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Challenges in Health Care Experienced by Gender and Sexual Minorities

Literature Review

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The purpose of this thesis was to describe gender and sexual minorities' challenges in health care. The aim of this descriptive literature review was to use its knowledge to develop health care of gender and sexual minorities (GSM).

The literature review includes 13 articles (N = 13) which were collected by using electronic databases CINAHL and MEDLINE. Data was analysed by using inductive principles of content analysis. The data was divided into two main categories: gender and sexual minorities' challenges related to health care and gender and sexual minorities' challenges related to health care provider-patient relationship.

The results showed that GSM experience multiple challenges concerning health care. Barriers to seek help, lack of policies and structural barriers like stigma and discrimination were factors for GSM to delay or avoid health care. In relationship with health care providers patients were scared to disclose their gender identity or sexual orientation due to providers' negative behaviour and facial expressions. GSM also felt that providers' competency levels are not enough and some had cases where they had to educate their own provider.

Further research should be done for developing the well-being of GSM. Therefore, creating culturally-sensitive environment by educating providers and spreading the word about GSM and their challenges is important.

Keywords	Gender minority, sexual minority, challenges, health care, sexual orientation, gender identity, gender expression

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Tämän opinnäytetyön tavoitteena oli kuvailla sukupuoli- ja seksuaalivähemmistöjen haasteita terveydenhuollossa. Kuvailevan kirjallisuuskatsauksen tavoitteena oli kehittää sukupuoli- ja seksuaalivähemmistöjen terveydenhuoltoa käyttämällä siitä saatua tietoa.

Kirjallisuuskatsaus sisältää 13 artikkelia (N = 13), jotka kerättiin käyttämällä elektronisia tietokantoja CINAHL ja MEDLINE. Aineisto analysoitiin käyttämällä induktiivisen sisällönanalyysin periaatteita. Aineisto jaettiin kahteen pääluokkaan: sukupuoli- ja seksuaalivähemmistöjen haasteet terveydenhuollossa ja sukupuoli- ja seksuaalivähemmistöjen haasteet terveydenhuollon ammattilaisen ja potilaan välisessä hoitosuhteessa.

Tuloksista ilmeni kuinka paljon sukupuoli- ja seksuaalivähemmistöt kokevat haasteita terveydenhuollossa. Esteet avun haussa, käytäntöjen puuttuminen ja rakenteelliset esteet kuten stigma ja syrjintä saivat sukupuoli- ja seksuaalivähemmistöt viivästyttämään tai välttämään terveydenhuoltoa. Hoitosuhteessa potilaita pelotti paljastaa sukupuoli-identiteettinsä tai seksuaalinen suuntautumisensa terveydenhuollon ammattilaisten negatiivisen käyttäytymisten ja ilmaisun vuoksi. Potilaista tuntui myös, että työntekijöiden pätevyys ei ollut riittävä ja joissakin tapauksissa heidän täytyi jopa itse opettaa ammattilaisia.

Lisätutkimuksia tarvitaan, jotta voidaan kehittää sukupuoli- ja seksuaalivähemmistöjen hyvinvointia. Siksi kulttuuri-sensitiivisen ympäristön luominen opettamalla ammattilaisia ja levittämällä sanaa heistä on tärkeää.

Avainsanat	Sukupuolivähemmistöt, seksuaalivähemmistöt, haasteet, terveydenhuolto, seksuaalinen suuntautuminen, sukupuoli-identiteetti, sukupuolen ilmaisu

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Appendix 1.

1 Introduction

People have become more aware of different forms of gender and sexuality, yet social expectations about gender roles influence how men and women are expected to behave including their sexual behaviour, attitudes, and feelings (Jackson 2006). Gender and sexual minorities (GSM) differ from these norms by being a diverse and varied population. Society's stigma and prejudice are targeted at them causing them to have additional challenges in health care. (Gay and Lesbian Medical Association 2001, p.12.)

Access to health care is an opportunity to fulfil all health care needs and eliminate health disparities. Irrespective of gender identity or sexual orientation, race, ethnicity or religion, it is a fundamental human right of all people. (Levesque, Harris & Russell 2013.) Individuals using health care services have right to receive good quality care in a manner which does not violate their dignity or privacy (Laki potilaan asemasta ja oikeuksista 785/1992).

However, historical events and consequences of prevailing homophobic attitudes have affected on the stigmatization of GSM and harmed their well-being and interaction with health care (Graham et al. 2011, p. 32). For instance, in the United States homosexuality was considered as a mental disorder until 1973 and only after that researches focused also on their mental health needs (Gay and Lesbian Medical Association 2001, p. 211). In Finland, homosexual activity was a crime until 1971 and it was classified as a mental disorder until 1981 (SETA 2016). In addition, in 1980s with the outbreak of AIDS, stigma and discrimination of GSM was exacerbated for being initially found among men who have intercourse with men (Gay and Lesbian Medical Association 2001, p. 173).

In recent world GSM variance is more visible and accepted. Knowledge about their health has been developed though much is still unknown about their health status and health care needs. They might still face unique health disparities and challenges concerning health care services. (Graham et al. 2011 pp.1, 10.)

To better understand the challenges that GSM face, the purpose of this thesis is to describe gender and sexual minorities' challenges in health care. This is a descriptive literature review aiming to use its knowledge to develop health care of gender and sexual minorities.

2 Background

In background, relevant concepts to this literature review are defined and background information is presented. Gender and sexual minorities (GSM) are a broad and diverse group of people that differ from society's expectations with respect to gender identity and sexual orientation (Graham et al. 2011, p.11). This literature review mostly focuses on "LGBT community" (lesbian, gay, bisexual, and transgender individuals) leaving out for example people who have same-sex attractions but do not consider themselves as homosexual. "Coming out" is nowadays a lot easier because social acceptance and awareness is clearly moving forward. However, GSM still share the historical status of being the "others" who differ from gender and sexuality norms, and have experienced stigma, discrimination, and violence. It is emphasized that GSM individuals have each their own health-related concerns but they still have some similar health concerns and specific health needs. (Graham et al. 2011, pp.11-14.)

