Title
Reproductive Health Care Priorities and Barriers to Effective Care for LGBTQ People Assigned Female at Birth: A Qualitative Study.

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ABSTRACT

Background: Little research documents the self-identified reproductive health priorities and healthcare experiences of LGBTQ-identified individuals who may be in need of services.

Methods: We conducted in-depth interviews with a diverse sample of 39 female-assigned-at-birth individuals (ages 18-44), who also identified as lesbian, bisexual, queer and/or genderqueer, or transmasculine. Interviews were primarily conducted in-person in the Bay Area, CA and Baltimore, MD, with 11 conducted remotely with participants in other U.S. locations. We asked participants about their current reproductive healthcare needs, topics they felt researchers should pursue, and past reproductive healthcare experiences. Data were analyzed using a framework method, incorporating deductive and inductive thematic analysis techniques.

Results: Reproductive healthcare needs among participants varied widely and included: treatment of polycystic ovary syndrome and irregular menses, gender-affirming hysterectomies, and fertility assistance. Many faced challenges getting their needs met. Themes related to these challenges cross-cutting across identity groups included: primary focus on fertility, provider lack of LGBTQ health competency relevant to reproductive health priorities and treatment, and discriminatory comments and treatment. Across themes and identity groups, participants highlighted that sexual activity and reproduction were central topics in reproductive healthcare settings. These topics facilitated identity disclosures to providers, but also enhanced vulnerability to discrimination.

Conclusion: Reproductive health priorities of LGBTQ individuals include needs similar to cisgender and heterosexual groups (e.g. abortion, contraception, PCOS) as well as unique needs (e.g. gender affirming hysterectomies, inclusive safer sex guidance) and challenges in pursuing...
Future reproductive health research should pursue healthcare concerns prioritized by LGBTQ populations.

**BACKGROUND**

Reproductive health researchers have begun to explore inclusion of LGBTQ female-assigned-at-birth (FAAB) individuals, including lesbian and bisexual women and transgender men (female assigned at birth, identify as male), in studies on contraception, abortion, and other acute health topics (Cipres et al., 2017; SFP, 2017), due in part to increased funding opportunities for researchers pursuing questions of LGBTQ health (Pérez-Stable, 2016).

Current research on lesbian and bisexual women and transgender men suggests that each of these groups face pregnancy-related challenges. For cisgender, female, same-sex couples, who typically lack a sperm-carrying partner, family formation and child-bearing can involve complex decision-making, burdensome legal and insurance navigation, and additional fertility support (Schwartz & Baral, 2015; Somers et al., 2017; Tornello & Bos, 2017). Transgender men often fight stigma and isolation associated with being male-presenting and pregnant, while also managing gender dysphoria during pregnancy and early child care (Ellis, Wojnar, & Pettinato, 2015; Light, Obedin-Maliver, Sevelius, & Kerns, 2014; MacDonald et al., 2016, 2016). Testosterone hormone replacement therapy (HRT) may also impact fertility of transgender men (IOM, 2011).

Preventive sexual and reproductive healthcare is also pertinent. Lesbian and bisexual women and transgender men are less likely to receive pap tests than their heterosexual and cisgender counterparts (Agénor, Krieger, Austin, Haneuse, & Gottlieb, 2014; Agénor, Muzny,
Lesbian women may also have an increased risk of polycystic ovary syndrome (PCOS), though results are uncertain (Agrawal et al., 2004; De Sutter et al., 2008; Smith et al., 2011). Cisgender women who have sex with women, particularly young women with both male and female partners, may be at increased risk of HIV and sexually transmitted infections based on reported risk behaviors, including multiple sexual partners, substance use during sexual activity, and experiences with sexual coercion (Knight & Jarrett, 2017; Marrazzo & Gorgos, 2012). Transgender men who have sex with men may also be at increased HIV risk (Reisner & Murchison, 2016).

