, or any other health care professional, can promote and safeguard sexual health and rights for transgender people by: avoiding the assumption that whomever you meet identifies with the gender you perceive him to identify with; avoiding the assumption that whomever you meet is heterosexual; avoiding the assumption that transgender persons share similar experiences – meet the person as an individual and find out how you can assist his health needs; avoiding the treatment of whomever you meet as a source of knowledge – and acquire basic knowledge for yourself elsewhere.

What does this paper contribute to the wider global clinical community?

- Transgender and non-binary people worldwide do not get their sexual rights respected, and are continuously exposed to stigmatization, discrimination and legal, economic and social marginalization and exclusion. This takes place also within different health care settings.
- In this interview study 20 transgender persons share their experiences from meetings with different health care professionals in a variety of settings.

- The results points at several improvement areas where the nurse can play an important role in promoting and safeguarding sexual health and rights for transgender people. Basic transgender knowledge and respect are key elements in this process.

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