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

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1ABSTRACT

2**Background:** Little research documents the self-identified reproductive health priorities and
3healthcare experiences of LGBTQ-identified individuals who may be in need of services.

4**Methods:** We conducted in-depth interviews with a diverse sample of 39 female-assigned-at-
5birth individuals (ages 18-44), who also identified as lesbian, bisexual, queer and/or genderqueer,
6or transmasculine. Interviews were primarily conducted in-person in the Bay Area, CA and
7Baltimore, MD, with 11 conducted remotely with participants in other U.S. locations. We asked
8participants about their current reproductive healthcare needs, topics they felt researchers should
9pursue, and past reproductive healthcare experiences. Data were analyzed using a framework
10method, incorporating deductive and inductive thematic analysis techniques.

11**Results:** Reproductive healthcare needs among participants varied widely and included:
12treatment of polycystic ovary syndrome and irregular menses, gender-affirming hysterectomies,
13and fertility assistance. Many faced challenges getting their needs met. Themes related to these
14challenges cross-cutting across identity groups included: primary focus on fertility, provider lack
15of LGBTQ health competency relevant to reproductive health priorities and treatment, and
16discriminatory comments and treatment. Across themes and identity groups, participants
17highlighted that sexual activity and reproduction were central topics in reproductive healthcare
18settings. These topics facilitated identity disclosures to providers, but also enhanced vulnerability
19to discrimination.

20**Conclusion:** Reproductive health priorities of LGBTQ individuals include needs similar to
21cisgender and heterosexual groups (e.g. abortion, contraception, PCOS) as well as unique needs
22(e.g. gender affirming hysterectomies, inclusive safer sex guidance) and challenges in pursuing

23care. Future reproductive health research should pursue healthcare concerns prioritized by
24LGBTQ populations.

25

26BACKGROUND

27 Reproductive health researchers have begun to explore inclusion of LGBTQ female-
28assigned-at-birth (FAAB) individuals, including lesbian and bisexual women and transgender
29men (female assigned at birth, identify as male), in studies on contraception, abortion, and other
30acute health topics (Cipres et al., 2017; SFP, 2017), due in part to increased funding opportunities
31for researchers pursuing questions of LGBTQ health (Pérez-Stable, 2016).

32 Current research on lesbian and bisexual women and transgender men suggests that each
33of these groups face pregnancy-related challenges. For cisgender, female, same-sex couples, who
34typically lack a sperm-carrying partner, family formation and child-bearing can involve complex
35decision-making, burdensome legal and insurance navigation, and additional fertility support
36(Schwartz & Baral, 2015; Somers et al., 2017; Tornello & Bos, 2017). Transgender men often
37fight stigma and isolation associated with being male-presenting and pregnant, while also
38managing gender dysphoria during pregnancy and early child care (Ellis, Wojnar, & Pettinato,
392015; Light, Obedin-Maliver, Sevelius, & Kerns, 2014; MacDonald et al., 2016, 2016).
40Testosterone hormone replacement therapy (HRT) may also impact fertility of transgender men
41(IOM, 2011).

42 Preventive sexual and reproductive healthcare is also pertinent. Lesbian and bisexual
43women and transgender men are less likely to receive pap tests than their heterosexual and
44cisgender counterparts (Agénor, Krieger, Austin, Haneuse, & Gottlieb, 2014; Agénor, Muzny,

45Schick, Austin, & Potter, 2017; Peitzmeier, Khullar, Reisner, & Potter, 2014). Lesbian women
 46may also have an increased risk of polycystic ovary syndrome (PCOS), though results are
 47uncertain (Agrawal et al., 2004; De Sutter et al., 2008; Smith et al., 2011). Cisgender women
 48who have sex with women, particularly young women with both male and female partners, may
 49be at increased risk of HIV and sexually transmitted infections based on reported risk behaviors,
 50including multiple sexual partners, substance use during sexual activity, and experiences with
 51sexual coercion (Knight & Jarrett, 2017; Marrazzo & Gorgos, 2012). Transgender men who have
 52sex with men may also be at increased HIV risk (Reisner & Murchison, 2016).