2.1 Gender minorities, gender identity and expression

Gender generally classifies individuals as masculine or feminine based on their biological, psychosocial, and cultural factors that society delineates (Leidolf et al. 2008). *Gender minorities* are defined according to their gender identity and expression typically including transgender individuals. Transgender is an inclusive umbrella term for people whose gender desires, identities and behaviours are not in line with traditional expressions of masculine and feminine and they might not conform to what is usually linked with assigned sex. They may feel to be the opposite gender and some of them have went through medical and surgical treatments to change their sexual characteristics. (Graham et al. 2011, p. 26; Leidolf et al. 2008.) Transgender umbrella includes most commonly cross-dressing people, intersex people, non-binary gender people, performers and transsexuals. Terms and definitions of these subgroups change and grow over time, but most common ones are explained in table 1. Transgender individuals can also vary from their sexual orientation but it is highlighted that gender identity, assigned sex, and sexual orientation may be distinct from one another (Graham et al. 2011, p. 27).

Gender identity is an individual picture of self as a particular gender, regardless of gender appearance. It is separate from person's sex assigned at birth as it is internally defined. (Eckstrand and Ehrenfeld 2016, p.6.) Person can identify as a boy or man, a girl or

woman or another gender. *Gender expression* is based on one's personality, appearance, and behaviour. It is about expressed gender which is culturally defined as masculine or feminine. (Graham et al. 2011, pp. 25-26.)

Table 1. Transgender umbrella terminology

Term	Definition
Cross-dressing people -Also known as transvestites	People who identify their physical gender at birth but occasionally wear clothes associated with the opposite gender, and may live sometimes in that role. Usually heterosexual men. (Graham et al. 2011, p.26.)
Intersex people	Having variation in biological sex characteristics meaning variations in reproductive anatomy compared to what is thought normal for either female or male. Some of the variations are visible at birth and some are not. (Richards et al. 2016, p. 95.)
Non-binary gender people / genderqueer -Androgynous -Agender -Bigender -Pangender -Third gender	Gender identities are different from the traditional expressions of female and male. For example, they can identify as both genders at one time, both genders at different times, being more than just one gender or having no gender at all. (Richards et al. 2016, pp. 95-96.)
Performers -Drag queens -Drag kings	Wear clothes connected with the opposite gender in hyperfeminine or -masculine way for entertainment, and appear partly in the cross-gender role. It is not an identity, some identify as transgender or homosexual but some do not. (Graham et al. 2011, p.26.)
Transsexual -Female-To-Male -Male-To-Female	People who identify the opposite gender they are born into and want to or have transitioned from one sex to another. (Graham et al. 2011, p.26.)

2.2 Sexual minorities and sexual orientation

Sex is determined by biological characteristics meaning sexual and reproductive anatomy, dividing people as male, female or intersex (Lee & Kanji 2017, p. 82). *Sexual minorities* are defined based on their sexual attraction, behaviour, and identity which conclude one's sexual orientation. Their preference regarding sex can be seen as against the grain because of the fact that they are not exclusively heterosexual. This group typically include lesbian, gay and bisexual individuals which are explained in table 2. However, sexual orientation can vary a lot and these labels are not as valid as before. Sexual minorities can also be transgender, but most are not. (Graham et al. 2011, p.12.)

Sexual orientation is about enduring patterns of experiencing sexual or romantic desires, behaviours or relationships with men, women or both sexes (Graham et al. 2011, p.27). It is essential to note that sexual orientation is a separate term from gender identity and does not indicate that, and vice versa (Eckstrand & Ehrenfeld 2016, p. 26).

Table 2. Bisexual, gay and lesbian terminology

Term	Definition
Bisexual	Women and men oriented and having sexual or romantic desires to both women and men (Johnson et al. 2008).
Gay	Men oriented and having sexual or romantic desires primarily to other men (Johnson et al. 2008).
Lesbian	Women oriented and having sexual or romantic desires primarily to other women (Johnson et al. 2008).

2.3 Health status of gender and sexual minorities

Interest of gender and sexual minorities' health status has mostly been on sexual transmitted diseases in the past two decades. There is now a growing awareness of other

negative health disparities. (Muller & Hughes 2016.) Significant clinical concern for all gender and sexual minorities are mental health disorders. GSM individuals have a higher prevalence of having anxiety, depression, low self-esteem, negative body image and eating disorders. Mental health disorders are likely to be connected with stigma and discrimination. GSM individuals are stressed about hiding their own gender identity or sexuality, or being judged and rejected by friends, family and community members. Because of social exclusion, it is easier for some to deny their identity and that is a way to "fit in" to social norms. (Ash & Mackereth 2013; Mayer et al. 2008; Muller & Hudges 2016.) One study using data from the Massachusetts behavioural risk factor surveillance system survey of adults (N = 67,259) showed that sexual minorities are more likely to report activity limitation, anxiety, substance abuse, asthma, sexual violence, and HIV testing compared to heterosexual adults (Conron et al. 2010). In addition to adults, the GSM youth are more prone to have suicidal thoughts and to attempt suicide. They have also higher odds for substance abuse, unsafe sexual behaviours and sexually transmitted diseases. Men who have intercourse with men have higher odds for anal cancer due to greater occurrence of anal human papillomavirus. (Graham et al. 2011, p. 170, Mayer et al. 2008.)

Use of mental health services is more common among GSM, but they still have more negative experiences compared to others. One reason may be that providers assume that one's sexual orientation, gender identity and mental health issue are connected. All the negative experiences together with lack of GSM competent services cause them to delay access to health care, at the same time inhibiting GSM to receive routine preventive health screenings causing them to have increased risk for some cancers. (Mayer et al. 2008; Muller & Hudges 2016.)

Nowadays, sexual minorities' health status is more known and researched. However, there is still huge lack of data related to transgender health which is why it has not been in a focus. Transgender individuals have more clinical issues regarding their care because knowledge about their health and care has not been taught or widely disseminated. They also face financial care barriers, given that transition-related care is expensive. (Mayer et al. 2008.)

Little focus has been on GSM peoples' family lives which also affect their well-being and satisfaction with care. More and more GSM individuals are building families and seeking appropriate services such as GSM-friendly adoption services. GSM youth are "coming out" in early ages and they might be in need of provider's support. GSM elders have fewer family connections and are less protected when their partner dies. There is a need

of policy changes and supportive programs to ensure equity for GSM patients. (Mayer et al. 2008.) It would be beneficial if laws changed to better direction for GSM people, but that does not guarantee it would change people's perceptions about difference. Hereby, GSM identify "being accepted" as the most important element. (Ash & Mackereth 2013.)