Despite burgeoning interest and documented concerns, reproductive health research on LGBTQ populations often lacks input from LGBTQ individuals in priority setting. We conducted in-depth interviews with 39 LGBTQ FAAB individuals to explore their priorities and experiences with reproductive healthcare.

MATERIALS AND METHODS

Sampling & Recruitment

We conducted in-depth interviews with 39 LGBTQ FAAB individuals between December 2016 and March 2017 after receiving human subjects approval by University of California, San Francisco. Interviews were conducted as part of a project to explore LGBTQ FAAB individuals’ attitudes toward standard reproductive health survey items and to develop new, inclusive survey items and overall best practices for LGBTQ inclusion in reproductive health research (Ingraham, Wingo, Foster, & Roberts, 2017). We recruited participants through community-based social networks, including LGBTQ listservs, professional networks, postings at local LGBTQ
organizations and Craigslist (Robinson, 2014). The researchers also asked participants to refer other LGBTQ-identified people they knew. Individuals were eligible if they were LGBTQ-identified, FAAB, and between the ages of 15 and 45. Anyone who expressed interest (n=97) filled out a questionnaire that included age, race/ethnicity, sex assigned at birth, current gender identity, and sexual orientation.

After evaluating feasibility based on initial participation interest, we undertook a maximum variation sampling strategy, a type of purposeful sampling (Patton, 2002), to ensure diversity in age, race/ethnicity, sexual orientation, and gender identity. We conducted a second wave of targeted recruitment using social media and Craigslist to recruit people of color and younger people, broadly speaking, with no quotas for individual age, race/ethnicity categories, to balance our early interviews that were largely with White, older participants. The researchers who conducted interviews are both cisgender, White, queer women who are personally and professionally active in LGBTQ communities. These factors likely influenced social networks available for convenience and snowball sampling, level of comfort between participants and researchers, and framing of interview questions.

Questions used to elicit reproductive healthcare priorities and experiences of participants were: “What is the most important reproductive health care issue for you personally and why?”; “What has been your experience with reproductive health care?”; and “What should be done differently in reproductive health care?” We also asked participants about what topics they think reproductive health researchers should pursue. In discussing these topics, we did not define “reproductive health” for participants, instead letting them interpret the term for themselves. This allowed us to see what individuals considered reproductive health concerns and for what reasons individuals were seeking out reproductive healthcare providers. The interview guide was
reviewed within our reproductive healthcare research organization by two other researchers for clarity before data collection.

We conducted interviews in person in the Bay Area, California (N.I.) and Baltimore, Maryland (E.W.) in private locations agreed upon with participants. Eleven interviews were conducted over the phone or by video with participants located in other parts of the U.S. Prior to each interview, oral consent was obtained. Participants received a $40 gift card for their time.

After completion of 39 interviews, we concluded that saturation had been reached, as new interviews did not generate any new codes and confirmed existing codebook themes (Fusch & Ness, 2015).

Data analysis

Interviews were audio recorded, transcribed verbatim, and reviewed for accuracy of transcription. We conducted textual analysis via Dedoose (version 7.6.6). The two researchers who conducted data collection also completed data analysis; one is a sociologist with public health training and the other is a master’s level public health researcher, both familiar with the literature on LGBTQ health and trained in qualitative methods. We developed deductive codes based on research questions and previous literature. An additional set of emergent, inductive codes were created, agreed upon, and assigned during the review of the first five transcripts. To ensure inter-coder reliability, we developed a codebook and compared code usage between the first five coded transcripts and resolved any discrepancies by consensus. Analysis was conducted through a framework method (Pope, 2000; Ritchie & Lewis, 2014), placing coded transcripts into a series of coding matrices through which constant comparisons were made to establish themes. After identification of major themes, we reviewed transcripts stratified by sexual...
orientation and gender identity to understand both the breadth of applicability and variation between different groups.

RESULTS

Analysis of data generated two domains presented here: reproductive health priorities and future research topics and barriers to effective reproductive healthcare. The latter is further divided into four thematic areas: fertility and women’s care focus, LGBTQ erasure and health competency, discriminatory comments and care, and impact on future healthcare seeking behavior.

