



# “It’s a patient safety issue” A qualitative study with care professionals on their experiences of meeting trans people in obstetric and gynaecological care

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## ABSTRACT

**Objective:** The aim of this explorative study was to analyse how encounters with trans people in the obstetrics and gynaecological department are experienced by healthcare professionals and what needs to be implemented in practice to improve these encounters.

**Methods:** Six participants – physicians, midwives, and a nurse, from four different regions in Sweden – were interviewed, and the interviews were then analysed following inductive thematic analysis according to Braun and Clarke.

**Results:** The analysis of the interviews resulted in three themes: “Lack of structure, organization, and medical competence”; “Engaged healthcare professionals push the work forward”; and “Working continuously to improve access to healthcare and the clinical encounter”. The results indicated that the participating healthcare professionals experienced shortcomings regarding different aspects of encountering trans people in care settings. These concerned, for example, structure and organization of care, guidelines, routines, and administrative systems, and a lack of medical competence when it comes to trans people.

**Conclusion:** The results can be interpreted as indicating that there is an inequality in access to healthcare compared to cis people (those who identify with their gender assigned at birth). However, the study also shows that actions can be taken at both the individual level and the organizational level. Education about how to encounter trans people and having clear guidelines and routines are among the improvements that are needed to be more respectful towards trans people and to provide healthcare on equal terms as to cis people.

## Introduction

Studies have shown that trans people (an umbrella term for people whose gender identity does not match their gender assigned at birth) are a marginalized group in both society and healthcare [1]. Trans people experience a series of obstacles when seeking healthcare. For example, studies have shown that they are met with prejudice, stigma, and discrimination and that caregivers lack knowledge about trans people [2–7]. Trans people in Sweden and Canada, for example, have experienced having to educate caregivers, having to answer irrelevant questions, and being questioned about their gender and lifestyle [2,7,8]. Moreover, trans people tend to postpone and cancel their healthcare appointments due to a lack of trust in the healthcare system and fear of receiving poor care due to their trans experiences [2,3,6,8,9].

Some parts of healthcare might be even more difficult for trans people to seek and obtain adequately, for example, parts of the healthcare system that have strong gendered connotations such as gynaecological or obstetric care. As many trans men still carry a vagina, cervix, uterus, and/or ovaries, they will need to access reproductive and gynaecological healthcare and examinations. However, if they fear and

avoid seeking the care they need, they might face health issues [1,9]. Studies have shown that trans men are less likely to be up to date on cervical cancer screening and Pap smears (screening procedure for cervical cancer) compared to cisgender women (i.e., women who identify with the gender assigned at birth) [10,11]. Gynaecological care is also important for trans women who have undergone a genitoplasty (surgical alteration of external genitalia). Recurrent neovaginal infections, as well as urinary tract infections that need to be examined and treated, could occur after surgery [12]. A study with caregivers concluded that they feel that they are not being educated enough around trans issues and that encounters with trans people do not meet the same standards as meetings with cis people [4]. However, care professionals’ experience of encounters with trans people has not been studied in a Swedish healthcare setting before.

The purpose of this explorative study was to analyse how encounters with trans people in the obstetrics and gynaecological (OBGYN) department are experienced by care professionals and how encounters can be improved in clinical practice. The study will not primarily focus on care for gender dysphoria (i.e., care that aims to alter the gendered body such as genital surgery and hormones) but OBGYN care and

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encounters in general. We have chosen to focus on the OBGYN care as encounters with trans people in such settings have not been explored before in the Swedish context, and also because this type of care is traditionally seen as gender-segregated care in which trans people might feel uncomfortable and marginalized.

The following research questions served as a guide during the data collection and analysis:

- How do OBGYN professionals experience their preparedness and competence to meet trans people in care facilities?
- Which type of education and training do care professionals have about trans people’s health and healthcare needs?
- What suggestions for improvement do the participants have?

Trans-related questions in the Swedish healthcare setting is an emerging field of study, and this explorative study can help guide future research and give indications of how healthcare professionals perceive encounters with trans people in a care setting and which aspects need to be improved.