3 Purpose, Aim and Research Question of the literature review

The purpose of this thesis is to describe the challenges gender and sexual minorities have in health care. The aim is to use this knowledge to develop health care of the gender and sexual minorities.

Research question:

1. What kind of challenges do gender and sexual minorities have in health care?

4 Methods

In methods, literature review, data collection- and data analysis method are described. Database search table complements data collection process.

4.1 Literature review

This thesis is a literature review. Literature reviews seek to summarize a certain topic and evaluate existing literature. In literature reviews topic of interest and research questions are identified. Then answers to these questions are sought by searching, gathering, and analysing the relevant literature. (Aveyard 2007, p.6.) It requires research to fully analyse and justify a critical appraisal on any given topic. The review should provide the reader with the present succinct, logical summary of the knowledge and acceptance of the current topic. The data gathered must be processed in a systematic scientific manner allowing all relevant information to be included. Robust facts will allow the reader to make an informed judgement. (Coughlan et al. 2016, p.2.) Knowledge that comes from literature reviews is useful and can be implemented in professional lives (Aveyard 2007, p. 6).

There are different types of literature reviews that can be conducted. This review is a form of descriptive literature review which suits the topic as the experiences are studied.

It is useful when a summary and synthesis of a specific subject is wanted (Cronin et al. 2008, p.4). Descriptive literature review can range from broad to specific but it tends to be broad. In addition, data collection criteria is not limited by methodological rules. The aim is to "identify, analyse, assess and interpret a body of knowledge on a topic". (Coughlan et al. 2016, pp.12-13.)

4.2 Data collection

In this thesis, the data was collected by using electronic databases called Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE (table 3). CINAHL engine was used as it widely covers international nursing topics, it is specific, easy to use and provides literature in English. Medline covers a lot about medicine and healthcare in many different languages. Data collection was based on relevant and recent information that answers to the research question. In addition, manual search was conducted from other appropriate researches' references. Data was searched by using search terms: Gender AND sexual minorit* OR lesbian gay bisexual transgender people OR trans person* OR sexual minorit* AND health care.

Inclusion criteria was developed to answer merely the research question. Inclusion criteria helps to assess which information should be taken into the review and to ensure that only those relevant researches were included (Aveyard 2007, p. 14). Only gender and sexual minorities and their challenges within health care were included. Additionally, data was limited to those research articles from liable sources that are published in English, are up-to-date, and published no earlier than 2006.

From CINAHL 243 hits, and from MEDLINE 138 hits were gotten. Reviewed from title, abstract and context it was possible to outline irrelevant materials, leaving in total 12 articles. From those, eight were chosen to this thesis. Database search is shown in table 3. In addition, manual search was conducted from other appropriate researches' references. Overall, 13 articles were chosen to this literature review published in Canada, England, Ireland, South Africa, and United States (appendix 1).

Table 3. Database search table

Database	**Search terms**	**Limits**	**Hits**	**Re-viewed from title and ab-stract**	**Re-viewed by con-text**	**Articles used**
CINAHL 3.5.2017	Gender AND sexual mi-norit* OR les-bian gay bi-sexual transgender people OR trans person* OR sexual mi-norit* AND health care	2006-2017 English lan-guage	243	21	7	6
Medline 3.5.2017	Gender AND sexual mi-norit* OR les-bian gay bi-sexual transgender people OR trans person* OR sexual mi-norit* AND health care	2006-2017 English lan-guage	138	20	5	2
Manual Search 3.5.2017						5

4.3 Data Analysis

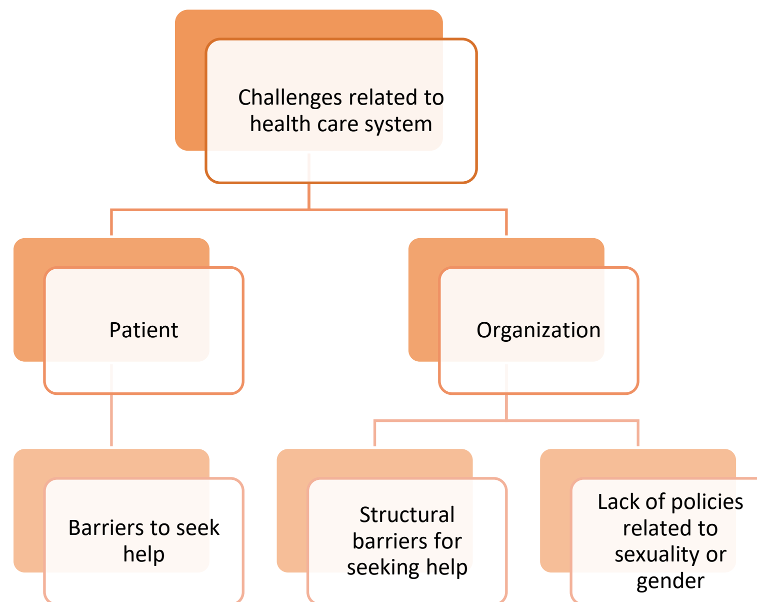
In order to classify the data qualitative analysis method by applying the inductive principles of content analysis was used. Content analysis is a form of classifying literature, organizing and giving meaning to the data (Burns & Grove 2007, p. 41). In inductive content analysis, the content is derived directly from the data and theoretical whole is created (Tuomi & Sarajärvi 2009, p. 95).

Literature materials were read multiple times, and classifying was based on the research question “what kind of challenges do gender and sexual minorities have in health care”. Similarities in the data were found and condensed, next they were combined to create subcategories and upper categories. After that main categories were created: challenges related to health care system and health care provider-patient relationship. By categorizing data, the phenomenon can be described easily which increases understanding and generates knowledge (Elo & Kyngäs 2008, p.111).

5 Findings

The research articles used in this descriptive literature review studied challenges in health care services experienced by gender and sexual minorities. The results included two main categories divided in "Gender and sexual minorities' challenges related to the health care system" and "Gender and sexual minorities' challenges related to health care provider-patient relationship". These main categories are presented from both the health care side and the patient side, yet telling only the patient point of view. They are shown in figures 1 and 2.

Figure 1. Challenges gender and sexual minorities experience in health care system



5.1 Gender and sexual minorities' challenges related to the health care system

5.1.1 Challenges related to patient

Barriers for seeking help consist mainly of two main issues: (1) Absence of information and (2) concerns and fears about care providers and treatments. Creation of these challenges is seen in figure 1.