Participant Characteristics

A total of 39 participants, between the ages of 18 and 44, were interviewed with a mean age of 29.9. The majority of our sample (n=25) identified as queer, and a third identified as gay or lesbian (n=5) or bisexual (n=7). Just over half of the sample identified as female (n=21). An additional third (n=13) identified as genderqueer or gender non-conforming (identifying with neither, both, or a combination of male and female genders), and a sixth (n=5) identified as transgender men/transgender male. Over half of participants (n=22) identified as White, 15% as Black or African American (n=6), 15% as Hispanic (n=6); the remainder identified as Asian (n=2) or biracial (n=3). Overall, the sample was highly educated, with over three-quarters reporting at least a college degree (n=33). Slightly more than half reported full time employment (n=21).

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1 Participants were asked about gender identity using the Williams Institute measure (Gender Identity in U.S. Surveillance (GenIUSS), 2014). This instrument uses the terms “female” and “male”, generally associated with sex, instead of the equivalent gender terms “women” and “man.” Based on interviews with participants, all who indicated “female” identified as a cisgender woman.
Reproductive health needs and future research topics

Self-identified reproductive healthcare needs, listed in Table 2 [insert table 2 here], varied. Acute and preventive concerns were reported by cisgender, genderqueer, and transgender male participants. Younger participants identified routine preventive care, such as pap tests, sexually-transmitted infection (STI) prevention, and birth control as priorities, while older participants were generally concerned with childbearing or menopause. Participants across all ages reported acute reproductive health concerns, such as pain management for PCOS or menses. Two cisgender, queer participants were pregnant at the time of their interview and reported LGBTQ-inclusive prenatal care as their most immediate need. Other cisgender, transgender, and genderqueer participants interested in future pregnancy also cited fertility assistance and support as a reproductive planning concern. Transgender participants with future desire to become pregnant wanted to learn about the impact of testosterone hormone treatment (HRT) on fertility. Transgender participants also cited gender-affirming care as a primary need, including some combination of HRT, top surgery and hysterectomies. Two genderqueer participants had received hysterectomies prior to interview. One reported concerns with HRT post-hysterectomy, while the other sought further surgeries, such as oophorectomy (ovary removal). Lastly, one bisexual, genderqueer participant and one queer, cisgender female participant mentioned abortion access as an important service to have available.

We also asked participants about what reproductive health topics they thought researchers should pursue. Many participants cited the experiences of LGBTQ FAAB individuals broadly, or transgender people specifically, in reproductive-health settings as a priority, including discrimination in reproductive health settings and cost of reproductive healthcare for LGBTQ

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FAAB individuals. Many also wanted to understand aspects of LGBTQ pregnancy, including: the experience of pregnancy for genderqueer people; how same-sex couples handle grief for pregnancy loss; and how HRT among transgender men impacts pregnancy-related outcomes. A few expressed interest in how LGBTQ individuals conceptualize family formation. Lastly, some participants listed sexual health research questions, including how LGBTQ individuals engage in sex (particularly transgender men) and what LGBTQ individuals use sex for (pleasure, reproduction, income, etc.), how to measure cisgender female same-sex safer sex practices, risk of STIs for women who have sex with women, and the reasons LGBTQ FAAB individuals use contraception—i.e. pregnancy prevention versus other reasons.

**Reproductive healthcare barriers to effective care**

We identified a number of barriers encountered within reproductive healthcare settings, including: provider fertility focus, LGBTQ erasure and health competency, discrimination by providers, and impact of previous experiences on reproductive healthcare-seeking behavior. Participants defined “reproductive healthcare settings” as a broad range of settings, including: hospitals, private obstetrics and gynecology practices, and family planning clinics.