53 Despite burgeoning interest and documented concerns, reproductive health research on
 54LGBTQ populations often lacks input from LGBTQ individuals in priority setting. We conducted
 55in-depth interviews with 39 LGBTQ FAAB individuals to explore their priorities and
 56experiences with reproductive healthcare.

57

58**MATERIALS AND METHODS**

59**Sampling & Recruitment**

60 We conducted in-depth interviews with 39 LGBTQ FAAB individuals between December
 612016 and March 2017 after receiving human subjects approval by University of California, San
 62Francisco. Interviews were conducted as part of a project to explore LGBTQ FAAB individuals'
 63attitudes toward standard reproductive health survey items and to develop new, inclusive survey
 64items and overall best practices for LGBTQ inclusion in reproductive health research (Ingraham,
 65Wingo, Foster, & Roberts, 2017). We recruited participants through community-based social
 66networks, including LGBTQ listservs, professional networks, postings at local LGBTQ

67organizations and Craigslist (Robinson, 2014). The researchers also asked participants to refer
 68other LGBTQ-identified people they knew. Individuals were eligible if they were LGBTQ-
 69identified, FAAB, and between the ages of 15 and 45. Anyone who expressed interest (n=97)
 70filled out a questionnaire that included age, race/ethnicity, sex assigned at birth, current gender
 71identity, and sexual orientation.

72 After evaluating feasibility based on initial participation interest, we undertook a
 73maximum variation sampling strategy, a type of purposeful sampling (Patton, 2002), to ensure
 74diversity in age, race/ethnicity, sexual orientation, and gender identity. We conducted a second
 75wave of targeted recruitment using social media and Craigslist to recruit people of color and
 76younger people, broadly speaking, with no quotas for individual age, race/ethnicity categories, to
 77balance our early interviews that were largely with White, older participants. The researchers
 78who conducted interviews are both cisgender, White, queer women who are personally and
 79professionally active in LGBTQ communities. These factors likely influenced social networks
 80available for convenience and snowball sampling, level of comfort between participants and
 81researchers, and framing of interview questions.

82 Questions used to elicit reproductive healthcare priorities and experiences of participants
 83were: “What is the most important reproductive health care issue for you personally and why?”;
 84“What has been your experience with reproductive health care?”; and “What should be done
 85differently in reproductive health care?” We also asked participants about what topics they think
 86reproductive health researchers should pursue. In discussing these topics, we did not define
 87“reproductive health” for participants, instead letting them interpret the term for themselves. This
 88allowed us to see what individuals considered reproductive health concerns and for what reasons
 89individuals were seeking out reproductive healthcare providers. The interview guide was

90reviewed within our reproductive healthcare research organization by two other researchers for
91clarity before data collection.

92 We conducted interviews in person in the Bay Area, California (N.I.) and Baltimore,
93Maryland (E.W.) in private locations agreed upon with participants. Eleven interviews were
94conducted over the phone or by video with participants located in other parts of the U.S. Prior to
95each interview, oral consent was obtained. Participants received a \$40 gift card for their time.

96 After completion of 39 interviews, we concluded that saturation had been reached, as
97new interviews did not generate any new codes and confirmed existing codebook themes (Fusch
98& Ness, 2015).

99**Data analysis**

100 Interviews were audio recorded, transcribed verbatim, and reviewed for accuracy of
101transcription. We conducted textual analysis via Dedoose (version 7.6.6). The two researchers
102who conducted data collection also completed data analysis; one is a sociologist with public
103health training and the other is a master's level public health researcher, both familiar with the
104literature on LGBTQ health and trained in qualitative methods. We developed deductive codes
105based on research questions and previous literature. An additional set of emergent, inductive
106codes were created, agreed upon, and assigned during the review of the first five transcripts. To
107ensure inter-coder reliability, we developed a codebook and compared code usage between the
108first five coded transcripts and resolved any discrepancies by consensus. Analysis was conducted
109through a framework method (Pope, 2000; Ritchie & Lewis, 2014), placing coded transcripts
110into a series of coding matrices through which constant comparisons were made to establish
111themes. 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.

114

115RESULTS

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.

121Participant Characteristics

A total of 39 participants, between the ages of 18 and 44, were interviewed with a mean age of 29.9. [insert Table 1 here] 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)¹. 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).