Absence of information was a significant barrier to seeking help for gender and sexual minorities. They did delay or avoid seeking care because finding important, accurate and relevant information about care was challenging for them, especially for transgender people. (Bauer et al. 2009; Stotzer et al. 2014.) There is a huge lack of research concerning transgender related health greatly affecting how easily transgender people can access to health care services. Transgender people would like to have more information about mental health, family practice, transition-related care along with basic health care concerns. (Bauer et al. 2009; Dargie et al. 2014; Stotzer et al. 2014). Considering mental health, transgender individuals had most symptoms of stress, depression and anxiety which indicates the importance of support and ability to access health care (Dargie et al. 2014).

Produced information about gender identity might not be incorporated into educational textbooks, health care protocols, or other documents. In some produced information, gender identity might be misunderstoodly conflated or connected with sexual orientation even though they do not necessarily mean the same thing. This reflects the suppositions and biases of writers and publishers, thinking that all people are living in gender assigned at birth. It was mentioned that information in health care community-sensitive policies and practices is often meant to be for all lesbian, gay, bisexual and transgender patients leaving transgender specific health care needs outside. In addition, transgender people might have to search more information in order to find a competent and culturally sensitive health care provider, and there might not be such a provider available (Rounds et al. 2013). Sometimes health care providers who were specialized in HIV were the only ones willing to monitor and provide transition-related care to the transgender people. (Stotzer et al. 2014). Stunted knowledge production, slow dissemination of information along with challenges finding consistent health care provider largely affected as a barrier to seeking help. (Bauer et al. 2009, Rounds et al. 2013).

Concerns and fears about treatments and care providers acted as another barrier for gender and sexual minorities to seek help. Concerns focused mostly on health care providers, how they will handle and face the diversity in gender identity and sexual orientation. (Bauer et al. 2009; Dahlhamer et al. 2016; Rounds et al. 2013; Shires & Jaffee 2015; Stotzer et al. 2014.) Especially going in gynecological care raised anxiety and fear due to heterosexist bias (Shires & Jaffee 2015; Stotzer et al. 2014). However, one study showed that delaying seeking care was even higher than the actual discrimination in health care services (Stotzer et al. 2014). Some patients had previous negative experiences of discrimination which, understandably, made some individuals avoid going to health care services (Bauer et al. 2009; Bauer et al. 2014). For instance, some transgender patients had to choose services according to their assigned sex at birth. Discrimination and feelings of indignity were common fears suffered when being placed to those wards or sex-specific clinics that were not suitable for their gender identity. Some felt that everything changed when their gender identity was found out. (Bauer et al. 2009.)

5.1.2 Challenges related to organization

Structural barriers of seeking help was a difficult factor including lack of health insurance, social stigma, and systemic discrimination. They are shown in figure 1. *Experiencing lack*

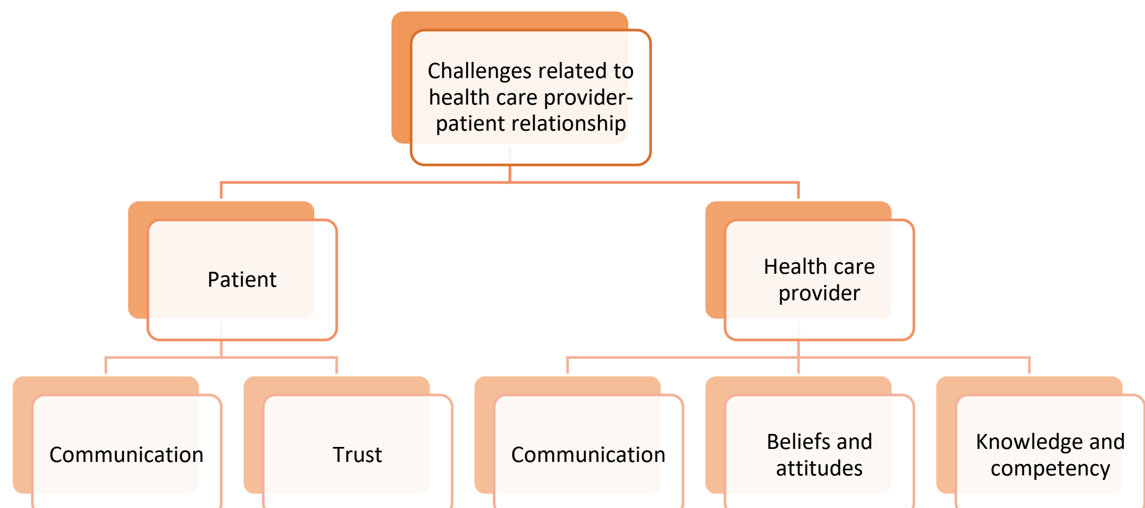
of health insurance was a common challenge shared by gender and sexual minorities (Benson 2013; McCann & Sharek 2014a; Stotzer et al. 2014). Health insurance remains an important determinant of utilization thus it is connected with poor healthcare access and treatment outcomes (Stotzer et al. 2014). Especially young transgender individuals face difficulties when many of them are under or uninsured and cannot simply afford medical treatment (Benson 2013; Stotzer et al. 2014). It was also suggested that lower socioeconomic status could be behind of sexual minorities avoiding health care (Dahlhamer et al. 2016).

Health care and well-being of GSM have already been violated because of the historical *stigma and discrimination* which have not vanished yet. GSM still experience it. Some individuals told that experiences of stigmatization and discrimination are the major reasons for not receiving good quality care as well as avoiding and delaying care. (Cele et al.2015; Dargie et al. 2014; McCann & Sharek 2014a.) Massive stigma is around especially older GSM generation which is not as approbated as the new generation (McCann & Sharek 2014a). Stigma was for example seen when patient had "different" appearance or when the patients were dressed in a different way. This irreverence was not only coming from the care providers but also from the other patients. Some patients just ignored the stares by the care providers and other patients. However, in extreme cases, laughing, mocking, and swearing from the other patients caused some GSM patients to leave the service. (Cele et al. 2015.) Even well-meaning health care providers did cause discomfort to the patients by accidently using inappropriate names and by asking questions that were not related to their current health issue (Stotzer et al. 2014).