**Fertility and women’s care focus**

The association of reproductive care with fertility and womanhood pervaded stories in our sample. Many participants sought reproductive healthcare for acute health concerns. However, providers often steered them toward conversations about fertility, which “kind of sends the message that a woman’s only purpose is to shoot children out of her uterus.” (30-year-old, Black, queer woman). This made participants feel like their own health concerns were not as important to providers as filling child-bearing expectations externally ascribed to them. Several
participants noted that this can be alienating to some LGBTQ FAAB individuals, including
lesbian and bisexual women and transgender men, many of whom are not at risk of pregnancy
and do not plan on having children.

This redirection was especially frustrating for participants seeking care for disruptive
reproductive health issues. One queer woman described her experience being told that she had
PCOS-associated infertility:

Two different doctors told me this very, very gently, this was going to be terrible news to me. Yeah, not terrible
news, really not. Just a lot of making assumptions about me wanting to protect or get involved in fertility ...and now
I feel like I’m not getting good enough attention around the pain I’m having with my menstrual cycle. I call off work
at least one day a month. This is not acceptable. -43-year-old, White, queer woman

The participant had pronounced symptoms that she felt the provider was unprepared to handle,
with the provider described as focusing on the aspect of PCOS least relevant to her life. This
both obstructed quality healthcare and made her feel insignificant. For others, this framing by
providers was dehumanizing. One 35-year-old, Black, queer, genderqueer person reflected:
“They’re just looking at me as a source of breeding.”

Transgender men experienced the added level of complexity of reproductive care not
only being associated with fertility, but with womanhood. One 29-year-old, White, queer,
transgender man described how reproductive health centers are often labeled “women’s health
care” and as a result he feels uncomfortable and anxious as “the only guy in the waiting room
that [isn’t] with a woman.” This created an additional obstacle to obtaining care for masculine-
presenting individuals in our sample.
Descriptions of erasure and inadequate provider competency were pervasive across both cisgender and gender variant participants. Many participants cited non-inclusive and outdated protocols as barriers to care. One pregnant cisgender participant, who used a known sperm donor for insemination, described how intake forms were confusing for her when receiving prenatal care:

In both my obstetricians' offices, all the paperwork was very hetero-normative. It was very father of the baby, male partner. I did a lot of scratching out and writing over things. We have a known donor, so I’m lucky to know his medical history and all of that. And I recognize that that’s important on the documentation, but it’s unclear. Are you looking for this information for medical reasons or what? Because if it’s for family reasons, my partner’s information is more valid. -34-year-old, White, queer, cis woman

Lack of specificity and flexibility within intake forms made it difficult to properly communicate relationship and medical history information relevant to prenatal care. Similar observations were made by genderqueer and cisgender participants seeking preventive reproductive care, such as pap tests and STI screenings, who were unable to accurately report sexual behavior and gender or sexual identity on intake forms. The inexact language, based on embedded cis- and heteronormative assumptions, impacted their ability to communicate about risks.

Some providers also made behavioral assumptions when discussing sexual activity:

Whenever health professionals throughout most of my life have asked me if I’m sexually active, they mean are you currently having a penis in your vagina, because in the end, they don’t actually care about my sexual health. They care about … am I at risk for becoming pregnant, do I want to become pregnant, or do I have a risk of getting an STI from a penis? -26-year-old, White, queer, transgender man
Both cisgender and transgender participants described how providers inquired imprecisely about sexual activity while taking sexual histories and assessing risk. This left many participants feeling confused and invisible and lacking practical information. One cisgender participant summarized this feeling in relation to her gynecologist’s lack of engagement about same-sex sexual activity: "I don't know what the heck I'm supposed to do. And no one is talking about this [safe same-sex sexual activity]. Is it just not a thing? Does this not exist?" (22-year-old, biracial, queer, cis woman).

