Title

Sexual Health Among LGBTQ+ People Assigned Female at Birth from Diverse Racial/Ethnic Backgrounds: Manifestations of Power, Oppression, and Resistance in the Clinic

Author

Perez, Ashley E

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Sexual Health Among LGBTQ+ People Assigned Female at Birth from Diverse Racial/Ethnic Backgrounds: Manifestations of Power, Oppression, and Resistance in the Clinic

by

Ashley Perez

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Approved:

DocuSigned by:
Howard Pinderhughes
Howard Pinderhughes
Chair
A8909580B86E46F...

DocuSigned by:
Madina Agénor
Madina Agénor
[illegible]48A...

DocuSigned by:
Carol Dawson-Rose
Carol Dawson-Rose
[illegible]45F...

DocuSigned by:
Janet Shim
A58526EDCCB041A...

Committee Members

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Sexual Health Among LGBTQ+ People Assigned Female at Birth from Diverse Racial/Ethnic Backgrounds: Manifestations of Power, Oppression, and Resistance in the Clinic

Ashley E. Perez

ABSTRACT

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people in the U.S. experience numerous sexual health and sexual health care inequities compared to cisgender, heterosexual people. However, LGBTQ+ sexual health research has overwhelmingly focused on HIV/AIDS, while comparatively little research documents LGBTQ+ individuals' experiences navigating sexual health care. Further, existing studies overwhelmingly represent the experiences of White LGBTQ+ individuals, limiting understanding of the experiences of LGBTQ+ people of color who, theoretical literature suggests and limited empirical studies have shown, experience particularly pronounced sexual health inequities due to their location at the intersections of multiple systems of oppression and inequality. Informed by theoretical frameworks of intersectionality, stigma, and socio-structural determinants of health, this multiple methods dissertation examines how stigma impacts the sexual health and gender affirming care experiences of LGBTQ+ people assigned female at birth (AFAB). The project combines nationally representative data from the National Survey of Family Growth with data from 76 in-depth interviews conducted between 2019 and 2021 with a racially/ethnically diverse sample of 64 LGBTQ+ individuals AFAB recruited from the San Francisco Bay Area.

Three empirical chapters comprise this dissertation. Chapter 3, which draws on U.S. survey data from the National Survey of Family Growth, finds that White, Black, and Latina bisexual women and Black or Latina lesbian women aged 15-44 years have higher odds of a medical provider having asked them questions about their sexual behavior compared to White heterosexual women. Notably, Black bisexual women have the highest predicted probability of having been asked these questions in the past year, which may be a reflection of assumptions of promiscuity rooted in both racism and biphobia. The first and third empirical chapters use constructivist grounded theory methods to qualitatively examine sexual health and gender affirming care seeking and care experiences among a racially/ethnically diverse sample of LGBTQ+ people assigned female at birth. The first chapter identifies interpersonal and structural factors–primarily related to anticipated and experienced interpersonal stigma and discrimination (e.g., heterosexism, (cis-)sexism, racism) and experiences of inclusive, affirmative, and person-centered care–that inform sexual health and gender affirming care seeking and quality of care. I find the impacts–both positive and negative–of these factors are particularly heightened in the contexts of sexual health and gender affirming care and for multiply marginalized patients. The third chapter illuminates strategies that LGBTQ+ people assigned female at birth use to navigate barriers in order to obtain needed care and, at times, resist oppressive practices and policies. Combined these two chapters point to the role of trusting patient-provider collaborations in shaping patients' care seeking and quality of care.

As (re-)illuminated and exacerbated by the COVID-19 pandemic, health inequalities reflect broader social inequalities yet are often over-attributed to individual decisions and behaviors, particularly without recognizing how individual behaviors are shaped and, often, constrained. This dissertation examines how sexual health care inequities among LGBTQ+ people assigned female at birth manifest and are reproduced through health care practices and policies, which uphold systems of power and oppression. Findings point to the importance of structurally competent, anti-oppressive health care programs, policies, and practices in order to advance health equity for all.

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ACRONYMS, ABBREVIATIONS, AND DEFINITIONS

AFAB	Assigned female at birth
Cis	Cisgender Definition: a term used to describe people who identify with their sex assigned at birth; i.e., when one's gender identity is the same as their sex assigned at birth
LGBQ+	Lesbian, gay, bisexual, or another queer identity
LGBTQ+	Lesbian, gay, bisexual, transgender, or another queer identity
NSFG	National Survey of Family Growth
OB/GYN	Obstetrics and gynecology
STI	Sexually transmitted infection
Trans+	Transgender and/or nonbinary Definition: when one's gender identity is different than their sex assigned at birth

CHAPTER 1: Introduction

OVERVIEW

Lesbian, gay, bisexual, transgender, and other queer (LGBTQ+) populations assigned female at birth (AFAB) in the U.S. experience pronounced disparities in health and health care. While these health inequities are often tied to *individuals* based on their social identities (i.e., being a lesbian, gay, bisexual, or queer [LGBQ+] or trans or nonbinary person), there is increasing acknowledgment of power and oppression as the root causes of these inequities. Indeed, structural and interpersonal stigma and discrimination (e.g., heterosexism, cissexism)–both historical and present-day–are fundamental causes of health inequities experienced by LGBTQ+ people assigned female at birth (Hatzenbuehler, Phelan and Link 2013).

Historically, the term "LGBTQ health" was often associated with HIV and HIV prevention, specifically, especially among people assigned male at birth. The HIV epidemic paved a critical path toward broader recognition of LGBTQ+ populations and for health and social services and research focused on these populations. However, the majority of NIH-funded LGBT health research remains HIV-related (Coulter, Kenst, Bowen et al. 2014), although the number of LGBT health-related projects has been increasing and diversifying in terms of populations and outcomes of interest (Parker 2019). In fact, I began my research career working on projects focused on HIV care and prevention in the U.S. In working on these projects which, like much U.S. HIV research, enrolled samples of predominantly White gay, bisexual, and other men who have sex with men, I came to recognize through secondhand experience that their foci and implications were often misaligned with the needs and wants of LGBTQ+ populations of color.

Seeking to broaden my research scope and move into lesser studied lines of inquiry more in line with my personal interests and passions, I pursued and collaborated on projects focused on non-HIV sexual health issues and LGBTQ+ health more broadly and, particularly, projects taking an intersectional approach to examining health inequities among LGBTQ+ populations. My engagement in this work shed light on public health's overemphasis on the individual level, including individual behaviors and "risk factors," the limited amount of research utilizing multilevel frameworks to examine health inequities, despite the existence of such frameworks (e.g., Bronfenbrenner 1979, Krieger 2001), and, in particular, the lack of research recognizing stigma and, in turn, discrimination as fundamental causes of health inequities (Bailey, Krieger, Agenor et al. 2017, Phelan and Link 2015). Through my sociological training, I became increasingly attuned to how power undergirds the (re-)production of social and health inequalities and how interpersonal interactions reflect and contribute to population level inequalities.

With this prior experience and theoretical training, I came to this project seeking to continue to pursue lesser studied areas of LGBTQ+ health in line with my interests and to increase representation of the experiences of LGBTQ+ people of color in LGBTQ+ health research. Further, I sought to leverage qualitative methods to incorporate the voices of LGBTQ+ people in my work, which to date was predominantly quantitative, in order to center and provide a more nuanced and comprehensive understanding of LGBTQ+ people AFAB's lived experiences. With a personal passion for sexual health, this project set out to examine how sexual risk discourses impact the health and well-being; health care experiences; sexuality; and sexual orientation and gender identity development of LGBTQ+ people assigned female at birth, who have been understudied in sexual health research. Given the broad nature of this aim, this dissertation focuses specifically on how stigma and discrimination impact the sexual health and gender affirming care experiences of LGBTQ+ people assigned female at birth and how LGBTQ+ people assigned female at birth navigate clinical encounters. Specifically, this multiple methods dissertation centers around three research questions, each of which is the focus of one of three empirical chapters:

1) What interpersonal and structural factors shape sexual health and/or gender affirming care seeking and quality of care among a racially diverse sample of LGBTQ+ people assigned female at birth?
2) Among U.S. women aged 15-44 years, are there differences in having received a sexual history from a medical provider in the last 12 months by race/ethnicity and sexual orientation identity?
3) Recognizing that LGBTQ+ people assigned female at birth experience pronounced barriers to care and that patients are active participants in health care, what strategies do LGBTQ+ people assigned female at birth use to navigate clinical encounters?

This project began as a project focused on sexuality and sexual health. The World Health Organization defines (2017) *sexual health* as:

> a state of physical, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

As this broad definition might suggest, the term *sexual health* has a wide array of meanings in professional and lay domains (Epstein and Mamo 2017), a feature which this project embraced. In lieu of "sexual health," the umbrella term "sexual and reproductive health" is often used, which seems to inherently tie sexual health to the reproductive system. In order to maintain the broad scope of this project and avoid assumptions of reproductive desires that are often made of people assigned female at birth (Wingo, Ingraham and Roberts 2018), I intentionally use the term *sexual health* rather than *sexual and reproductive health*.

In fact, while not examined in this dissertation given its specific focus on health care experiences and interactions, study interview participants were asked how they defined sexual health, and their definitions contrasted with how they characterized popular understandings of sexual health (e.g., emphasizing STI risk). Although participants typically did not include gender affirming care services in their explicit definitions of sexual health, many of those who had utilized or considered seeking gender affirming care services included these experiences when asked about their sexual health care experiences. Gender affirming care includes "social, psychological, behavioral or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity" (WHO, as cited in Gomez, Ranji, Salganicoff et al. 2022). As a result of participants' inclusion of gender affirming care experiences when asked about sexual health, the scope of the qualitative chapters (Chapters 2 and 4) of this dissertation spans sexual health and gender affirming care experiences, which, notably, are both types of gendered health care.

Given the sexual health of LGBTQ+ people assigned female at birth is understudied yet these populations experience pronounced social and health inequities, it is critical to better understand how stigma and, in turn, discrimination impact the sexual health of LGBTQ+ people assigned female at birth in order to identify places for potential intervention to promote sexual health equity. This project is incredibly timely given the current U.S. climate in which LGBTQ as well as sexual reproductive rights are consistently under attack. On the one hand, care access among LGBTQ individuals has increased with recent progress in LGBTQ rights, such as passage of the Affordable Care Act and legalization of same-sex marriage, which have also been associated with improved health outcomes among LGBTQ+ people (Raifman, Moscoe, Austin et al. 2017). There has also been significant community activism related to queer health and burgeoning research aimed at identifying health inequities experienced by LGBTQ+ populations and improving health care access and quality. Conversely, in recent years there has been a growth of racist, xenophobic, and anti-LGBTQ+ rhetoric and policy, both at the state- and national-level, which puts the health (Raifman, Moscoe, Austin et al. 2018), and often safety, of LGBTQ+ people and people of color in jeopardy. Those impacted by multiple forms of social inequality, such as queer, transgender, and gender non-conforming people of color, are likely to experience these consequences the most.

BACKGROUND

Sexual Health Inequities among LGBTQ+ People Assigned Female at Birth

Studies have identified numerous sexual health inequities among LGBQ+ cisgender women and transgender and nonbinary people assigned female at birth compared to heterosexual women and cisgender women, respectively. LGBTQ+ people assigned female at birth are at risk for STIs and cervical cancer regardless of the sex, gender, or body parts of their sexual partners. In fact, due to lower cervical cancer screening and HPV vaccination rates and increased prevalence of cancer risk factors, they may be at increased risk of cervical cancer compared to heterosexual, cisgender women (Conron, Scott, Stowell et al. 2012, Lee, Griffin and Melvin 2009, McCabe, Matthews, Lee et al. 2018, Operario, Gamarel, Grin et al. 2015).

Indeed, studies have found that lesbian women have lower odds of regular Pap testing than heterosexual women and women who have sex with men only (Agénor, Krieger, Austin et al. 2014, Charlton, Corliss, Missmer et al. 2011, Diamant, Wold, Spritzer et al. 2000, Kerker, Mostashari and Thorpe 2006). Furthermore, studies have found that lesbians and women with only female past-year sexual partners have lower odds of initiating (Agénor, Peitzmeier, Gordon et al. 2015b, Agénor, McCauley, Peitzmeier et al. 2016) and completing (Agénor, Peitzmeier, Gordon et al. 2016) the HPV vaccine compared to heterosexual women.

Research about sexual health among transgender men and nonbinary people assigned female at birth remains somewhat limited (Edmiston, Donald, Sattler et al. 2016). However, studies have found that transgender men and nonbinary people assigned female at birth have lower odds of regular Pap testing compared to cisgender women (Peitzmeier, Khullar, Reisner et al. 2014, Tabaac, Sutter, Wall et al. 2018) despite recommendations that they adhere to the same cervical cancer screening guidelines as cisgender women (Committee on Health Care for Underserved Women 2011, Potter, Peitzmeier, Bernstein et al. 2015). Further, studies have found low rates of HIV and STI testing (James, Herman, Rankin et al. 2016, Pitasi, Oraka, Clark et al. 2017) and HPV vaccination (Stewart, Lee and Damiano 2020) as well as unmet reproductive health needs (Gomez, Đỗ, Ratliff et al. 2020, MacLean 2021) among transgender men and nonbinary people assigned female at birth.

Many micro-level factors have been associated with lower utilization of sexual health care services among LGBTQ+ people assigned female at birth. For example, several studies have found that queer, cisgender women do not perceive themselves to be at risk for STIs or cervical cancer, and/or are uncertain of what types of sexual health care they should be seeking (Curmi, Peters and Salamonson 2014, McIntyre, Szewchuk and Munro 2010, Power, McNair and Carr 2009). These low risk perceptions may contribute to disparities in utilization of preventative sexual health services among this population, despite the fact that they are still at risk of STIs and cervical cancer. In addition to low risk perceptions, transmasculine individuals experience unique barriers to care, such as gender dysphoria and vulnerability during pelvic/frontal examinations (Hoskin, Blair and Jenson 2016, Johnson, Nemeth, Mueller et al. 2016, McDowell, Pardee, Peitzmeier et al. 2017, Peitzmeier, Agénor, Bernstein et al. 2017), which may contribute to their underutilization of cervical cancer screening.

Research has also identified micro-level facilitators of improved sexual health care outcomes. For example, among LGBQ+ cisgender women, disclosure of sexual orientation to providers is associated with higher odds of Pap testing (Greene, Meghani, Sommers et al. 2018, Tracy, Lydecker and Ireland 2010, Tracy, Schluterman and Greenberg 2013, Youatt, Harris, Harper et al. 2017) and HPV vaccination (Youatt et al. 2017) compared to those who have not disclosed their sexual orientation. Moreover, knowledge that not having a Pap test is a cervical cancer risk factor (Tracy et al. 2013) and physician recommendation (Greene et al. 2018, Tracy et al. 2013) have also been associated with increased Pap testing among LGBQ+ cisgender women. Although research about cervical cancer screening among transmasculine people is more limited, patient empowerment and providers' affirmation of patients' gender identities have been associated with empowered use of cervical cancer screening (Peitzmeier, Bernstein, McDowell et al. 2019).

Patient-Provider Interactions in the Context of Sexual Health Care

Patient-provider interactions in clinical settings, an interpersonal factor and specific component of the micro-level, have been shown to independently impact sexual health care inequities among LGBTQ+ people assigned female at birth. For example, provider recommendation and patient-provider communication quality have been associated with Pap testing intentions (Tabaac, Benotsch and Barnes 2019), Pap test use (Plourde, Brown, Vigod et al. 2016), and receipt of an HPV vaccine (Agénor, Bailey, Krieger et al. 2015a, McRee, Katz, Paskett et al. 2014) among LGBTQ+ people assigned female at birth. Professional organizations, such as the World Health Organization and American College of Obstetricians and Gynecologists (ACOG), advise that clinicians discuss STI risk, including STI risk associated with oral and anal sex (American College of Obstetricians Gynecologists 2013), with patients (World Health Organization 2015). In fact, ACOG explicitly states that providers should discuss STI risk with *queer* women (American College of Obstetricians Gynecologists 2012). However, studies have found that these patient-provider conversations are infrequent among both heterosexual patients and queer patients (Alexander, Fortenberry, Pollak et al. 2014, Baldwin, Dodge, Schick et al. 2017a, Fuzzell, Fedesco, Alexander et al. 2016). If providers do not initiate conversations about sexual behavior and/or identity, LGBQ+ patients are put in the position of actively disclosing their sexual orientation (i.e., bringing it up themselves to providers) or remaining silent about it, both of which may have health consequences and impact patient-provider trust (Daley 2010). Furthermore, transmasculine individuals may struggle with deciding whether to reveal their gender identity to providers (Dutton, Koenig and Fennie 2008).

Moreover, most providers are well-prepared to discuss sexual behavior, STI risk, and cervical cancer as it relates to cisgender, heterosexual people but are far less informed about the potential for STI transmission via other types of sexual activity and LGBTQ+ health in general (Dean, Victor and Guidry-Grimes 2016). Despite calls to improve medical education and training so that it includes LGBTQ+ health training, specifically, research suggests that such trainings are still significantly lacking (Bonvicini 2017) and most providers remain largely unaware of LGBTQ+ health information (Khalili, Leung and Diamant 2015). Thus, many providers believe that queer women have a lower STI risk and lower need for Pap testing than heterosexual women (McIntyre et al. 2010) and that transmasculine individuals are at low risk of cervical cancer

(Agénor, Peitzmeier, Bernstein et al. 2016). As a result, LGBTQ+ people assigned female at birth are often misinformed by providers about their STI and cervical cancer risk (Jahn, Bishop, Tan et al. 2019).

In addition to a lack of comprehensive LGBTQ+ health education, providers often assume patients are heterosexual which, in turn, shapes the content and quality of the clinical encounter and can compromise care (Agénor et al. 2015a, Arbeit, Fisher, Macapagal et al. 2016, Carabez, Pellegrini, Mankovitz et al. 2015, LaVaccare, Diamant, Friedman et al. 2018, Mravcak 2006). For example, with female patients, clinicians focus on contraception and pregnancy, which many queer women feel is irrelevant to them (Baldwin et al. 2017a, Jahn et al. 2019, Wingo et al. 2018). Sexual identity disclosure is associated with improved health outcomes and with seeking care, but heteronormative presumptions made by providers can, in turn, discourage patients from disclosing their sexual orientation (Baldwin et al. 2017a, Durso and Meyer 2013, Fredericks, Harbin and Baker 2017, Johnson and Nemeth 2014, LaVaccare et al. 2018), which results in invisibility of LGBTQ people and their experiences in the clinic (Bauer, Hammond, Travers et al. 2009, Fredericks et al. 2017).

Heteronormative (and gender normative) presumptions can also result in a breakdown in patient-provider communication—patients may be unwilling to speak up about their sexuality and hold back sexual health-related questions due to fear of stigma and discrimination (Agénor et al. 2015a, Jahn et al. 2019). Given the power dynamic inherent in patient-provider interactions, patients may be hesitant to reveal their sexual orientation due to fear of jeopardizing their relationship with their provider or prior sexual orientation disclosure experiences in which the patient felt the provider did not acknowledge or respect their sexual identity (Agénor et al. 2015a). These power dynamics may be especially pronounced for transgender and nonbinary people if they seek transition-related care, as providers have control over the distribution of therapies (von Vogelsang, Milton, Ericsson et al. 2016). Further, transgender and nonbinary people may be misgendered, often within a binary gender paradigm, resulting in distress (Paine 2018) but also reinforcing the power of providers (Poteat, German and Kerrigan 2013).

The aforementioned scholarship has largely focused on the micro (i.e., individual or interpersonal, specifically, patient-provider)-level, which ignores the larger societal context in which the phenomenon of sexual health care seeking is situated (Plourde et al. 2016) and which shapes the aforementioned individual and interaction-level factors (Bronfenbrenner 1979, Krieger 2001). Systems of oppression, including but not limited to heterosexism, cisgenderism, and racism, which exist simultaneously (Collins and Bilge 2016, Crenshaw 1990), function at the micro- (i.e., individual and interpersonal), meso- (i.e., system; e.g., health care), and macro- (i.e., societal) levels (Metzl and Hansen 2014) and interlock (Collins and Bilge 2016, Crenshaw 1990). Focusing on the micro-level and focusing on one dimension of social identity and inequality (e.g., sexual orientation and heterosexism) oversimplifies the complex processes that inform perceptions of, access to, and engagement with the health care system among LGBTQ+ people assigned female at birth. Seeking to further understanding of these complex processes, as a whole this dissertation is attentive to the role of power in (re-)producing social and health inequities at the micro-, meso-, and macro-levels in the context of sexual health and gender affirming care among LGBTQ+ people assigned female at birth.

THEORETICAL FRAMEWORKS

Three theoretical frameworks–intersectionality, stigma, and structural and social determinants of health–were essential to the overall framing of this dissertation. While these theoretical frameworks informed this dissertation as a whole, additional theories relevant to each of the three empirical chapters are described in Chapters 2, 3, and 4. Next, I provide an overview of the key theoretical contributions of intersectionality, stigma, and structural and social determinants of health and how these frameworks informed my thinking about this dissertation.

Intersectionality

Developed in order to describe and examine how multiple systems of power and oppression simultaneously shape the experiences of multiply marginalized populations through multiple interlocking social identities, intersectionality is a framework rooted in Black feminist thought and practice that examines how systems of power are mutually constructed (Bowleg 2012, Collins and Bilge 2016). In other words, because systems of power interlock and do not exist independently, social identities, which are tied to one's place in the social hierarchy, and social inequalities are interdependent, mutually constitutive, and jointly shape one's lived experiences (Collins and Bilge 2016:25, Crenshaw 1990). Although today the term "intersectionality" is often readily associated with Kimberlé Williams Crenshaw (1989), a feminist legal scholar who coined the term in the late twentieth century, intersectional thinking or recognition began at least decades earlier outside of the academy, with roots in Black feminism (e.g. Combahee River Collective 1982, Davis 1981/2011, hooks 2014). Specifically, intersectionality has been traced back to the work of Black women during resistance to slavery and Jim Crow laws (Collins and Bilge 2016, Truth 1851). Thus, intersectionality emerged from Black women's concerns about social inequalities, with early forms of intersectional thinking particularly focusing on the intersections of race, gender and, often, class (Collins and Bilge 2016, Combahee River Collective 1982, Davis 1981/2011).

There is variation in the way that people think about and apply intersectionality as a theoretical framework. Notably, as a result of the concept's rise in popularity, intersectionality has increasingly become individual focused, with much scholarship centering around social identities rather than the systems of power and oppression which individual level experiences reflect. Given intersectionality was originally intended to recognize the simultaneous, joint, and interlocking nature and impacts of multiple systems of power and oppression, it is important to retain a structural focus rather than overemphasize social identities (Cho, Crenshaw and McCall 2013, Collins 2019).

Collins and Bilge (2016) describe six core ideas that they argue may, but need not all be, present when using intersectionality as an analytic tool: 1) social inequality, 2) relationality, 3) power, 4) social context, 5) complexity, and 6) social justice. As an analytic tool, intersectionality "encourages us to move beyond seeing social inequality through race-only or class-only lenses" (Collins and Bilge 2016:26) and instead to acknowledge that social inequality typically results from multiple factors and the interconnections of several categories. Power systems are viewed as interlocking (i.e., they intersect) and mutually constructed. There is an inherently relational component of these systems because there are oppositional categories of "normal" and a "deviant" – one cannot be considered deviant without a clear definition of what is normal, thus one cannot be defined without the other (Collins 2005:95-96). For example, the normalization of White heterosexuality depends on Black heterosexuality being characterized as "deviant". Yet the normalization of White heterosexuality also depends on the deviance of White homosexuality. This provides an example of how systems of oppression, in this case racism and heterosexism, are mutually constructed and reinforce one another. As Collins describes, the Black community is often characterized as promiscuous, with the assumption that promiscuity refers specifically to heterosexual practices. Homosexuality is characterized as a threat only to White people. As a result, "LGBT Black people are less authentically Black because they engage in allegedly 'White' sexual practices" (Collins 2005:106). Thus, "neither system of oppression makes sense without the other" (Collins 2005:88) because "there is not pure racism or sexism" (Collins and Bilge 2016:27).

Furthermore, when using intersectionality as an analytic tool, power relations should be analyzed across domains of power, which include structural, disciplinary, cultural, and interpersonal. Relationality "embraces a *both/and* frame" (Collins and Bilge 2016:27). Power is relational. In examining inequalities, relationalities, and power relations, it is important to attend to social contexts, as these shape what people, including myself as the researcher, think and how they act. The aforementioned four ideas all are intertwined, which leads us to the fifth core idea, complexity. The social world itself, which intersectionality seeks to understand, is complex, as is using intersectionality as an analytic tool. Finally, Collins and Bilge argue that intersectionality is not only intended to help us analyze social inequalities but also to engage in social justice efforts, although they note that this is the most contentious idea of the six.

Although shifts are gradually taking place, most research focused on sexual health among LGBTQ+ people assigned female at birth, similar to most LGBTQ+ health scholarship in general, includes samples of predominantly White LGBTQ+ populations and considers the axis of sexual orientation but omits other axes of subordination, including race/ethnicity and racism (Charlton et al. 2011, Everett 2013, Greene et al. 2018, McCauley, Silverman, Decker et al. 2015). This limits the generalizability of these findings and limits our understanding of the specific and unique sexual health care experiences of LGBTQ+ people of color, a multiply marginalized population. Furthermore, relatively few studies have investigated the sexual health and health care experiences of transgender men and gender non-conforming populations, who are also often lumped together despite their likely different health care experiences (Cruz 2014), let alone those of transgender men and nonbinary AFAB people of color (Agénor, Geffen, Zubizarreta et al. 2022a, Agénor, Zubizarreta, Geffen et al. 2022b). Yet intersectionality highlights the fact that the experiences of those subjected to multiple forms of discrimination or oppression do not entirely fit into any one form of discrimination because these multiple forms result in a unique experience created by "the interaction between two or more axes of subordination" (Crenshaw 2000/2014:17).

Given studies have identified significant sexual health inequities among women of color (Musselwhite, Oliveira, Kwaramba et al. 2016, Spencer, Calo and Brewer 2019, Wang, Sheppard, Schwartz et al. 2008), particularly among Black and Latina women, as well as among men of color (Kalmuss and Austrian 2010, Quinn, Dickson-Gomez, Zarwell et al. 2019, Sullivan, Purcell, Grey et al. 2018), Black, Latinx, and other LGBTQ+ people of color AFAB birth may be particularly likely to experience barriers to sexual health care and negative clinical encounters. By considering multiple dimensions of social identity and inequality including, but not limited to, sexual orientation and heterosexism, race/ethnicity and racism, and gender identity and cisgenderism, this project contributes to a small but growing body of literature examining how multiple social identities and social inequalities, due to their relations to systems of oppression, simultaneously impact health and health care experiences. Specifically, this project sought to heed calls for LGBTQ+ research containing more racially/ethnically diverse samples (Edmiston et al. 2016) by recruiting a sample of interview participants comprised predominantly of LGBTQ+ people of color. Indeed, while the qualitative portion of this project adhered to constructivist grounded theory techniques (Charmaz 2014), intersectionality served as an analytic tool in my analysis of interview data (Chapters 2 and 4), particularly in sensitizing me to power relations and the interwoven and mutually reinforcing nature of systems of power.

Further, intersectionality informed how I approached my quantitative analysis, in which I focus on two social categories at the individual level—sexual orientation identity and race/ethnicity—as linked to heterosexism and racism at the interpersonal and structural level.

Stigma

Stigma, famously theorized by symbolic interactionist Erving Goffman (1963), undergirds this project, which takes for granted the assumption that LGBTQ+ people AFAB belong to one or more (depending on one's individual positionality) stigmatized groups. Goffman, who sought to explain how stigma manifests and what it means, described stigma as "an attribute that is deeply discrediting" (Goffman 1963:3). However, Goffman's conceptualization of stigma emphasizes not the characteristic or attribute in and of itself but rather the relational nature of stigma–the linkage of the stigmatized attribute and the body. Stigma results from categorization, which determines which differences have social significance, and the meanings that society attaches to those differences or characteristics. In contrast to *normals*, who do not have a stigma, stigmatized people are othered and viewed as inferior. As the linkage between stigmatized attribute and the body becomes more "natural" or systematized and thus more invisible, stigma becomes all the more powerful as the inferiority of stigmatized people becomes rationalized via ideology (Goffman 1963).