In many researches, it was highlighted that of gender and sexual minorities transgender individuals are at most risk of being stigmatized and discriminated and they might not receive respectful or appropriate care (Bauer et al. 2009; Dahlhamer et al. 2015; Rounds et al. 2013; Shires & Jaffee 2015). Being transgender or in non-gender role was seen as a risk because of a greater stigma: possibility of dressing in different way or having transition-related medical treatments done. (Rounds et al.2013, Shires & Jaffee 2015). In addition, there is a dual stigma of being transgender and being HIV infected, which made some of the patients feel disrespected and uncomfortable. It even made them hide their gender identity or avoid health care (Bauer et al. 2009). Some health care providers insisted checking HIV and all the other sexual transmitted diseases from transgender people, which was apart from the actual concern of health (Stotzer et al. 2014).

Lack of policies related to gender and sexuality consists of challenges with sex designation and sex-segregated systems. Problems with sex designations in health-related documents were a common challenge that affected negatively on patients' experience. Transgender patients had difficulties to get their documentations correctly reflecting their felt gender identity. Health care providers had assumed that there is a mistake within the gender marked and tried to get it corrected which caused more distress to the patient. Even though patients modified to reflect their need some health care providers still called patients by their assigned name or sex instead of preferred name or gender. (Bauer et al. 2009; Bauer et al. 2014; James-Abra et al. 2015.) The fact that clinical documentations did not give the option for other identities made it easier for care providers to use names and pronouns that are not appropriate. Even though clinical documentation would say one's chosen name, health care providers might still use their legal birth name. (James-Abra et al. 2015.) In addition, patients were more likely to get discriminated when they had their felt gender on their clinical documents (Shires & Jaffee 2015). As mentioned earlier, transgender patients had to sometimes choose services according to their assigned sex and felt really embarrassed when being placed to sex-segregated wards including some hospital wards and women's clinics that did not reflect or feel appropriate to their felt or visible gender (Bauer et al. 2009.)

Figure 2. Challenges gender and sexual minorities experience in relationship with health care provider



5.2 Gender and sexual minorities' challenges related to health care provider- patient relationship

5.2.1 Challenges experienced by patient

Challenges related to health care provider – patient relationship from patient's point of view consist of how patients experienced communication and trust in their relationship with the health care provider. The challenges are shown in figure 2.

Communication between patients and health care providers caused problems to some of the patients (Bauer et al. 2009). Interaction made patients feel sometimes negatively judged by care provider's behavior when patient was not taken seriously or provider made own conclusions without listening (Rounds et al. 2013; McCann & Sharek 2014a). Some patients did feel uncomfortable talking about transgender related issues and needs (Bradford et al. 2013). Due to health care providers' negative attitude patients felt dissatisfied with the care. Spending time in treatment, answering questions which were not related to the actual problem patient had, and having to leave the care without receiving needed help caused disappointment to patients. (Cele et al. 2015.) Patients did not feel safe and welcomed to care because care providers did not take gender identity and trans issues into account (Rounds et al. 2013). Patients expressed appreciating care providers who listened and took patient's needs into account. GSM patients could communicate more openly when the care provider treated them with respect and dignity. (McCann & Sharek 2014a; McCann & Sharek 2014b.)

Trust is what patients needed in a relationship with a care provider. It is important that the health care provider understands about gender identity and transgender related issues and can support their identity. (Benson 2013; McCann & Sharek 2014b.) Being able to talk about gender identity and sexual orientation to the care provider varied among the patients. Most of the gender and sexual minorities were open about being part of LGBT (lesbian, gay, bisexual, transgender) community and did not see their gender or sexual identity problematic (James-Abra et al. 2015; McCann & Sharek 2014b; Stotzer et al. 2014). However, significant number of patients could not disclose due to fear (McCann & Sharek 2014b). Differences varied due to patients' experiences. If patient experienced that gender identity was an important part of the treatment, it was necessary to have an GSM friendly care provider (Benson 2013). For some the gender identity and sexual orientation had nothing to with the treatment they were undergoing and therefore did not feel the need to disclose it (McCann & Sharek 2014b).

Some of the patients could not accurately tell about their sexuality, gender or even about the real problem why they sought for help because of negative attitudes of the care providers (Rounds et al. 2013). Patients who had previous bad experiences or were assuming that the care provided is not GSM friendly felt agitated and might even avoid accessing care (Cele et al. 2015; Rounds et al. 2013). Some transgender patients were tired of correcting care providers' assumptions and calling them with wrong names, therefore eventually they stopped correcting them because the effort was useless (James-Abra et al. 2015).

5.2.2 Health care provider's communication, attitudes and competency

Challenges related to health care provider – patient relationship from health care provider's side shows the ways care providers communicated verbally and non-verbally, what kind of beliefs and attitudes they had, as well as care providers' knowledge and competency. These are shown in figure 2.

Verbal and non-verbal communication from health care provider's side towards GSM patients was most of the time negative and inappropriate. Negative experiences which patients reported included the health care provider ignoring or not taking patient and patient's concerns seriously and not listening (Rounds et al. 2013; McCann & Sharek 2014b). Also, care providers made faces, gave blank stare, were looking embarrassed and blushing while patient was answering questions (Rounds et al. 2013). Some patients experienced that the care provider was belittling patient's responses or the fact that they were transgender. Some care providers even refused to talk about GSM issues. (Bauer et al. 2014; Rounds et al. 2013.) Hurtful or insulting language and negative comments (McCann & Sharek 2014b; Shires & Jaffee 2015) as well as care provider disapproving to explore gender were experienced by patients (Bauer et al. 2014).

Beliefs and attitudes of the health care providers were shown by making assumptions about GSM people (Bauer et al. 2009; James-Abra et al. 2015; McCann & Sharek 2014a; Rounds et al. 2013). Care providers were not sensitive enough and they were giving stereotyping comments (Bauer et al. 2009; Rounds et al. 2013). GSM patients were discriminated and care providers denied equal treatment to them (Shires & Jaffee 2015). Some patients reported that care provider did not want to examine patient's body and did not want to provide care or even ended care due to gender identity and sexual orientation (Bauer et al. 2014). Several health care providers claimed to the patient that their

mental illness was caused by being part of GSM or the other way around (Bauer et al. 2009; McCann & Sharek 2014a; McCann & Sharek 2014b). Health care providers also thought that gender identity or sexual orientation could be caused by a trauma or upbringing. They thought it was just a phase which would pass. (McCann & Sharek 2014b.)