When cisgender participants proactively asked about same-sex sexual activity, providers were often described as unprepared. One 30-year-old, Black, queer, cisgender woman asked her provider during her postpartum visit when and how she could safely reinitiate sexual practices with her cisgender female partner. The participant described the provider as surprised and unprepared. Another participant was given expired dental dams without explanation of proper usage. One provider even inverted the provider-patient dynamic by asking their lesbian patients where the clinic could purchase dental dams. For individuals with acute sexual health concerns, the lack of guidance was especially frustrating. A cisgender woman with vaginismus was unable to obtain provider guidance on how to manage sexual activity with other cisgender women: “There was zero direction or image of what it meant to be a queer woman with vaginismus getting treatment. There was no end game. That basically didn’t exist, not really” (26-year-old, White, bisexual woman). For many participants, lack of both data and provider guidance made them feel invisible and anomalous, hindering their ability to receive relevant healthcare.

Discriminatory comments and care

Participants also encountered homophobic or transphobic remarks from providers. Transgender male participants described providers misgendering them (using incorrect
pronouns), and prying into aspects of their identity irrelevant to the care being sought. A few
transgender and genderqueer participants found that identity disclosure related to their
reproductive medical care opened them up for transphobic mistreatment:

She asked to do the chest exam. And I was like, “I’m having top surgery in, less than a month. They’re going to be
gone.” And she then gave me a lecture about how [my top surgery] is a poor life choice, and I need to reconsider
things. “And, I don’t even know what that would mean for your future.” …in the end I didn’t actually get anything
out of [the exam], besides, “You’re healthy, I guess,” and “Take more ibuprofen.” -25-year-old, biracial, queer,
genderqueer person

Here the provider scrutinized the patient’s decision to pursue gender-affirming surgeries instead
of providing relevant care, prompted by a discussion about a routine exam in reproductive
healthcare settings. The patient left the appointment feeling that they had endured emotional
discomfort disproportionate to care received.

Transgender men and genderqueer participants also described being met with
discrimination when seeking medical advice related to gender transition. Both HRT and gender-
affirming surgeries pertain to health of the reproductive system, so the choice to engage
reproductive healthcare provider type felt logical. However, most described providers as ignorant
of transgender-related health issues and some refused support of gender-affirming care. One
participant described discussing HRT with their provider:

I wanted to start hormones. And she was like, I don’t know about all of that. And I was just like, but could you refer
me to someone who does? And she was like, well, there’s nothing wrong with being a woman, and just really
believed that it was from a place of hate for women, just internalized hate for women that was making me ask her
this. And that was my first time like coming out to a medical professional. -28-year-old, Hispanic, queer,
genderqueer person
After the patient's disclosure, the provider was described as conflating gender affirmation with misogyny. She then obstructed access to requested medical care by not providing a referral to an appropriate provider or engaging with the patient about their medical needs.

Interrogation about and invalidation of identity also occurred around sexual orientation. One participant described their first routine preventive care visit with a gynecologist. They disclosed their queer identity to the provider, who then:

spent the whole visit talking about his daughter's friend, who wasn't - who said that she wasn't straight, but she had sex with a guy who was cis[gender]…all while all the things that go along with being at the gynecologist are happening for the first time ever... Everything is too big and too hard and too fast and really terrible. And basically, his story was, “She ended up having a kid, and I delivered it. Because nobody is actually gay. And you always go back to men and have children, and she's straight.” – 25-year-old, biracial, queer, genderqueer person

The combination of gruff examination technique and homophobic comments made this participant feel distressed and disrespected. This juxtaposition within this participant’s story highlights the heightened vulnerability reproductive healthcare settings generated for some participants.

The experience of providers saying discriminatory remarks instead of providing medical care made participants feel both uncomfortably visible and unwelcome in reproductive healthcare spaces.