Goffman described three types of stigma: "abominations of the body" (i.e., physical deformities), blemishes of individual character (e.g., mental illness), and tribal stigma (e.g., race, religion) (Goffman 1963:4). Historically LGBTQ+ people have often been viewed as having character blemishes (Bradford and Clark 2011). However, although in contrast to Goffman's (1963) description of tribal stigma being LGBTQ+ is not transmitted through lineages, the stigmatization of LGBTQ+ people might alternatively be viewed as tribal stigma because, similar to race/ethnicity, membership in LGBTQ+ communities is associated with stereotypes (Eliason, Donelan and Randall 1992, Howansky, Wilton, Young et al. 2021, Israel and Mohr 2004). Indeed, stigma is a large part of the reason that "LGBTQ+" is considered a socially meaningful category, as it brings together various stigmatized groups into a single, although vastly heterogenous, social group or "tribe" (Graham, Berkowitz, Blum et al. 2011, Herek 2016).

Further, Goffman differentiated between stigmas that are *discredited*–in which the stigmatizing attribute (i.e., differentness) is known on the spot–and *discreditable*–in which the stigmatizing attribute is not immediately perceivable. Given this differentiation, in contrast to race/ethnicity and racialization, in many (most would probably argue in most) cases the stigma associated with being LGBTQ+ is discreditable rather than discredited. Importantly, this enables LGBTQ+ people to manage whether or not, and to whom, they disclose their LGBTQ+ identity(ies), which, in turn, may shape their experiences of stigma and discrimination (Feinstein, Xavier Hall, Dyar et al. 2020, Schrimshaw, Downing and Cohn 2018). However, this is a privilege not afforded to all because, whether or not accurate, people often assume others' sexual orientation and/or gender identity based on appearance or presentation. While there is increasing societal recognition of the inaccuracy of assuming one's sexual orientation or gender based on appearance alone, it remains common practice. While an in-depth discussion is beyond the scope of this project, it is here that the notion of "passing" plays a critical role in stigmatization (Haas 2019, Kalei Kanuha 1999). Thus, although most are stigmatized upon LGBTQ+ identity disclosure, some are stigmatized based on sexual orientation and/or gender based on appearance alone, whether or not they are LGBTQ+.

Significant theoretical development and empirical application of stigma have occurred since Goffman's (1963) elaboration of the concept. For example, social psychologists have examined how people construct categories and how these categories then become linked to prejudice, stereotypes, and discrimination (Crocker, Major and Steele 1998). Taking a more sociological approach, Link and Phelan (2001) highlighted that status loss and discrimination occur as a result of the stigma process and that power is required in order for stigma to be produced. As they describe:

> stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Thus, we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold. (Link and Phelan 2001:367)

This conceptualization stresses unequal power as a prerequisite for the production of stigma. Combined these understandings of stigma point to stigmatization as a process that has significant negative social consequences. While stigma refers to the process of categorization, labeling of individuals based on these categories, and subsequently having negative attitudes and beliefs about certain groups and individuals in those groups, resulting in status loss, social rejection, and discrimination, discrimination refers specifically to behaviors and actions taken as a result of stigma (Link and Phelan 2001). In other words, discrimination "occurs when stigmatization is acted on by concrete behaviors" (Abbey, Charbonneau, Tranulis et al. 2011). Indeed, the labeling, stereotyping, and discrimination that result from stigma contribute to social inequalities, with stigma being considered a "fundamental cause" of inequalities (Hatzenbuehler et al. 2013), as elaborated below.

Historically most stigma research focused on individual-level or interpersonal stigma, including perceptions and consequences of stigma, stereotypes, and discrimination. Scholarship has included examinations of *self-stigma* (Herek 2016) or *internalized stigma*, which occurs when a person possessing a stigmatized attribute views themselves in line with how society views them (i.e., they self-stigmatize), resulting in feelings such as guilt and shame. Further, individuals may experience *perceived stigma* (i.e., *anticipated* or *felt* stigma) due to fear of being stigmatized or discriminated against by others (Herek 2016). Finally, *interpersonal stigma* occurs when the stigma process unfolds between a member(s) of a non-stigmatized group and a member(s) of a stigmatized group (Hatzenbuehler 2016, Hebl and Dovidio 2005). For example, in health care settings, stigma impacts patient-provider interactions (Link and Phelan 2006) in which providers are in a position of power and thus have the power to stigmatize patients (Mason-Whitehead and Mason 2007), which may be based on providers' assumptions about patients (Weiss and Ramakrishna 2006). A variety of sources of stigma in health care settings has been examined, including sexual orientation (Gessner, Bishop, Martos et al. 2020), gender (Velasco 2022), race/ethnicity (Bird and Bogart 2001), and having public insurance (Martinez-Hume, Baker, Bell et al. 2017). Anticipated and experienced stigma in health care settings has been associated with poorer health and health care outcomes, including delaying care and reduced quality of life.

Given LGBTQ+ people remain stigmatized and viewed as deviant in the U.S. (Worthen 2016), stigma has served as a useful concept and been taken up in a range of ways to examine the lived experiences of LGBTQ+ populations who experience *sexual* and/or *gender minority stigma*. Herek (2016:397) defined *sexual stigma* as "all facets of stigma associated with same-sex desires, sexual behaviors, and relationships, as well as sexual minority communities" and *gender minority stigma* as "stigma directed at nonnormative gender identities, experiences, and expressions, as well as gender minority communities." While a robust body of literature has examined how stigma is associated with health inequities among LGBTQ+ people AFAB, similar to empirical stigma research more broadly, studies examining stigma among LGBTQ+ people AFAB have overwhelmingly focused on individual and interpersonal level stigma. For example, studies have found that internalized (Molina, Lehavot, Beadnell et al. 2014) and perceived (Gessner et al. 2020) stigma may help partially explain some health disparities among LGBTQ+ people AFAB and that perceived stigma may impact LGBTQ+ people's expectations about their future care interactions (Eliason and Schope 2001) and prevent sexual orientation identity disclosure (Austin 2013).

However, there is increasing recognition of the multilevel nature of stigma, which makes it all the more challenging to prevent (Hatzenbuehler et al. 2013). While Link and Phelan (2001) included descriptions of both individual and structural level stigma and discrimination in their conceptualization of stigma, researchers have been slower to uptake the concept of structural stigma. Structural discrimination results from "societal conditions that constrain an individual's opportunities, resources, and well-being" (Hatzenbuehler et al. 2013:813). The concept of structural stigma draws attention to the ways that structures, systems, and policies (re-)produce stigma and discrimination. In fact, the origins of the concept are in institutional racism, which was conceptualized to bring attention to the how ideology and institutions perpetuate racism (Carmichael, Ture and Hamilton 1992).

Despite slow uptake of the concept, more recently, increasing attention has been paid to the role of both historical and present-day structural stigma and discrimination in the (re-)production of LGBTQ+ health inequalities (Baldwin, Dodge, Schick et al. 2017b, Mayer, Bradford, Makadon et al. 2008). In fact, Herek (2016) describes structural stigma as one reason why health related data about LGBTQ+ populations is so limited is because the default is cisgender and heterosexual people. Given the fundamental role that stigma plays in shaping the health of LGBTQ+ (as well as other socially marginalized) populations, there are ongoing calls for more studies measuring and assessing the impacts of structural stigma among LGBTQ+ populations (King, Hughto and Operario 2020).

Finally, important to this project is the concept of *intersectional stigma*, an application of intersectionality focused specifically on how people simultaneously experience multiple forms of stigma (Sievwright, Stangl, Nyblade et al. 2022). *Intersectional stigma*, as defined by Berger (2004:24), is the "total synchronistic influence of various forms of oppression which combine and overlap to form a distinct positionality." Thus, intersectional stigma, which is enabled by systems of power (Sievwright et al. 2022), is a way of recognizing that different types of stigma are mutually constituting, that they shape one another, rather than are merely additive (Bowleg 2008). With the understanding that centering those who are most socially marginalized helps us understand how oppression–including stigma, discrimination, and social and health inequities–are reproduced in order to mitigate stigma and discrimination and advance social and health equity (Stangl, Earnshaw, Logie et al. 2019, Turan, Elafros, Logie et al. 2019), intersectional stigma is an important framework through which to examine health inequities.

Notably, like intersectionality, while Berger (2004) originally coined the term *intersectional stigma* to describe the structural and social realities of people living with HIV, applications of intersectional stigma have increasingly moved away from structural stigma and structural intersectionality. Indeed, many have come to define intersectional stigma in ways that focus on multiply stigmatized populations and individuals rather than the enactors of stigma and the systems of power and oppression that perpetuate stigma and, in turn, discrimination (Bowleg 2022). While intersectional stigma is a useful framework through which to examine stigma as a fundamental cause of health inequities and advance health equity, most studies that employ the concept of intersectional stigma “obscure interlocking oppressive social-structural systems such as structural racism, sexism, and heterosexism,” to which Bowleg (2022:S344) recently called attention.

While existing studies are limited, a growing body of research examines intersectional stigma and discrimination among LGBTQ+ populations (e.g., Agénor et al. 2022a, Paine 2021, Schmitz, Robinson, Tabler et al. 2020). For example, studies have found that among LGBTQ+ people of color the impacts of heteronormative and gender normative clinical encounters may be compounded by fears and experiences of providers holding racialized stereotypes (including heteronormative racialized assumptions) (Agénor et al. 2015a), which can exacerbate provider mistrust and lead to poorer patient-provider communication (Jahn et al. 2019).

Structural and social determinants of health and health care

Given the role of stigma in the (re-)production of social inequalities, including health inequalities, stigma can also be viewed as a social and structural determinant of health (Hatzenbuehler et al. 2013). This project draws heavily on theories of the social and structural determinants of health and health care. Social determinants of health, defined by the World Health Organization as,

> the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (World Health Organization 2022)

have been increasingly used as a lens through which to examine the distribution of health and illness. Structural determinants of health include, but are not limited to social and public policies and societal values and norms which, in turn, shape social determinants such as socioeconomic position (Solar and Irwin 2010).

In particular, this dissertation recognizes stigma, racism, and socioeconomic status as fundamental causes of social and health inequalities. Originally developed to explain the persistence of socioeconomic inequalities in health and mortality, *fundamental cause theory* demonstrates how social inequalities lead to health inequalities and, importantly, why changes in risk factors, diseases and medical interventions might not reduce health disparities (Link and Phelan 1995). Fundamental causes of poor health, according to Link and Phelan (1995), influence multiple disease outcomes via multiple risk factors; involve access to flexible resources (e.g., money, knowledge) which are used to avoid risks and adopt protective strategies to minimize effects (e.g., through treatment seeking); and are reproduced over time via replacement of intervening mechanisms. Resource access should be considered at both the individual and collective levels, referred to as "collective health agency" (Clouston and Link 2021). Because those with greater access to flexible resources (i.e., with greater privilege) consistently leverage those resources to avoid disease and maintain health regardless of the specific disease, place, or time, health inequities are perpetuated. In fact, interventions have the potential to exacerbate inequality.

Since conceptualization of fundamental cause theory, many have tested and/or applied the framework, leading to several key extensions, three of which are particularly relevant for this project (see Clouston and Link 2021 for a more comprehensive review). First is recognizing stigma as a fundamental cause. As Hatzenbuehler et al. (2013:813) argue:

> because of its pervasiveness, its disruption of multiple life domains (e.g., resources, social relationships, and coping behaviors), and its corrosive impact on the health of populations, stigma should be considered alongside the other major organizing concepts for research on social determinants of population health.

Stigma is both associated with disadvantage and results in stress for those who are stigmatized (Major and O'Brien 2005, Meyer 2003). Indeed, research has shown that stigma is associated with a range of outcomes (e.g., health care, health, employment) and, consistent with Link and Phelan's (2001) conceptualization of stigma, that stigma inhibits or reduces access to resources compared to nonstigmatized groups (i.e., status loss). Intervening mechanisms including reduced access to resources, increased social isolation, psychological or behavioral responses (e.g., self-stigmatization, emotion regulation), and stress mediate the relationship between stigma and adverse health outcomes (Hatzenbuehler et al. 2013).

Viewing stigma as a fundamental cause of health underscores the multilevel nature of stigma (Hatzenbuehler et al. 2013, Link and Phelan 2001) and the association between stigma and social determinants of health including socioeconomic status and social support for LGBTQ+ people assigned female at birth. and intervening mechanisms (e.g., resource availability, stress), including among LGBTQ+ populations, specifically (Badgett 1996, Coker, Austin and Schuster 2010, Meyer 2003). For example, being LGBTQ+ and/or being a person of color are linked, due to structural discrimination (i.e., heterosexism, cissexism, and racism) with resource disadvantages, including lower socioeconomic status, compared to being of a nonstigmatized group. The intervening mechanisms linking stigma to health are often subtle and thus may not be readily detected (Hatzenbuehler et al. 2013). For example, stigma has contributed to limited info about LGBTQ+ populations, resources dedicated to these populations, and limited provider knowledge about LGBTQ+ health (Hatzenbuehler et al. 2013).

While racism experienced by racial/ethnic minority groups could be viewed through the aforementioned stigma as a fundamental cause framework (Hatzenbuehler et al. 2013), it is important to recognize racism, specifically, as a fundamental cause. Racism–both due to it being a fundamental cause of socioeconomic disparities which, in turn, are fundamental causes of health inequalities but racism also, independent of socioeconomic status–is a fundamental cause of health inequalities (Phelan and Link 2015). Indeed, via inequalities in intervening mechanisms including resources, neighborhood context, and health care, independent of socioeconomic status racism is also linked to health.

Fundamental cause theory draws attention to the fact that fundamental causes–including stigma, racism, and socioeconomic inequalities–must be addressed in order to eliminate health inequalities. However, a common critique is that “in its emphasis on the persistence of socioeconomic inequalities in health, research that applies FCT can perpetuate the assumption that social stratification is static” (Riley 2020). In order to address this critique as well as mitigate what she characterizes as a mismatch between studying inequalities within a population rather than between populations, Riley (2020) calls for studying fundamental causes as “systems of exposure.” Most health inequalities follow patterns of social inequalities, often leading to “theorizing health deficits” and, often, viewing social and health inequalities as “natural” (and, thus, inherent and immutable), as reflected in many research study assumptions and framings. As a result, health inequalities seem nearly impossible to change. Rather than focusing on stigmatizing characteristics, Riley calls for considering stratification systems such as gender, sexual orientation, and racial hierarchy as systems of exposure and examining how they are created and maintained rather than “natural” or static, with attention to context (e.g., policies of the time). Systems of exposure takes a relational approach to fundamental cause theory–one’s positionality in the system determines their access to power and resources–recognizing both disadvantage and privilege–and, in turn, exposure to the social determinants of health. This approach–which facilitates consideration of one’s positionality in relation to multiple systems of exposure simultaneously–lends itself well to an intersectional perspective for conducting health inequities research (Riley 2020).

Theoretical frameworks related to structural and social determinants of health are many. This dissertation draws specifically on fundamental cause theory, which emphasizes the importance of tacking social factors (e.g., socioeconomic inequality, stigma) rather than risk factors (i.e., mechanisms linking social factors to health) commonly identified and targeted in public health. Otherwise, reproduction of health inequalities continues via new intervening mechanisms. This project also draws on key tenets common to many structural and social determinants of health theoretical frameworks, including the social ecological model (Bronfenbrenner 1979, McLaren and Hawe 2005) and ecosocial theory (Krieger 2001, Krieger 2021) Specifically, the project draws on the following tenets: First, it recognizes that a complex system of factors at multiple levels informs health and health care outcomes. Second, it acknowledges that both historical and present-day context shape health and health care-related outcomes and experiences and thus should be incorporated into analyses (Krieger 2001, McLaren and Hawe 2005). Finally, it is attuned to the insidiousness of systems of power and oppression, including heterosexism, cissexism, and racism (Hatzenbuehler et al. 2013, Krieger 2020, Phelan and Link 2015, Riley 2020).

METHODOLOGICAL APPROACHES

This multiple methods study utilized primary qualitative data collected through individual in-depth interviews (n=76) and secondary quantitative data from the National Survey of Family Growth. The qualitative component of this study was intended to address some of the limitations inherent in the quantitative component, particularly by enabling me to examine, from the perspective of LGBTQ+ people AFAB, what assumptions providers make about LGBTQ+ patients AFAB (Chapter 2), whether and how these assumptions impact patients' care seeking and quality of care (Chapter 2), and how patients navigate these assumptions (Chapter 4). In contrast to Chapter 3, in which participants are categorized into a limited number of pre-specific racial/ethnic and sexual orientation identity groups, interviews provided participants the space to self-identify and, while not elaborated in this dissertation, describe their lived experiences related to realizing their identity and, in many cases, coming out.

Multiple methods projects have many advantages over projects that utilize only quantitative or qualitative methods, including, as Kelle (2006:293) describes, the fact that they "can serve for the mutual validation of data and findings as well as for the production of a more coherent and complete picture of the investigated domain than monomethod research can yield." While I undertook a multiple methods study design primarily in order to gain a more holistic understanding of the sexual health care experiences of LGBTQ+ people, utilizing multiple methods enabled me to achieve both of the advantages outlined by Kelle. Although I do not integrate qualitative and quantitative methods in any single empirical chapter, as described below, methods were integrated at various points during study design and data collection and complemented one another in my thinking about this project as a whole.

This project began as a pilot qualitative study focused specifically on queer, cisgender Latina women in the San Francisco Bay Area. Pilot interviews (n=11) conducted with eight women informed the study aims and research questions, including, in combination with secondary data availability, the aims of Chapter 3, the sole quantitative empirical chapter. Data analysis for Chapter 3 was conducted after pilot data collection but prior to subsequent interview recruitment launching in September 2020. This enabled me to ask a handful of interview participants for their reactions to and/or feedback on my quantitative findings. While reactions are not elaborated herein, interviewees' responses in combination with their sexual health care experiences served as a way to better understand some of the mechanisms that might be at play in unpacking my quantitative findings (Chapter 3). Indeed, the few participants I discussed my quantitative findings with were, unfortunately, unsurprised by the differences that I observed, which is a noteworthy finding in and of itself. Thus, rather than continuing to ask interviewees to reflect on those findings, I only did so in select interviews in order to optimize the time that interviewees had to share their own experiences which, ultimately, were in line with the hypotheses that undergird Chapter 3.

Before turning to each method briefly, in turn, below, it is important to note that given the different data sources, the chapters differ in setting/geographic scope: while Chapters 2 and 4 examine the experiences of a racially/ethnically diverse sample of LGBTQ+ people assigned female at birth aged 21 and older recruited from the San Francisco Bay Area, data analyzed for Chapter 3 are designed to be nationally representative of civilian, noninstitutionalized women aged 15-44 years in the U.S. Indeed, the qualitative findings reported in Chapters 2 and 4 are not intended to be generalizable in the same ways as the findings of Chapter 3. Rather, it is important to contextualize and recognize the situatedness of the qualitative findings while simultaneously recognizing their potential transferability (Tracy 2010). Specifically, interview participants were recruited from the San Francisco Bay Area, which is consistently ranked the “most LGBTQ friendly city” in the U.S. (Moving Waldo 2022) and has played, and continues to play, an integral role in the LGBTQ rights movement (Stryker and Van Buskirk 1996, Stryker 2008). Furthermore, and of particular relevance to this study, San Francisco has been and continues to be a major center of HIV/AIDS activism (Shilts 2011), which has shaped local sexual health care, programs, and policies, and California is one of only a few states that requires LGBTQ-inclusive sex education be taught in public schools (SIECUS 2020). While some study participants had lived only part of their lives in the Bay Area, it is important to note that the findings that follow are situated in this context. Indeed, many participants had lived in the Bay Area for most, if not all, of their lifetime, and several others noted that they moved to the area due to it being considered a very LGBTQ friendly place.

Qualitative Methods

Chapters 2 and 4 of this dissertation draw upon qualitative data collected via in-depth, semi-structured interviews conducted with a racially/ethnically diverse sample of LGBTQ+ people assigned female at birth (AFAB), aged 21 and older, and living in the greater San Francisco Bay Area. Qualitative data collection and analysis was guided by constructivist grounded theory (Charmaz 2014), which entails ongoing analysis (coding, memo writing) throughout the data collection process until theoretical saturation is reached. Rooted in social constructionism, constructivist grounded theory is a highly inductive method that seeks to understand social processes and emphasizes reflexivity on the part of the researcher (e.g., reflection on one's own assumptions, awareness of power dynamics that exist in research settings). This method openly acknowledges that research is constructed rather than objective, with the researcher and interviewees co-constructing a shared reality (Charmaz 2014). While the goal of this study was not theory development, constructivist grounded theory was an appropriate methodology for this project given its emphasis on social processes, giving voice to members of the study population, and inductive methods, which recognize multiple ways of knowing and allowed the proposed research aims and questions for this project to evolve throughout data collection.

Acknowledging the critical role that community-based organizations play in LGBTQ+ health and that in order to move away from the elitist notion that researchers and professionals are the "experts," lay experts need to be actively involved in the research process (Popay and

Williams 1996), this was intended to be a community-engaged project. Recruitment and data collection, originally intended to be conducted in person, shifted to online and snowball sampling recruitment and remote interviews due to the COVID-19 pandemic. Indeed, the COVID-19 pandemic, which both shifted my research plans and placed strains on the capacity of many community-based organizations to support community needs, coupled with personal circumstances ultimately limited my ability to pursue ongoing community engagement and conduct member validation, though these remain part of my future research plans (see Chapter 5).

Recruitment would not have been possible without support from the San Mateo County Pride Center, where I have been a volunteer since 2018. Center staff and a few community members reviewed recruitment flyer, survey, and interview guide drafts, which were revised based on their feedback prior to study launch. The Center supported initial project recruitment, which began in September 2020, by disseminating study recruitment materials in their monthly newsletter and on social media. I subsequently recruited participants by posting advertisements online (e.g., Craigslist), contacting community organizations and student groups who disseminated study flyers via listservs and social media, and snowball sampling. Pilot interviews were conducted at a mutually agreeable location (e.g., participant's home, library), and subsequent interviews were conducted via phone or Zoom, whichever was most feasible and comfortable for each participant. This helped to optimize access to the study as not all participants were familiar with Zoom or had a location in which they felt comfortable taking a video call, which was important given the stigma associated with LGBTQ+ identity and sexual health, which were the foci of the interviews. Notably, two of the Black interview participants described having to schedule the interview for a time when they would be able to talk in private.

Memoing, Positionality, and Reflexivity

Memo-writing was used as a tool throughout data collection and analysis to track conceptualizations and decisions, develop my codebook, help me think through my analysis, and reflect on my positionality. As a highly educated, White, queer-identifying cisgender woman, I was conscious of how I approached interviews, my interpretations of the data, and the assumptions that I brought to the project. I began each interview with an introduction of myself, including that I am a White, queer-identifying cisgender woman, why I am interested in this work, and how I came to pursue this project to help establish rapport and for transparency as I did not want respondents to assume I was Latina based on my name. This undoubtedly shaped interviews in numerous ways, for example, respondents of color and transgender and nonbinary respondents may have been less comfortable sharing their experiences. On the other hand, many participants seemed to assume I understood or could relate to their experiences and that I knew what certain terms–in English or Spanish–meant. In these situations, I asked respondents to clarify what they meant or share how they define or understand a term or concept, couching it in me not wanting to make assumptions. This was an effective approach to get respondents to share additional information and, in some cases, to realize that terms could mean different things to different people and that meanings change over time. While I included reflexive notes in my fieldnotes following each interview in order to mitigate any assumptions I brought into data analysis, I am conscious that my positionality impacts my interpretation of the data.

Quantitative Methods

Chapter 3 uses quantitative methods to assess whether there are differences in a medical provider having conducted a sexual history assessment in the last 12 months across sexual orientation and racial/ethnic subgroups (e.g., Black heterosexual, Latina bisexual, White lesbian) of U.S. women aged 15-44 years. I analyzed publicly available secondary data from women who participated in the 2013-2015, 2015-2017, and 2017-2019 waves of the National Survey of Family Growth (NSFG), which uses a multi-stage sampling design to select a national probability sample of civilian, noninstitutionalized women (N=14,019). I examined five separate dichotomous (yes/no) outcome measures: whether respondents reported their provider had asked about “sexual orientation or the sex of [their] sexual partners,” “number of sexual partners”, condom use, types of sex in which they engage (vaginal, oral, or anal); or any of the aforementioned questions. Covariates were selected a priori based on scientific literature and included demographic factors, which were conceptualized as potential confounders, and socioeconomic and health care factors, which were conceptualized as potential mediators.

Analyses included the age-standardized (Aschengrau and Seage 2014, Howden and Meyer 2011) percent distribution of covariates and outcome measures overall and in relation to sexual orientation identity and race/ethnicity subgroup followed by nested logistic regression models. Models first adjusted for survey wave only, then further adjusted for demographic, followed by socioeconomic and health care, factors. Separate models were run for each of the four sexual history questions and in relation to *any* receipt of a sexual risk assessment in the last 12 months (yes/no). Models were adjusted for survey wave, and analyses were adjusted for NSFG’s complex survey design using the *svy* feature in Stata 16 (College Station, TX).

DISSERTATION OVERVIEW

This project sought to examine how sexual risk discourses impact patient-provider interactions and the health care experiences of LGBTQ+ people assigned female at birth from diverse racial/ethnic backgrounds. Further, it aimed to capture how discourse shapes sexual identity development, health, and well-being of LGBTQ+ people assigned female at birth from diverse racial/ethnic backgrounds. In this dissertation, I focus specifically on the health care experiences of LGBTQ+ individuals assigned female at birth, centering their sexual health and gender affirming care experiences. The dissertation is comprised of three papers described briefly in turn below.

In Chapter 2, I investigate interpersonal and structural factors that inform sexual health and/or gender affirming care seeking and their impact on quality of care among a racially/ethnically diverse sample of LGBTQ+ individuals assigned female at birth recruited from the San Francisco Bay Area. My analysis found that experienced and anticipated interpersonal stigma and discrimination and structural factors–including resource-related factors and structural stigma and discrimination–strongly influenced participants' care seeking behaviors and the quality of their clinical encounters. I argue that interpersonal and structural stigma and discrimination have an especially detrimental impact on patients' sexual health and/or gender affirming care experiences given the particularly socially stigmatized nature of these interactions. Furthermore, I demonstrate that the impact of interpersonal and structural stigma and discrimination on patient trust in providers and, in turn, care seeking is particularly detrimental for multiply marginalized populations such as LGBTQ+ people of color.

While Chapter 2 finds that provider assumptions often function as barriers to care and negatively impact the quality of care among LGBTQ+ people assigned female at birth, Chapter 3 takes a deep dive into potential implications of provider assumptions on sexual history taking. Driven by hypotheses related to sexual risk-related assumptions that health care providers might make about patients, in Chapter 3 I use an intersectional approach to quantitatively examine racial/ethnic and sexual orientation differences in having received a sexual history assessment from a health care provider among U.S. women aged 15-44 years (N=14,019). This paper was motivated by the idea that differential sexual history assessment, whereby certain groups are more or less likely to be asked questions about their sexual behavior, may lead to differential sexual health care and counseling. Specifically, I expected that, due to racist gendered stereotypes and heterosexist stereotypes, Black heterosexual, Latina heterosexual, Black bisexual, Latina bisexual, and White bisexual women may have higher odds of having been asked sexual history questions by their health care provider compared to White heterosexual women. In line with intersectionality, I hypothesized that odds would be the highest among Black and Latina bisexual women.

Using nationally representative data from the 2013-2019 waves of the National Survey of Family Growth, I find that Black heterosexual, Latina heterosexual, White bisexual, Black bisexual, Latina bisexual, and Black or Latina lesbian women have higher odds of having received a sexual history assessment in the last 12 months compared to White heterosexual women. Notably, in line with my hypothesis, Black bisexual women had the highest probability of being asked about their sexual behavior by a provider. While I am unable to comprehensively examine mechanisms for this association in the paper, this may, in part, result from providers holding biased assumptions of promiscuity rooted in both racism and biphobia. An abbreviated version of this paper was published in *Women's Health Issues* in March 2022 (Pérez and Agénor 2022).

In Chapter 4, I describe strategies LGBTQ+ people assigned female at birth use to navigate sexual health care in order to obtain needed services including, but not limited to, strategies used to resist stigma and discrimination. I use data collected during 76 interviews with a racially/ethnically diverse sample of 64 LGBTQ+ people assigned female at birth aged 21 and older recruited from the San Francisco Bay Area. I find that LGBTQ+ assigned female at birth use a variety of strategies when navigating sexual health and gender affirming health care, including care avoidance; conforming to biomedicine and provider recommendations; advocacy and resistance; active information seeking; stigma management; leveraging social capital; and intentional selection of healthcare. This chapter sheds light on how power dynamics unfold and shape patient-provider interactions, the potential for patient-provider collaborations, and the role of cultural health capital in patient-provider encounters.