Method

For this explorative study, an interview-based study design was used and thematic analysis was used for the analysis of data [13]. The study was conducted in a Swedish context, where almost every county hospital has an obstetrics and gynaecological ward. Often patients can access the out-patient part of the clinics without referrals.

Recruitment and participants

An ad was created for the recruitment of participants which briefly described the study, including the purpose of the study, contact information, and a statement of ethics. Participants who were interested in the study were invited to contact MK for more information and to book an interview if they were still interested. The inclusion criteria were that the participants had to be certified healthcare workers and that they worked in OBGYN-related departments.

The recruitment ad was distributed to OBGYN wards and polyclinics in Region Stockholm, Västerbotten, and Västernorrland. The ad was also distributed in several OBGYN and midwife-related groups on social media (Facebook) with national coverage.

A total of six participants were recruited from multiple regions in Sweden. Five participants identified as women and one as a man. The participants represented four different regions in Sweden – Region Västerbotten, Region Västernorrland, Region Stockholm, and Region Värmland. Half of the participants were physicians, and two were midwives and one was a mid-wife in training (nurse).

Data collection

The interview guide consisted of 12 open-ended questions which were organized under two main themes:

1. The clinical encounter, their experienced knowledge, and competence
2. Need for change and improvement

A pilot interview was conducted to test the questions and see if they were readily understandable. The pilot interview was included in the analysis since the questions did not change substantially after it was carried out.

The interviews were semi-structured, meaning that every participant was asked the questions in the guide, and follow-up questions were asked depending on the participants’ answers. All interviews were held by telephone in October and November 2020. The interviews were recorded, and the length ranged from 30 to 50 min. All but one of the

interviews were transcribed verbatim by the first author, and one was sent to a professional transcribing company (due to time constraints). The phone calls were carried out in a private environment so that no one could overhear the conversation.

Analysis

Thematic analysis according to Braun and Clarke was used for the analysis of transcripts [13]. The analysis followed the step-by-step process suggested by Braun and Clarke. An inductive approach of thematic analysis was used for this research, meaning that the themes identified and reported are based in the interviews. In this particular study, this stepwise approach meant first reading through the transcribed interviews several times, then coding by putting phrases and words in the margins of the transcripts. Thereafter the codes were reviewed several times to search for themes. Afterward, the themes were defined and named, quotes were chosen, and the production of the final report was started.

Ethics

The study was approved by the national Ethical Review Authority (Dnr: 2020-00929). Due to confidentiality reasons, all names mentioned in this article are pseudonyms.

Results

The analysis resulted in three themes (see Table 1). In the following, these three themes and their sub-themes are presented.

Lack of structure, organization, and medical competence

This theme revolves around how the participants experienced a general lack of structure, organization, and coordination in the treatment of trans people in their healthcare setting, and difficulties in navigating around these obstacles. It also highlights that the participants feel that they lack medical competence when it comes to trans people.

Shortage of clear and specific guidelines

Several of the participants emphasized a lack of guidelines regarding healthcare for trans people, as Simon (specialist in OBGYN) said: “It seems like there’s a lack of good guidelines within the regions on how to deal with these issues.” Simon thought that there might be more focus on trans issues in larger regions. Other participants also talked about competence being clustered in regions or places where there is specialist healthcare for gender dysphoria. This was, however, contrasted by experiences of participants who work in such hospitals and still experience a lack of guidelines.

Simon continued by saying:

Table 1  
Themes identified during data analysis and their sub-themes.

Lack of structure, organization, and medical competence	Engaged healthcare professionals push the work forward	Working continuously to improve access to healthcare and the clinical encounter
Shortage of clear and specific guidelines	Individual initiatives are needed from care professionals	Improvements can counteract shortcomings in access and the encounter
Administrative systems are not customized to fit trans people	From personal interests to professional exceptions	Small steps can go a long way
A disruption in medical competence	Time is needed	

***A lot of the problems that have arisen are mainly about coordination and organizations between different clinics and units at the hospitals.***

The National Board of Health and Welfare have guidelines and recommendations for both caregivers and care recipients [14,15], but according to our participants, these are not clear enough and they are not always readily understandable, Anna said:

***The national Board of health and Welfare has some guidelines that have some information, but it's not always that easy [to understand and follow them]. – Anna, OBGYN resident***

Moreover, they are not clinic- and region-specific in the sense that they are not specific enough for OBGYN care or that the structure for referrals for care for gender dysphoria is differently organized in different regions. Anna mentioned that the content was somewhat basic at times and that many of the questions that had arisen were not answered by the guidelines. Hence, the specific issues that arise in the OBGYN setting might leave the professionals without clear guidance.