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.

132

133 **Reproductive health needs and future research topics**

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

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

155FAAB individuals. Many also wanted to understand aspects of LGBTQ pregnancy, including: the
 156experience of pregnancy for genderqueer people; how same-sex couples handle grief for
 157pregnancy loss; and how HRT among transgender men impacts pregnancy-related outcomes. A
 158few expressed interest in how LGBTQ individuals conceptualize family formation. Lastly, some
 159participants listed sexual health research questions, including how LGBTQ individuals engage in
 160sex (particularly transgender men) and what LGBTQ individuals use sex for (pleasure,
 161reproduction, income, etc.), how to measure cisgender female same-sex safer sex practices, risk
 162of STIs for women who have sex with women, and the reasons LGBTQ FAAB individuals use
 163contraception—i.e. pregnancy prevention versus other reasons.

164**Reproductive healthcare barriers to effective care**

165 We identified a number of barriers encountered within reproductive healthcare settings,
 166including: provider fertility focus, LGBTQ erasure and health competency, discrimination by
 167providers, and impact of previous experiences on reproductive healthcare-seeking behavior.
 168Participants defined “reproductive healthcare settings” as a broad range of settings, including:
 169hospitals, private obstetrics and gynecology practices, and family planning clinics.

170*Fertility and women’s care focus*

171 The association of reproductive care with fertility and womanhood pervaded stories in
 172our sample. Many participants sought reproductive healthcare for acute health concerns.
 173However, providers often steered them toward conversations about fertility, which “kind of sends
 174the message that a woman’s only purpose is to shoot children out of her uterus.” (30-year-old,
 175Black, queer woman). This made participants feel like their own health concerns were not as
 176important 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.

198

200 *LGBTQ Erasure & Health Competency*

201 Descriptions of erasure and inadequate provider competency were pervasive across both
 202 cisgender and gender variant participants. Many participants cited non-inclusive and outdated
 203 protocols as barriers to care. One pregnant cisgender participant, who used a known sperm donor
 204 for insemination, described how intake forms were confusing for her when receiving prenatal
 205 care:

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

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

217 Some providers also made behavioral assumptions when discussing sexual activity:

218 Whenever health professionals throughout most of my life have asked me if I'm sexually active, they mean are you
 219 currently having a penis in your vagina, because in the end, they don't actually care about my sexual health. They
 220 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
 221 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 reinstate 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

245pronouns), and prying into aspects of their identity irrelevant to the care being sought. A few
 246transgender and genderqueer participants found that identity disclosure related to their
 247reproductive medical care opened them up for transphobic mistreatment:

248 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
 249gone.” And she then gave me a lecture about how [my top surgery] is a poor life choice, and I need to reconsider
 250things. “And, I don’t even know what that would mean for your future.” ...in the end I didn’t actually get anything
 251out of [the exam], besides, “You’re healthy, I guess,” and “Take more ibuprofen.” -25-year-old, biracial, queer,
 252genderqueer person

253Here the provider scrutinized the patient’s decision to pursue gender-affirming surgeries instead
 254of providing relevant care, prompted by a discussion about a routine exam in reproductive
 255healthcare settings. The patient left the appointment feeling that they had endured emotional
 256discomfort disproportionate to care received.

257 Transgender men and genderqueer participants also described being met with
 258discrimination when seeking medical advice related to gender transition. Both HRT and gender-
 259affirming surgeries pertain to health of the reproductive system, so the choice to engage
 260reproductive healthcare provider type felt logical. However, most described providers as ignorant
 261of transgender-related health issues and some refused support of gender-affirming care. One
 262participant described discussing HRT with their provider:

263I 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
 264me to someone who does? And she was like, well, there’s nothing wrong with being a woman, and just really
 265believed that it was from a place of hate for women, just internalized hate for women that was making me ask her
 266this. And that was my first time like coming out to a medical professional. -28-year-old, Hispanic, queer,
 267genderqueer person

268After the patient's disclosure, the provider was described as conflating gender affirmation with
 269misogyny. She then obstructed access to requested medical care by not providing a referral to an
 270appropriate provider or engaging with the patient about their medical needs.