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CHAPTER 2: “I don’t have a regular doctor, and I don’t have a relationship with a doctor”: Interpersonal and structural factors influencing sexual health and gender affirming care among LGBTQ+ people assigned female at birth

ABSTRACT

Research examining factors associated with sexual health care utilization among lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+) populations assigned female at birth (AFAB) in the U.S. has largely relied on predominantly White samples to investigate barriers to care utilization. Fewer studies have investigated barriers and facilitators and their implications on LGBTQ+ patients’ care experiences beyond avoidance of care. Using data collected from qualitative interviews (n=76) conducted between 2019 and 2021, this study examines interpersonal and structural factors that inform sexual health and gender affirming care seeking and their impact on quality of care among a racially diverse sample of LGBTQ+ people AFAB (n=64) recruited from the San Francisco Bay Area. Findings highlight the negative impacts of experienced and anticipated interpersonal stigma and discrimination (e.g., heterosexism, cissexism, racism) in clinical interactions and structural factors, including resource-related factors (e.g., the patchwork nature of health coverage in the U.S.) and structural stigma and discrimination, on care seeking and quality of care received among LGBTQ+ people AFAB. Facilitators to care seeking and improved quality of care are also discussed. The impacts of identified factors are especially heightened in the contexts of sexual health and gender affirming care and for multiply stigmatized individuals. Notably, results point to the importance of patient-provider relationships built on trust to facilitate health care utilization and optimize patient care experiences. Changes at multiple levels, including implementing healthcare practices and

policies aimed at providing inclusive, person-centered, and structurally competent sexual health and gender affirming care, are needed to combat the manifestation of stigma and discrimination in healthcare and promote sexual health equity.

Introduction

Studies have identified numerous inequalities in health care utilization and quality of care among lesbian, gay, bisexual, transgender, and other queer (LGBTQ+) people assigned female at birth compared to cisgender, heterosexual women in the U.S., including lower rates of preventive care utilization (Fish, Turpin, Williams et al. 2021, Grant, Motter and Tanis 2011). In the context of sexual health, studies have found that lesbian, gay, bisexual, and other queer (LGBQ+) women and trans and nonbinary people AFAB are less likely to engage in cervical cancer screening (Agénor, Peitzmeier, Gordon et al. 2015b, Agénor, Muzny, Schick et al. 2017, Charlton, Corliss, Missmer et al. 2011, Peitzmeier, Khullar, Reisner et al. 2014, Tabaac, Sutter, Wall et al. 2018) and HPV vaccination (Agénor et al. 2015b, Agénor, Peitzmeier, Gordon et al. 2016) compared to heterosexual women and cisgender women, respectively. However, LGBTQ+ people AFAB are at risk of acquiring sexually transmitted infections (STIs) and cervical cancer, indeed perhaps at increased risk, compared to cisgender, heterosexual women (Bauer, Travers, Scanlon et al. 2012, Charlton et al. 2011, Everett 2013, McCauley, Silverman, Decker et al. 2015, Singh, Fine and Marrazzo 2011).

Sexual health care inequalities among LGBTQ+ people AFAB are driven by a complex array of multilevel factors that pose barriers to accessing care and impact care experiences (Eiduson, Murchison, Agénor et al. 2021, Gessner, Bishop, Martos et al. 2020). While some barriers, such as lack of insurance and other financial barriers, are not unique to LGBTQ+ people

AFAB, structural and interpersonal heterosexism and (cis)sexism have historically placed, and continue to place, LGBTQ+ people AFAB at particularly high risk of experiencing these barriers. For example, while capitalism and the corporatization, commodification, and centralization of biomedical services (Clarke, Shim, Mamo et al. 2003) have resulted in cost being a commonly cited barrier to care among the general population, LGBTQ+ people experience pronounced socioeconomic disparities compared to cisgender, heterosexual women (Badgett, Durso and Schneebaum 2013). Further, while studies conducted prior to the Affordable Care Act (ACA), which greatly expanded insurance coverage for sexual minority adults (Gonzales, Henning-Smith and Ehrenfeld 2021), found that sexual minority women were less likely than heterosexual women to have health insurance (Diamant, Wold, Spritzer et al. 2000, Heck, Sell and Gorin 2006), post-ACA studies find that these differences no longer exist (Fish et al. 2021, Hsieh and Ruther 2017, Jackson, Agénor, Johnson et al. 2016). However, closing insurance coverage gaps has been insufficient to address inequalities in sexual health care utilization, as evidenced by post-ACA studies continuing to observe lower sexual health care utilization among LGBTQ+ people AFAB compared to cisgender, heterosexual women (Agénor et al. 2017, Tabaac et al. 2018).

A range of health care-related factors have been associated with sexual health care utilization and experiences among LGBTQ+ people AFAB. For example, lack of provider knowledge about LGBTQ+ health (Khalili, Leung and Diamant 2015), including a misperception that LGBQ+ women have a lower STI risk and lower need for Pap testing than heterosexual women (McIntyre, Szewchuk and Munro 2010) and that transmasculine individuals are at low risk of cervical cancer (Agénor, Peitzmeier, Bernstein et al. 2016) contributes to care avoidance and reduced service utilization. Additionally, LGBTQ+ people AFAB commonly report experiencing stigma and discrimination if they disclose same-sex sexual practices and/or their sexual or gender identity to providers (Dean, Victor and Guidry-Grimes 2016). Further, although less research has examined the care experiences of trans and nonbinary populations, studies report that transmasculine individuals experience unique barriers to sexual health care, such as gender dysphoria and vulnerability during pelvic/frontal examinations (Hoskin, Blair and Jenson 2016, Johnson, Nemeth, Mueller et al. 2016, McDowell, Pardee, Peitzmeier et al. 2017, Peitzmeier, Agénor, Bernstein et al. 2017), which may contribute to their underutilization of cervical cancer screening. These studies point to the role of stigma–which involves labeling, stereotyping, "othering," and, subsequent status loss and discrimination (Link and Phelan 2001)–and discrimination–behaviors enacted due to stigma (Abbey, Charbonneau, Tranulis et al. 2011)–in driving sexual health care disparities among LGBTQ+ people AFAB (Gessner et al. 2020).

Having another stigmatized identity in addition to being LGBTQ+ may compound experiences of stigma, which I use to refer to the process of linking a negative attribute and associated negative attitudes or beliefs (e.g., negative stereotypes) to an individual or group (Goffman 1963, Link and Phelan 2001), and discrimination in health care settings. Studies focused on barriers to care among LGBTQ+ people AFAB have predominantly sampled White individuals, despite well-documented knowledge that patients of color experience pronounced barriers to care as well, shaped by structural and interpersonal racism both inside and outside of healthcare (Bailey, Krieger, Agenor et al. 2017, Feagin and Bennefield 2014, Nelson 2002, Williams, Lawrence and Davis 2019). However, informed by intersectionality, a growing body of literature has examined the health care experiences of racially/ethnically diverse LGBTQ+ people (e.g., Agénor, Geffen, Zubizarreta et al. 2022a, Howard, Lee, Nathan et al. 2019, Schmitz, Robinson and Tabler 2019). With roots in Black feminist theory and praxis, intersectionality is an analytic framework that conceptualizes systems of power and oppression as simultaneous and co-constitutive (Collins and Bilge 2016). Further, it sheds light on the fact that the lived experiences of those who experience multiple forms of stigma and discrimination (e.g., Black lesbian women) cannot be explained by one form of stigma and discrimination alone and are more than the mere sum of multiple forms of stigma and discrimination (Bowleg 2012, Collins and Bilge 2016, Combahee River Collective 1982).

Indeed, prior studies show that intersectional stigma and resultant discrimination is associated with care avoidance and patient mistrust of health care providers (Arnold, Rebchook and Kegeles 2014, Peek, Lopez, Williams et al. 2016, Turan, Elafros, Logie et al. 2019). Among LGBTQ+ people AFAB specifically, studies document that multiple forms of discrimination shape sexual and reproductive care access among Black (Agénor, Bailey, Krieger et al. 2015a) and Latina (Schmitz et al. 2019) LGBQ+ women (Flanders, Khandpur and Fitzgerald 2022) and transmasculine young adults of color (Agénor et al. 2022a, Agénor, Zubizarreta, Geffen et al. 2022b). For example, Agénor et al. (Agénor et al. 2022a, 2022b) found that fear of racism and cissexism, such as providers making stereotypical assumptions, led transmasculine young adults of color to delay or avoid gynecological care and that accessing care often had negative mental health effects.

This study, part of a larger, multiple methods study investigating the impact of sexual risk discourses on the health and well-being and health care experiences of LGBTQ+ people assigned female at birth, builds on prior literature by examining the sexual health and gender affirming care experiences of a sample of predominantly LGBTQ+ individuals of color. Specifically, this analysis examines barriers and facilitators to care seeking and their implications on patients' care experiences. I argue that interpersonal and structural stigma and discrimination have an especially detrimental impact on patients' sexual health and gender affirming care experiences given the more socially stigmatized nature of these interactions. Furthermore, through the experiences of LGBTQ+ people AFAB, I demonstrate that the impact of interpersonal and structural stigma and discrimination on patient trust in providers and, in turn, care seeking is particularly detrimental for multiply stigmatized populations. In doing so, the study adds to our understanding of the countless ways that health care inequities are constantly reproduced, resulting from the lack of uniformity and universal health care coverage in the U.S. and deeply entrenched systemic oppression both inside and outside of healthcare.

METHODS

LGBTQ+ individuals assigned female at birth aged 21 or older were recruited from the greater San Francisco Bay Area. The age criterion was selected based on cervical cancer screening guidelines at the time of study initiation (US Preventive Services Task Force 2018), as respondents were asked questions about whether or not they had previously had a cervical cancer screening and, if so, their experiences with screening during interviews. Maximum variation sampling (Patton 2014) was used in order to capture a sample comprised of people from diverse sexual identities, racial/ethnic groups, and gender identities, which allowed for consideration of how heterosexism, racism, and (cis)sexism impact care experiences and ensured a variety of perspectives and experiences were captured.

Eight LGBQ+ cisgender Latina women were recruited as pilot participants between October 2018 and February 2019 via physical flyers, emails to university student group listservs, and online postings on Reddit and Craigslist. Subsequent study participants were recruited between September 2020 and July 2021 through online postings disseminated via community organization and student group email listservs and social media, Craigslist, and snowball sampling. This study aimed to include a sample comprised predominantly of people of color. Therefore, after an initial wave of recruitment, subsequent recruitment efforts and materials focused solely on recruiting participants of color. Drafts of the study flyers and screener survey were reviewed and revised based on feedback from staff and community members from a local LGBTQ+ organization prior to formal study launch in September 2020. Potential study participants completed the brief screener survey electronically or via phone to ensure eligibility and to facilitate maximum variation sampling by allowing the PI to monitor the characteristics of the study sample.

Data Collection

Individual interviews were conducted in English following a semi-structured interview guide at a time convenient for respondents. The interview guide included questions related to identity; discourse around sexuality, gender, and sexual health; sources of sexual health information; general health care experiences and sexual health care preferences and experiences, specifically; and suggestions to improve sexual health care. The interview guide was informed by literature on LGBTQ+ sexual health and on conducting qualitative research using an intersectional lens (Bowleg 2008) and was reviewed by qualitative methods experts, pilot tested prior to and during pilot interviews, and revised throughout data collection, consistent with constructivist grounded theory methods (Charmaz 2014).

In person interviews (n=11) were conducted with pilot participants (n=8) between October 2018 and November 2019 at a mutually agreeable location. Subsequent interviews (n=65) were conducted with 56 respondents via phone or video call due to the COVID-19 pandemic. Participants provided verbal consent prior to beginning the interview, which typically lasted 60-100 minutes (mean: 87 minutes), and were compensated $35 via cash (pilot participants) or an electronic gift card of their choosing. Interviews were audio-recorded and transcribed verbatim. At the conclusion of the interview, participants completed a brief survey including demographic and health care-related questions to help contextualize study findings and were asked whether they would be willing to participate in subsequent interviews. Field notes were immediately taken following each interview. Follow-up interviews were conducted with select respondents and were intended to follow-up on some of the topics that arose during initial interviews and further develop themes emerging from the data. Participants received $15 cash or electronic gift card for any subsequent interviews. Study procedures were reviewed by the University of California, San Francisco Institutional Review Board.

Analysis

Transcripts and field notes were uploaded into MAXQDA for analysis. Constructivist grounded theory, a highly inductive method that seeks to understand social processes, acknowledges that research is constructed, and emphasizes reflexivity on the part of the researcher (e.g., awareness of power dynamics) was used for data collection and analysis (Charmaz 2014). Coding and memo writing took place throughout the data collection process until theoretical saturation was reached. An initial codebook was created after open coding of pilot and six subsequent interviews (n=17 total). After collapsing similar codes and categorizing codes into parent codes, the final codebook included some deductive codes based on the interview guide but was comprised primarily of inductive codes based on transcript and fieldnote data.

To examine factors that inform the sexual health and gender affirming care seeking among LGBTQ+ people AFAB and the care implications of these factors, the present study draws on an analysis of the following parent codes along with their associated child codes:

barriers to care; provider making assumptions; privilege in healthcare; building trust and rapport; and positive health care experiences. Coding revealed that participants overwhelmingly focused on interpersonal and structural factors, which are the focus of this analysis. Notably, participants were asked specifically about their sexual health care experiences but many who had utilized or considered seeking gender affirming care services included these experiences when asked about sexual health care. Therefore, the scope of this study spans not only sexual health but also gender affirming care, defined by the WHO as "social, psychological, behavioral or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity" (as cited in Gomez, Ranji, Salganicoff et al. 2022).

Table 2.1. Sample sociodemographic characteristics

Characteristic	**n**	**%**
Age (years)	range: 21-77	median 27; mean 29.8
Race/ethnicity		
Arab or Middle Eastern	2	3
Asian	21	33
Asian and White	3	5
Black	3	5
Black, Latinx, and White	1	2
Latinx	14	22
Latinx and Asian	2	3
Latinx and White	4	6
White	14	22
Gender identity*		
Gender expansive, gender fluid, genderqueer, nonbinary, agender, bigender, or another gender identity	23	36
Not sure	7	11
Trans man	7	11
Woman	40	63
Sexual orientation identity*		
Asexual	4	6
Bisexual and/or pansexual	28	44
Gay and/or lesbian	19	30
Heterosexual	3	5
Queer	37	58
Questioning	2	3
Educational attainment		
≤ High school diploma	3	5
Some college or Associate’s degree	14	22
Bachelor’s degree	32	50
Graduate or professional degree	15	23
Employment status*		
Employed, full-time	27	42
Employed, part-time	15	23
Retired or unable to work	3	5
Student	15	23
Not working for pay	11	17
Has health insurance		
Yes	62	97
No	2	3
Has usual medical provider		
Yes	44	69
No	20	31
HIV test in lifetime		
Yes	42	66
No	13	20
Unsure	9	14
Pap test in lifetime		
Yes	54	84
No	10	16

Notes. * = response categories not mutually exclusive. Percentages may not add to 100% due to non-mutually exclusive categories and rounding. Participant characteristics described in text are based on interview transcripts and may be more descriptive, while data presented here are based on sociodemographic survey data.

RESULTS

Analyzing the sexual health and gender affirming care experiences of LGBTQ+ people AFAB revealed that experienced and anticipated interpersonal discrimination and structural factors–including resource-related factors and structural stigma and discrimination–strongly influenced participants' care seeking behaviors and the quality of their clinical encounters. Notably, while not all shared health care experiences took place in the Bay Area, participants often contextualized those that did by stating that the Bay Area is one of the most "LGBTQ+ friendly" places in the U.S. Thus, they mentioned anticipating that in many areas of the country the health care experiences of LGBTQ+ patients AFAB are far worse.

Experienced and anticipated stigma and discrimination

LGBTQ+ individuals AFAB reported experiencing and anticipating stigma and discrimination including, but not limited to, sexism, cissexism, heterosexism, and racism during health care encounters. Participant experiences also revealed the compounding and mutually constitutive nature of these systems of oppression as it related to their care seeking and the quality of their care experiences.

Sexism and the control of bodies assigned female at birth

Many participants described anticipating or having experienced sexism in health care settings, which they attributed to patriarchy and the ways that society attempts to silence, and control the bodies of, people AFAB. Several participants shared experiences during which providers assumed that participants wanted to carry biological children, an assumption rooted in heteropatriarchy and cisgenderism, which in two instances resulted in providers being hesitant to perform a hysterectomy aimed at reducing participants' menstruation-related pain. Moreover, for several participants of color seeking pain-related care, the control of bodies AFAB was intertwined with and exacerbated by racism enacted by providers. Indeed, several participants–all of whom were participants of color–said providers did not take their pain seriously, claiming that participants were exaggerating their pain levels. In other cases, participants, who also mentioned the challenges of articulating symptoms while actively in pain, recalled underplaying or self-censoring their responses when asked about their pain. For example, Finley, an Asian, nonbinary, pansexual individual, described understating their pelvic pain in clinical interactions:

> When you go to the doctor is not the time to hide your pain…but I would downplay it. Like, you know, they give you the chart, like in a pain meter, like, one to 10, 10 being' Oh, my God, I'm dying,' and one being like, 'I feel a little something.' Like, 'Where is this pain?' And I would be like, like a four or five. And realizing no, actually, I'm crawling out of bed barely to go get water. That's probably like a nine.

Finley and a few others attributed the underplaying of pain to stereotype threat and resultant social norms:

> I think part of the issue might be that the women themselves we're, we're used to downplaying everything, hiding our pain…If women complain it is all it is either dismissed–you're being hysterical, you're overreacting, it can't be that bad…we have just learned to deal with it.

Indeed, several participants also described the societal normalization of pain experienced during a Pap smear and during menstruation, noting the latter pain is typically silenced due to the stigma of menstruation.

Anticipated and experienced clinical interactions such as these led many to prefer seeing providers who were women, who participants characterized as better listeners, more trustworthy, and, for many, more able to relate to their sexual and reproductive health concerns. A few participants, including Brittney, an Asian lesbian woman, added that the tendency for men to talk down to women also informed their provider preferences:

> I also feel like men even without saying something, like even without consciously doing it…just think that they know more than women in general. So, I think that doubled with like being a doctor…I would trust a female doctor to be more trusting.

As Shan, a White, bisexual, cisgender woman, summarized, “Even just being someone with a uterus…immediately…throws up a lot of barriers in the health care system.”

Cissexism, heterosexism, and the definition of “sex”

Participant experiences called attention to the ways that most sexual health care–especially sexual history taking–assumes heterosexuality, sexual monogamy, and penis-in-vagina penetrative sex. In other words, these are the–notably, cissexist–norms to which patients are assumed to adhere unless they disclose otherwise. These assumptions were often built into the ways that providers asked and reacted to participants’ responses to sexual history questions. For example, Tracy, a queer, Asian woman, shared:

> it's like you tell a provider that you are sexually active, and then no, you're not using contraceptives. But then they look at you funny, and they're like, ‘why not?’ And you're like, ‘well, I'm queer, so that's why.’ But then they're like, ‘Oh, okay.’ And then they kind of…look at you differently, because you never really know what they think or how they feel about like treating a queer client…sometimes you tell them that, and then…there's a different, like, a definite shift in the aura of the room and the way they kind of just stop talking to you the same way or stop talking to you…it's like, when you give them their answer, they don't always want to know it.

As Tracy alludes to, many participants described that when providers ask about “sexual activity,” although the type of sex is unspecified, providers are referring specifically to penis-in-vagina sex, which many also described as the normative or societal definition of “sex”. Similar to Tracy, Brittney recalled:

> [the nurse asked] ‘Are you active?’ ‘Yeah.’ ‘Any chance you're pregnant?’ ‘No.’ Which then it was quiet, and I'm like, ‘Oh, yeah, it's like only women.’ And she's like, ‘Oh, okay. So you're a virgin.’ And I'm like, ‘I'm sorry. What?’ …she kind of argued with me too about it.

Thus, while the framing of and providers’ responses to sexual history questions reflect sexual norms, they also reproduce sexual stigma and reinforce heterosexism and cissexism, which are typically intimately interconnected in the framing of questions related to sexual behavior.

Additionally, those who fell outside assumptions of monogamous sexual activity often felt both invisible and stigmatized. For a few participants, navigating sexual history questions elicited anticipated stigma around being perceived by providers as “risky” or “dirty” due to not being sexually monogamous. Shan conveyed her hesitation divulging her non-monogamous sexual behaviors to providers:

> I'm pretty new to polyamory and I'm concerned about how that's going to... I haven't had to deal with it yet, but I'm pretty concerned about how that's going to be like ‘oh I have multiple...’ Like having to let them know I have multiple partners is going to impact how I am perceived by health care providers…The hesitation is largely because I think polyamory and other kinds of consensual non-monogamy are widely, widely misunderstood…this is going back to stereotypes, there’s this idea that you're probably gross and diseased riddled or something and that even goes into stigma around STDs.

Furthermore, a few participants, particularly those who identified on the asexual spectrum, expressed frustration that providers often approach sexual histories with an inherent assumption that patients are sexually active, which, participants noted, reproduces the pathologization and stigmatization of asexuality.

For trans and nonbinary participants and participants with trans and nonbinary partners, the cissexist nature of sexual history questions was particularly apparent and impactful. Shan recounted how she has responded when providers “ask…if your partner is man or woman”:

> I wish they would change that question to something more inclusive, because I have a gender-fluid partner and a trans-femme leaning nonbinary partner, and it's kind of like how do I even articulate that to a person who just asked me ‘is your partner a man or a woman’?...It's so hard to figure out what kind of information they would even need to know…Sometimes I feel like the only thing they would really need to know is whether or not I have a partner that could get me pregnant. And like, I wish they would kind of just ask that! But the way they ask the question brings up a whole slew of weirdness that they don't necessarily need to know…I think my most recent response was something like, ‘my partners assigned male at birth but they have had some type of surgery that means that they can't get me pregnant, if that's what the relevant part is.’…I mean it's just really frustrating because the questions are so terrible, so sometimes I respond in a way to try to bring up the fact that it's like, ‘You realize you didn't ask me the most relevant question, right?’

Indeed, many participants tied their sexual history experiences to experiences receiving counseling and/or services they felt were not applicable to them, such as being asked to take a pregnancy test even after having disclosed that they have not had penetrative sex with a sperm-producing individual and, therefore, are not at risk of pregnancy.

Participants overwhelmingly described the harm of the typical standardization of sexual history questions, or as Freida, a bisexual, cisgender Latina woman described them, “cookie cutter…assumed gender norms or sexual gender norms.” In contrast, in a few cases providers asked participants about which body parts they use during sexual encounters, which participants appreciated because this framing moved away from assumptions that body parts (and pregnancy risk) are associated with a particular sex or gender(s). Likewise, many participants who critiqued their prior health care experiences suggested providers ask questions centered around the information that they need (e.g., engagement in sex with a sperm-producing person) and better tailor their sexual history questions to individual patients rather than using standardized questions about sexual behavior.

Racism

All three Black participants, several Latinx participants, and a few Asian participants reported experiencing racism or shared experiences they wondered whether occurred due to racism, which were compounded due to sexism. Most common were racist beliefs and assumptions that Black and Latina women are sexually promiscuous and, in turn, put themselves at risk of unintended pregnancy. Additionally, as previously mentioned, several participants of color felt their pelvic pain was dismissed by providers.

Moreover, experiences of racism in health care settings were often intertwined with the stigmatization of being a low-income and/or publicly insured person, with all three Black participants having spoken about the challenges this posed to accessing care. For example, Meg, a Black, bisexual woman, shared:

> I don't feel like I was discriminated for being bisexual within the health care industry. I feel like I'm being discriminated against because of the kind of health insurance I have. And because of my socioeconomic status and my race…I think people who are poor, or who have MediCal, no matter what race they are are treated bad…people with private health insurance get treated better, regardless of what race they are. But I think that my bad [health care] experiences…has been because of what kind of health insurance I have, on top of the fact of my socioeconomic status. And, you know, Black women, we just get treated bad period. I mean, that's just, you know, how it goes…you just get used to being treated bad when you're a Black woman, you know. We have to live our lives differently than other races of people, because we're a Black woman…you just get used to being treated bad. And dealing with racism everywhere you go…I don't trust the government, …the government, and the United States healthcare system has, you know, done some very inhumane and unequitable things to people of color and Black people in the healthcare system…So I just, you know, I just mistrust the United States healthcare system. It's racist. And it just doesn't benefit us.

Meg and several others conveyed how not only their personal health care experiences but the healthcare and researchers' abuse of people of color–past and present–has resulted in a profound distrust of medicine and health care providers, exacerbated by the lack of providers who are women of color. In contrast, several Asian participants who described not having encountered racism in health care settings attributed this to living in the Bay Area, where Asian populations comprise a larger percentage of the population than in many other areas of the U.S. and where there are a significant number of Asian health care providers.

Several White participants acknowledged the privilege that whiteness grants them in health care settings. Reflecting on her experiences, Shan commented, "damn, if I get this much shit as a White person, I can't imagine what other people go through." Similarly, several Latinx participants noted that they believed having a lighter skin tone granted them greater privilege in health care settings compared to most of their peers.

Other forms of stigma and discrimination

A few participants were frustrated that rather than attending to their care needs, providers shifted the focus of their appointments to their weight. This led participants to avoid seeking care, made them less trusting of health care providers, and negatively impacted their mental health. In contrast, Adrienne, a White, queer, gender nonconforming individual shared that at one point they had “a doctor who was bigger as well, for the first time, which was like crazy to [them]. And it was just really validating.” Indeed, while this seemed to be Adrienne’s singularly affirming care experience, when asked what qualities in ideal health provider, Adrienne responded, “a doctor who's fat friendly. That would be great. I don't think a fat friendly doctor exists, but like, a doctor who won't like won’t be like, ‘oh, you're awful,’ you know?”

Further, a few participants reported that stigma related to mental health and substance use shaped their care experiences. For example, Brittney, reported:

> I have bipolar disorder…I think that has kind of, like, hurt my trust in doctors…I'm a little bit wary of doctors. And I also worry that, seeing that on my chart, and also seeing like, a past of like, drug abuse. I, um, yeah, I worry that like, they'll worry that I'm like making stuff up, especially for drugs. So that is not, like, the greatest thing…I have medication. I'm not prescribed to take every day it’s as needed. But you know what's happening is that I need it every day. I can't take it, I can't take it every day because if I tell my psychiatrist, then he'll be like, ‘Oh, you just want more, you just want to do drugs.’ Which like, yes, I want to do drugs for my health, not recreationally.

Participants with mental health and/or substance use diagnoses in their medical charts both anticipated and experienced stigma and discrimination particularly when engaging with providers with whom they had built less of a rapport.

Structural factors influencing care access

Participants described two categories of structural factors influencing their utilization of sexual health and gender affirming care services: 1) resource-related constraints and 2) forms of structural discrimination. Resource-related constraints–which included cost, health insurance-related factors, and time during clinical encounters–underscored the fact that merely having health insurance does not guarantee quality health care access. Forms of structural discrimination included gatekeeping and lack of insurance coverage of gender affirming care, cissexist sexual and reproductive health care, limited access to providers knowledgeable about LGBTQ+ health, and limited access to LGBTQ+ providers and/or providers of color.

Resource-related constraints

Cost and insurance

Participants often reported that cost and insurance-related factors influenced how often and for what services they sought health care. Nearly all were insured at the time of their interview–two were uninsured–but participants commonly reported that their health insurance status, including whether they were insured and their type of health insurance, had changed over time. The extent to which cost was a barrier to care varied depending on insurance coverage type and individuals' access to financial resources. For example, Avery, an Asian lesbian woman, reflected on privilege and the differential impact of cost on care seeking:

> class & socioeconomic status are heavy factors in one's experience and access…even as an insured person, my copays are quite high, and that…sometimes dissuades me from seeing a doctor. I imagine this sentiment is stronger for folks who are uninsured or underinsured as a result of class/income level.

Participants also discussed barriers posed by navigating the patchwork nature of U.S. health insurance, which often requires that people take the initiative to identify in-network providers and presents challenges for patients trying to gauge out-of-pocket cost estimates. Because health insurance is commonly tied to employment, several participants described having limited ability to stay with the same health care provider(s). Moreover, many described challenges they encountered when trying to identify providers, such as insurance search systems yielding out of date results of in-network providers, which led some to keep their current provider even though they were unsatisfied with the care they were receiving. In contrast, some participants who felt their insurance provider had a clear, easy to access system in place for enrollees to select and change their provider(s) were easily able to search for and switch providers until they found one matching their needs. Furthermore, several participants described experiences trying to identify whether or not certain services, such as abortion-related care, were covered and what their out-of-pocket costs would be.