*Administrative systems are not customized to fit trans people*

A common experience amongst all the participants was that the administrative systems, such as medical records, are not adjusted to fit trans people and that such limitations might even create unsafe situations for the patient.

One of the midwives who was interviewed described a situation where a trans man who had legally changed to a male social security number came to give birth at the labour ward where she worked:

***It was messy on our side because the social security number couldn't be entered into our data system, so we had to have a special procedure regarding those practical things. We would've liked to avoid focusing on things that are so simple and obvious for all other patients. Having to use paper medical records and not having access to all the test results that you have for every-one else – it's a patient safety issue. – Kerstin, midwife.***

Hence, as Kerstin's experiences show, this could be a serious issue when time is taken from caregiving to instead try to find solutions to an administrative issue that is not present for cis-women patients.

Another of the participants commented on missed PAP smears because of miscommunication and administrative shortcomings.

***Partly I think there's a problem with PAP screenings, those who have a male social security number fall out of the screening programme if it's not reported. So sometimes the uterus and cervix remain and they can remain for the rest of life, therefore they must be contacted for screening. – Elin, specialist OBGYN.***

Elin mentioned the risk of trans men falling out from the PAP-smear screening programme and hence potentially missing important care for preventing cervical cancer.

Another issue that was mentioned by the participants is that there is no good and common strategy for how to write down the chosen name and pronoun in the journal system and that it is up to the individual care professional to write it down accordingly. However, in some parts of the healthcare system this worked better, according to the participants:

***I did as the others did at the youth clinic, I could also write "uses pronoun ze" if I knew that there's a certain pronoun that ze uses. But I also knew that the personnel checked those things [pronouns, preferred name, etc.] differently there [at the youth clinic]. – Anna.***

Hence, Anna said that they were more thorough regarding how to write such things in the medical records in the youth clinics. This could indicate that it is easier to be respectful if there are routines for requesting and recording this information at every clinic.

*A disruption in medical competence*

Connected to the previous sub-theme, participants also felt that they and/or their colleagues lacked deeper medical knowledge and thus felt that they were failing to give proper treatment and care. Some of the participants were unsure of where and whom to turn to when they needed answers to their questions.

***I would like to learn more and get better at it [trans-related questions]; I feel that sometimes when there are more difficult medical issues, the level of knowledge of my colleagues, from whom I am learning as an OBGYN resident, is also quite low. – Anna.***

Anna mentioned that her senior colleagues did not always have answers to her questions, thus making it harder for her to give proper care to her patients. From this quote, it can also be interpreted as there being a general lack of knowledge amongst Anna's colleagues.

Not only did the participants feel that they were lacking in theoretical medical knowledge, they had also experienced a lack of knowledge about more practical things. When asked, "Which specific knowledge do you think that you lack?", Sofia (midwife) said:

***So, for example, when I used to work at the sexual and reproductive health centre and had to do STI tests, like what's the anatomy like, which mucous membrane is placed where? In other words, which tests should I do if the patient has gone through some type of genitoplasty, and stuff like that, you know....***

Such lack of knowledge might create difficulties in getting adequate tests and possibly hinder the detection of STIs if the tests are not performed correctly.

**Engaged healthcare professionals push the work forward**

This theme highlights that a lot of the work that leads to improvement at the clinics was carried out by people that are very engaged in trans-related questions. Hence, in relation to the previous theme that showed several shortcomings in encounters with trans people, this theme shows that individual healthcare professionals became responsible for improving the OBGYN healthcare for trans people.