Impact on reproductive healthcare-seeking behavior

Participants also shared how previous reproductive healthcare experiences affected their desire to seek future care. Some who had negative prior experiences with reproductive healthcare have since avoided those care settings:
Being a rape survivor, being a non-binary person, and then my really only other experience in that kind of setting being negative or giving me a negative recollection of that, all of those things combined made me not want to go for the longest time. -29-year-old, White, queer, genderqueer person

Many also discussed story-sharing about reproductive healthcare among LGBTQ FAAB persons. Statements from cisgender women like, “virtually every queer female I know has had the experience of having providers not take them at their word that they’re not pregnant.” (33-year-old, Hispanic, queer, genderqueer person) or, from genderqueer or transmasculine participants, “My friends, we have…the longest thread of horror stories getting Pap [smears]” [due to lack of provider sensitivity to patient discomfort with female reproductive organs] (28-year-old, Hispanic, queer, genderqueer person) were common among participants. A lesbian participant called reproductive healthcare “a running joke in the LGBTQ community” because of how incongruous so many feel in this setting. Negative experiences in reproductive healthcare settings, such as harassment or inappropriate treatment, not only impact individual healthcare seeking behavior, but also circulate though LGBTQ social networks.

DISCUSSION

Our analysis of a cross-cutting sample of LGBTQ FAAB individuals highlights that LGBTQ FAAB individuals seeking reproductive healthcare have diverse needs and face unique challenges. To our knowledge, this is the first attempt to document the breadth of reasons that LGBTQ FAAB individuals --including lesbian, bisexual and queer women, genderqueer individuals, and transgender men -- pursue reproductive healthcare. Some participants, including lesbian and queer cisgender women and transgender men, want to have children and may need specialized care or information, such as assistance in insemination and—specifically for
Transgender men and genderqueer people—guidance on the impact of testosterone treatment on pregnancy. Some also seek reproductive healthcare for non-fertility-related health concerns, including symptom management for menstruation and PCOS and post-hysterectomy care. Transgender men and genderqueer individuals also engage reproductive health providers about gender-affirming care. While this is an exploratory as opposed to exhaustive list, it highlights the range of priorities for sexual and gender minorities across the reproductive lifespan. Research topics that participants wished to see pursued by researchers largely mapped onto the personal priorities conveyed, including experiences of LGBTQ groups through pregnancy, quality of reproductive healthcare, sexual behavior, and biomedical concerns. Reproductive health researchers should consider this diverse set of priorities when developing future studies.

Findings presented here on reproductive healthcare experiences are consistent with literature on quality of LGBTQ healthcare experiences. Previous research shows that two main barriers to quality healthcare access for LGBTQ adults are: lack of providers knowledgeable about LGBTQ health and fear of discrimination in healthcare settings (Bonvicini & Perlin, 2003; James, Se et al., 2016; Poteat, German, & Kerrigan, 2013; Roberts & Fantz, 2014). Reproductive healthcare—traditionally associated with womanhood and childbearing (Kimport, 2017)—is particularly disposed toward these offenses. This can create two related challenges. One, it can alienate individuals who need reproductive health services, but do not identify as female, or individuals not interested in childbearing and not at risk of pregnancy. And two, it can create inaccurate expectations for providers about who is seeking care and why. In our study, providers were described as largely unprepared or unresponsive to family formation methods or sexual behaviors that fall outside of cis- or heteronormative expectations.
Additionally, reproductive healthcare, where sexual activity and reproductive anatomy are central topics, lends itself toward disclosure of gender identity and sexual orientation. For multiple participants, including cisgender queer women and genderqueer individuals, the first time they disclosed sexual orientation or gender identity in a medical context was in a reproductive healthcare setting, due, in part, to the nature of care. Sexual orientation disclosure in clinical settings can lead to higher patient satisfaction (Bergeron & Senn, 2003; Steele, Tinmouth, & Lu, 2006), but disclosure also may be met with discriminatory treatment by providers.

Examples of provider discrimination and inexperience were described by participants in all gender identity and sexual orientation groups. For lesbian, bisexual and queer women and genderqueer individuals, assumptions about sexual activity and pregnancy, and childbearing desire created barriers to obtaining useful sexual and reproductive health guidance. Similar experiences have been documented in lesbian and bisexual women seeking pap testing (Agénor, Bailey, Krieger, Austin, & Gottlieb, 2015; Curmi, Peters, & Salamonson, 2016). For sexual minority women who seek prenatal care, pervasive heteronormativity can impede patient provider communication (Cherguit, Burns, Pettle, & Tasker, 2013; McManus, Hunter, & Renn, 2006; Röndahl, Bruhner, & Lindhe, 2009).