Finally, several described, based on first or second-hand experience, that uninsured and publicly insured populations often have limited care options and navigating care can be especially challenging due to added bureaucratic barriers. Additionally, because these care options are often overburdened, care may not be available when patients need it. However, Grant's (mixed race, gay, trans man) experience at a clinic providing specialized LGBTQ+ health services, demonstrated how clinic programs and practices can help mitigate these structural barriers:

> they [community health clinic] helped me like get my health insurance together 'cause I was uninsured for a long time and they were just like, you don't have to do that. We can help you apply for Medi-Cal and stuff. So overall they're the greatest. They're number one, as far as I know.

While cost and insurance are by no means barriers unique to LGBTQ+ populations, as I later demonstrate, the implications of these barriers are heightened for LGBTQ+ people AFAB and other socially stigmatized populations.

Time during clinical encounters

In sharing their health care experiences, most participants highlighted that the limited amount of time allotted for each medical appointment negatively impacts the quality of their health care. Similar to many other participants, Finley characterized this as a structural issue resulting from the nature of traditional biomedical care in the U.S. at present day rather than placing blame on individual providers:

> I can't blame the medical professionals who didn't help me. Because I think, and maybe I'm giving them too much credit, but I honestly feel that their hands are tied, the way the medical system is in the U.S., currently, the way it's run…The medical system, the way the insurances work here, it's not set up for anybody's benefit except the insurance company. They make it extremely difficult for the patients to get the care and also for the professionals to do their job…They're on this appointment book where they have to, they only get one question, one symptom they get to look at, and then they have to go to the next appointment, right? And it's a systemic flaw…And then there's mistrust from the patients with doctor and yeah. So. And I honestly don't think it has to be that way. But being in a capitalist society, I don't see how that's going to change. The only way that will change is if there are regulations in place to allow those changes.

Alluding to U.S. healthcare as a capitalist institution that aims to maximize the number of patients seen in a given time span, Finley also gestures to the negative impact of limited time during clinical encounters on patient-provider relationships.

In contrast, those who felt their providers intentionally made an effort to get to know them by, for example, asking non-health-related (e.g., employment, family) questions spoke much more highly of their care experiences and their providers. Grant summarized what he and several others felt was an important distinction between individual providers and healthcare as an institution:

> I don't trust the [healthcare] system…I don't believe that it's set up in a way to facilitate actual healthcare because it's limited to, whoever's able to access it. Um, which completely destroys the point of health care…but what I do have, uh, any sort of belief in is people…I believe that there are people who enter into the medical field and the healthcare profession with the sole intent to provide care to as many people as they can. So, I believe in people, I don't believe in the systems.

Indeed, given the near omnipresence of these constraints in U.S. clinics, it is impossible to know how individual provider behaviors would be different were time constraints not in place, but it was clear that some resisted existing time constraints. While limited time is also not a barrier specific to LGBTQ+ patients AFAB, participant experiences highlighted how, similar to cost and insurance, the implications of this constraint are heightened for LGBTQ+ people AFAB.

Structural discrimination

Gatekeeping and insurance coverage of gender affirming care

Several trans and nonbinary participants shared their experiences seeking gender affirming care, including their experiences navigating health insurance and trying to secure coverage of services. In some cases, participants spoke of the hurdles and time delays that they encountered but ultimately were able to obtain coverage for gender affirming services. Angel, a nonbinary, transmasculine, queer Latino, shared, "I was able to get [top surgery] but it was one year for the approval and then like a seven month wait until having it." However, in other cases participants remained unable to secure insurance coverage despite significant time, energy, and, often, emotional investments. For example, Fern, a White, queer, nonbinary individual shared how they approached securing insurance approval for and scheduling their top surgery:

> I initially went to like a regular plastic surgeon to try and talk about getting a reduction so that I could just like, maybe if I made them smaller….but I could still at least look like a woman, so people wouldn't be upset with me or whatever, like, I wouldn't be weird, I would just be smaller. But that wouldn't really make me happy. But it would be like a compromise between what I want and what the world wants…I got approved for that, like insurance approval and everything to do that. But then I lost that insurance and had to like, get new insurance. And…by that point that I was starting to think that like no, I really don't want to compromise anymore. Like the whole point is not to compromise who I am anymore. Now I've gotten a surgery consult to actually have like the whole top surgery where they're just gone. And scheduled for next summer.

When Fern approached their new insurance about covering breast removal rather than breast reduction, insurance denied their request because they did not fit insurance criteria for gender affirming top surgery. As Fern described:

> Insurance in a letter was like, you know, didn't satisfy this criteria and didn't satisfy this criteria. But one of the criteria was like, does not want to live full time as a man. I was like, no, I don't. I don't want to live full time as a man, that's not my goal. But I still don't

> want these breasts anymore. But it was just this whole like, there has to be basically greater events of suffering to get insurance to cover it, you know, and it's like well, I'm not like suffering, suffering. I'm 39, I've made it this far. I'm not suicidal about having breasts, but I'm not happy with them. So, is that not enough suffering for you?

While Fern's insurance plan covered gender affirming top surgery, it was only covered in certain cases, exemplifying the gatekeeping role that insurance plays in trans and nonbinary people accessing gender affirming care. Specifically, Fern's story highlights the re-entrenchment of the gender binary in, and transphobic nature of, insurance coverage policies, as insurance required that Fern "want to live full time as a man" in order to cover the surgery.

Fern also called attention to the double standard that they encountered in terms of insurance coverage of breast surgery:

> And also, like, it was weird that the insurance of like, 'well, if you're, if you're a woman, you could have your breasts reduced as long as you still make sure that, you still promise to have them. But like, if you want them gone, then that's like weird and we can't possibly do that.'

While insurance had been willing to cover surgery for breast *reduction*, they were unwilling to cover surgery for breast *removal*, unless there was a medical necessity (excluding gender affirming care) for doing so. In fact, upon mentioning that they recently found a lump in their breast, Fern added, "I'm supposed to be like this is terrible. But in fact, it would be really convenient…it was weird to be like, I almost want there to be something because that would solve my problem." In addition to insurance, several trans and nonbinary participants described the gatekeeping they encountered from providers when trying to obtain gender affirming services, such as being denied requests to alter their testosterone regimen due to a provider's concern that the participant was abusing the hormones.

Cissexist sexual and reproductive health care

Many trans and nonbinary participants, as well as a few cisgender participants, described the unnecessary gendering of, and cissexism built into, sexual health care. While some had sought sexual health care from community-based clinics and clinics specializing in LGBTQ+ health, most participants had sought care from an obstetrics and gynecology (OB/GYN) clinic at some point in their lifetime. Comments made by Fern summarize feelings expressed by many trans and nonbinary participants:

> that whole OB/GYN world is set up for straight, cis women. And there's not– there's nowhere on any forms indicate if you're not. No doctors have, or no OB/GYN– no one in any of that context has ever asked. It's just, it's presumed that if you're at the women's health clinic, that you are a straight White woman…

Trans and nonbinary participants described the ways that OB/GYN offices, in particular, are designed to serve White, cisgender, heterosexual women and can often cause dissociation for trans and nonbinary patients. In some cases these feelings were exacerbated by providers using participants' incorrect names and/or pronouns.

Further, some expressed having internalized stigma about being in an extremely gendered space surrounded predominantly by cisgender patients. Bryan, a White bisexual trans man, shared how he typically feels waiting for his appointments:

> it is quite uncomfortable to sit in a waiting room of an OB/GYN's office when you are the solo dude. It is uncomfortable. Especially when they call you back there by yourself. You get looked at…don't look at me funny. I'm okay. I'm supposed to be here. But no, most the time, dude, like when you go and the only guys you see are with their pregnant partners. So it, it gets- it's a little uncomfortable to sit there by myself and wait to be called. But I don't know that there's really anything you can do about that. Because that's more society, both on my end and outside like that. That is definitely me being uncomfortable with being in what's seen as a typically women's space. But I'm not a woman just because I happen to have some parts that coincide with women.

In contrast a few participants mentioned ways that OB/GYN clinics help normalize providing care to all and, in turn, improve the care experiences of trans and nonbinary patients. For example, William, a Chinese American, straight, trans man shared:

> after [hysterectomy] surgery I had to go for follow up…to get a pap smear…And throughout that experience was really good…And my even being self-conscious at a gynecology clinic, in the lobby I was self-conscious, but throughout the experience with the welcome desk, check in people, with this staff there, I didn't feel a single moment I was being rejected or not affirmed. Like it was just a natural health appointment… that it was just like any other appointment you would go to. And it was never about your gender identity or about- never about my identity or never about my body. I never got any weird stare or anything. It's, it's things that they didn't do in terms of discrimination…Nothing microaggressive in that nature…it just made me feel good about myself more like, yeah. Like they were being extra careful to make sure that I wasn't feeling left out, discriminated or feel any different. Like, I shouldn't feel any different, that's the way they approached it.

While, as William's story demonstrates, due to societal stigma and structural discrimination many trans and nonbinary patients feel uncomfortable when seeking sexual health care, there are concrete strategies that clinics and providers can use to mitigate this discomfort such as providing inclusive rather than gendered care and implementing provider trainings.

Limited access to knowledgeable providers

Most participants described health care providers as having limited knowledge about LGBTQ+ health which, in turn, informed participants' care seeking and care interactions. Many hoped to have and had intentionally sought out providers knowledgeable about LGBTQ+ health. However, participants noted that these providers are limited in number and challenging to identify, as traditional medical education curriculum does not prepare providers for how to provide quality care to and support LGBTQ+ patients. Notably, several participants contrasted their experiences searching for an "LGBTQ+ friendly" sexual health or primary care provider to their experiences searching for a therapist, noting that while it has become fairly easy to identify LGBTQ+ friendly therapists, the same is not true for other types of providers. Indeed, participants wished they could, for example, search for LGBTQ+ friendly providers via their insurance portal.

Access to LGBTQ+ providers and providers of color

In addition to most participants seeking care from providers who were women, participants commonly reported they would prefer LGBTQ+ providers, although many mentioned never having had a queer health care provider. Similar to many others, Lee, a queer, Asian participant, shared that they felt LGBTQ+ providers would be able to relate to their lived experiences:

> With healthcare providers now, I, I assume that they're not queer, and so I kind of think…there are just some things that I would *have* to explain that are also very *hard* to explain, but I think that like from one queer person to another queer person, it's like, you know, I don't have to go as *in depth* when I'm explaining something. And usually they'll say like, 'yeah, I've felt that, like, I know exactly what you're talking about.' And it's like this just, just kind of like, you know, um, innate thing that like, we've both been through most like 90% of the time, like most queer people have been through like kinda similar things. And so it's easier to just be like, I don't even have to talk about it, but you understand that this is a thing that is, um, significant or something that has happened.

Indeed, in a few cases participants had received care from an LGBTQ+ provider and shared how this improved their care experiences. Grant shared his experience receiving care from a clinic offering specialized LGBTQ+ health services:

> there were a lot of trans people who were working there, like the nurse practitioners, and um, like the people behind the desk and stuff. And…it just felt like it was a more, um, organic experience than it being so sterile and like clinical and being looked at like I was a science experiment kind of, cause I feel like that's- the times that I've seen, um, cis[gender] people…I can feel the weight of them trying to navigate trans people in healthcare. Whereas it doesn't feel that way when it's, you know, trans people helping other trans people. And just from what I see and like hear from my friends as well…their cis providers that it just doesn't feel as, um, it really just yeah ups the clinical sterile vibe. I don't like that.

Many trans and nonbinary participants, in particular, described the hurdles that having a cisgender care provider who does not share being a person of a stigmatized gender identity and who typically also has limited knowledge about trans health. In contrast, Grant's exceptional experience exemplifies how having a trans provider has the potential to help put trans and nonbinary patients at ease in the clinic.

Additionally, most, though not all, participants of color, as well as a few White participants reported preferring providers of color, who were described as more caring, personable, and relatable. For some, this meant having to prioritize which identity participants sought out in providers. For example, Alexandra, a gay Latina woman, shared:

> I wanted like a health care provider…who was a woman. It was really important to me, especially because I, I knew that I was going to have to get like a Pap smear...it's always been a woman that made me feel safer. And also, I would always prefer a woman of color…the hierarchy was like, can I get a woman to like assist me? And if it's not a woman, can I get like a person of color to assist me?

Alexandra, who described having attended a free clinic where she felt "immediately comfortable" because all of the providers were women and/or people of color, went on to describe the lack of providers of color and providers who are women and, especially, providers who are women of color as a structural issue:

> I think also a part of me, being in like, a very privileged place like [university] has made me realize like how hard it is for like a woman and a person of color or both to, to get to like an advanced degree or to get to like a really great respected profession…I want to reward them by like giving them like my services by, I don't know, by supporting them in that sense. Especially because I feel like also in medicine and dentistry like I don't know, like, I can't think of anyone in like, growing up who, who I know, that is a person of color specifically who went into that field. When I think back, I think of like, all of like my White high school friends who did.

Indeed, several participants recommended that clinics prioritize hiring and, importantly, supporting, LGBTQ+ providers and providers of color in order to better support LGBTQ+ and patients of color.

Implications of barriers

Participants described several implications of the aforementioned factors in their care seeking behaviors and the quality of the care that they received. Implications related to misinformation, mental health and well-being, delays and avoidance of care, limited patient-provider trust, and medical mistrust.

Misinformation

In several cases, limited provider knowledge about LGBTQ+ health led to providers relaying false or misleading information to participants which, in some instances, led to their delaying or avoiding sexual health-related services. For example, Brittney shared:

> even my own doctor, my primary care physician, he told me…it's really unlikely that I'll get an STD. I'm having sex with like, cis[gender] women…And he said like– he said the illness that causes cervical cancer is often transmitted through men.

Misinformation results from cissexism and heterosexism–which contribute to the lack of LGBTQ+ health training among providers. Misinformation, in turn, is a form of cissexism and heterosexism which contributes to the reproduction of sexual health inequalities among LGBTQ+ people AFAB.

Mental health and well-being

Experiences of both interpersonal and structural discrimination negatively impacted many participants', particularly trans and nonbinary participants', mental health and well-being. For example, Fern emphasized the implications of transphobic policies on trans and nonbinary people's well-being and the ways in which the suffering of trans people is normalized:

> the medical community, or at least the insurers especially, like, they don't want to do anything unless you're sufficiently suffering enough…when I actually think about, like, the trans people that I know, a lot of them are like, perfectly happy, they're not suffering, now that they've transitioned…like they were suffering when they were forced *not* to be trans. And the suffering comes from pressure to not be and then when you just go ahead and transition and you get the care that you need, then you don't suffer anymore, and you

> actually are happy. And so I think there's this way that the medical community sees nonbinary and trans people as like, necessarily suffering and miserable. But it's not. They're not suffering because of who they are. They're suffering because of how hard this society makes it for them to be who they are, and how hard the medical community like gatekeeps access to these things, access to appropriate care…and it's like, well, if you didn't make it so hard, we wouldn't have to be like, absolutely suffering and miserable and suicidal in order to qualify for treatment.

As Fern notes, suffering among trans and nonbinary people results from transphobia and, particularly, structural discrimination that, through various mechanisms including gatekeeping (e.g., requiring referrals) and insurance coverage denial of gender affirming services, perpetuates the suffering of trans and nonbinary people seeking gender affirming care by restricting access to services. Several participants also mentioned experiences of feeling invisible because their identities–typically gender but sometimes also sexual orientation–were not recognized in clinical settings. This occurred due to lack of information collection and/or providers not recognizing and affirming participants' identities, names, and/or pronouns and, in turn, could have significant impacts on patients' mental health and/or care seeking behaviors.

Further, for some anticipated cissexism in clinical settings resulted in participants' lying about their gender identity or avoiding care in order to avoid the negative mental health effects of experiencing cissexism. Grant described how anticipated heterosexism and cissexism shaped his care seeking:

> they [health care providers] need to be more informed on the fact that there is, there's more than two genders. There's more than fucking three or four sexualities. There's so many different types of ways, ways to be. And like the sooner that people who aren't with the shit in the health care system get with the shit, then it's going to facilitate people being able to be themselves. And without having to be afraid of what kind of care they're going to receive or not receive, because that's it, I mean, it's like, for me, I didn't want to, I didn't want to deal with trying to live because I didn't feel like I was going to get the care I needed to live until I found it. And now I'm living, now I'm **living.** I can say that I'm alive and I'm not just like waking up every morning waiting to get drunk so I can get a move on dying, you know?

Thus, for some, the potential benefit of seeking care was, at least under certain circumstances, outweighed by anticipated oppression in clinical spaces.

Delays and avoidance of care

As alluded to in many of the aforementioned examples, many participants reported delaying or avoiding seeking health care, particularly preventive care, as a result of resource-related barriers to care and anticipated and experienced discrimination in health care settings. For example, Adrienne, who described being concerned about experiencing fatism, but not heterosexism, based on their previous clinical experiences shared:

> I threw out my back earlier this summer…I like couldn't move for like a week. It was so bad that I was like, if I go they're just gonna call me fat and they're going to tell me that I just need to lose weight or else this is going to happen again. I already know it…that's basically what happened…I just don't like going because I already know what they're gonna say.

For many, delays and avoidance of care, especially sexual health care, were intertwined with the limited trust many had of their health care providers, as described below. For example, Emily, a questioning Latinx immigrant, described her doctor being a “stranger” who would be looking at “a private area” as contributing to her avoidance of her first Pap smear. Further, those who reported having experienced multiple forms of stigma and discrimination in health care described how this uniquely informed their continued avoidance of care. Papi, a queer, Chicanx, genderfluid individual who was currently avoiding OB/GYN (obstetrics and gynecology) offices after several negative sexual health care experiences, Papi reflected on if and, if so, when they would resume seeking care from an OB/GYN:

> I would have to just…put my foot out there and try it. But I've been okay right now, haven't had any issues. So hopefully, things just stay that way. And maybe, maybe once I feel more rooted, I'll be able to start getting regular services like checkups…I was even thinking to do maybe like [a specific community health clinic aimed at providing culturally appropriate care], but I was like, how gay are they?

While Papi was considering this specific clinic due to it being known as a provider of culturally appropriate care, mostly to low-income patients and patients of color, Papi was still hesitant that the clinic might not *also* be knowledgeable about LGBTQ+ health and openly accepting of queer patients. For now, they were appreciative that lately they had remained healthy and thus not felt compelled to seek sexual health services.

Limited patient-provider trust

Anticipated and experienced interpersonal discrimination in clinical settings and structural discrimination limited many participants' trust in their health care provider(s). This, in turn and exacerbated by participants' limited time with their providers due to limited appointment lengths and care discontinuity, limited the amount of information some participants shared with their providers. For example, Freida commented:

> I think just reminding people not to be so rushed. I think that…would be a lot easier to talk to my doctor about my sexual needs, and, you know, things like I would have questions about and…things like that I think if I didn't feel like I was just being like, pushed in and pushed out that I would be more comfortable opening up to my doctor about.

For many participants, lack of patient-provider trust both contributed to and was exacerbated by a lack of having a usual provider and consulting with them regularly. Lack of consistent care resulted from a range of factors including anticipated and experienced discrimination, infrequently seeking care, relocating, as well as structural factors (e.g., lack of a stable job, lack of stable insurance). As a result, many participants had providers who had limited knowledge about their health history and, importantly, with whom they had limited rapport and trust. Participants associated these situations with their being less likely to disclose information and having a reduced willingness to openly and honestly communicate with their provider(s), which is at odds with feeling safe, able to be their authentic selves, and receiving affirming care, which respondents cited as qualities they sought in their care experiences. Indeed, many participants spoke of the importance of patients openly discussing their sexual health–including being honest about their behaviors and feeling comfortable asking any questions–with their providers and of their providers being aware patients are LGBTQ+, at least in the context of sexual health. However, many participants reported not disclosing this to their provider due to lack of established patient-provider relationships built on trust, anticipated discrimination, and discomfort.

As a few participants noted, lack of disclosure, in turn, further hindered their relationship with their provider. Lee, a queer Asian participant who reported presenting as a woman in healthcare settings, commented:

> I don't even know if I would like really feel comfortable…like going through like the whole discussion [about my gender identity] with, with a doctor, like, especially if I were *just* meeting them, which is usually what happens…it [not disclosing gender identity] doesn't really affect my health necessarily, but it is something that's just, I guess like kind of a barrier between me and like my healthcare person.

Indeed, Lee noted that not only would they be more comfortable if they trusted their provider, but also "if I had a stronger relationship with a primary care doctor or if I knew like that person was queer, I probably would've brought it [transitioning] up at some point during a visit." Similar to Lee, many participants mentioned that they anticipated having a queer provider would enhance patient-provider relationships.

Participant experiences highlighted how the implications of the aforementioned barriers–including those experienced by the general population (e.g., insurance) and those unique to LGBTQ+ populations (e.g., heterosexism)–are heightened in the context of sexual health and gender affirming care. For example, Avery, shared how not having a regular relationship with a provider has contributed to her delaying care and feeling “out of place” and uncomfortable during sexual health care interactions:

> I think that if I had a regular doctor, um, that I had a relationship with and like was familiar with in some way, um, I would feel more at ease...I don't have a regular doctor, and I don't have a relationship with a doctor. So every time I go, it's some stranger who's asking me questions and you know, prodding me. And so like it, it just doesn't feel comfortable and then it's expensive. And so I, um, I feel like for me personally, like having it be less of a like cold and, and uh, unfamiliar experience would, would help.

Like Avery, many participants emphasized that lack of patient-provider trust particularly impacts sexual health and gender affirming care, as patients are in a state of heightened vulnerability during these consultations yet expected to divulge what many consider to be private information and, often, physically expose their genitalia (e.g., during a Pap smear) to people (i.e., providers) they may be meeting for the first time.

Experiences in which patient-provider trust was lacking outnumbered and contrasted to very consistent experiences that several participants mentioned having had when seeking care from a pediatrician during adolescence and the present-day experiences of select participants who had developed trusting relationships with their providers. Those who developed trusting relationships with providers trusted them with their care and were more willing to have open discussions. For example, Esther, a bisexual Latina woman who was pregnant at the time of her interview, noted of her OB/GYN, “I’ve seen her really advocate for me.” Participants characterized these providers as having tendencies that resist the tendencies of biomedicalization (Clarke et al. 2003), such as taking the time to ask about other aspects of patients’ health and lives. For a few trans and nonbinary patients who had developed such relationships with their providers, the invaluable nature of these relationships was especially clear. Bryan described:

> I've had my- I've pretty much had my care team be the same for about 4 years now. So, they know me. And they all, like, they all met me when my when I was beginning to transition. So they've seen me, they, they've grown with me, I guess. Having to find and

> explain it to someone new will be a– It's not something I look forward to. Because I know what's gonna happen at some point. I'm gonna move, I'm gonna have to– ugh, yeah. But I'm comfortable with people that I have now. I don't want to add anybody else. I don't want to have to change anything.

Participants' experiences also highlighted how the implications of the aforementioned barriers are heightened for patients of color, especially for Black and Latinx LGBTQ+ people of color. Due to anticipated and experienced oppression, including, but not limited to, racism and heterosexism, many Black and Latinx participants approached health care settings and providers with hesitation and medical mistrust. In contrast, the few participants who had developed a consistent, trusting relationship with their provider detailed the positive implications this had on their care experiences and, in turn, care seeking. For example, Meg, a Black, bisexual woman, shared:

> my OB/GYN is my favorite doctor…I have a really good gynecologist, even though she's not Black, but, you know, I'm just, you know, very, very comfortable sharing with her and talking about, you know, my body and sexuality and, you know, sexual issues or, you know, sexual history and, you know, being honest with her about it…because she's culturally competent…I've been going there for about 20 years. And I've had my current gynecologist for 10 years and the other one for 10 years. And she retired and I got the new one. But they're just awesome…how I started going with to them is because when I got pregnant with my son…they specialize in high-risk pregnancies and stuff…they know my whole situation and all my struggles. And, yes, it's like when I go there, it's like I'm talking with a friend. And it's like, we could talk about anything…And I never feel judged or anything…that's like the only doctor that I've had that I felt like that.

As Meg, who noted she "absolutely" talks about her sexual partners and being bisexual with her provider, and Bryan's stories suggest, while the most socially marginalized patients may experience more barriers to establishing quality, trusting patient-provider relationships, it is important to recognize that the costs of having to change providers are also highest for these patients.

Medical mistrust

In describing their care seeking behaviors, previous care experiences, and suggested changes to improve health care for LGBTQ+ people AFAB, several participants noted that, due to the U.S. healthcare system having been built on and continuing to engage in heterosexist, cissexist, and racist practices and uphold oppressive policies, they were uncertain they could ever fully trust healthcare. As Lee described:

> there's kind of little that a hospital can do to like really convince me that they would, um, understand, unless it was like a very long sustained, like very clear policy or something. Like, I feel like they would have to literally have pride flags around the office for like years before I would be like, oh, they would like genuinely care, like before then, like, like when I see pronoun forms and stuff …I'll put the pronouns down, but I don't think that they internally, I'm just kind of assuming that these people are- don't really, you know, understand it or see that in me. Um, they kind of just like, it's like this pre–precursor thing that they're obligated to do as like a very superficial of like, 'Hey…we're woke about gender' kinda thing… I don't have, um, that much faith in healthcare providers, um, as of right now…So, uh, yeah, I don't really know if they could, what changes they could make that would like really convince me to my core that it's like, 'oh yeah, they really get it.'

Participants who shared a similar sentiment likewise noted that while small changes such as creating a more inclusive clinic environment (e.g., LGBTQ+ representation in posters) is necessary, the superficial nature of these changes would be insufficient to convince them that they would receive quality, person-centered care free from bias and discrimination. Rather, significant structural changes coupled with sustained changes in their clinical encounters (i.e., interpersonal changes) would be necessary to mitigate medical mistrust and for participants to be open to trusting medicine and health care providers.

DISCUSSION

The present study identified a range of interpersonal and structural factors reflective of systems of oppression that jointly impact LGBTQ+ people AFAB's sexual health and gender affirming care seeking behaviors and care experiences with compounding effects. Some of these factors–such as cost and health insurance–are commonly reported barriers to care among the general population (Han, Call, Pintor et al. 2015, Montero, Kearney, Hamel et al. 2022), but the experiences of this sample of predominantly insured LGBTQ+ individuals highlight the particularly detrimental impact of the nature of U.S. healthcare and health insurance coverage, resultant from privatization of U.S. healthcare, on LGBTQ+ (Avila 2021) and other stigmatized communities. Specifically, the nature of U.S. healthcare poses cost and care navigation barriers, constrains patient selection of health care providers, and hinders patients' abilities to maintain relationships with the same providers (i.e., continuity of care), thereby hindering rapport and trust building between patients and providers. While, to my knowledge, little prior research has examined continuity of care among LGBTQ+ populations (Eiduson et al. 2021, Hoskin et al. 2016), continuity of care is associated with patient satisfaction (Saultz and Albedaiwi 2004) as well as improved health outcomes in the general population (Saultz and Lochner 2005, Van Walraven, Oake, Jennings et al. 2010).

Additionally, results suggest that regardless of health insurance status, heterosexism, cissexism, and racism along with other systems of oppression (e.g., classism, capitalism) at both the interpersonal and structural levels contribute to the (re-)production of existing health care, and social, inequalities (Bailey et al. 2017, Feagin and Bennefield 2014, Williams et al. 2019). For example, the lack of inclusivity in sexual history questions (Barbara, Quandt and Anderson 2001, Dean et al. 2016, Eiduson et al. 2021), gendering of sexual and reproductive health care (Eiduson et al. 2021, McDonald, McIntyre and Anderson 2003), lack of providers knowledgeable about LGBTQ+ health (Eiduson et al. 2021, Scherzer 2000) and who identify as LGBTQ (Hoskin et al. 2016) as well as provider assumptions about patients' sexual behavior (Barbara et al. 2001, Dean et al. 2016) exemplify heterosexist and cissexist practices in health care, which reflect cissexism and heterosexism in society in general. These findings demonstrate how the institution of medicine perpetuates the oppression of stigmatized populations such as LGBTQ+ people AFAB (Wilkerson 1994), including through shaping definitions of and norms related to sexuality and sex/gender (Paine 2018).

Similar to past studies (Hoskin et al. 2016), many participants reported delaying and avoiding care due to anticipated and experienced discrimination, which in turn is linked to poorer health outcomes among LGBTQ+ people AFAB (Everett and Mollborn 2014, Grant et al. 2011, Wagner, Kunkel, Asbury et al. 2016). However, their experiences particularly highlighted the impact of discrimination in healthcare–both historically and present-day–on patient-provider relationships. Consistent with prior studies of various subpopulations of LGBTQ+ people AFAB (Scherzer 2000), participants reported mistrust of biomedicine and providers and a lack of rapport with their providers, exacerbated by lack of continuity of care. This, in turn, impacted their care seeking, the quality of their care experiences, and their willingness to disclose their LGBTQ+ identity(ies) and/or sexual behaviors to providers. This is consistent with at least one prior study which similarly found that having a long-term relationship with a health care provider was associated with increased comfort in talking about sexual health and gender affirming care (Eiduson et al. 2021).