In some cases, patients' personality and physical appearance were judged and their identity and orientation evoked prejudice and stigmatisation. Religious and cultural beliefs of health care providers were a challenge for sexual minorities in Umlazi, South Africa. Some care providers thought they could "heal" the homosexuality out of them by imposing them to behave according to "right" beliefs and not what is against God's will. They also tried to change patients' beliefs to match their own. (Cele et al. 2015.)

Care providers do not have enough knowledge, education or interest about GSM related issues (Bauer et al. 2009; Bauer et al. 2014; Benson 2013; Cele et al. 2015; Dahlhamer 2016; McCann & Sharek 2014b; Rounds et al 2013; Shires & Jaffee 2015). Many patients had to educate their own care providers (Bauer et al. 2009; Bauer et al. 2014; Benson 2013; Bradford et al. 2013; Cele et al. 2015). Providers failed to understand patients' gender and sexual identities which lead them misunderstanding the patients' needs. They treated transgender patients easily in their biological birth gender. (James-Abra et al. 2015.) Many patients did not find health care environment with adequate care nearby and they had to travel to find it. Some patients were even told to seek help from different place. (Bauer et al. 2009.)

Patients were given poor treatment or services were not provided to them due to sexual orientation or gender identity (Stotzer et al. 2014). Health care providers asked irrelevant questions that had nothing to do with the reason why the patient accessed the service nor helped the patient in any way (Cele et al. 2015). Care providers focused on the gender identity instead of the patient's actual problem. It is important to understand that they have also needs which have nothing to do with being GSM. Some services advertised being GSM friendly but did not provide competent care for them. (Rounds et al. 2013.) Some GSM patients were advised not to reveal their sexual orientation and care providers claimed that homosexuality can be changed to heterosexual. They told patient to change their thinking and accept being straight. (McCann & Sharek 2014b.)

Patients wished that in the future health care services would be improved by spreading acceptance towards GSM people. Hospitals could display materials, policies and provide

forms which are LGBT friendly. (McCann & Sharek 2014b.) Appreciating diversity, educating staff, being competent and sensitive in transgender matters were important to the patients (Bradford et al. 2013; McCann & Sharek 2014b). Health care providers should not assume anyone's sexual orientation or gender identity (McCann & Sharek 2014b, Dargie et al. 2014).

6 Discussion

The main purpose of this thesis was to describe the challenges that gender and sexual minorities experience in health care. The articles (13) were chosen in order to answer the research question: What kind of challenges do gender and sexual minorities have of health care? The results were divided into two main categories – Gender and sexual minorities' challenges related to the health care system and Gender and sexual minorities' challenges related to health care provider-patient relationship. All the results were presented from the patient's point of view.

6.1 Discussion of the main findings

Findings indicate that despite of the fundamental human right, gender and sexual minorities (GSM) have to endure a lot of distress in health care. It is evident that more research about this topic is needed to develop more knowledge about the care and health of GSM. With further research, it is more possible to identify their gaps in health care and know how to prevent those gaps. Relative to previous literature, the findings suggest that barriers to seek help, structural barriers and lack of policies and practices are significant factors for GSM to delay or avoid health care system. Absence of information was already noticed from the previous literature. It was difficult to find relevant information and to trust health care providers' competency levels, making lack of information a huge barrier when trying to access to health care. (Graham et al. 2011; Gay and Lesbian Medical Association 2001; Mayer et al. 2008.) With decreased engagement in health care they are more likely to struggle with their mental health issues. They are also unlikely to receive important health screenings resulting GSM to have higher risk for developing for example breast cancer. (Graham et al. 2011; Gay and Lesbian Medical Association 2001; Mayer et al. 2008; muller & Hughes 2016.)

The theme of experiencing stigma and discrimination was most worrying. Transgender patients had the greatest risk for stigma and discrimination which corresponds to the previous literature (Graham et al. 2011; Gay and Lesbian Medical Association 2001). Some transgender patients felt that HIV and other STD's were too often linked to their gender identity, and health care providers were not interested in the actual health concern. Chance to get discriminated is even higher when GSM are in certain age, they have “different” race or ethnicity compared to others or they have poor socioeconomic status (Graham et al. 2011; Gay and Lesbian Medical Association 2001).

The ignorance towards transgender patients was seen and they had not been considered in health care systems. The most common challenges for transgender individuals was to find trans-related information, to afford transition-related medical treatment and to find culturally sensitive health care provider and environment. It was also difficult to find policies and practices that would reflect their felt gender. For example, clinical documentations and wards made them feel invisible as they were not taken into account. This kind of lack of considering transgender individuals does not tell about their existence or importance in health care system. It was also discussed in previous literature whether there should be more GSM specific services or more support in general services to become more GSM friendly. Some GSM individuals emphasized the need of being equal and same as everybody else, not to go as a "special" group with different services. (Ash & Mackereth 2013.)

The results also suggested that patients felt negatively judged by health care providers' behaviour. Care providers had negative attitudes and did not take patients seriously. Also care providers showed negative facial expressions and gave hurtful comments which lead patients often feeling uncomfortable to talk about transgender issues. Care provider who understood about gender identity and transgender issues made patients disclose their issues more easily. Fear was a great reason for not disclosing. Some patients did not feel the need to disclose when they saw that GSM identity did not have anything to do with the treatment they were undergoing. Patients appreciated if care provider listened and treated them with respect.

Care providers' beliefs and attitudes were shown to be discriminating in the results. They often had false beliefs which lead to unprofessional behaviour and treatment. Care was even denied from some of the patients due to sexual orientation or gender identity. Patients had to educate their care providers about GSM issues which shows that they do not have enough knowledge about it. Wrong things were focused on and the patients did

not get the help they were seeking. Some care providers even believed and told patients that their sexual orientation could be changed. Supporting the previous literature, GSM have many reasons for not disclosing their gender identity or sexual orientation based on negative experiences (Ash & Mackereth 2013). More awareness and acceptance are needed. This requires more education, appreciating diversity and being sensitive with GSM matters.

Research articles used in this literature review were mainly from the United States and Canada, representing mostly challenges from Western countries point of view. In Finland, there is a law about patient's status and rights which should protect patients from poor quality of care (Laki potilaan asemasta ja oikeuksista 758/1192). However, presumably the situation is almost the same in Finland as in other Western countries as inequality can already be seen in some way. Given stigma and discrimination by GSM people in Western counties, it is more likely to be even higher in countries where for example same-sex activity is considered as criminal activity. In most parts of Africa, it is seen as a crime and such laws directly affect the health of GSM. (Muller & Hughes 2016.) This supports the research article (Cele et al. 2015) used in this literature review where it was noticed that awareness and acceptability of GSM was worst in South Africa due to religious beliefs with the most severe cases of challenges for homosexual people.