For transgender men and genderqueer individuals FAAB, framing of reproductive healthcare as women’s care can be an obstacle to presenting for care. Within care settings, attempts to disclose identity or seek guidance on gender-affirming care were, at times, erroneously reframed by providers as internalized misogyny, making patients feel unwelcome. Providers were also described as unable to provide useful information or referrals for transgender patients. This is consistent with literature that shows that providers are unprepared to provide guidance on pap
tests for transgender men (Agénor et al., 2015) or provide transgender men adequate support and resources throughout prenatal care (Light et al., 2014). If transgender men seek referrals to transition-related care through unprepared providers, their entry into care may be delayed, which can impact quality of life (White Hughto & Reisner, 2016).

Discrimination in reproductive healthcare settings and low-quality care provision may impact health outcomes for these groups across the reproductive lifespan. Transgender men who have sex with cisgender men may be at increased risk of HIV acquisition (Reisner & Murchison, 2016). Young bisexual women report higher rates of risky sexual behavior (Marrazzo & Gorgos, 2012). Avoidance of sexual healthcare or inadequate examination within healthcare settings may lead to missed screening or treatment. Similarly, lack of pap testing is equated with higher rates of cervical cancer mortality (Landy, Pesola, Castañón, & Sasieni, 2016). Future research should document health outcomes related to inadequate reproductive healthcare by these groups.

Limitations

As our study was exploratory, there are limitations. Data were drawn from a convenience sample, and findings may not be generalizable to all LGBTQ FAAB individuals. We utilized various recruitment channels to diversify our sample, however, our final sample was predominantly White, urban, and educated. Participants may have different reproductive healthcare priorities and experiences and better access to care than those not represented in our study. We were unable to reach individuals with less access to physical and/or virtual social networking sites, which likely included less-educated, lower-income, and housing-unstable individuals. These individuals may face additional barriers to quality healthcare due to lack of coverage or under-insured status that limits their healthcare options. To better recruit hard-to-reach individuals, future studies could consider intensive community engagement and utilization...
of peer recruitment (Tourangeau, Edwards, Johnson, Wolter, & Bates, 2014). Many participants chose to participate in order to share their experiences, which may have influenced overrepresentation of negative experiences within our study. Future research should investigate what facilitates reproductive healthcare access for LGBTQ FAAB individuals. Similarly, we did not purposefully seek out representation from individuals with no previous exposure to reproductive healthcare and cannot comment on how their priorities may deviate. Our decision to include participants across a range of sexual orientations and gender identities allowed us to comment on cross-cutting themes, however, we could not analyze experiences unique to each included group. Future research should explore these topics in each group separately.

**Implications for Practice and/or Policy**

Reproductive health priorities of LGBTQ FAAB individuals include needs similar to cisgender and heterosexual groups (e.g. abortion, contraception, PCOS management), as well as unique needs (e.g. gender-affirming hysterectomies, inclusive safer sex guidance) and challenges to accessing relevant care. Discriminatory treatment in reproductive healthcare settings can impede access to important medical care, such as cervical cancer screening (Agénor et al., 2015; Curmi et al., 2016; Johnson, Mueller, Eliason, Stuart, & Nemeth, 2016) and prenatal care (Light et al., 2014). Our study identified mechanisms through which discrimination and exclusion manifest in reproductive healthcare broadly, including imprecise protocols, marginalization and denial of patient priorities, and irrelevant focus on fertility. These qualities, alongside overt discrimination, can influence reproductive healthcare avoidance among LGBTQ FAAB individuals. Future reproductive health research should pursue healthcare concerns prioritized by LGBTQ FAAB individuals.
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