Further, findings demonstrate that LGBTQ+ people AFAB are subjected to multiple forms of discrimination simultaneously including, but not limited to, (cis)sexism, heterosexism, racism, fatism, and classism. The majority of participants reported experiencing stigma and discrimination due to being a person assigned female at birth as well as another form, in some cases multiple forms, of stigma and discrimination. For example, questions about sexual behavior are overwhelming centered around assumptions that patients are heterosexual (i.e., heterosexism) and cisgender (i.e., cissexism), which are intertwined and mutually reinforcing in the way that most providers talk about sex (e.g., the term “men” is used to refer to cisgender men). Notably, the care experiences of Black and some Latinx participants reflected the interdependent and mutually constitutive ways that racism intersects with heterosexism and classism to impact the sexual health and gender affirming care experiences of Black and Latinx LGBTQ+ people AFAB.

Limitations

There are several study limitations worth noting. This was a convenience sample comprised of individuals residing in the San Francisco Bay Area, nearly all of whom were currently enrolled in health insurance and had previously sought sexual health care. Therefore, the experiences upon which these findings are based reflect the lived realities of these individuals and may not reflect those of people living in other areas of the U.S., uninsured populations, or individuals who have not sought sexual health care. While I systematically asked participants whether or not they were currently insured, I did not systematically ask what type of insurance they had at the time of their interview(s). Therefore, the present analysis was limited in its ability to assess how type of coverage impacts care seeking and the care experiences of LGBTQ+ people AFAB, which is important given prior research shows that insurance type shapes access to and quality of health care (Han et al. 2015, Shi 2000). Additionally, while efforts were made to recruit a racially/ethnically diverse sample, only three Black respondents and no Native respondents were included in the sample. Moreover, due to COVID-19, recruitment was conducted primarily online and thus may have biased the sample to exclude those with no or limited online access. Finally, findings should be interpreted in light of the potential for recall bias.

Implications

As suggested by participants, healthcare institutions and providers can take a range of actions to combat stigma and discrimination and better support LGBTQ+ patients AFAB. For example, healthcare institutions can make their clinic environments more welcoming and inclusive, such as by displaying posters and other materials that incorporate multiple dimensions of diversity (e.g., race, sexual orientation) (Dean et al. 2016, DeMeester, Lopez, Moore et al. 2016). In addition to general LGBTQ+ health trainings (Bonvicini 2017, Dean et al. 2016), providers should receive training on how to provide more inclusive care and person-centered sexual history taking, specifically (Greene, Carpenter, Hendrick et al. 2019, Krempasky, Harris, Abern et al. 2020). Although there are mixed findings about short-term improvements in provider attitudes and knowledge resulting from trainings (e.g., Maina, Belton, Ginzberg et al. 2018, Morris, Cooper, Ramesh et al. 2019, Stroumsa, Shires, Richardson et al. 2019), evidence of longer-term change and change in actual provider behaviors is lacking (Hagiwara, Kron, Scerbo et al. 2020). Instead, cultural changes in the way that providers approach medicine, such as practicing cultural humility (Tervalon and Murray-Garcia 1998) and structural competency by, for example, reflecting on how historical context and structural factors inform and constrain patients' health care access, health, and behaviors (Metzl and Hansen 2014) are needed. This would better equip providers to provide tailored care that centers the needs and experiences of individual patients, especially those who are multiply stigmatized, in social context (Baig, Lopez, DeMeester et al. 2016, Chin, Lopez, Nathan et al. 2016, Tan, Xu, Lopez et al. 2016).

Findings point to the importance of patient-provider relationships built on trust to facilitate health care utilization and optimize patient care experiences. As re-highlighted by the COVID-19 pandemic, patient trust of the U.S. healthcare system is critical to facilitate health services use and advancing health equity (Griffith, Bergner, Fair et al. 2021). However, medical mistrust among socially stigmatized communities, including people of color and LGBTQ+ populations (Ho, Sheldon and Botelho 2022), persists due to historical and present-day structural inequalities and results in reduced care utilization and satisfaction (Jaiswal 2019, LaVeist, Isaac and Williams 2009). Trust is even more critical in vulnerable situations (Richmond, Boynton, Ozawa et al. 2022), as demonstrated by participants' emphasis on the importance of patient-provider trust in the contexts of sexual health and gender affirming care, specifically. As suggested by participants and prior literature, providers can foster quality, trusting patient-provider relationships by providing person-centered care in which patients have the maximum input possible (Downey and Gómez 2018, Ragosta, Obedin-Maliver, Fix et al. 2021), mirroring patient language, and developing ongoing, genuine relationships with patients.

However, trust lies not only at the hands of individual providers but also healthcare as an institution. Ongoing commitments to structural change within healthcare are needed to mitigate medical mistrust and foster patient-provider trust, such as holding individual employees and healthcare institutions accountable for systemic biases and discriminatory experiences, which requires that systems to track such incidents are in place and utilized as intended (Paton, Naidu, Wyatt et al. 2020). As suggested by many participants, efforts to hire, retain, and equitably treat a diverse workforce that includes LGBTQ+ providers and providers of color, ensuring diversity exists at all professional levels, as well as to change institutional norms and practices to not only avoid discrimination but better support both patients and providers of color and/or who are LGBTQ+, may also help facilitate patient-provider trust (DeMeester et al. 2016, Peek et al. 2016, Prather, Fuller, Jeffries IV et al. 2018). Further, clinics can establish equitable partnerships with trusted community-based organizations or, ideally, supporting local communities in creating new community-based clinics developed by and for the community to foster trust and comfort (DeMeester et al. 2016). Indeed, stigma and racism are fundamental causes of health (Hatzenbuehler, Phelan and Link 2013, Phelan and Link 2015), with the institution of medicine serving as merely one institution perpetuating associated oppressive ideologies. Thus, anti-oppressive interventions to radically change norms both inside and outside of healthcare are needed to truly achieve sexual health equity in which quality, person-centered, and structurally competent care is equitably provided to all.

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CHAPTER 3: Racial/ethnic and sexual orientation identity differences in receipt of a sexual history assessment from a medical care provider among U.S. women

ABSTRACT

Many studies have identified racial/ethnic and, increasingly, sexual orientation disparities in sexual health outcomes, but fewer studies have investigated the role that differences in health care provision, which may be driven in part by stereotypes, may play in these disparities. For example, differential sexual history assessment, whereby certain groups are more or less likely to be asked questions about their sexual activity, may lead to differential care provision and counseling. Using nationally representative data from the 2013-2019 waves of the National Survey of Family Growth, this study examined, among U.S. women aged 15-44 years (N=14,019), racial/ethnic and sexual orientation identity differences in receiving a sexual history assessment from a medical provider in the last 12 months. We found that, adjusting for survey wave, Black heterosexual, Latina heterosexual, White bisexual, Black bisexual, Latina bisexual, and Black or Latina bisexual women had higher odds of having received any sexual history assessment compared to White heterosexual women. However, findings varied by type of sexual history question asked. For example, adjusting for sociodemographic and health care factors, White lesbian and Black or Latina lesbian women had lower odds of being asked about condom use, while Black or Latina lesbian women had higher odds of being asked their sexual orientation or sex of sexual partners, compared to White heterosexual women. Notably, for four out of five sexual history outcomes assessed, Black bisexual women, about whom assumptions of promiscuity may be made based on both their race and sexual orientation, had the highest predicted probability of being asked by providers. Structurally competent, anti-oppressive

practices and programs aimed at combating provider bias and facilitating an inclusive clinic environment are needed in order to combat differential provision of health care services and promote sexual health equity.

INTRODUCTION

Past research has identified both racial/ethnic and sexual orientation identity disparities in sexual and reproductive health outcomes. For example, Black and Latina women are at increased risk of acquiring sexually transmitted infections (STIs) compared to White women (Centers for Disease Control and Prevention 2019), and bisexual women have higher STI rates compared to heterosexual women (Everett 2013). Notably, Black and Latina LGBQ women may experience particularly pronounced sexual and reproductive health disparities (Mojola and Everett 2012). The CDC along with numerous other organizations recommends that health care providers routinely conduct sexual history (or “sexual risk”) assessments with patients during health care visits to help control and prevent STIs (US Preventive Services Task Force 2020, Workowski and Bolan 2015). Such sexual history assessments include questions about behaviors that may increase STI risk, such as condom use, number of sexual partners, type(s) of sex (e.g., oral, anal, vaginal), and number of sexual partners. Responses to these questions can inform the clinical encounter by guiding STI testing and risk reduction counseling (US Preventive Services Task Force 2020), thereby tailoring care to the patient.

As a result, it is plausible that differential sexual history assessment, such as providers more consistently asking certain patients sexual history questions than other patients, may result in differential STI testing and/or health advice, which may, in turn, impact behaviors and use of preventive health services. Indeed, prior research shows that health care provider bias contributes to health disparities (Chapman, Kaatz and Carnes 2013, Dovidio and Fiske 2012, Hall, Chapman, Lee et al. 2015). In the context of sexual health, specifically, many studies have investigated racial/ethnic differences in contraceptive counseling and type of contraceptive use. However, fewer studies have investigated how provider bias and discrimination may contribute to sexual history taking. Given evidence that racist stereotypes impact provider decision-making about other clinical outcomes (Hall et al. 2015) and evidence that stereotypes about lesbian women result in providers less often recommending Pap testing (McIntyre, Szewchuk and Munro 2010), research into additional ways that provider bias contributes to sexual health disparities is warranted. Indeed, Copen (2018) found that Black and Latina women were more likely to receive a sexually history assessment than White women but found no statistically significant differences by sexual orientation. However, these findings were unadjusted for potential confounders such as age, only examined differences in receipt of *any* sexual history assessment, and examined race/ethnicity and sexual orientation identity separately.

To extend on this work, in the current study we conducted a multivariate analysis examining racial/ethnic and sexual orientation identity differences in receipt of a sexual history assessment *simultaneously*. Specifically, we used nationally representative data from the National Survey of Family Growth to investigate racial/ethnic and sexual orientation identity differences in having received a sexual history assessment from a health care provider in the last 12 months among U.S. women aged 15-44 years. We examined differences in having received any sexual history assessment and in having been asked about sexual orientation or sex of sexual partners, number of sexual partners, condom use, and types of sex. This study contributes to a limited but growing body of research that considers how provider bias might simultaneously reinforce multiple systems of oppression (e.g., racism, heterosexism), thereby most greatly impacting those most marginalized (Agénor, Bailey, Krieger et al. 2015, Bowleg 2012).

BACKGROUND

Racialized sexual stereotypes

Black and Latina women in the U.S. are often characterized as promiscuous and sexually available, stereotypes that function as a form of gendered racism (Rosenthal and Lobel 2020). The origins of these gendered and racialized stereotypes origins date back centuries (Hammonds 2004). For example, one of the most pervasive sexual archetypes associated with Black women, the Jezebel, who is depicted as seductive, manipulative, and sexually aggressive (West 1995), was used to justify the sexual exploitation of enslaved Black women by their White enslavers (Collins 2002). Thus, since their origins, these stereotypes have been tied to colonialism and the oppression of Black and Latina women (Collins 2002, Roberts 2017).

These stereotypes continue to have a powerful influence in society today (Collins 2002, Collins 2005). Although the Jezebel stereotype has evolved over time (Stephens and Phillips 2003), characterization of Black and Latina woman as hypersexual and seductive persists, particularly in popular media such as television and music videos. These stereotypes contribute to others' perceptions of Black and Latina woman, such as the assumption that Black and Latina women have more sexual partners, are less likely to use birth control, and are more likely to have children (Rosenthal and Lobel 2016), furthering racist sentiments. Moreover, these stereotypes may be reinforced by health disparities scholarship that characterizes Black and Latina women as "at risk" for higher rates of STIs and unintended pregnancy without contextualizing the role of structural racism in these statistics (Prather, Fuller, Marshall et al. 2016).

Stereotypes and racial discrimination in health care

Given racialized sexual stereotypes influence societal perceptions of Black and Latina women, health care providers' attitudes and behaviors are likely similarly influenced by these stereotypes, thereby leading to racism in health care provision. Indeed, studies have confirmed racial bias among health care providers (Hall et al. 2015, Maina, Belton, Ginzberg et al. 2018), consistent with Black and Latinx patient reports of discriminatory experiences within health care settings. In turn, health care provider bias contributes to health disparities (Chapman et al. 2013, Dovidio and Fiske 2012, Hall et al. 2015). For instance, studies have found racial bias is associated with poorer-patient provider communication, lower health care satisfaction, and less patient centered care (Maina et al. 2018). Though these findings are strongest for patient-provider interactions, there is also some evidence that implicit racial bias among providers is associated with clinical decision-making and treatment adherence (Hall et al. 2015).

In the context of sexual and reproductive health, it is important to recognize the historical context of medical experimentation and disenfranchisement that continues to shape the sexual and reproductive health of Black and Latina women in the U.S. (Prather, Fuller, Jeffries IV et al. 2018, Roberts 2017) as well as how discriminatory practices persist today, often in more covert forms. A robust body of literature has examined racial disparities in contraceptive methods and contraceptive counseling finding, for example, that Black and Latina women have higher odds of receiving contraceptive counseling, and Latina women of being counseled about sterilization in particular, compared to White women (Borrero, Schwarz, Creinin et al. 2009). In one recent study, young Black and Latina women reported feeling implicitly pressured when their providers seemed to favor a particular contraceptive (Gomez and Wapman 2017). This is consistent with increasing recognition that increasing use of long-acting reversible contraception among Black and Latina women is not consistent with a reproductive justice framework if intended to reduce rates of unintended pregnancy rather than fulfill women's reproductive desires (Gubrium, Mann, Borrero et al. 2016).

Despite this robust literature on contraceptive care, only a limited body of literature has examined providers' assumptions about sexual risk and potential racial biases in conducting sexual history assessments. However, studies that have done so have found results consistent with the hypothesis that racialized sexual stereotypes influence provider behaviors. For example, in one study of 326 Black women, over half reported having experienced providers making race-based assumptions about them, such as that they engage in "riskier" sexual behaviors like having multiple sexual partners (Thorburn and Bogart 2005). Additionally, Black adolescents are significantly more likely than White adolescents to have had a sexuality talk with their provider (Alexander, Fortenberry, Pollak et al. 2014), and one study found that providers had higher odds of testing Black and Latina women for chlamydia compared to White women (Wiehe, Rosenman, Wang et al. 2010).

Sexual stereotypes and beliefs about bisexual and lesbian women

Bisexuality is often tied to promiscuity, hypersexuality, and non-monogamy in popular discourses, which permeate not only U.S. society in general but also the LGBTQ+ community specifically (Hayfield, Clarke and Halliwell 2014, Klesse 2005). Indeed, studies have found that bisexual individuals are perceived as being more promiscuous (Spalding and Peplau 1997, Zivony and Saguy 2018), less likely to be monogamous (Zivony and Saguy 2018), and more likely to transmit STIs (Spalding and Peplau 1997) compared to heterosexual and lesbian women. Furthermore, sexual infidelity stereotypes are associated with perceptions that bisexual people are unreliable relationship partners (Feinstein, Dyar, Bhatia et al. 2014). Although endorsement of anti-bisexual prejudice or binegativity has been found to vary by demographic characteristics, studies have consistently found bisexual individuals are perceived more negatively than heterosexual and lesbian women (Dyar and Feinstein 2018). Finally, these stereotypes may be reinforced when sexual health literature and public health campaigns report that bisexual women are at increased risk of STIs without contextualizing the factors that place them at risk (e.g., binegativity) (Lee, Landrine, Martin et al. 2017).

In contrast, it is often assumed that lesbian women are at low risk of acquiring STIs (Workowski and Bolan 2015). Common beliefs that lead to this assumption are that lesbian women never have sex with men and that risk of STI transmission is not possible during sex between women. However, it is important not to confuse sexual orientation *identity* with sexual behavior: it is incorrect to assume that lesbian women only have sex with cisgender women unless they have explicitly disclosed that information. Likely as a result of these myths and the absence of lesbian women in sex education curricula (Elia and Eliason 2010), several studies have found that lesbian women do not perceive themselves to be at risk for STIs or cervical cancer and/or are uncertain of what types of sexual health care they should be seeking (McIntyre et al. 2010, Power, McNair and Carr 2009).

Sexual orientation-based discrimination in health care

Studies have found that medical students and clinicians have a bias in favor of heterosexual individuals (Leslie, Sawning, Shaw et al. 2018, Sabin, Riskind and Nosek 2015). Furthermore, studies have shown that providers who claim to treat patients equally regardless of sexual orientation exhibit negative attitudes and beliefs that likely contribute to health inequities (Nowaskie and Sowinski 2019, Patterson, Jabson Tree and Kamen 2019), consistent with LGBQ+ patient reports of discriminatory health care experiences. Fear of discrimination has been linked to delaying seeking preventive health care services among lesbian women (Tracy, Lydecker and Ireland 2010).

In the context of sexual and reproductive health care, some studies have found that many health care providers believe that lesbian women have a lower STI risk and lower need for Pap testing (McIntyre et al. 2010) compared to heterosexual women. These low risk perceptions could lead to lower rates of sexual history assessment by providers and utilization of preventative sexual health services among lesbian women, despite the fact that they are still at risk of STIs and cervical cancer. In contrast, higher STI rates among bisexual women and stereotypes about bisexuality could lead providers to assume high STI risk among this population.

Intersectionality, stereotypes, and sexual health

While the aforementioned scholarship on stereotypes and provider bias considers the way that two identity dimensions, gender and either race/ethnicity or sexual orientation, less research has examined how stereotypes and provider bias may be simultaneously shaped by all three dimensions given their links to systems of oppression. However, as suggested by intersectionality theory (Bowleg 2012, Collins and Bilge 2016) and a growing body of empirical work (e.g., Agénor et al. 2015, Mojola and Everett 2012, Stevens 1998), the sexual health of LGBTQ+ women of color may be adversely affected by multiple forms of discrimination, including sexism, racism, and heterosexism. Given what is known about racialized stereotypes of Black and Latina women and stereotypes and assumptions made about bisexual and lesbian women, Black and Latina bisexual women may be particularly likely to be stereotyped as “promiscuous” and therefore providers may be likely to assume they engage in “risky” sexual behaviors.

RESEARCH AIMS AND HYPOTHESES

We build on prior research examining health care provider bias by assessing whether there are differences in receiving a sexual history assessment from a health care provider in the last 12 months across racial/ethnic and sexual orientation subgroups (e.g., Black bisexual) of U.S. women aged 15-44 years. Based on the aforementioned literature and guided by intersectionality theory, we hypothesized that Black heterosexual, Latina heterosexual, Black bisexual, and Latina bisexual women would report higher odds, while White lesbian women would report lower odds, of having received a sexual history assessment compared to White heterosexual women. Further, we hypothesized a priori that Black and Latina bisexual women would report the highest odds of having received a sexual history assessment relative to all other racial/ethnic and sexual orientation identity subgroups.

METHODS

Data and study sample

We analyzed secondary data from U.S. women who participated in the 2013-2015, 2015-2017, and 2017-2019 waves of the National Survey of Family Growth (NSFG). NSFG is a cross-sectional survey that uses a multi-stage sampling design to select a national probability sample of civilian, noninstitutionalized women in the U.S. In 2013-2015, women aged 15-44 years were eligible to participate, while in 2015-2017 and 2017-2019 women aged 15-49 years were eligible to participate (National Center for Health Statistics 2018). Given this difference in age eligibility, we restricted our analytic sample to women aged 15-44 years at time of survey screening (n=16,008). Publicly available NSFG data includes the following racial/ethnic groups: Hispanic/Latina, non-Hispanic White, non-Hispanic Black, and multiracial or another race/ethnicity. Given the heterogeneity of the latter group (n=1,553; 10.5%), our sample includes only White, Black, and Latina respondents. For the same reason we also excluded those who responded “don’t know” or “something else” to the sexual orientation identity question (n=260; 1.5%). Finally, we excluded individuals with missing data for any of the variables included in these analyses (i.e., complete case analysis). Our final analytic sample included 14,019 women aged 15-44 years at time of screening.

Measures

Dependent variables: sexual history. The key outcomes of interest related to whether participants’ medical providers conducted a sexual history during a health care encounter in the last 12 months. All participants were asked the following four questions via audio-computer-assisted self-interviewing (ACASI): “In the last 12 months, has a doctor or other medical provider asked you about…1) Your sexual orientation or the sex of your sexual partners? 2) Your number of sexual partners? 3) Your use of condoms? 4) The types of sex you have, whether vaginal, oral, or anal?” Given these items do not comprise a standardized scale, we examined them in two ways: 1) individually (yes/no) and 2) any receipt of a sexual history assessment (i.e., responded *yes* to one or more of the four items; yes/no), consistent with the approach used by Copen (2018).

Independent variables: race/ethnicity and sexual orientation identity. Respondents separately self-reported their race (White, Black) and Hispanic/Latinx ethnicity, based on which NSFG categorized respondents into the following racial/ethnic groups based on 1997 OMB standards: non-Hispanic White (hereafter, White), non-Hispanic Black (hereafter, Black), and Hispanic (hereafter, Latina). Sexual orientation identity was assessed in 2013-2015 by asking respondents, “Do you think of yourself as: heterosexual or straight; homosexual, gay, or lesbian; or bisexual?” In 2015-2017 and 2017-2019, sexual orientation identity was assessed either using the aforementioned question or by asking respondents, “Which of the following best represents how you think of yourself?”, with response options including “lesbian or gay”, “straight, that is, not lesbian or gay”, “bisexual”, and “something else.” A random half of the 2015-2017 and 2017-2019 samples received one version of the sexual orientation identity question and the other half received the other version of the question. In all survey waves, participants could also respond “don’t know” or refuse to answer the sexual orientation identity question.

Based on these measures, we constructed a single variable to reflect racial/ethnic and sexual orientation identity subgroup (e.g., Latina bisexual). Per NSFG analytic guidance (National Center for Health Statistics 2018), Black and Latina lesbian women were combined into a single group in all presented analyses in order to ensure a minimum sample denominator of 100 cases. While this decision was consistent with our hypotheses, we also conducted all analyses with Black and Latina lesbian women included as two separate groups (results not presented) in order to ensure the groups were trending in the same direction for all outcomes.

Covariates. The categorization of covariates, which were selected a priori based on the scientific literature, is shown in Table 1. They included demographic factors (age, relationship status, nativity, and place of residence), socioeconomic factors (educational attainment, household federal poverty level, and employment status), and health care factors (health insurance status and usual source of care).

Analytic methods

We first assessed the unweighted count distribution and age-adjusted weighted percent distribution of all outcomes, predictors, and covariates overall and by racial/ethnic and sexual orientation identity subgroup among U.S. women aged 15-44 years. In order to account for the younger age distribution of bisexual and lesbian women, direct age standardization was performed using the 2010 U.S. Census for women (Aschengrau and Seage 2014, Howden and Meyer 2011). Then, we used logistic regression modeling to assess the association between racial/ethnic and sexual orientation identity subgroup and having received a sexual history assessment by a medical provider in the last 12 months. Separate nested logistic regression models were estimated for each of the four sexual history assessment questions (yes/no) and in relation to *any* receipt of a sexual history assessment in the last 12 months (yes/no). Model 1 included survey wave only to assess differences across racial/ethnic and sexual orientation identity subgroup adjusted for potential period effects only. Model 2 further adjusted for demographic factors: age, place of residence, nativity, and relationship status. Model 3 further adjusted for socioeconomic factors: educational attainment, household federal poverty level, and employment status. Model 4 further adjusted for health care factors: health insurance status and usual source of care. Finally, we used Stata's *margins* command to calculate average adjusted predictions in order to transform regression results into predicted probabilities.

Given NSFG respondents were not asked a separate question about whether in the last 12 months a medical care provider asked whether they were sexually active, it is possible that differences in sexual activity could contribute to observed differences in having received a sexual history assessment. Therefore, we also ran sensitivity analyses among sexually active women (N=11,460) to examine whether the pattern of results differed from that of analyses among all women aged 15-44 years. All analyses were adjusted for NSFG's complex survey design using the *svy* feature in Stata 16 (StataCorp LLC, College Station, TX).

RESULTS

Descriptive results

Age-adjusted descriptive characteristics of the sample of U.S. women aged 15-44 years are presented in Table 3.1. Consistent with our decision to age standardize sample characteristics, all bisexual and lesbian subgroups were younger than heterosexual subgroups. All racial/ethnic and sexual orientation identity subgroups, but particularly Black bisexual, White lesbian, and Black or Latina lesbian women, were less likely than White heterosexual women to be currently married to a male partner. Furthermore, all subgroups were less likely to live in a non-MSA and to have a Bachelor's degree or higher compared to White heterosexual women. All subgroups were also more likely to live below the household federal poverty level compared to White heterosexual women, though disparities in socioeconomic measures were particularly pronounced among Black bisexual women. Additionally, Latina heterosexual and bisexual women were more likely to be under- or uninsured and less likely to have a usual source of care compared to other racial/ethnic and sexual orientation identity subgroups, though all subgroups were at least slightly more likely to be uninsured or underinsured and less likely to have a usual source of care compared to White heterosexual women.

Overall, 45.1% of women received any sexual history assessment from a medical care provider in the last 12 months, ranging from 40.5% among White heterosexual women to 61.9% among Black bisexual women. The distributions also varied by sexual history question. While nearly a third of women had been asked about their number of sexual partners (30.4%) or condom use (32.7%) and nearly a quarter (24.5%) had been asked their sexual orientation or the sex of their sexual partners, less than a fifth (17.2%) had been asked about the types of sex they have. Moreover, the most endorsed item varied by sexual orientation identity. While heterosexual and bisexual subgroups most endorsed having been asked about condom use, the most endorsed item among lesbian subgroups was sexual orientation or sex of sexual partners. However, the second most endorsed item among all racial/ethnic and sexual orientation identity subgroups was number of sexual partners.

Table 3.1. Age-standardized[a] weighted characteristics of U.S. women aged 15-44 years by race/ethnicity and sexual orientation identity, National Survey of Family Growth 2013-2019 (N=14,019)

Variable	Total	White hetero. (n=6,146; 55.4%)	Black hetero. (n=2,789; 13.4%)	Latina hetero. (n=3,481; 20.9%)	White bisexual (n=660; 5.2%)	Black bisexual (n=290; 1.2%)	Latina bisexual (n=304; 1.7%)	White lesbian (n=166; 1.4%	Black or Latina lesbian (n=183; 0.9%)
Dependent measures									
Any sexual history assessment	45.1	40.5	54.9	49.0	48.5	61.9	52.8	43.9	52.9
Sexual orientation or sex of sexual partners	24.5	21.3	33.7	25.1	25.5	35.9	25.9	31.4	44.2
Number of sexual partners	30.4	27.1	37.1	34.8	31.1	48.3	33.9	21.1	26.5
Condom use	32.7	28.1	44.5	37.1	33.3	51.2	43.2	14.9	24.5
Type(s) of sex	17.2	13.3	25.9	20.1	20.6	35.8	21.8	10.9	19.5
Demographic measures									
Age (at time of interview, years)[b]									
15-19	15.5	13.7	14.6	17.3	22.8	23.7	28.1	16.2	19.7
20-29	34.7	33.0	36.1	33.4	45.1	45.3	47.3	39.2	44.5
30-39	33.8	35.6	33.6	33.5	25.6	23.0	18.6	33.5	28.6
40-45	15.9	17.6	15.7	15.8	6.5	8.1	6.0	11.1	7.2
Place of residence									
MSA, central city	33.2	24.5	44.3	45.1	33.6	52.1	45.5	37.3	54.4
MSA, other	49.8	53.6	41.9	47.0	47.3	38.7	50.4	44.9	38.7
Non-MSA	17.1	21.8	13.8	7.9	19.2	9.2	4.1	17.8	6.9
U.S. born									
Yes	87.6	96.1	90.6	59.2	99.2	92.6	86.1	96.9	81.4
No	12.4	3.9	9.4	40.8	0.8	7.4	13.9	3.1	18.6
Marital status									
Currently married to a male partner	36.2	42.7	19.8	36.5	25.0	6.1	26.4	4.4	1.7
Not currently married to a male partner	63.8	57.3	80.2	63.5	75.0	93.9	73.6	95.6	98.3

Variable	Total	White hetero. (n=6,146; 55.4%)	Black hetero. (n=2,789; 13.4%)	Latina hetero. (n=3,481; 20.9%)	White bisexual (n=660; 5.2%)	Black bisexual (n=290; 1.2%)	Latina bisexual (n=304; 1.7%)	White lesbian (n=166; 1.4%	Black or Latina lesbian (n=183; 0.9%)
Socioeconomic measures									
Educational attainment									
< High school degree	19.1	14.6	19.3	31.1	18.8	29.2	20.4	15.1	19.4
High school diploma/GED	23.0	20.2	28.0	25.4	22.8	34.5	32.8	29.4	27.0
Some college/Associate's degree	30.4	30.3	33.2	28.9	34.0	27.5	26.9	24.7	37.2
Bachelor's degree or higher	27.5	34.9	19.5	14.5	24.5	8.8	19.9	30.8	16.4
Household federal poverty level (%)									
< 100	25.6	18.4	36.5	36.3	24.8	42.9	29.4	24.0	35.7
100-199	22.5	18.6	26.3	28.6	28.5	29.1	25.7	15.7	22.3
200-299	16.8	18.0	16.0	15.4	17.6	13.9	12.4	14.0	15.1
≥ 300	35.0	45.0	21.3	19.7	29.0	14.1	32.5	46.4	27.0
Employment status									
Working for pay	68.9	71.0	70.5	63.6	65.5	57.9	69.3	73.0	74.4
Not working for pay	20.2	18.8	18.4	24.3	24.1	32.2	19.0	16.8	14.5
Student	10.9	10.3	11.1	12.1	10.3	9.9	11.8	10.2	11.1
Health care measures									
Health insurance status									
Private	61.6	72.8	50.5	43.4	54.2	32.5	49.5	70.3	52.2
Public	24.8	18.1	36.6	31.4	30.2	56.0	30.3	15.5	29.2
Uninsured or underinsured[c]	13.6	9.1	12.9	25.3	15.7	11.5	20.2	14.2	18.6
Usual source of care									
Yes	85.8	88.8	86.8	79.4	82.0	87.1	79.7	82.9	80.0
No	14.2	11.2	13.2	20.6	18.0	12.9	20.3	17.1	20.0

Note. hetero.: heterosexual, MSA: Metropolitan Statistical Area, GED: General Educational Development. Percentages may not add up to 100% due to rounding.