271 Interrogation about and invalidation of identity also occurred around sexual orientation.
 272One participant described their first routine preventive care visit with a gynecologist. They
 273disclosed their queer identity to the provider, who then:

274...spent the whole visit talking about his daughter's friend, who wasn't - who said that she wasn't straight, but she
 275had sex with a guy who was cis[gender]...all while all the things that go along with being at the gynecologist are
 276happening for the first time ever... Everything is too big and too hard and too fast and really terrible. And basically,
 277his story was, "She ended up having a kid, and I delivered it. Because nobody is actually gay. And you always go
 278back to men and have children, and she's straight." – 25-year-old, biracial, queer, genderqueer person

279The combination of gruff examination technique and homophobic comments made this
 280participant feel distressed and disrespected. This juxtaposition within this participant's story
 281highlights the heightened vulnerability reproductive healthcare settings generated for some
 282participants.

283 The experience of providers saying discriminatory remarks instead of providing medical
 284care made participants feel both uncomfortably visible and unwelcome in reproductive
 285healthcare spaces.

286*Impact on reproductive healthcare-seeking behavior*

287 Participants also shared how previous reproductive healthcare experiences affected their
 288desire to seek future care. Some who had negative prior experiences with reproductive healthcare
 289have since avoided those care settings:

290 Being a rape survivor, being a non-binary person, and then my really only other experience in that kind of setting
 291being negative or giving me a negative recollection of that, all of those things combined made me not want to go for
 292the longest time. -29-year-old, White, queer, genderqueer person

293Many also discussed story-sharing about reproductive healthcare among LGBTQ FAAB persons.
 294Statements from cisgender women like, “virtually every queer female I know has had the
 295experience of having providers not take them at their word that they’re not pregnant.” (33-year-
 296old, Hispanic, queer, genderqueer person) or, from genderqueer or transmasculine participants,
 297“My friends, we have...the longest thread of horror stories getting Pap [smears]” [due to lack of
 298provider sensitivity to patient discomfort with female reproductive organs] (28-year-old,
 299Hispanic, queer, genderqueer person) were common among participants. A lesbian participant
 300called reproductive healthcare “a running joke in the LGBTQ community” because of how
 301incongruous so many feel in this setting. Negative experiences in reproductive healthcare
 302settings, such as harassment or inappropriate treatment, not only impact individual healthcare
 303seeking behavior, but also circulate through LGBTQ social networks.

304

305DISCUSSION

306 Our analysis of a cross-cutting sample of LGBTQ FAAB individuals highlights that LGBTQ
 307FAAB individuals seeking reproductive healthcare have diverse needs and face unique
 308challenges. To our knowledge, this is the first attempt to document the breadth of reasons that
 309LGBTQ FAAB individuals --including lesbian, bisexual and queer women, genderqueer
 310individuals, and transgender men -- pursue reproductive healthcare. Some participants, including
 311lesbian and queer cisgender women and transgender men, want to have children and may need
 312specialized 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.

335 Additionally, reproductive healthcare, where sexual activity and reproductive anatomy
 336are central topics, lends itself toward disclosure of gender identity and sexual orientation. For
 337multiple participants, including cisgender queer women and genderqueer individuals, the first
 338time they disclosed sexual orientation or gender identity in a medical context was in a
 339reproductive healthcare setting, due, in part, to the nature of care. Sexual orientation disclosure in
 340clinical settings can lead to higher patient satisfaction (Bergeron & Senn, 2003; Steele,
 341Tinmouth, & Lu, 2006), but disclosure also may be met with discriminatory treatment by
 342providers.

343 Examples of provider discrimination and inexperience were described by participants in
 344all gender identity and sexual orientation groups. For lesbian, bisexual and queer women and
 345genderqueer individuals, assumptions about sexual activity and pregnancy, and childbearing
 346desire created barriers to obtaining useful sexual and reproductive health guidance. Similar
 347experiences have been documented in lesbian and bisexual women seeking pap testing (Agénor,
 348Bailey, Krieger, Austin, & Gottlieb, 2015; Curmi, Peters, & Salamonson, 2016). For sexual
 349minority women who seek prenatal care, pervasive heteronormativity can impede patient
 350provider communication (Cherguit, Burns, Pettie, & Tasker, 2013; McManus, Hunter, & Renn,
 3512006; Røndahl, Bruhner, & Lindhe, 2009).