6.2 Discussion of the ethical considerations

Ethical consideration is an essential part of research to provide good responsible conduct of research and to avoid any ethical misconduct. The research should be conducted in a way that it is ethically acceptable and reliable (TENK 2012, pp. 30-31). The ethical conduct of research is carried out through the whole research process: from identifying the study topic until publishing the study. (Burns & Grove 2017, p. 187.) The research ethics are rounded by validity and evaluation criteria which help to apply ethically sustainable data (Tuomi & Sarajärvi 2009, p. 127). According to TENK (2012, p. 30) ethically acceptable research is conducted, presented, and evaluated with integrity, meticulousness, and accuracy. The research articles used in this literature review were chosen, evaluated and presented in this manner.

Falsification, fabrication and plagiarism are often counted in misconduct. The research should not be based on invented observations or theory that fabricates the methods claimed to be used. Data or results cannot be changed or presented in a way that they are distorted from the original research. It is also important to give credit to someone's

words and use appropriate references to avoid representing someone else's material as own. (TENK 2012, pp. 32-33). To provide good research ethics this literature review followed honesty, diligence, and accuracy from the beginning. The work was presented and evaluated discreetly without causing any harm to anyone, without using any offensive words, or without belittling or falsifying any previous works or achievements of original researchers. In addition, references and citations are shown appropriately to respect other authors. To avoid any plagiarism this literature review was checked in Turn it in – program and had no attention needed similarities with previous literature.

6.3 Discussion of the validity

Literature review should have a "truth value" and it should be re-evaluated throughout the whole research process (Aveyard 2010, p. 110). The validity determines the accuracy and the quality of the research and it can be applied by using appropriate methods (Burns & Grove 2017, pp. 375). In order to provide validity only research articles from reliable databases were used. Databases CINAHL and Medline were used in this literature review. In addition, manual search was done by using references of some trustworthy articles. The authors of this thesis have ensured that all the data were critically chosen, evaluated and presented according to the research question, and only accepted data analysis method was used. It was made sure that the literature is adequate enough, data was read by both authors, and all the results were derived from the data.

Some of the researches used were done with a small sample size meaning that results of this literature review may not be able to put into practice. Other limitation was that authors of this thesis did not have much previous experience of conducting research and literature review, and may not have taken every aspect of the data into account. However, effort was made to provide research with good quality. As author's own biases can affect the validity of the data, it was ensured that data collection, data analysis and interpretation were based on objectivity. To get whole picture and better understanding of the thesis authors worked together almost throughout the whole process.

7 Conclusion

This literature review was undertaken not only to describe gender and sexual minorities (GSM) challenges in health care but also to provide more knowledge, and help to get

better understanding of the existing situation. Based on the research articles used, GSM experience a lot of different challenges in health care which in the end affects largely their quality of life. Challenges can be summarized into four main issues: (1) Absence of information which prevents them from accessing health care, (2) structural barriers that impede access to health care, (3) fear of being their own self and disclose their sexual orientation or gender identity in health care due to worries about providers' behaviour, (4) a lack of culturally competent and GSM friendly health care providers. Challenges they experience are similar to previous literature but still they are not somehow acknowledged. It may be possible that GSM patients do not want to complain about inappropriate care due to fear of denying care or it could be possible that health care providers are not aware of their inappropriate actions. It is obvious that enough research about this topic has not been made.

As these challenges seem to cause distress to GSM, more culturally-sensitive approach is needed. Information about GSM including the difference between gender identity and sexual orientation as well as information about most common specific health care needs should be put into educational textbooks and curricula, especially for health care providers. In order for care providers to feel competent enough and to create non-judgmental environment they should be able to get educated and address their knowledge gaps. Most importantly health care providers should establish a trusting relationship with their patients; feel comfortable enough and recognize the importance of being able to talk openly about patients' issues. As mentioned in the main findings patients wished more spreading of acceptance and knowledge. They expect GSM-friendly health care and educated and competent health care providers. (McCann & Sharek 2014b; Bradford et al. 2013.)

Future research could focus, not only on challenges GSM face, but focus more inclusively on understanding the reasons behind persistent disparities, to find ways to decrease the disparities and disseminate the best practices. In addition, the research should emphasize more the difference between gender and sexual minorities as they are two separate matters. For example, gender minorities have more issues with health care thus policies and practices should consider and support the diversity of gender more clearly. When patients are taken into account in health care system and providers have more knowledge about current challenges it is easier to create optimal health care to them: prevent any rejection, develop well-being of GSM and take care of the patient as a whole.

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Author(s), year, country **Title of the article**	**Purpose of the study**	**Sample, data collection and data analysis**	**Main findings**
Bauer, G.R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K.M., & Boyce, M., 2009. Canada *"I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people"*	To describe experiences of transgender people of health care services and to provide an understanding how to acknowledge these challenges.	N=85. Focus group-interview and survey for background. Qualitative. Nvivo version 7. Grounded theory approach-thematic analysis.	Study showed transgender people have difficulties finding appropriate care; trans-competent providers and trans-friendly environment. Tran's patients have experiences where they had to educate the providers or being put to sex-segregated wards that were inappropriate to their gender identity. Negative experiences and fears of them causes some transgender individuals to avoid accessing care.
Bauer, G.R., Scheim, A.I., Deutsch, M.B., & Massarella, C., 2014. Canada *"Reported emergency department avoidance, use and experiences of transgender persons in Ontario, Canada: results of respondent-driven sampling survey"*	To describe their need and courage to access emergency department services during past year, including lifetime experiences of emergency department avoidance and trans-related discrimination amidst trans people in Ontario.	N=408. Survey by using respondent-driven sampling. Quantitative. Analysis Tool, version 6.0.1	21 % participants in need of emergency department services avoided ED services because they were afraid of trans-related discrimination due to perceptions and previous experiences. More than half of them had negative experiences of emergency department services.
Benson, K.E., 2013. USA *"Seeking support: transgender client experiences with mental health services"*	To describe trans people's experiences with mental health clinicians.	N=7. Half structured interview with open ended questions. Qualitative. Inductive thematic analysis.	The participants wanted to see a therapist who accepts and supports them in their felt gender and is aware of trans issues. Participants believed that the therapists did not have enough knowledge and training about