[a] Percent distributions for sexual orientation identity and racial/ethnic subgroups and age are not age-standardized.

[b] Women aged 15-44 years at time of screening were included in the analytic sample. However, some women had turned age 45 by the time of their interview.

[c] Underinsured refers to individuals enrolled in a single service plan or Indian Health Service only.

Regression results

Table 3.2 presents logistic regression results. Adjusting for survey wave only, Black heterosexual (OR=1.86; 95% CI: 1.64, 2.12), Latina heterosexual (OR=1.47; 95% CI: 1.26, 1.70), White bisexual (OR=1.69; 95% CI: 1.31, 2.18), Black bisexual (OR=2.71; 95% CI: 1.90, 3.87), Latina bisexual (OR=2.00; 95% CI: 1.41, 2.84), and Black or Latina lesbian (OR=1.58; 95% CI: 1.02, 2.46) women all had higher odds of having received any sexual history assessment compared to White heterosexual women (Table 3.2, Model 1). The difference between Black or Latina lesbian women and White heterosexual women was no longer significant after adjusting for demographic factors (Model 2). All other odds ratios were only slightly attenuated after adjusting for demographic factors and persisted after further adjusting for socioeconomic (Model 3) and health care factors (Model 4). Based on this fully adjusted model, the predicted probability of having received any sexual history assessment was highest among Black bisexual women (probability [pr]=0.586), followed by Black heterosexual (pr=0.529) and Latina bisexual (pr=0.522) women, while White heterosexual (pr=0.409) followed by White lesbian (pr=0.415) women had the lowest probability (Figure 3.1).

Specifically, all racial/ethnic and sexual orientation identity subgroups had higher odds of having been asked their sexual orientation or the sex of their sexual partners relative to White heterosexual women. Differences between White bisexual, Latina bisexual, and White lesbian compared to White heterosexual women were no longer significant after adjusting for demographic factors (Model 2). While the odds ratios comparing Black heterosexual (OR=1.68; 95% CI: 1.44, 1.95), Black bisexual (OR=1.96; 95% CI: 1.37, 2.79), and Black or Latina lesbian (OR=2.11; 95% CI: 1.31, 3.40) women to White heterosexual women were slightly attenuated after adjusting for demographic factors, the odds ratio for Latina heterosexual women was unchanged (OR=1.28; 95% CI: 1.08, 1.51). Further adjusting for socioeconomic and health care factors did not attenuate these differences: Black heterosexual (OR=1.67; 95% CI: 1.43, 1.94), Latina heterosexual (OR=1.32; 95% CI: 1.12, 1.56), Black bisexual (OR=1.95; 95% CI: 1.38, 2.76), and Black or Latina lesbian (OR=2.18; 95% CI: 1.37, 3.46) women had significantly higher odds of having been asked their sexual orientation or the sex of their sexual partners relative to White heterosexual women. Consistent with logistic regression results, based on our fully adjusted model Black or lesbian (pr=0.364) followed by Black bisexual (pr=0.341) women had the highest predicted probability of having been asked their sexual orientation or the sex of their sexual partners, while White heterosexual (pr=.214) followed by White bisexual (pr=.264) had the lowest probability (Figure 3.2).

Furthermore, adjusting for survey wave only, Black heterosexual (OR=1.66; 95% CI: 1.44, 1.92), Latina heterosexual (OR=1.49; 95% CI: 1.27, 1.75), White bisexual (OR=1.50; 95% CI: 1.18, 1.90), and Black bisexual (OR=2.69; 95% CI: 1.83, 3.96) women reported higher odds of having been asked their number of sexual partners compared to White heterosexual women. After adjusting for demographic characteristics, the difference between White bisexual and White heterosexual women was no longer significant, while differences between Black heterosexual, Latina heterosexual, and Black bisexual compared to White heterosexual women were slightly attenuated. These differences persisted after further adjusting for socioeconomic (Model 3) and health care (Model 4) factors. Predicted probabilities generated based on our fully adjusted model showed that Black bisexual (pr=0.434) followed by Black (pr=0.350) and Latina heterosexual (pr=0.350) women had the highest predicted probability, while White (pr=0.198) followed by Black or Latina (pr=0.215) lesbian women had the lowest predicted probability, of having been asked their number of sexual partners.

Table 3.2. Adjusted odds of receiving a sexual history assessment from a medical care provider in the last 12 months by race/ethnicity and sexual orientation identity among U.S. women aged 15-44 years (N=14,019)

Outcome	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Any sexual history assessment[a]				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**1.86 (1.64, 2.12)**	**1.62 (1.43, 1.84)**	**1.69 (1.48, 1.92)**	**1.67 (1.47, 1.90)**
Latina heterosexual	**1.47 (1.26, 1.70)**	**1.29 (1.12, 1.48)**	**1.40 (1.21, 1.61)**	**1.43 (1.24, 1.65)**
White bisexual	**1.69 (1.31, 2.18)**	**1.37 (1.05, 1.78)**	**1.41 (1.09, 1.83)**	**1.44 (1.11, 1.88)**
Black bisexual	**2.71 (1.90, 3.87)**	**2.01 (1.41, 2.85)**	**2.20 (1.55, 3.13)**	**2.14 (1.51, 3.04)**
Latina bisexual	**2.00 (1.41, 2.84)**	**1.45 (1.01, 2.09)**	**1.54 (1.06, 2.23)**	**1.62 (1.12, 2.36)**
White lesbian	1.22 (0.82, 1.83)	0.98 (0.65, 1.48)	0.99 (0.66, 1.49)	1.03 (0.69, 1.53)
Black or Latina lesbian	**1.58 (1.02, 2.46)**	1.13 (0.71, 1.79)	1.16 (0.73, 1.85)	1.20 (0.76, 1.88)
Sexual orientation or sex of sexual partners				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**1.93 (1.65, 2.26)**	**1.68 (1.44, 1.95)**	**1.68 (1.44, 1.96)**	**1.67 (1.43, 1.94)**
Latina heterosexual	**1.29 (1.10, 1.52)**	**1.28 (1.08, 1.51)**	**1.29 (1.09, 1.52)**	**1.32 (1.12, 1.56)**
White bisexual	**1.52 (1.18, 1.95)**	1.18 (0.91, 1.53)	1.18 (0.91, 1.53)	1.21 (0.93, 1.56)
Black bisexual	**2.70 (1.86, 3.92)**	**1.96 (1.37, 2.79)**	**2.00 (1.41, 2.84)**	**1.95 (1.38, 2.76)**
Latina bisexual	**1.70 (1.11, 2.61)**	1.25 (0.82, 1.89)	1.27 (0.83, 1.94)	1.33 (0.86, 2.05)
White lesbian	**1.72 (1.06, 2.77)**	1.34 (0.81, 2.20)	1.35 (0.82, 2.22)	1.40 (0.85, 2.30)
Black or Latina lesbian	**2.85 (1.80, 4.52)**	**2.11 (1.31, 3.40)**	**2.11 (1.31, 3.39)**	**2.18 (1.37, 3.46)**
Number of sexual partners				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**1.66 (1.44, 1.92)**	**1.44 (1.25, 1.66)**	**1.45 (1.25, 1.67)**	**1.43 (1.24, 1.66)**
Latina heterosexual	**1.49 (1.27, 1.75)**	**1.36 (1.16, 1.58)**	**1.40 (1.20, 1.63)**	**1.44 (1.23, 1.68)**
White bisexual	**1.50 (1.18, 1.90)**	1.22 (0.96, 1.55)	1.24 (0.97, 1.57)	1.26 (0.99, 1.60)
Black bisexual	**2.69 (1.83, 3.96)**	**2.04 (1.40, 2.99)**	**2.13 (1.44, 3.14)**	**2.08 (1.42, 3.05)**
Latina bisexual	1.45 (0.99, 2.14)	1.09 (0.73, 1.64)	1.12 (0.74, 1.68)	1.17 (0.77, 1.76)
White lesbian	0.77 (0.47, 1.26)	0.61 (0.36, 1.04)	0.62 (0.37, 1.04)	0.63 (0.38, 1.07)
Black or Latina lesbian	0.95 (0.64, 1.42)	0.69 (0.46, 1.04)	0.69 (0.45, 1.04)	0.71 (0.47, 1.06)

Outcome	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Condom Use				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**2.13 (1.86, 2.44)**	**1.85 (1.61, 2.12)**	**1.90 (1.66, 2.19)**	**1.88 (1.64, 2.16)**
Latina heterosexual	**1.55 (1.35, 1.79)**	**1.40 (1.21, 1.62)**	**1.50 (1.30, 1.73)**	**1.53 (1.32, 1.76)**
White bisexual	**1.48 (1.15, 1.92)**	1.22 (0.94, 1.59)	1.25 (0.96, 1.62)	1.27 (0.98, 1.64)
Black bisexual	**3.13 (2.16, 4.54)**	**2.39 (1.66, 3.42)**	**2.57 (1.80, 3.68)**	**2.49 (1.74, 3.56)**
Latina bisexual	**2.17 (1.49, 3.18)**	**1.66 (1.10, 2.49)**	**1.75 (1.17, 2.62)**	**1.82 (1.22, 2.74)**
White lesbian	**0.48 (0.25, 0.91)**	**0.38 (0.20, 0.71)**	**0.38 (0.20, 0.73)**	**0.39 (0.21, 0.74)**
Black or Latina lesbian	0.77 (0.49, 1.21)	**0.55 (0.35, 0.88)**	**0.57 (0.35, 0.91)**	**0.58 (0.36, 0.93)**
Types of sex				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**2.39 (2.02, 2.83)**	**2.02 (1.71, 2.38)**	**1.92 (1.62, 2.28)**	**1.93 (1.62, 2.28)**
Latina heterosexual	**1.72 (1.46, 2.03)**	**1.57 (1.32, 1.86)**	**1.52 (1.28, 1.81)**	**1.55 (1.30, 1.85)**
White bisexual	**2.00 (1.52, 2.63)**	**1.56 (1.17, 2.06)**	**1.53 (1.15, 2.04)**	**1.56 (1.17, 2.08)**
Black bisexual	**4.19 (2.75, 6.39)**	**2.99 (1.99, 4.47)**	**2.89 (1.92, 4.33)**	**2.89 (1.92, 4.34)**
Latina bisexual	**2.37 (1.46, 3.85)**	**1.68 (1.05, 2.70)**	**1.63 (1.01, 2.63)**	**1.71 (1.05, 2.78)**
White lesbian	0.81 (0.47, 1.38)	0.61 (0.35, 1.06)	0.61 (0.35, 1.07)	0.62 (0.35, 1.10)
Black or Latina lesbian	1.61 (0.98, 2.64)	1.11 (0.67, 1.85)	1.07 (0.65, 1.78)	1.10 (0.67, 1.82)

Note. Bolded values refer to p-values <0.05. Model 1 is adjusted for survey wave only. Model 2 adds demographic factors (i.e., age, place of residence, nativity, and relationship status) to Model 1. Model 3 adds socioeconomic factors (i.e., educational attainment, household federal poverty level, and employment status) to Model 2. Model 4 adds health care factors (i.e., health insurance status, usual source of care) to Model 3. All models are adjusted for survey wave and account for the survey's complex sampling design.

[a] Any sexual history assessment is based on a "yes" response to one or more of the four questions (sexual orientation or sex of sexual partners, number of sexual partners, condom use, types of sex) about whether a doctor or medical provider asked the respondent about their sexual behaviors in the last 12 months.

Additionally, Black heterosexual (OR=2.13; 95% CI: 1.86, 2.44), Latina heterosexual (OR=1.55; 95% CI: 1.35, 1.79), White bisexual (OR=1.48; 95% CI: 1.15, 1.92), Black bisexual (OR=3.13; 95% CI: 2.16, 4.54), and Latina bisexual (OR=2.17; 95% CI: 1.49, 3.18) women had significantly higher, while White lesbian women (OR=0.48; 95% CI: 0.25, 0.91) had significantly lower, odds of having been asked about condom use compared to White heterosexual women adjusting for survey wave (Model 1). After adjusting for demographic characteristics, the difference between White bisexual and White heterosexual women was no longer significant, while Black or Latina lesbian women had significantly lower odds (OR=0.55; 95% CI: 0.35, 0.88) of having been asked about condom use relative to White heterosexual women (Model 2). Other odds ratios were slightly attenuated. After further adjusting for socioeconomic and health care factors, Black heterosexual (OR=1.88; 95% CI: 1.64, 2.16), Latina heterosexual (OR=1.53; 95% CI: 1.32, 1.76), Black bisexual (OR=2.49; 95% CI: 1.74, 3.56), and Latina bisexual (OR=1.82; 95% CI: 1.22, 2.74) women had higher, while White lesbian (OR=1.39; 95% CI: 0.21, 0.74) and Black or Latina lesbian (OR=0.58; 95% CI: 0.36, 0.93) women had lower, odds of having been asked about condom use relative to White heterosexual women. Based on this fully adjusted model, Black bisexual (pr=0.489) followed by Black heterosexual (pr=.423) and Latina bisexual (pr=0.416) women had the highest, while White lesbian (pr=0.140) followed by Black or Latina lesbian (pr=0.192) women had the lowest, predicted probability of having been asked about condom use.

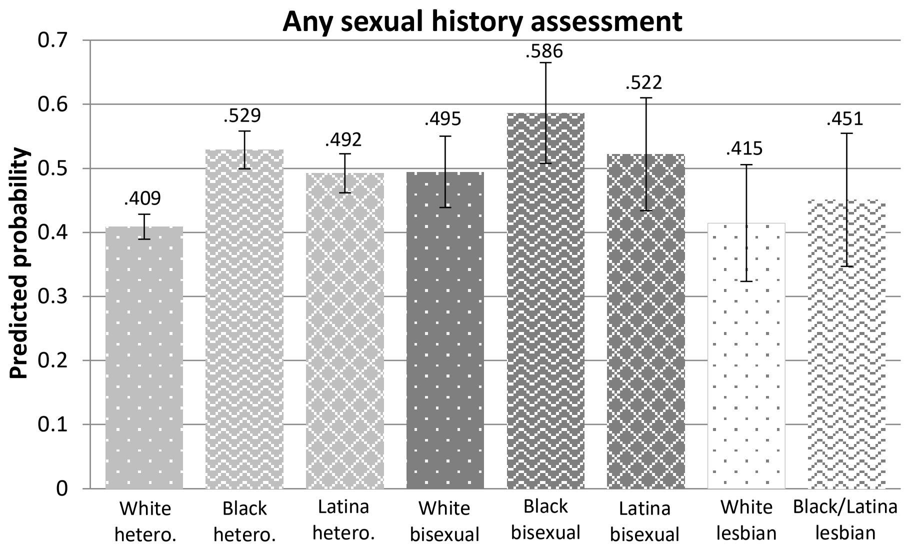

Figure 3.1. Predicted probability of receiving any sexual history assessment from a medical provider in the last 12 months by race/ethnicity and sexual orientation identity among U.S. women aged 15-44 years (N=14,019)

Note. Predicted probabilities are based on fully adjusted models (Model 3).

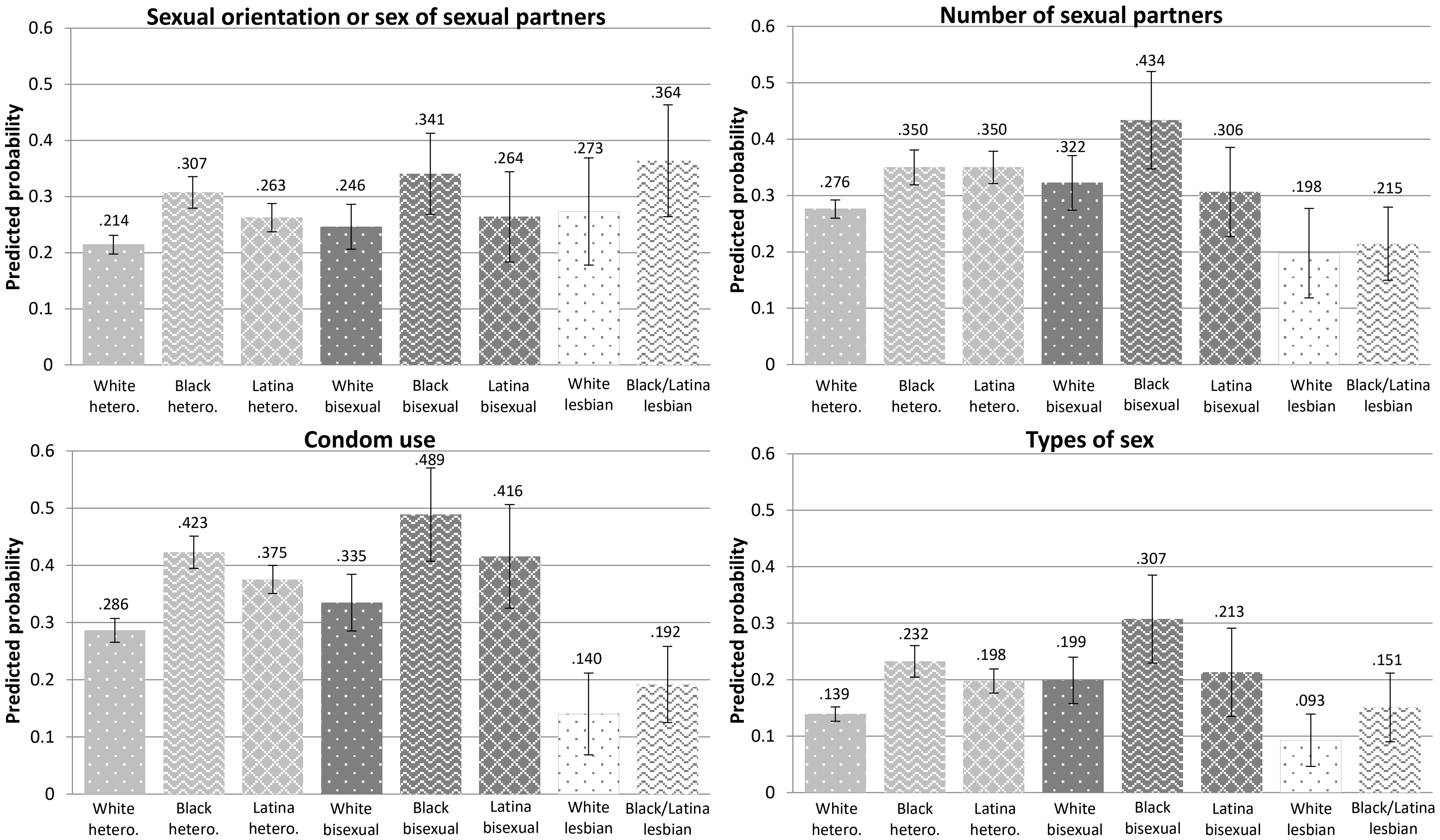

Figure 3.2. Predicted probability of receiving a sexual history assessment from a medical provider in the last 12 months by race/ethnicity and sexual orientation identity among U.S. women aged 15-44 years (N=14,019)

Note. Predicted probabilities are based on fully adjusted models (Model 3).

Finally, adjusting for survey wave (Model 1), Black heterosexual (OR=2.39; 95% CI: 2.02, 2.83), Latina heterosexual (OR=1.72; 95% CI: 1,46, 2.03), White bisexual (OR=2.00; 95% CI: 1.52, 2.63), Black bisexual (OR=4.19; 95% CI: 2.75, 6.39), and Latina bisexual (OR=2.37; 95% CI: 1.46, 3.85) women had higher odds of having been asked about the types of sex they have compared to White heterosexual women. These differences were slightly attenuated after adjusting for demographic factors (Model 2) but persisted after further adjusting for socioeconomic (Model 3) and health care (Model 4) factors. Predicted probabilities based on this fully adjusted regression model showed that Black bisexual (pr=0.307) followed by Black heterosexual (pr=0.232) and Latina bisexual (pr=0.231) women had the highest, while White lesbian (pr=0.093) women had the lowest, predicted probability of having been asked about the types of sex they have. It should be noted that in regression analyses for types of sex, Black and Latina lesbian women were trending in opposite directions (Black lesbian women with non-significantly higher odds and Latina lesbian women with non-significantly lower odds) when analyzed as two separate groups rather than as a single group.

Although point estimates varied slightly, in general the aforementioned regression results patterns persisted in sensitivity analyses among those who reported any sexual activity in the last 12 months (i.e., excluding those who did not report sexual activity in the last 12 months; Appendix A). Aside from a few results that were significant in one set of analyses and only marginally significant in the other, the only somewhat more noticeable discrepancy observed in sensitivity analyses was that the odds of having been asked about types of sex were not significantly higher among Latina bisexual compared to White heterosexual women in adjusted models, though findings were trending in this direction.

DISCUSSION

Consistent with our hypothesis, we found that Black heterosexual, Latina heterosexual, White bisexual, Black bisexual, and Latina bisexual women had higher odds of having received a sexual history assessment from a medical provider compared to White heterosexual women. Our findings contribute to a growing body of empirical literature examining how gender, race/ethnicity, and sexual orientation simultaneously shape health care experiences. While the present study was unable to directly assess whether stereotypes play a role in these observed differences, these findings are consistent with prior literature that has identified racialized sexual stereotypes as well as sexual orientation-based stereotypes (e.g., Collins 2002, Collins 2005, Hayfield et al. 2014, Klesse 2005, Rosenthal, Overstreet, Khukhlovich et al. 2020) and literature that has found that stereotypes impact health care provision (Hall et al. 2015, Jahn, Bishop, Tan et al. 2019, Maina et al. 2018, McIntyre et al. 2010). We also found that differences varied across type of sexual history question asked. For example, while all racial/ethnic and sexual orientation identity subgroups had higher odds of having been asked their sexual orientation or the sex of their sexual partners compared to White heterosexual women, higher odds of having been asked about number of sexual partners, condom use, and types of sex were concentrated among Black heterosexual, Latina heterosexual, Black bisexual, and Latina bisexual women. Furthermore, we found that some differences persisted after adjusting for demographic, socioeconomic, and health care factors while others did not.

Of the racial/ethnic and sexual orientation identity subgroups included in our analyses, Black bisexual women had the highest predicted probability of having been asked about number of sexual partners, condom use, and types of sex, as well as the highest probability of any sexual history assessment. This was consistent with our hypothesis that due to promiscuity stereotypes associated both with Black womanhood and bisexuality that Black bisexual women may simultaneously experience, Black bisexual women would report the highest odds of reporting receipt of a sexual history assessment. However, we also hypothesized that, for similar reasons, Latina bisexual women would report the highest odds of having received a sexual history assessment, which findings did not entirely support. While Latina bisexual women had higher odds of many outcomes compared to White heterosexual women, this was not observed for all outcomes. Furthermore, Black heterosexual, rather than Latina bisexual, women generally had the second highest predicted probability of receipt of most sexual history questions. Additional research is needed to confirm and unpack these findings, including the potential role of sexual orientation disclosure. For example, if a lesbian or bisexual patient has not disclosed their sexual orientation to their provider, this information is not available for the provider to make assumptions based on (though providers may make assumptions based on other visible traits, such as gender presentation). However, this preliminary evidence that Black compared to Latina women may be more likely to receive a sexual history assessment is consistent with Copen's (2018) finding that, among sexually active women in the 2013-2015 NSFG, a slightly higher percentage of Black than Latina women had received a sexual history assessment.

We also found that Black or Latina lesbian women had higher odds of having received a sexual history assessment compared to White heterosexual women. However, this finding seems to be driven by their higher odds of having been asked their sexual orientation or the sex of their sexual partners, specifically. In contrast, in adjusted models we found that White lesbian and Black or Latina lesbian women had lower odds of having been asked about condom use relative to White heterosexual women. These findings highlight that more nuanced a priori hypotheses about lesbian women were likely warranted given the nature of the sexual history questions.

However, it is also important to recognize that external condoms are not the only type of protective barrier and that protective barrier use is encouraged for most types of sexual activity, including sex between cisgender women (Workowski and Bolan 2015). Given how this outcome was measured, we were unable to assess whether "condom" was assumed to imply external condom use (which may not be relevant depending on one's sexual activities). Particularly given existing disparities among lesbian women, such as lower odds of regular Pap testing (Agénor, Krieger, Austin et al. 2014), relative to heterosexual women and false perceptions about low STI risk among lesbian women (McIntyre et al. 2010), additional research is needed to ensure that lesbian women are appropriately counseled based on their sexual behaviors, which should not be assumed based on their sexual identity only (Workowski and Bolan 2015).

Whether or not a patient receives a sexual history assessment should not be based on their characteristics – whether race/ethnicity, sexual orientation, or other characteristics such as income or relationship status – or where they are seeking care. The biomedical purpose of taking a sexual history is to inform counseling and clinical decisions, Therefore, it is important that the same questions are asked to all patients. Despite this, studies have found that although providers are recommended to discuss STI risk with all women (American College of Obstetricians Gynecologists 2012), patient-provider conversations about STI risk are infrequent among both heterosexual patients and queer patients (Alexander et al. 2014, Baldwin, Dodge, Schick et al. 2017), and our study finds that patient characteristics are, indeed, associated with whether or not patients receive a sexual history assessment. Medical provider behaviors such as these reinforce oppressive stereotypes which may result in poorer patient-provider communication and trust and have adverse effects on patients' health and well-being (Agénor et al. 2015, Maina et al. 2018).

Furthermore, this practice contributes to the over-surveillance of socially marginalized groups (Bridges 2011).

Calls have increasingly been made to improve medical education and training to address topics such as cultural and structural competency, bias, and LGBTQ+ health (e.g., Crear-Perry, Maybank, Keeys et al. 2020, Metzl and Hansen 2014). However, research suggests such trainings and skills are still significantly lacking (e.g., Bonvicini 2017), and significant racial/ethnic and sexual orientation disparities in health persist. In addition to efforts to expand provider training on these topics, it is important to recognize that the broader organizational context influences health care interactions, particularly those of marginalized patients, as well and thus to implement changes beyond additional trainings. For example, clinics can work to create a welcoming physical clinic space through use of visual cues and to provide tailored educational materials, particularly those that incorporate multiple dimensions of diversity and can clearly include commitments to patient-centered, culturally competent care in mission statements, though it is important that these commitments are consistent with practice (DeMeester, Lopez, Moore et al. 2016). Further, organizational commitment and improvements to hiring and, particularly, retaining a diverse workforce are needed in order to achieve better clinician-patient concordance (e.g., based on race and/or sexual orientation, language), which can facilitate patient comfort and satisfaction (DeMeester et al. 2016, Peek, Lopez, Williams et al. 2016). Clinics should also work to build relationships and collaborate with community organizations that serve historically underserved populations (DeMeester et al. 2016, Rosenthal and Lobel 2020).