*Individual initiatives are needed from care professionals*

A common pattern that was seen throughout the interviews was that someone must be particularly interested in trans-related questions at the clinics. Without them, the topic did not get discussed enough, and nothing was done to make changes that integrate trans people into the clinical practice in a natural manner.

***It generally feels, as I mentioned previously, that it's required that someone is particularly interested when it comes to these types of questions... As now I am at my clinic. – Anna.***

Simon voiced a similar experience:

***It's probably partly due to lack of educated and, not the least, interested people and/or caregivers [...] As it has become down here [where the participant works], it's a bit about individual initiatives from various care providers, that they want to work with this issue.***

Hence, participants described that a lot of the trans-competence and responsibility regarding these questions are dependent on individual efforts rather than on central decisions or the leadership at the clinics.

This is particularly true for two of our participants who had become the people in charge of trans-related questions that can arise at their clinics. One of the two was also the one who meets with trans people at the clinic in the region where she works. On one hand, this can be interpreted as positive as it increases the chances that trans patients meet a more competent care professional, but on the other hand, it can also be a vulnerable situation as it requires that trans people meet the

right person to get access to appropriate healthcare, as we will come back to in the discussion.

#### *From personal interests to professional exceptions*

As we have shown above, some healthcare professionals at OBGYN clinics became responsible for developing the care for trans people. Based on these interviews with the participants, it seems like those who are particularly interested in trans-related questions often experience or have contact with the Lesbian, Gay, Bisexual, Trans, Queer, and Intersex (LGBTQI) community. This could be either from their own experience or that of friends and/or family who are tightly linked to this community. Anna, herself part of the LGBTQI community, said:

***I haven't attended any specific education [about trans-related questions], but I've picked up bits and pieces from here and there.***

In Simon's case, it was a mixture of meeting trans people in the clinic and also personal interest:

***I have people in my friend circle who've gone through [transition] or thought about transitioning. I've also been involved in arranging Pride here where I live.***

This quote illustrates that interest and knowledge do not mainly come from a clinical or professional context but from somewhere else, sometimes a more personal context.

Some of the participants also mentioned that their curiosity and knowledge came about after hearing interesting lectures by trans activists and sexologists or by writing their master's thesis about trans people and healthcare.

***A sexologist held a lecture for us. He works quite a lot with LGBTQI questions and so on, and that lecture was amazing. – Angelica, nurse, and midwife in training***

However, there are some exceptions. Some participants learned about trans-related issues when they had rotations at youth clinics, which they considered to be at the forefront when it comes to encountering trans people. According to the participants, the care professionals at youth clinics were more open and friendly, and they have more strategies on how to talk about thoughts the patient might have about their gender and how to ask for pronouns. Youth clinics were also said to have more respectful forms that the patient might have to fill in, and their waiting rooms were described as more adapted to the patients.

#### *Time is needed*

The lack of time is a constant battle for healthcare professionals, and this was also an issue for those that want to develop OBGYN care for trans people. Many of the participants indicated that they had to use their own time in order to manage reading and stay up to date. Making changes around the office regarding posters and models was also something that must be managed outside office hours. When our participant Anna was asked if she would have liked to do something different when she encountered patients that were trans, she mentioned that there are posters and models that she wants to change in their clinics but that that takes time and interest, and time was something she has too little of. She continues:

***It requires special interest quite simply put, but we don't have any extra time left during the day, [for example,] we have to do this interview in the evening. It's a very intense workplace, someone has to be really interested to take it on since there's far too little time in our work for things like this, unfortunately.***

This can be interpreted not only as an indication that the development of the clinical work is time-consuming but also that dedication is needed for this cause and the responsibility that comes with it. This quote also shows that this it is not something that the clinic allocated

enough time to. Elin also said:

***We're supposed to write PM's, so now I have a lot of learning to do; I need to read up on stuff and I need to do some travelling and go away on field trips [to collect experience and knowledge].***

Hence, this is something that requires time and dedication. Extra time was also required to create a safe environment in which the patient feels comfortable, especially when it comes to an OBGYN appointment. Anna said:

***He was very nervous and felt very anxious about being there and he had waited until the last minute to come to the clinic (...) but I think that we got a good connection, we talked for a quite a while before the examination, which I try to do with every-one who's feeling the way he was feeling. I think it's a good method, to talk a while before the examination to establish a connection.***

However, as already touched upon, this is something that took both time and energy, hence putting an extra burden on the healthcare professionals that invest in this.