352 For transgender men and genderqueer individuals FAAB, framing of reproductive healthcare
 353as women's care can be an obstacle to presenting for care. Within care settings, attempts to
 354disclose identity or seek guidance on gender-affirming care were, at times, erroneously reframed
 355by providers as internalized misogyny, making patients feel unwelcome. Providers were also
 356described as unable to provide useful information or referrals for transgender patients. This is
 357consistent with literature that shows that providers are unprepared to provide guidance on pap

358tests for transgender men (Agénor et al., 2015) or provide transgender men adequate support and
 359resources throughout prenatal care (Light et al., 2014). If transgender men seek referrals to
 360transition-related care through unprepared providers, their entry into care may be delayed, which
 361can impact quality of life (White Hughto & Reisner, 2016).

362 Discrimination in reproductive healthcare settings and low-quality care provision may impact
 363health outcomes for these groups across the reproductive lifespan. Transgender men who have
 364sex with cisgender men may be at increased risk of HIV acquisition (Reisner & Murchison,
 3652016). Young bisexual women report higher rates of risky sexual behavior (Marrazzo & Gorgos,
 3662012). Avoidance of sexual healthcare or inadequate examination within healthcare settings may
 367lead to missed screening or treatment. Similarly, lack of pap testing is equated with higher rates
 368of cervical cancer mortality (Landy, Pesola, Castañón, & Sasieni, 2016). Future research should
 369document health outcomes related to inadequate reproductive healthcare by these groups.

370Limitations

371 As our study was exploratory, there are limitations. Data were drawn from a convenience
 372sample, and findings may not be generalizable to all LGBTQ FAAB individuals. We utilized
 373various recruitment channels to diversify our sample, however, our final sample was
 374predominantly White, urban, and educated. Participants may have different reproductive
 375healthcare priorities and experiences and better access to care than those not represented in our
 376study. We were unable to reach individuals with less access to physical and/or virtual social
 377networking sites, which likely included less-educated, lower-income, and housing-unstable
 378individuals. These individuals may face additional barriers to quality healthcare due to lack of
 379coverage or under-insured status that limits their healthcare options. To better recruit hard-to-
 380reach individuals, future studies could consider intensive community engagement and utilization

381of peer recruitment (Tourangeau, Edwards, Johnson, Wolter, & Bates, 2014). Many participants
 382chose to participate in order to share their experiences, which may have influenced
 383overrepresentation of negative experiences within our study. Future research should investigate
 384what facilitates reproductive healthcare access for LGBTQ FAAB individuals. Similarly, we did
 385not purposefully seek out representation from individuals with no previous exposure to
 386reproductive healthcare and cannot comment on how their priorities may deviate. Our decision to
 387include participants across a range of sexual orientations and gender identities allowed us to
 388comment on cross-cutting themes, however, we could not analyze experiences unique to each
 389included group. Future research should explore these topics in each group separately.

390**Implications for Practice and/or Policy**

391 Reproductive health priorities of LGBTQ FAAB individuals include needs similar to
 392cisgender and heterosexual groups (e.g. abortion, contraception, PCOS management), as well as
 393unique needs (e.g. gender-affirming hysterectomies, inclusive safer sex guidance) and challenges
 394to accessing relevant care. Discriminatory treatment in reproductive healthcare settings can
 395impede access to important medical care, such as cervical cancer screening (Agénor et al., 2015;
 396Curmi et al., 2016; Johnson, Mueller, Eliason, Stuart, & Nemeth, 2016) and prenatal care (Light
 397et al., 2014). Our study identified mechanisms through which discrimination and exclusion
 398manifest in reproductive healthcare broadly, including imprecise protocols, marginalization and
 399denial of patient priorities, and irrelevant focus on fertility. These qualities, alongside overt
 400discrimination, can influence reproductive healthcare avoidance among LGBTQ FAAB
 401individuals. Future reproductive health research should pursue healthcare concerns prioritized by
 402LGBTQ FAAB individuals.

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404

405

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410

411

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