Limitations

These findings should be interpreted in light of several limitations. First, we restricted our sample to White, Black, and Latina women given available race/ethnicity data in publicly available NSFG data. Second, NSFG does not oversample based on sexual orientation, resulting in small cell sizes for some racial/ethnic and sexual orientation identity subgroups. As a result, following NSFG analytic guidelines we combined Black and Latina lesbian women into a single analytic group, thereby losing heterogeneity that may exist between the groups. Further, small cell sizes may have resulted in insufficient statistical power to detect some differences. Third, also given small cell sizes, we were unable to further stratify our analyses by age. By controlling for age, we accounted for the fact that providers may be more likely to ask younger people about their sexual history given higher STI rates in this population (Centers for Disease Control and Prevention 2019). However, future research should investigate whether the association between race/ethnicity and sexual orientation identity and receiving a sexual history assessment varies by age (i.e., moderation). Fourth, data were self-reported and may be subject to recall bias. Lastly, our study was limited by the scope and framing of the sexual history-related measures. For example, the dimension(s) (identity, attraction, and/or behavior) of "sexual orientation" the measure refers to is/are ambiguous. This is compounded by the fact that the question asks both about "sexual orientation or the sex of your sexual partners" despite the importance of not equating sexual identity and sex of sexual partners. While measures enabled us to get a general sense of differences in receiving a sexual history assessment, other and more nuanced sexual history questions should be considered. Furthermore, we were unable to assess the quality and inclusiveness of sexual history question phrasing, which is an important direction for future research.

CONCLUSION

These findings are situated within a broader body of literature which has demonstrated that health care provider biases, attitudes, and beliefs influence provider behavior. This contributes to disparities in health care outcomes and poorer patient-provider interactions among Black and Latinx, LGBTQ+, and, particularly, Black and Latinx LGBTQ+ populations. Our findings provide evidence that health care providers may differentially conduct sexual history assessments based on patients' race/ethnicity and sexual orientation identity. This is significant because, in turn, it may lead to differential health advice and over-surveillance of certain groups. Additional quantitative and qualitative research is needed to confirm these findings, to investigate mechanisms driving these findings, and to better understand whether the quality and content of sexual history assessments varies across populations and contexts, as well as how this impacts patient care. In order to reduce potential provider bias and create a more inclusive clinic environment, structurally competent, anti-oppressive, and patient-centered practices and programs should be implemented. However, it is also important to recognize that undoing stereotypes that may underlie these findings will require radical societal transformation that extends far beyond the clinic.

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CHAPTER 4: Healthcare navigation strategies among LGBTQ+ individuals assigned female at birth

INTRODUCTION

Stigma and discrimination in health care settings, at both present and historically, contribute to medical mistrust among lesbian, gay, bisexual, transgender, and other queer LGBTQ+ populations (Cahill, Taylor, Elsesser et al. 2017). Studies have documented that LGBTQ+ individuals often experience negative health care interactions due to stigma and discrimination experienced and anticipated in clinical settings (Agénor, Zubizarreta, Geffen et al. 2022b, Graham, Berkowitz, Blum et al. 2011, James, Herman, Rankin et al. 2016). Experiences range from providers with little training in LGBTQ+ health who are uncertain how to support patients (Khalili, Leung and Diamant 2015), especially those seeking gender-affirming services, to overt discrimination based on sexual and/or gender identity (James et al. 2016). Given the cisgender, heterosexual assumptions upon which the field of sexual and reproductive health, especially obstetrics and gynecology, is built (Carpenter 2021), LGBTQ+ individuals assigned female at birth (AFAB) may be especially likely to encounter stigma and discrimination (e.g., heterosexism, cissexism) in these settings. Combined with lack of LGBTQ+ inclusion in sex education curriculum and provider misinformation (Baker, Jahn, Tan et al. 2020), stigma and discrimination in health care settings has been associated with reduced sexual health care seeking and lower quality of care among LGBTQ+ patients AFAB (Agénor, Geffen, Zubizarreta et al. 2022a, Higgins, Carpenter, Everett et al. 2019, James et al. 2016, Johnson, Nemeth, Mueller et al. 2016, Kcomt, Gorey, Barrett et al. 2020, Wingo, Ingraham and Roberts 2018).

While increasingly studies have investigated LGBTQ+ individuals’ health care experiences, the primary focus has been on summarizing barriers to care, including the ways that bias and discrimination are enacted in the clinic. Fewer studies have examined how patients navigate barriers to care and negative care experiences. However, there is increasing recognition of patients as agents with the potential to actively resist and otherwise respond to oppressive encounters (Carpenter 2021, Paine 2018, Seelman and Poteat 2020). For example, Seelman and Poteat (2020) examined how trans and nonbinary individuals AFAB resist transgender stigma and found that strategies included social support, advocacy, identity disclosure management, avoidance of mainstream healthcare, and persistence in order to attain one’s needs. Other strategies previously identified include patients intentionally concealing their identity(ies) in order to avoid anticipated discrimination (Carpenter 2021, Hoffkling, Obedin-Maliver and Sevelius 2017) and seeking care from queer or queer-informed providers (Agénor et al. 2022a, Carpenter 2021). Building on this emerging body of work, this study examined strategies that LGBTQ+ people AFAB use to navigate sexual health care in order to obtain needed services and, in some cases, resist stigma and discrimination.

Expertise and power relations in the clinic

Past research shows that, due to lack of provider knowledge and/or patients being dismissed by providers, various patient populations do their own research, which is increasingly possible with the plethora of online resources (e.g., Barker 2008). While traditional clinical encounters reproduce the divide between layperson and expert, patients doing their own research can, in some ways, challenge provider expertise and the traditional power differential between patients and providers (Filc 2006). Indeed, patients possess a wealth of knowledge–including knowledge from patient experiences; cultural framings and understandings of health, illness, and disease; and collective knowledge and practice. However, providers have far greater authority in the clinic where the biomedical knowledge held by providers is privileged, if not exclusively recognized over lay knowledge (Foucault 1994, Popay and Williams 1996, Wilkerson 1994).

Given limited knowledge and training about LGBTQ+ health among clinicians, the knowledge and expertise that patients bring to clinical encounters may be particularly important and likely to challenge provider expertise and traditional patient-provider power relations (Poteat, German and Kerrigan 2013, Seelman and Poteat 2020). For example, given limited provider knowledge about trans health, many trans and nonbinary patients put in the emotion work to educate their providers (Carpenter 2021, James et al. 2016). Yet, above and beyond the lay-expert knowledge divide, providers serve as gatekeepers with the ability to grant or deny access to services and resources, further reproducing medical authority and the power differential between patients and providers (Filc 2006).

Capital

As suggested by prior research conducted among various LGBTQ+ populations and by prior theoretical literature, various forms of capital may inform how LGBTQ+ people AFAB navigate health care and whether or not they are able to obtain needed services and resist stigma and discrimination in the clinic. This analysis draws primarily on social capital and cultural health capital. *Social capital* refers to the resources available as a result of one's group membership, social status, or social network (Bourdieu 1983/1986:248-49). Past studies have found that LGBTQ+ people AFAB, particularly trans and nonbinary people, rely heavily on social capital to obtain knowledge and support outside of traditional biomedical institutions when navigating health care (Agénor et al. 2022a, Eiduson, Murchison, Agénor et al. 2021, Seelman and Poteat 2020, Taylor 2013).

Cultural health capital refers to "the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships" (Shim 2010:1). In other words, there are certain skills and resources, such as health literacy and the ability to communicate health-related information, that are valued in health care interactions and can facilitate patients' engagement with their providers. These skills may be especially important in the context of LGBTQ+ sexual health and gender affirming care, as patients often must navigate stigma and discrimination in order to successfully obtain needed services. A central component of cultural health capital is its relational aspect: providers can contribute to patients' development of cultural health capital (e.g., by sharing medical knowledge) but also contribute to patients' abilities (or lack thereof) to *mobilize* their cultural health capital (i.e., to convert their capital into advantage during a health care encounter) in the ways that they communicate and interact with patients (Dubbin, Chang and Shim 2013, Shim 2010).

Current study

Research has documented barriers to care among LGBTQ+ populations AFAB, including how stigma and discrimination impact their care experiences. In order to access needed care, LGBTQ+ people AFAB often must overcome these barriers. Furthermore, many have developed strategies to resist oppressive practices and policies. Therefore, this study builds on a limited body of literature examining strategies that LGBTQ+ people AFAB use to navigate clinical encounters, with an emphasis on sexual health and gender affirming care. Notably, it considers how context, power relations, and cultural health capital inform how participants navigate encounters.

METHODS

This study is part of a larger, multiple methods study that examined how sexual risk discourses impact the sexuality, sexual identity development, and health and well-being of LGBTQ+ people assigned female at birth (AFAB) from diverse racial/ethnic backgrounds as well as their interactions with health care providers. A total of 76 semi-structured interviews were conducted with 64 LGBTQ+ individuals assigned female at birth, aged 21 and older, and currently residing in the San Francisco Bay Area. Because participants were asked questions about whether or not they had previously had a cervical cancer screening, and, if so, their experiences with screening during interviews, cervical cancer screening guidelines at the time of study initiation (US Preventive Services Task Force 2018) informed eligibility criteria.

Pilot study participants (n=8), all LGBQ+ cisgender Latina women, were recruited between October 2018 and February 2019 via physical flyers, emails sent to university student group listservs, and online postings on Craigslist and Reddit. Subsequent participants (n=56) were recruited between September 2020 and August 2021 via online postings disseminated via community organization and student group email listservs and social media, Craigslist, and snowball sampling. Staff and community members from a local LGBTQ+ organization reviewed study flyer and screener survey drafts, which were revised prior to formal study launch in September 2020. In an effort to capture a sample comprised of people from diverse sexual identities, racial/ethnic groups, and gender identities and ensure a variety of standpoints and experiences were captured, maximum variation sampling (Patton 2014) was used after pilot round interviews. To confirm study eligibility and as a means to facilitate maximum variation sampling by allowing the PI to monitor the characteristics of the study sample, potential participants completed a brief demographics screener survey online via Qualtrics or via phone prior to scheduling an interview.

Data collection

In person pilot interviews (n=11) were conducted with eight individuals between October 2018 and November 2019 at a mutually agreeable time and location (e.g., participant's home, public library). Due to the COVID-19 pandemic, subsequent interviews (n=65) were conducted with 56 individuals via phone or video call. Interviews typically lasted 60-100 minutes (mean: 87 minutes), and verbal consent was provided prior to beginning the interview. Participants were paid $35 in cash (in-person interviews) or electronic gift card for initial interviews and $15 for any subsequent interviews.

All interviews were conducted in English following a semi-structured interview guide. Interview guide topics included identity; discourse around sexuality, gender, and sexual health; sources of sexual health information; provider preferences and general health care experiences; sexual health care preferences and experiences, including identity disclosure; and suggestions to improve sexual health care. Interview guide topics and questions were informed by literature on LGBTQ sexual health and on conducting qualitative research using an intersectional lens (Bowleg 2008). The guide was reviewed by qualitative methods experts, pilot tested prior to and during pilot interviews, and, consistent with constructivist grounded theory (Charmaz 2014), revised in an ongoing fashion. Initial interviews and coding illuminated that participants were not passive recipients of care but had developed strategies for navigating clinical encounters and, in some cases, directly challenged their providers. Thus, these strategies and particularly experiences reflective of implementing these strategies were probed in subsequent interviews.

Interviews were audio recorded and subsequently transcribed verbatim. At the conclusion of the interview, participants were asked a brief series of survey questions including demographic and health care-related measures and asked whether they would be willing to participate in subsequent interviews to follow up on topics that emerged during our initial conversation and were emerging from the data. Fieldnotes were taken after each interview. The University of California, San Francisco Institutional Review Board reviewed all study procedures.

Data analysis

Data were analyzed using constructivist grounded theory methods, which included iterative adjustments to the recruitment strategy, semi-structured interview guide questions, and coding (Charmaz 2014). Constructivist grounded theory is a highly inductive method that seeks to understand social processes and that emphasizes that research is constructed–researchers and participants co-construct a shared reality (Charmaz 2014). Coding and memo writing took place throughout data collection until theoretical saturation was reached. Open coding was conducted on pilot interviews and six subsequent interviews (total n=17) to generate an initial codebook. which was then revised to collapse similar codes and organized into parent and child codes. The final codebook was comprised primarily of inductive codes based on transcript and fieldnote data, along with a few deductive codes based on the interview guide. Transcripts were coded using this final codebook in MAXQDA 2022 software. This analysis draws primarily on the parent code and relevant subcodes for navigating oppressive experiences as well as the parent codes provider qualities; positive healthcare experiences; sexual history; and sex education. During analytical memo writing, attention was given to factors including, but not limited to, dimensions of social identity (e.g., sexual orientation, race, gender) and social inequality (e.g., heterosexism, racism, cisgenderism) that inform how LGBTQ+ people AFAB navigate clinical encounters and how power relations manifest and inform how encounters unfold.

PARTICIPANT CHARACTERISTICS

Sample sociodemographic characteristics are presented in Table 4.1. Participants ranged in age from 21 to 77 years (median 27; mean 29.8). Of the 64 participants, 21 were Asian, 14 Latinx, 14 White, three Black, two Arab Middle Eastern, and the remaining ten reported being multiracial. Thirty-two participants were cisgender women, while the remaining participants were transgender, nonbinary, and/or questioning their gender identity. In terms of sexual orientation identity, thirty-seven participants identified as queer, with many also identifying with another sexual identity (e.g., pansexual, lesbian).

Table 4.1. Sociodemographic characteristics of the sample

Characteristic	**n**	**%**
Age (years)	range: 21-77	median 27; mean 29.8
Race/ethnicity		
Arab or Middle Eastern	2	3
Asian	21	33
Asian and White	3	5
Black	3	5
Black, Latinx, and White	1	2
Latinx	14	22
Latinx and Asian	2	3
Latinx and White	4	6
White	14	22
Gender identity*		
Gender expansive, gender fluid, genderqueer, nonbinary, agender, bigender, or another gender identity	23	36
Not sure	7	11
Trans man	7	11
Woman	40	63
Sexual orientation identity*		
Asexual	4	6
Bisexual and/or pansexual	28	44
Gay and/or lesbian	19	30
Heterosexual	3	5
Queer	37	58
Questioning	2	3
Educational attainment		
≤ High school diploma	3	5
Some college or Associate’s degree	14	22
Bachelor’s degree	32	50
Graduate or professional degree	15	23
Employment status*		
Employed, full-time	27	42
Employed, part-time	15	23
Retired or unable to work	3	5
Student	15	23
Not working for pay	11	17
Has health insurance		
Yes	62	97
No	2	3
Has usual medical provider		
Yes	44	69
No	20	31

Notes. * = response categories not mutually exclusive. Percentages may not add to 100% due to non-mutually exclusive categories and rounding. Participant characteristics described in text are based on interview transcripts and may be more descriptive, while data presented here are based on sociodemographic survey data.

RESULTS

While not all participants felt they had a poor or “negative” clinical encounter to share, nearly all described cultivating strategies to navigate sexual health care in order to obtain the services they sought and/or resist oppressive assumptions and practices in health care. I found that LGBTQ+ individuals AFAB used the following strategies to navigate healthcare: conforming to biomedicine and provider recommendations; advocacy and resistance; stigma management; seeking information and support; and intentional selection of healthcare. I also consider whether specific strategies are particularly likely to be mobilized by certain groups or under certain conditions and the role of providers in shaping how patients navigate care. Notably, avoidance of care, oft cited as one repercussion of the structural, interpersonal, and internalized stigma and discrimination that LGBTQ+ people AFAB, especially LGBTQ+ people of color, face, could be considered a strategy developed to resist stigma and discrimination in health care settings. However, given avoidance of care is commonly discussed in existing literature, this analysis focuses on other navigation strategies.

Conforming to biomedicine and provider recommendations

Many participants described upholding the traditional power relationship between patients and providers, in which providers are an authority figure, in order to obtain needed care services. Rather than resisting or challenging providers, participants at times preferred to, or felt pressured to, conform to provider requests. In other cases, participants leveraged the patient-provider power differential to meet their health care needs. As a whole, these examples illustrate the reproduction of providers’ authority due to their role as gatekeepers of knowledge and services which, in many instances, leaves patients with limited options and/or power.

“They’re the professional”

A few participants described the trust that they had in their medical providers due to their expertise in health and illness. For example, Emily, a questioning, Latinx immigrant from El Salvador, who was trained as a health care provider herself, noted:

> I do place like a lot of value in like what my doctor says that I should do, like that I should get. I think just because I think they are like knowledgeable enough to like, trust them. And I do what they say.

In some cases, recognition of providers as professionals with a particular type of specialized knowledge resulted in participants readily agreeing to providers’ requests and recommendations. In fact, in a few instances, it led to participants wishing that providers more readily offered direct guidance. As Hayden, a gay, nonbinary, African American individual, shared various medical experiences, it became clear that, at times, they were disappointed by the lack of guidance that providers often gave:

> I've actually had to go into a doctor's office before because I had a cold and tell them, ‘Hey, I'm experiencing these symptoms. What do you suggest?’ And…I have had more than one doctor tell me, ‘Hmm, what do you think we should do about this?’ I've had more than one doctor say that to me. And every time I tell them, 'you know, if I knew for sure what to do about this, I'll be frank with you. I don't think I would be here right now.’…I'm dumbfounded by that question. When people ask me- when doctors, I'll say it that way, when doctors ask me that question it dumbfounds me and that's usually my response to it…in my opinion, if you are a patient, your job is just to come into a doctor and be as frank as possible about your condition. And then it's up to the doctor to find the best way to help you.

This expectation reproduces the traditional power relations between patients and providers, in which providers dominate, yet simultaneously alludes to the productive collaboration that, under ideal circumstances, is forged between patients and providers.

However, for some, the hegemonic patient-provider relationship dominates, and productive collaborations are not forged. For Adrienne, a White, queer, gender nonconforming individual, this power dynamic meant that they continued to experience fatism, or weight-based discrimination, in their medical encounters. For example, Adrienne spoke of their experiences in which providers were hyper focused on their weight and body size, which, in turn impacted Adrienne's body language in the clinic:

> So starting when you're like a little kid, if every time you go to the doctor, they're like, 'your body is wrong, and you need to fix it.' It's just like, sort of, for me, turned into walking into the doctor and immediately beginning with like, being like, apologetic and like physically small, like, 'I am weak. I'm sorry.' And I would like to formally apologize for my body and the way that it is…so that's sort of like, what I expect from a doctor…'you're fat'…or like, 'you should, like, run more. Did you know that if you like, eat less, you can like lose weight?'…and I'm like, 'No shit.'…I shrink, I make myself like some, like that little 15-year-old kid who's like scared and feels like shit. And when I was a kid, it turned into me being like, 'you're right. If I eat less, I will lose weight, I'm gonna restrict myself to 1000 calories a day, and it's gonna be really horrible for me, and I'm gonna feel like I'm gonna pass out every day, but it'll be fine.' Um, and now I just kind of like sit there feel like absolute garbage…I would never fight them because they're the professional.

Providers' comments about Adrienne's body and the need to 'fix it,' which implicitly, and incorrectly, equate body size and weight to health status, impacted Adrienne's eating habits growing up. Further, previous clinical experiences persistently shaped Adrienne's body language in the clinic and, inevitably, their engagement with providers and the quality of their care interactions. Indeed, due to anticipated stigma, Adrienne felt pressured to be apologetic in order to prevent anticipated discrimination. However, recognizing providers as "the professionals" with specialized knowledge and greater power than patients, Adrienne felt there was little they could do to challenge their authority.

Acquiescence in order to obtain services

In other cases, participants reported following providers' requests despite hesitancy and/or disagreement, largely due to fear they might otherwise be denied services. By far, the most common example was pregnancy tests, which many reported being required to take in order to receive care. Many recalled explaining to their provider that there was no chance they were pregnant (i.e., they had not had sex with a sperm-producing individual) but conceding to take the test, nonetheless.

For Black and Latinx participants, these requests carried a particular weight and connotation due to their being intertwined with gendered racist assumptions that Black and Latina women are promiscuous and more likely to have an unplanned pregnancy than White women. Papi, a queer, Chicanx, genderfluid individual shared such a health care encounter:

> I was bleeding and like, it was not normal. I was like, hey, this isn't my period. Like, this is something way worse. And I just felt like, I just kept getting treated like, 'you're pregnant,' you know. 'You're pregnant, we need to do a pregnancy test.' And I was like, 'I'm not pregnant.' And this lady…had written a story in her head. She thought that I was embarrassed to tell her that I was sexually active, you know, and that I wasn't using protection. She looked at me and was like, 'Oh, you're brown, you're young, Latina. Maybe you don't know how your body works….and you're over here having sex, you know, and you're going to get pregnant'…. she asked me if I was sexually active, and I told her, 'No, I don't have time for that right now.' And I was like, 'Well, you know, um, I think I may have had, like, an encounter with a girl,' or something like that. And I told her about that, like I told her, 'Oh, I did have one person that, you know, like, a couple months ago that, that I engaged with,' you know. And she was like, 'oh, you had sex?' And I was like, 'Yeah, but, you know, it wasn't with someone who could have gotten me pregnant.' And she was like, 'what does that mean?' And I was like, 'well, it was with someone who had the same body as me, like the same parts as me.' And she was like, 'Oh, it's it sounds like it could be a miscarriage, maybe' …And I was telling her, 'I'm really worried. I know I'm not pregnant. There's no fucking chance I'm pregnant. I haven't had a dick inside me in a long ass time. Trust me, it's not that. Um, can you please like, help me find out what's happening?'

Despite Papi trying to advocate for themself (another strategy described below) by noting it was not physically possible for them to be pregnant, the provider persisted in her comments about pregnancy risk.

Because the provider was unwilling to provide other services without a pregnancy test result, eventually Papi, similar to other participants, acquiesced to the request:

> So I was frustrated. And I was like, 'we need to handle this as fast as we can, and if you're not going to move until you do a pregnancy test then give me that cup, and I'll pee in it right now.' Like that's how I felt, so I peed in her cup…They said they needed to do that before they could do anything else. When that came back negative, then they started

> being like, okay, we need to do more tests… actually, when they had me come back and go to a specialty clinic, and then they did like a lab report, they asked me to do like a blood pregnancy test…so they did another test, just, 'just to make sure,' they said. So even though the first one came back negative, you know, brown people are just so fertile, they're popping out kids these days, so you just got to be sure. You just got to double check…But they should have done more tests from the jump, in my opinion… I feel like they could have done the pregnancy test through bloodwork and do all my blood work, like the first day that I came in…

While Papi seemed to understand the reasoning behind the pregnancy test requirement–many people do not realize they are pregnant, and this informs treatment recommendations–their frustration stemmed from the framing of the provider's request. Rather than acknowledging that Papi had no pregnancy risk, but a test was required nonetheless, the provider persistently suggested that Papi may be pregnant. Papi's frustration stemmed even more so from the fact that a full blood panel, which could have included a pregnancy test, was not run from the beginning. Instead, they first had to complete a urine pregnancy test prior to providers agreeing to proceed with bloodwork, which, Papi felt was again laden with gendered racist assumptions about fertility given the request that a blood pregnancy test be included.

Others similarly felt pressured to comply with providers' requests due to fear that they might not otherwise receive the care they were seeking. For example, Grant, a mixed race, gay, trans man, was hoping to increase his testosterone dosage. His previous provider, who was also a trans man, had left the clinic, so Grant had to make his request to the new provider, who told him he would need to complete bloodwork first:

> Then I was trying to, I was asking her if I could raise my dose and she was like, 'well, why?' And I tried to give her my reasons. And she's like, 'well, we're going to have to do blood work.' And I was like, okay. And so when– if they're trying to check my blood or test my blood for like the levels for my testosterone or whatever, I guess…they have to take my blood the day before I take my [testosterone] shot. So that way they can get like an accurate reading or whatever, like where my body is actually at and the schedule on which I take my medicine and they were trying to take my blood, it just wasn't adding up.

Given Grant's typical medication schedule was not lining up with the required bloodwork, the provider requested that he skip a day of his testosterone, to which he acquiesced at least in part due to fear that he might otherwise have his testosterone taken away:

> And so she's like, 'oh, well how about you just like skip a day and just take your medicine a day later.' And at the time I was like, 'oh yeah, sure.' Cause I was just, I'm so used to trying to…deal with people in the medical field…And so to me, I was like, okay, whatever. Like, I just don't want- I get really paranoid with cis[gender] providers because I don't want them to take my medicine away, you know, because it– because I don't know how seriously people can take it if they're not experiencing it.

Grant's fear reflected not only the patient-provider power differential and the gatekeeping role of providers but also the power differential between trans and nonbinary patients and cisgender providers, specifically. Indeed, when I subsequently inquired how Grant responded when the provider asked why he wanted to up his dosage, he again alluded to how power relations and the gatekeeping role that providers play unconsciously impacted how he approached the encounter:

> I was in kind of away in my head, like I was kind of going through it and was already feeling stressed out…cause I was like nervous to even ask…and a lot of times I feel like when I get questioned about things, I immediately get defensive because I'm like, well, this is just what I want. You know, why? Um, and I wasn't really able to explain myself in a way that I felt I did myself justice, you know, like, I didn't have a clear reason. And I felt like because I didn't have a clear reason it wasn't going to happen.

While the provider had given off the impression that asking Grant to have bloodwork done before agreeing to increase his testosterone dosage, and asking him to alter his administration schedule in the process, was no big ask, skipping a day had major implications on Grant's health and well-being. Indeed, other trans people he spoke with were surprised that any provider knowledgeable about gender affirming hormone use would make such a request:

> That really fucked up my whole hormonal balance of taking it every week at the same time. And that ended up, I ended up really spiraling out of control…and every– all my trans people that I was talking to…I was like, 'yeah, my doctor asked me to like, wait a day.' And everyone was just kinda like, 'why the fuck would they ask you to do that?...if I miss a day it sucks, it sucks for like two weeks.'

Unfortunately, the gatekeeping role of providers–the blood test requirement–coupled with the power differential between himself and the provider–who was cisgender and in an authority role–offered Grant few alternative options if he wanted to adjust his testosterone dosage.

Leaning into power relations

In a few instances, participants leaned into patient-provider power relations by reproducing the lay and expert knowledge divide upon which these power relations are built. Perhaps most exemplary of this strategy was Leo, a queer Latino trans man who sought to change his testosterone dosage schedule. After having had a very negative experience with a particular endocrinologist, as later described, Leo was surprised at the provider's willingness to change his dosage schedule. Leo attributed this to the way that he framed the request to his provider:

> I recently just I did a bunch of research on like, injecting biweekly versus weekly, because as long as I've been on T [testosterone], I've injected biweekly. And I've noticed that it, I have like a huge surge. And then I have like a lot of oil produced. And just like I know, that comes with it. But I'm, I did a lot of research on it. And a lot of people really benefit from giving weekly injections because they're more consistent, and there's not a huge like, like surge, and then a drop in, in moods. And…I asked my endo[crinologist]…and so I was really surprised when he emailed me back, he's like, 'Sure, let's, let's try that.' But I had to do it in a way to make it more like his idea…I think that his ego was really hurt [after a previous encounter in which others intervened and advocated on Leo's behalf]… and if it's not his idea then he's not going to really allow it. So, I tried to like entertain that for him.

Specifically, in his request to the endocrinologist, Leo tried to construct the request as having emerged from information provided by the endocrinologist during a previous encounter rather than from the information that Leo himself had gathered through online research:

> I like started by saying like, 'Oh, I remember you giving me like a plethora of like information on like hormones and how they can affect the body, and I really appreciated that, so I did a little bit of my own research. It was like really inspiring, so I did some, some research of my own and…you, **you** did all of this,' right? 'You did all of this for me.' So it is like, 'I know that you, you mentioned like different dosages could mean different things for different people, right? And, and I was wondering if maybe you

> would suggest–**you** would suggest–that I go on maybe 50 milligrams every week instead of 100 milligrams every two weeks? Because I think that sounded like a great idea'...

Leo's emphasis on "you," referring to the endocrinologist, was intended to signal his primary reliance on the knowledge shared by his provider, thereby gesturing to his assumed expertise. Leo reflected on the fact that in his approach he intentionally leaned into and reproduced medical authority. Further, he drew a parallel between this encounter and encounters between female patients and male providers, in which patriarchal social relations are often reproduced, which he himself recalls having engaged in pre-transition:

> And it's like, it's, it's so like gross when I think about it that. I don't know, I think like a lot of– and this is a completely other issue in itself. I think like a lot of female-identifying people have to go through this on a regular basis with men. And I just like, I don't know, I'm such like a feminist that I just– I can't, I just– I just hate it so much. So, yeah. So it's, it's hard to like see me go there to that, that place like that I used to go all the time, um, to try to make things easier for some man in my life.