#### **Working continuously to improve access to healthcare and the clinical encounter**

This theme is about how to continuously improve the encounter with and access to healthcare for trans people. It highlights both the bigger and the smaller picture of the encounter and how improving the clinical setting is always a continuous process.

#### *Improvements can counteract shortcomings in access and the encounter*

One of the biggest shortcomings experienced by our participants was that not all healthcare professionals in the clinic where they worked were properly trained in how to encounter trans people and how to ask for and use pronouns in a clinical setting. Anna recollects a meeting with a trans man who had not undergone genitoplasty and came to her for a check-up.

***I think that I'm one of the better-equipped physicians when it comes to meeting trans people at our clinic. It feels kind of nice to meet these persons and I try to help them as well as I can, just as I would for all of my patients, but... It was just good luck that he got to meet with me.***

Anna is an example of someone who has experience with meeting trans people, but this may also indicate that not all trans patients are so lucky when it comes to encounters with health professionals.

Hence, improvements can be made both on an individual level, as Anna's experience shows, and, as also mentioned in previous themes, by taking extra time and educating oneself. But improvements can also be made on an organizational level, for example, by having the clinic LGBTQ-certified, which according to our participants can improve the clinical encounter. This certification ensures that the clinic has gone through a series of seminars and lectures which aim to raise the clinic's competence in dealing with LGBTQI issues and gives it tools to work systematically with norms linked to gender and sexuality. Many of the clinics that the participants have worked in have been LGBTQ-certified clinics. Participants recognized this as good training to get basic knowledge about trans people. They recognized a difference between certified and uncertified clinics that they have worked in:

***The clinic where I work at the moment is not LGBTQI certified, but the place where I worked before was certified and we had the whole package with flags and signs etc., so I got some [knowledge] there, but it's quite a small topic of discussion at the clinic where I'm at now. – Kerstin***

This is an example of how the LGBTQ certification opens for

discussion amongst the employees at the clinic, leading to new ideas for improvements that can be carried out at the clinics.

Another organizational improvement mentioned was a need for more cooperation between clinics to enable better communication and made it easier for patients to get proper care.

***There should be some type of coordination unit that organizes the care that is needed and makes sure that it's carried out since there are so many different clinics and specialties involved in the process and right now that's something that isn't working properly. Maybe it's partly due to lack of educated [caregivers]. – Simon***

Even if the participants did not work where care was provided for gender dysphoria, they still sometimes became involved in such care and felt the need to have one unit that coordinates care for gender dysphoria, both so that caregivers could give adequate care and care recipients could get the care that they need.

Elin said that, going forward, they must take in knowledge and experience from other specialties: *"I think that we need to collaborate with the endocrinology department [in the future]."* This could mean that knowledge gaps experienced by the clinicians at the OBGYN clinics could be narrowed by coordinating and taking in external knowledge. The region in which one participant worked had hired a person in the OBGYN unit that will act as a support person who can answer questions and give advice on whom to contact etcetera when it comes to providing care for trans people. This was a part of their plan to be able to give good and easily accessible care for trans people.

#### *Small steps can go a long way*

There are things that can be done to reduce some of the shortcomings that are prevalent when it comes to encounters with trans patients, and not all solutions have to be grand. One of the participants mentioned small steps such as changing posters and anatomical models:

***We have these posters hanging in the toilets on how to take a chlamydia test, but the title on them is "chlamydia testing for women". We have gotten a gender-neutral poster, but I haven't had a chance to change them yet due to lack of time. – Anna***

Simon mentioned the importance of listening to what the patient is saying and thinking of possible things that one can help them with. It could be as simple as prescribing birth control pills:

***I often meet these people because of their periods; they hate them. It's a constant reminder for them that they're in the wrong body. They have a female body, but they don't feel like a female, so I've helped them get rid of their periods, to relieve some of the stress they experience.***

Moreover, as mentioned previously, a consistent topic throughout many of the interviews was that it does not always require very much to make the patient comfortable. Sometimes all that was needed is some extra time to establish a trustful relationship so that these patient feels safe and comfortable.