			transgender issues. Participants found therapists by getting suggestions from their transgender friends.
Bradford, J., Reisner, S.L., Honnold, J.A. & Xavier, J., 2013. USA *"Experiences of transgender-related discrimination and implications for health: results from the Virginia transgender health initiative study*"	To view relationships between discrimination of transgenders and social determinants of health reported by transgender people in Virginia.	N=350. 1-time cross-sectional survey. Quantitative. Analysis tool=SAS statistical software. Version 9.2.	Participants reported discrimination specifically caused by either transgender status, gender expression, or both. Overall 26.9% felt discrimination in health care. It is challenging for transgender individuals to access health care services; culturally sensitive health care services and well-trained health care providers are needed but difficult to find.
Cele, N.H., Sibiya, M.n. & Sokhela, D.G., 2015. South Africa "*Experiences if homosexual patients' access to primary health care services in Umlazi, KwaZulu-Natal*"	To describe the experiences of homosexual patients utilising primary health care services in Umlazi.	N=12. Semi-structured interviews. Qualitative. Content analysis.	Worrying themes were the prejudice against homosexual patients and homophobic behavior from the health care providers and other patients in the primary health care services.
Dahlhamer, J.M., Galinsky, A.M., Joestl, S.S., & Ward, B.W., 2016. USA *"Barriers to Health Care Among Adults Identifying as Sexual Minorities"*	To explore the barriers to healthcare for LGB (lesbian, gay, and bisexual) adults whose age fell between 18 to 64 years.	N=25 885 (Straight: 25 149 Gay or lesbian: 521 Bisexual: 215) National Health Interview Survey All analyses were stratified by gender. Descriptive statistics for all variables along with prevalence rates for each barrier-to-health care measure by sexual orientation was	Gay, lesbian and bisexual individuals have higher chance for delaying care because of cost than straight adults. They have also higher chance to get stigmatized and discriminated.

		presented. Two-tailed significance tests were conducted to determine whether there were significant differences ($P < .05$) by sexual orientation.	
Dargie, E., Blair, K.L., Pukall, C.F. & Coyle, S.M., 2014. Canada *“Somewhere under the rainbow: Exploring the identities and experiences of trans persons”*	To explore the gender and sexual identities of transgender people and to investigate group differences, and to examine what creates better psychological and physical well-being.	N=1559 Website survey. Descriptive analysis and subsequent inferential analysis.	Many challenges experienced by sexual and gender minorities are similar. However, transgender individuals have unique mental and physical health issues which indicates the importance of support and ability to access health care. It is important to understand the complexity and diversity of transgender identities and the meaning of social support.
James-Abra, S., Tarasoff, L.A., Green, D., Epstein, R., Anderson, S., Marvel, S., Steele, L.S., Ross, L.E., 2015. Canada *"Trans people's experiences with assisted reproduction services: a qualitative study"*	To describe the experiences of trans persons who searched or accessed assisted reproduction (AR) services in Ontario, Canada, during 2007-2010.	N=11. Semi-structured qualitative interview. Qualitative. Qualitative analysis with descriptive phenomenological approach.	Trans people had negative experiences with service providers of AR. Trans persons had barriers to access it. Participants listed that service providers need more education and practice as well as improvement in environment.
McCann, E., & Sharek, D., 2014a. Ireland *"Challenges to and opportunities for improving mental health services for lesbian, gay, bisexual, and transgender people in Ireland"*	To examine experiences of LGBT people concerning mental health services in Ireland.	N=20. Semi-structured interviews. Qualitative. Nvivo version 8.0 was used to analyze the data. The interviews were open coded, themes were developed and in the end the main categories were formed.	While some of the participants reported positive experiences, it was clear that mental health services are not in line with national policy. In order to be more responsive to LGBT needs, changes should be made. This including increasing access to services

			and knowledgeable and responsible providers. Most wanted services were they are treated with respect and does not have to fear of stigma and discrimination.
McCann, E., & Sharek, D., 2014b. Ireland *"Survey of lesbian, gay, bisexual, and transgender people's experiences of mental health services in Ireland."*	To examine LGBT people's experiences of mental health service provision in Ireland. The aim was to find barriers, gaps in service, find out what kind of practice promotes mental health practice and well-being of LGBT individuals.	N=125. Survey and interview. A mixed methods research design of quantitative and qualitative approaches. Quantitative data was analyzed using descriptive statistics. Qualitative data was analyzed thematically.	Most of the participants reported that mental health services did not respond to their mental health needs. Some felt that they could not bring out their LGBT issues to the care provider. Staff had assumptions of patients being heterosexual and did not have enough competence in LGBT issues.
Rounds, K.E., McGrath, B.B. & Walsh, E., 2013. USA *"Perspectives on provider behaviors: A qualitative study of sexual and gender minorities regarding quality of care"*	To portray if care providers' behaviour promoted or reduced care for LGBTQ patients and to describe those provider behaviours.	N=11. Focus group-interview and brief background survey. Qualitative. Audio recordings. Data was analyzed into qualitative themes.	Participants described difficulties within communication, accessing health care and advertises. All participants said that transgender patients receive poorer care than other LGBTQ persons. Providers need more education and they need more knowledge about LGBTQ patients.
Shires, D.A., & Jaffee, K., 2015. USA *"Factors Associated with Health Care Discrimination Experiences among a National Sample of Female-to-Male Transgender Individuals"*	To resolve how gender identity affects in discrimination for female-to-male people after demographic and socio-economic characteristics are controlled.	N=1.711. Cross-sectional survey. Quantitative. Chi-square tests and a two-step logistic regression analysis.	High amount of participants felt discrimination (over 40%). Transgender individuals may be refused medical care and they do not feel safe in health care services.

Stotzer, R.L., Ka'opua, L-S.I., & Diaz, T., 2014. USA *”Is healthcare caring in Hawai’i? Preliminary results from a health assessment of lesbian, gay, bisexual, transgender, questioning, and intersex people in four countie”*	To describe LGBTQI health status and risks related to their health as well as assessment of their needs.	N=710. Survey. Also, open-ended questions. Guantitative.	LGBTQI generally self-assessed their health as very good or excellent. however their reported challenges with health, health insurance and negative experiences with healthcare. LGBTQI friendly and competent health care access is of significant concern. LGBTQI individuals have issues with insurance and they have difficulties finding a consistent health care provider. They also experience discrimination.