## Discussion

This was an explorative study, meaning more studies have to be conducted to confirm the results and get a more in-depth understanding. However, our results show important tendencies that need to be considered, both clinically and in future studies. The participating care professionals experienced shortcomings in several aspects, and guidelines, routines, medical competence, and how trans people are encountered need to be improved. Our results imply that both individual healthcare professionals and clinics are already trying to make improvements when it comes to trans-related questions, but more must be done. Improvements can be made at an individual level, for example, giving more time to create a safe and secure environment, and they can

also be made at an organizational level by, for example, having the clinic become LGBTQ certified and implementing strategies used in youth clinics.

Overall, the results indicate, based on the experience and perspective of healthcare professionals, that there is unequal access to OBGYN healthcare between trans and cis people. One of the problems is that the participants perceive that the care professionals in OBGYN clinics do not know how to encounter trans people properly. Earlier studies have concluded that this is one of the reasons why trans people tend to postpone and cancel their appointments to a greater extent compared to cis people [2,3,8]. This can be understood as connected to *cisnormativity* [16], the norm that assumes that every-one has a gender identity that matches their sex assigned at birth, and how the healthcare system is mainly built and adapted for cis people. For example, as shown in the results, the administrative data system is not compatible with trans embodiment (for example, having a male social security number while at the same time having a cervix). This is not just excluding trans people, it can also lead to patient safety issues.

A severe medical consequence of a cisnormative administrative system is the fact that when someone changes from a female social security number to a male social security number, they are automatically removed from the cervical cancer screening programme. Hence, they are not automatically called for an appointment unless they themselves or healthcare professionals have noted this change and reported it. This is in line with previous studies that have shown that trans men are more likely to have less up-to-date cervical cancer screenings and PAP smears compared to cis women [10,11]. Hence, improving the administrative system is crucial for the health of trans people. Our result also shows that the participants had obtained their knowledge about providing medical care for trans people not mainly from their formal education but instead largely from personal interest and experience. This indicates that knowledge about trans is not a prioritized matter, neither in professional training nor in the improvements at the clinics. Future studies are needed to map out how trans-related issues are covered in education for healthcare professionals.

Connecting our result to Levesques et al.'s [17] understanding of accessibility, it seems that the practices at OBGYN clinics in many cases do not fit the needs of trans people. To counteract such consequences, individual healthcare professionals, such as the care professionals we interviewed, step in and take initiative to improve the quality of care given to trans people by taking charge and increasing the level of knowledge available at the clinic. This can have positive consequences, improving the competence and knowledge amongst these specific clinicians but also at their clinics more broadly. However, this also becomes a vulnerable system, since it creates a situation where everything depends on the specific care professionals the trans persons meet. Furthermore, to rely on individual healthcare providers are not in line with legislation on equity in healthcare [18].

This vulnerable care system is also shown in how the participants talk about the lack of good enough, or specific enough, guidelines and routines. By having sufficient guidelines and routines, good care could be ensured to trans people regardless of which care professional they meet, since care professionals who are less educated in trans-related matters can seek help in those specific guidelines and routines. As mentioned in the result, having routines decreases the risk of arbitrary decisions and processes. In other words, the result can be understood in relation to Levesques et al.'s [17] framework about accessibility; the access to OBGYN care for trans people is not only about whether the patient gets into the care facility; several aspects need to be improved in order for trans people to get the care that fits their needs, regardless of the care professional they meet.

#### *Methodological consideration*

For this study, we only had a small selection of participants. However, as the field is generally underexplored and the results are similar to



studies from other contexts [2–4,10,11], the study can serve as an important guide for more in-depth explorations. The people who responded to the ad and agreed to be interviewed seem to be more engaged in this question than others, both privately and in their clinics. This probably means that they are not representative of professionals working in OBGYN care. However, this is not just a limitation for this study; it can also be seen as a strength as these are participants who have reflected more about this question and might have more suggestions for improvements.

### Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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