Consistent with cultural health capital, this approach required that Leo be cognizant of (i.e., to have the cultural health capital) the fact that the provider placed value in being considered the expert. While Leo was far from proud of having leveraged traditional patient-provider power relations to his advantage and thus perpetuating them and invisibilizing the knowledge and value that patients bring to clinical encounters, it is what enabled him to receive care that met his health needs.

Advocacy and resistance

Participant experiences highlighted the role that advocacy efforts played in their sexual and reproductive health care. Most commonly this took the form of directly advocating for oneself in clinical interactions (i.e., self-advocacy). In a few cases it took the form of other's advocating on one's behalf or resisting oppressive assumptions and policies in order to advocate for the LGBTQ+ community as a whole, or subgroups thereof, through both formal and informal means in order to spread health information.

Self-Advocacy

Self-advocacy, the most common type of advocacy that appeared in interviews, took varying forms and had varying levels of success. Often self-advocacy seemed to emerge as a result of previous negative care experiences. For example, after Papi's experience having to take a urine pregnancy test before providers would offer any other services and then ultimately being asked to complete bloodwork, Papi recalled receiving a phone call about the results:

> I remember I was on my way down to SoCal when the doctor called me back and was like, 'Hey, your test results just came back.' And I was like, 'Okay, cool. What's– like, translate? What does that mean?' You know? 'What's going on?' And she was like, well, 'some things didn't come back–' And she was like worrying, you know, she was like, 'some things didn't come back the way, you know, I expected,' and she was like…'I'm gonna need you to come in and do an ultrasound. Can you come today?'… she was like, you know, putting pressure on me.

After having felt so invalidated and silenced in their previous interactions with the providers at this clinic, exacerbated by the fact that they had already left the geographic area and thus would need to travel back and alter their holiday plans, Papi vehemently pushed back when the provider insisted that they come into the clinic for an ultrasound that same day:

> I told her [the provider] like, I was like, 'Oh, I'm sorry, I can't come in today. Like, I'm going to SoCal [Southern California]. And so I won't be able to come in today or tomorrow.' And she was like, 'Oh, no.' Like, she was like, 'What are you driving down there? Are you flying down there?' And I was like, 'I'm driving.' And she was like, 'well, you can't leave.' And I was just like, what? Like, this bitch was literally telling me you can't- you got to come back here and do this ultrasound test. And I was like- and I raised my voice at her. And I was just like, 'I was telling you that this was urgent. I was telling all of y'all that this was urgent, and nobody seemed to care. I was brushed off. Now all of a sudden, you got some tests and *now* you want to pressure *me*?' I was like, 'Look, I care about this. *I've* been caring about this,' because she was like acting like I wasn't thinking that it was important. I told her, 'I've been caring about this. Y'all were the ones who just suddenly decided that this is important. And now you want to pressure me to work on your time.' And I was like, 'we need to find something in SoCal. Can I get an ultrasound in SoCal?' you know, and I told her I'm having a hard time keeping up with all of this

> and calling all these places to make these appointments and I'm honestly tired of it. I was like, I need help with finding a place and scheduling the appointment because this is supposed to be my break. You know, I'm a student. This is supposed to be my break, and I can't even have my break.

As a result of their self-advocacy, Papi, who noted being especially taken aback by the “patronizing” way the provider spoke to them, was able to have clinic staff identify and arrange for an ultrasound at another clinic in SoCal.

In a few cases, participants engaged in self-advocacy around receipt of a pelvic exam. Sam, a lesbian, Latina woman shared the story of her first Pap smear:

> I was probably, was 25 – my first pap smear. It was horrible because I was technically a virgin even though I had been with girls, and I think that they used a big stir – whatever it’s called. And I remember she made me bleed afterwards, and I felt like, honestly I felt like I was raped. And I remember I went to the bathroom and I was just crying. It was like a horrible experience…I didn’t want to go back for another Pap smear but I knew I had to. And I wanted my ex to be in the room with me and they didn’t allow her to be, which I was upset about.

While Sam had hoped her partner could be in the exam room with her to provide emotional support, her request was denied. After Sam shared what a traumatizing experience the Pap smear was, I inquired whether the clinician had asked anything about Sam’s previous sexual experiences before beginning the procedure. Sam responded:

> Yeah, that’s what kind of upset me ‘cause I felt like…she didn’t care. I said, ‘Look, I’m a virgin in terms of I’ve never been penetrated before. The hymen I think is still intact. I’ve been very sexual, but for me, I don’t like penetration, I don’t prefer that.’ And I even asked, ‘Do you have something smaller?’ She was like, ‘yeah, yeah, yeah’ and she said yes that they had different sizes and small ones for people that were virgins, but then I found out that she didn’t use that one.

Although Sam had directly disclosed information about her past behavior and her body to her clinician to optimize her care experience, *anticipating* that her body would not react well to the Pap smear, the clinician disregarded this information.

Finally, in contrast to most examples of self-advocacy which took place “on the fly” in the clinic, in select cases participants intentionally prepared for appointments in advance in order to self-advocate during their medical encounters. For example, I asked Hayden whether they felt like their pelvic pain was recognized and taken seriously, they replied:

> Honestly, I felt like I had to fight for that recognition. And if I said– I felt like if I were to even phrase things the wrong way with them, they would have just started just going over my head and just passing me off as, ‘oh no, that's in your head. It's not really– it's not as serious as you're trying to make it sound.’ Like I felt I had to be very careful in talking with them otherwise I wasn't going to be taken care of.

In describing how they approached these conversations, Hayden recounted the preparation they put in ahead of their appointments in hopes of being taken seriously. Specifically, they noted the anxiety and pressure they felt to make the most out of the short, infrequent visits they had with the provider:

> It took a lot of preparation for appointments…because I only see them [the provider] once a month and each month, I would be preparing what I was going to say. I would take the time to either write what I was saying. I had a therapist at the time I would talk with them. And that therapist was just like, ‘Hey, if you need me to, I can come and help you facilitate.’…But, uh, yeah, for the most part, it did end up just being me and the gynecologist, talking to each other one-on-one… I would tell her whether or not the– what we were trying at the time was working…And really each appointment was like a big, uh, I would say if– let me find a way to compare the feeling, um, a job interview. That times 10, I would say the amount of anxiety, the worry. That- it was like the worst job interview ever every time talking with her.

It was clear that Hayden put intense time and work–both in terms of thought and emotion work–into what they said during appointments in order to have their pain and concerns taken seriously. However, there was only so much preparation they could put into next treatment steps and replying to the provider because Hayden “never knew what she [the provider] was going to say.”

When, after over a year of trying various other treatments, Hayden’s provider recommended another treatment strategy, Hayden pushed back, eventually to the point of her provider agreeing to perform a hysterectomy procedure:

> So finally, after a year of all these different treatments and trials, and she tried to recommend me take this one thing that would stop my period entirely. Like she said, from her description, it would throw me into menopause and then she would stop the medication after so long just to see if that truly was going on. I was just like, ‘you know what? That sounds very extreme.’ And I did not want to put my body through anything else. And she was just like, ‘oh, well-’ Even after me saying that she was like trying to recommend another type of medication next to try. And she said that one could possibly like have me like grow hair and some other issues. And I was just like, ‘you know what?’ I talked to her. I said- cause I was open with her the whole time about me being willing to undergo, like if there was no treatment that was truly helpful for that, I was willing to undergo the surgery to have that [my uterus] removed…And finally there was an appointment where the gynecologist herself broke down crying and like we both were crying and hugging each other. And she finally was just like, ‘you know what? Okay, we’ll go through with this’… And I was elated. I was nervous, but I was elated.

After having spent an extensive amount of time trying various treatments and enduring various side effects with little reduction in their pain, Hayden hoped that surgery would finally bring them some relief.

Advocacy from others

While participants most commonly spoke about self-advocacy efforts, a few also spoke of the role that advocacy from members of their social network played in their health care. Most exemplary of this was a story shared by Leo, who sought most of his care through the VA system. He described having to establish care with another clinic in order to seek gender affirming top surgery, which was not offered through the VA. Soon after the surgery, Leo realized there were no refills left on his testosterone prescription, which was typically prescribed through the VA, so he requested the providers who performed his surgery submit the refill request:

> I was like, ‘Hey, I don't have any more T. I'm also like, up in bed right now. So um, can I, can I get some?’ They're like, ‘yeah, of course, we'll write your prescription, we'll even send it to you.’ So I get the prescription.

When Leo later went to try to get his testosterone through the VA the new endocrinologist called accusing Leo of “abusing the system” and threatening to cancel his prescription, citing his prior problems with substance use as justification:

> And then I tried to order my testosterone over at the VA. And, um, and now I have like a new endocrinologist, I guess the other one retired and that's why their prescription wasn't refilled…And so I get this call, and he's like, ‘I just want to let you know that I am canceling your prescription for testosterone.’ And I was like, ‘whoa, whoa, wait, is there like any reason?’ And he's like, ‘Well, it seems like you've been dipping into both systems here. And this is a controlled substance, and I just think you're really abusing the system. And I'm going to revoke this this right that you have,’ and, and I was like, holy shit, my whole world turned upside down. And I was like, ‘What? Well, you don't understand…this is my life we're talking about. Like I just went here, because the resources were there. If I knew this was a problem, I wouldn't have done it. I didn't know that you couldn't do that.’ He's like, ‘we take this very seriously…we treat it like a narcotic.’ And I was, like, ‘had I known that I would not have done this’…and he's like, ‘well, you should have thought about that before you made that decision.’ And, and I was like, ‘Hey, can we meet in the middle somewhere? I really sincerely apologize for this. But like, I don't think you understand, like, I need these hormones.’ And he's like, ‘well, it also says, like, in your chart, that you're an addict. And I think that you're really, really abusing these, these drugs.’ And I was like, ‘No, no, you don't understand because like, for a trans person…if I take too much testosterone, that it turns into estrogen to compensate, right, so, um, so I would have like, an increase in estrogen and it wouldn't work the same way’…he was just trying to talk circles around me and I'm like trying to like educate him at the same time. And…trying to like, just beg him to understand that this is this is like very crucial to like who I am as a person. And, and then so he was like, ‘I'm going to revoke your right to, to self-inject. You're going to have to come in for the duration of the time that you have the VA insurance.’ I was like. ‘so the rest of my life I have to come in and take an injection?’…it was a misunderstanding and he was just not willing to budge.

Although Leo tried to advocate for himself and sort out the misunderstanding with the endocrinologist, his efforts were to no avail in part because of the provider’s seemingly limited understanding of the vital role of gender affirming hormones and likely in part because of stigma associated with substance use.

Eventually, others stepped in to advocate for Leo:

> I had to like get the LGBTQ coordinator of the VA involved and then my gender therapist involved and all these people had to vouch and advocate for me, because it just wasn't going to work. And so I still had to come in. And I played his game. And, and now

> since COVID, I can take my injections at home. But, um, but yeah, it just really like, surprises me that there isn't more like justice for like trans people in the health system.

Notably, those who advocated for Leo were those also in the health care field and thus considered professionals and experts in their own areas, perhaps increasing their credibility in the eyes of the endocrinologist. However, as this example illustrates and Leo alludes to, without this social support trans people are at the will of their providers.

Challenging oppressive assumptions

Some participants described directly challenging or resisting oppressive assumptions made by providers or oppressive policies and practices in health care environments. Many of the participants who were most willing to actively challenge their providers or oppressive assumptions embedded in healthcare practices were also those who exhibited the strongest sense of self. While in the moment these resistance efforts often served as a form of self-advocacy, they were also aimed at improving health care for all LGBTQ+ patients AFAB.

The most common example of this was asking clarifying questions or otherwise pushing back when providers asked questions related to sexual activity, which, as participants described, assumed patients were cisgender, heterosexual, and engaging in penis-in-vagina sex. Several participants recommended that sexual history questions be changed in various ways intended to get at the information that providers really need to know (e.g., whether they had multiple partners or had penetrative sex with a sperm-producing person). Participants felt improved sexual history questions would facilitate information sharing between patient and provider, thereby enabling providers to provide more tailored, and thus more person-centered and higher quality, care.

Dylan, a Palestinian American, greysexual, polyamorous, nonbinary, transmasculine, agender individual described their approaches to relay information that would enable providers to ask more tailored sexual behavior questions:

> Generally they [providers] ask, 'Are you sexually active?' And I, I kind of push back with like, 'I mean, what do you– what do you want to know?' Like, like, obviously asking, 'What do you mean by sexually active?'...Me asking define sexually active hasn't worked in the past, so I haven't done that again. But what I do now is I try to be very like, 'well, I engage in, you know, hands on my genitals and sometimes oral sex.' I try to give them, you know, activities I do. And then they can launch into their spiel. 'Do you use condoms? Do you use birth control?' 'No, I don't, those don't apply.'

Rather than assume patients are cisgender, heterosexual, and engaging in monogamous sexual relationships, Dylan hoped they would "consider that every individual patient is not the same as [their] other patients." In their encounters with providers, Dylan resisted these assumptions in an attempt to, at the individual level, receive more tailored care and cause providers to reflect on their assumptions in order to move toward societal changes in health care practice.

Some participants also challenged information provided by providers when they believed the information was incorrect. Most commonly clinicians had misinformed women about their sexual risk. While both Alexandra and Maddie had been told that they were at a lower risk of cervical cancer because they were only having sex with women, Alexandra, a gay Latina woman, accepted this as true (and quite readily because it meant fewer health care costs). In contrast, Maddie, a queer Latina woman, had educated herself about her STI risk, and spoke up when the clinician provided this misinformation:

> Oh, I had my OB/GYN one time told me, which was wrong, because I educated my own self, but when she found out I was having sex primarily with women, told me that I no longer needed to have Pap smears, because I was at less risk for contracting things. I was like, 'Actually, I'm at a higher risk.' She was like, 'Are you?' I told her about this book that Fenway puts out.

While examples such as these depict lack of LGBTQ+ health information, or misinformation, among providers, they reflect the lack of LGBTQ+ health training in medical curricula at the structural level. Likewise, while Maddie's advocacy efforts aimed at advocating for herself (that she did, in fact, need Pap smears) and at improving the competency of her specific provider, it was also part of the greater advocacy movement to better equip providers with the knowledge and skills to provide quality, person-centered care to LGBTQ+ populations. Indeed, nearly all participants spoke of the need for improved knowledge among providers.

In a few instances, participants spoke of their efforts to challenge discriminatory policies and practices in health care settings. Fern, a White, queer, nonbinary individual, described their recent experience trying to donate blood:

> I was also denied to donate blood here. I've given like four gallons in my lifetime of blood, lots of donations, been a blood donor for years. But this year…I went to update my gender identity, then, and like I was so thrilled because they had the option for the first time of being able to list your gender is nonbinary, the very first time that female male nonbinary is a gender option…But then as soon as they went to check my hemoglobin, I got denied because it wasn't at the male level. So even though so basically, what happens is the drop-down menu says nonbinary, and it defaults to male because that's the higher level. And so with nonbinary, since they don't know they default to male, and I'm like, I'm not a default male…You've taken four gallons of my blood, and it's been fine. And now you're going to call me like basically a man.

While at first glance Fern was excited by the change that enabled them to accurately report their gender identity, their attitude quickly shifted when the implications of the change became apparent. Given the transphobic nature and severe repercussions of this change, Fern decided to contact staff from the blood bank to inquire about, and challenge, the new policy:

> So it was like, I went from being like, totally gender affirmed to absolutely denied, and they didn't even want my blood anymore. And I'm like this one could save three people's lives this way you tell me every time I come in here, but now that I'm nonbinary, it's no good to you and you don't want it anymore…And I called them on it. And they got back to me. And I talked to their like, medical director about it specifically, who wanted to hear my perspective and wanting to hear my story. And explain why they had to use the male, you know, that they had to use the male levels and like they didn't know how to phrase the question otherwise…I'm like, there's other ways you could ask the question or like, in a medical context, it's appropriate to ask what– what sex were you assigned at birth. I'm not going to get offended by that in a medical context, because in a medical context, when it's relevant, you may need to know that, like, it's not generally polite to

> ask people that question, but when there's a medical need to know, that's different. Like I need my doctor to know that I still have ovaries. I need my doctor to know that I have menstruation…It is offensive to be told that I'm basically a man…I mean, they should have had people who are like reviewing questions like that, like, that's not well.

Fern put in time and effort–sharing knowledge and putting in emotion work–to explain the discriminatory nature of the policy to blood bank staff and how they could go about rectifying the policy. When I asked Fern whether the blood bank was going to revisit the policy, Fern replied:

> They said they're gonna…keep thinking about it. Keep talking to more people and consulting more people…but they also felt medically justified in saying that if I was nonbinary, they have to meet the higher threshold to be considered safe. So, they still do. And every time they call me and say you're eligible and donate blood, I'm like, you don't fucking want my blood anymore…I always enjoyed the fact that I was saving people's lives, but it's not good enough anymore.

Not only has the blood bank maintained the discriminatory policy, but their outreach efforts to Fern serve as a continuous reminder of the experience and that Fern is "not good enough" to donate.

Stigma management

Participants also used stigma or impression management (Goffman 1963) to minimize stigmatizing and discriminatory health care experiences and, in some cases, to optimize patient-provider relationships and care quality. Indeed, many participants made intentional decisions about what information they did, and did not, disclose to their providers, most commonly whether or not they disclosed their sexual or gender identity. In contrast, others exhibited hypervigilance in clinical settings, paying close attention to the clinic environment and to providers' reactions when they disclosed their identity(ies).

Controlled information sharing

Freida, a bisexual Latina woman, described how the stigma and discrimination she experienced in the clinic made her unwilling to disclose her sexual orientation to health care providers. She shared her experiences of weight-based discrimination she experienced in clinical settings, which made her reluctant to go to the doctor:

> I've always struggled with my weight. And it's something that I always hated going to the doctor for, because I hate getting weighed. Because then that triggers a conversation…And I'm like, I don't fucking care…Is there anything else that's wrong? Why does the number on the scale matter?...I shut down with the doctor and I'll be like, I don't want to talk about this. There have been times where I've told like, the nurses like I don't want to be weighed. Or if I get weighed, don't tell me how much it is because that's traumatizing to me. Like it's triggering. And they'll be like, 'okay.' And through that it's like it's always been that same conversation with every doctor that I've seen where they're like, 'well you know, you're a bit heavy…we can put you in these webinars. We can put you in like this nutrition stuff…

Due to these experiences as well as providers make other comments about her acne, Freida anticipated that her sexual orientation would similarly be considered deviant and result in stigmatizing and discriminatory experiences. Therefore, she avoided disclosing her sexual orientation to providers:

> And it's just every little thing that is kind of like not normal is so demonized, like acne, and weight, and all of these things…I don't talk about like my sexual preferences with them. Like, it's not something that I would bring up because of my experiences with like these other topics.

Notably, Freida went on to share how the COVID-19 pandemic had drastically changed her health care experiences for the better:

> I don't think I've been to the doctor in two years…I've been thriving since COVID started because I don't have to go into the office and I don't have to get weighed and stuff…recently, I had…emailed my primary care doctor, because, you know, at the beginning of all of this, I was having really bad anxiety. So I had emailed my primary care doctor, and I told her, 'Hey, you know, these are the things that I'm feeling, I would really be interested in maybe talking to a psychiatrist. So thankfully, I didn't have to go in and do like my physical exam.' So she just asked me a couple questions, and she referred me over to the psychiatrists…So because of COVID, I have been more receptive of reaching out to my doctor, because I don't have to physically go in.

Another participant who had previously experienced weight-based stigma and discrimination similarly reported that the shift to online and increasingly asynchronous care during the pandemic had similarly resulted in increased care seeking and improved her care experiences presumably because the risk of weight-based stigma and discrimination is significantly lessened.

Several trans and nonbinary participants reported concealing their gender identity from providers. Lee, a queer, Asian participant, reported presenting as a woman, rather than a nonbinary, genderqueer individual, in healthcare settings:

> when I go to get healthcare, I'm just like…I'm a woman…I wouldn't usually say that, but it, it also doesn't *really* bother me, but it's definitely just like, oh yeah, like, you know, the M or F and I'm just kind of like F, like whatever. And everyone uses she/her pronouns…I'm like whatever with gender, so it doesn't bother me that much, but I think that's definitely one thing where I'm just kind of like resign–this is a hospital and everyone is working off of like the biological binary, not a binary, but like whatever…I'm just kinda like okay, I need to go to the gynecologist and they need to know that I don't have like a dick, so I'm just gonna be like female.

Recognizing that healthcare, and obstetrics and gynecology especially, is a system built upon and that reproduces cissexism and the gender binary, Lee opted to conceal their gender identity and pronouns. Instead, they conformed to the transphobic assumption that, given they are attending an OB/GYN clinic, they are a woman. Although this, in turn, allowed Lee to avoid any stigma in the clinic, for Lee the focus seemed to be on avoiding an unnecessary conversation about their identity.

However, for some trans and nonbinary participants, recognition that identity disclosure might not only negatively impact their care experiences but lead to outright *denial* of services left them with no other option but to conceal their identity. For example, Hayden recalled intentionally not disclosing their gender identity to their provider due to fear this would prevent the provider from taking their claims seriously and working to identify ways to reduce their period-related pain:

> I never felt comfortable telling that gynecologist I'm nonbinary because I was worried. I was worried that she would assume, okay, I'm not having a medical issue at all. I just want this done and that she would just not do it for me, even though, yes, while this

> [dysphoria] is also something that I had going on, I also am experiencing a medical issue behind this. So I did not– I didn't open up to her about me being nonbinary at all.

Hayden was particularly reluctant to disclose their gender identity because the provider was already hesitant to consider performing a hysterectomy, which Hayden ultimately ended up receiving, given Hayden's age—they were 21 at the time of the surgery, and 24 at the time of their study interview. In another case, Fern, a White, queer, nonbinary individual, attended the ER for "really heavy menstrual bleeding," and similarly reported concealing their gender identity for fear they would be denied care for being nonbinary due to the hospital's religious affiliation.

Hypervigilance in clinics and with providers

Another common stigma management strategy was being hypervigilant in sexual health care settings. For some, this meant being aware of potential symbols of inclusion and LGBTQ+ acceptance in the clinic environment such as pride flags, posters and brochures including same-sex couples and trans and nonbinary individuals, and pronoun stickers or questions on forms. Overwhelmingly, hypervigilance took the form of attentiveness to providers' responses when participants disclosed their sexual orientation.

In describing her experience coming out to a provider she had not previously seen, Alexandra, a gay, cisgender Latina woman, commented, "she [the provider] just kept moving on. She didn't make a big deal out of it, which was my fear." When I asked what gave her the impression that the provider was not making a big deal when Alexandra disclosed her sexual orientation, she replied:

> I think there's like, some, like very simple body behaviors that anyone can pick up on social cues. And like someone that kind of squint their eyes, like they don't really hear you correctly. When someone maybe like moves their head to the side, or also like, just like literal expressions with like, their mouth that I got purse, their lips or something like that, then those are like little tiny instances where I think someone's uncomfortable, confused. But then also, what they ask after I come out is like, really impactful. So there's been questions just like to like, elaborate, because they don't understand. And that's a bit

> awkward. But maybe it's necessary, because they might not know like, who my partners are, even if they are women, as in like, what, what their bodily bodies are like, but then there's been questions that have been like, ‘Oh, well, how does that work?’ Or like, ‘what do you use?’ And that's when it gets really uncomfortable because then it becomes a bit more invasive.

In fact, Alexandra went on to share, “I usually like right away come out and say, ‘Oh, I’m gay,’ and see how they react.” She viewed disclosing her sexual orientation to providers early on and then watching their reactions as a means to “test the waters,” so to speak.

While Alexandra was unique in the overtness of her tactic, others similarly reported heavily relying on providers’ body language to connote their (dis)comfort with patients’ sexual orientation disclosure and looking to providers’ verbal responses after disclosure. For many this was a way to screen providers–participants could switch providers if their response indicated discomfort, disbelief, or was otherwise not in line with the qualities the participant was looking for in a provider, thereby enabling participants to avoid starting to build a relationship with such a provider. However, for others with more limited care options or limited understanding of how to go about switching providers, these observations simply meant that participants had less trust in, and were less open with, their providers during future encounters.

Seeking information and support

Participants nearly universally reported having actively sought out sexual health and/or gender affirming care related information on their own from online resources (e.g., YouTube), social media (e.g., TikTok), queer individuals in their social networks, and books. While people increasingly seeking health-related information outside of the clinic is not unique to LGBTQ+ populations, for this sample of racially diverse LGBTQ+ people AFAB active information seeking was driven primarily by structural oppression. For example, participants reported that, given the stigma associated with same-sex sexual behaviors and societal construction of “sex” as penis-in-vagina sex between a cisgender man and cisgender woman, queer sex education was missing from sex education when they were in school. Thus, they actively sought out other avenues through which to obtain information both about STI risk and how to have same-sex sexual relations. Further, many participants actively sought information because they anticipated that providers would have limited–or in some cases incorrect–knowledge due to lack of provider knowledge and training about LGBTQ+ health.

Many shared how support–in the form of both informational and emotional support–from those in their social networks aided in navigating barriers uniquely experienced by LGBTQ+ populations, thereby enabling participants to translate social capital into cultural health capital. In addition to discussing sexual health in their queer social networks as a means to obtain personally relevant, and to spread LGBTQ+ inclusive, health information, many leveraged their networks to obtain recommendations for clinics and providers that were knowledgeable about LGBTQ health. Leveraging social capital was a particularly important strategy for trans and nonbinary participants, who described traditional healthcare as failing to meet their informational and care needs. For example, Grant, a mixed race, gay, trans man, had not been seeking care due to medical distrust and previous trauma. However, during a time he was in a bad place and not taking care of himself, a trans elder, and subsequently a different trans friend, recommended he seek care from a clinic specializing in LGBTQ health services. Grant described these interactions and the encouragement he received, "I was seeing all these people who were living…the life that I wanted to live and they're like, yeah, it's literally just across the bridge. Can you go ahead and do that for yourself?"

For those who had previously, were currently, or were considering seeking gender affirming services, social support often offered opportunities to learn about gender affirming services and navigating related health care. Lee, a queer, Asian individual, noted that while they believe health care providers have little knowledge about trans health and gender affirming care, they could instead rely on knowledge and experiences shared by their friends who have or are going through the transition process:

> I feel like I know more than my healthcare provider and so like they can't really help me with this situation because *I'm* the person that would be trying to educate *them*. So I kind of just don't think of them as someone that I would like depend on for…those [gender-related care] issues. Like I would think if…I was like, 'oh, maybe I should like try going on T and like transition' or something like that, that's something that I would not talk to, like any of my healthcare providers about, um, that's something that like, I would talk to one of my friends who's like transitioning now….I would definitely go to them…or another queer person that I thought was like more informed or someone I thought of as like, uh, as smarter than me I guess, basically…I don't think that they [providers] would, uh, be very helpful.

Leo, a Latino trans man, spoke of the critical roles finding a strong in-person community of LGBTQ people, online resources, and social media played as educational, community building, and emotional support tools in his journey. Eventually he came to use social media as a means of sharing his transition process with his social network and as a way to spread information about his experience and the process of navigating gender affirming health care, hopefully in turn helping support, other trans individuals:

> I use social media for like, a lot of different reasons. Now, I use it to, like, educate myself, but also, other people…I just feel like it's a really easy way to kind of like, put your, like, your position out there in the world, I guess…For like, when I first came out as [name], I came out on Facebook pretty much because I didn't want to have to go through those interactions with people like, 'oh, by the way, like I'm transitioning,' and blah, blah. Like I didn't want it– I didn't want to do it. So I just kind of did it on Facebook and everybody sees my Facebook all the time…I use Facebook and Instagram all the time too. I made my transition very public. And like every step like I did, like monthly videos of my voice dropping and but I also did like everything I was learning about myself. I kind of made that very transparent to everybody else… like I went through top surgery, I talked about that process…So yeah, for like education purposes for both ways, like so I can learn and so maybe I could help the next trans person out there, and then just providing resources for people.

Intentional selection of healthcare

Another strategy that some participants used was being selective about which clinic(s) and/or which provider(s) they sought care from. Some received care from clinics that offer care tailored to LGBTQ+ populations, which they often found out about through other LGBTQ individuals, as illustrated by the story of a trans elder connecting Grant to one such clinic. Several others reported seeking care from community-based clinics that specialize in women's health or in sexual health and STI testing, which most felt offered more personalized, and thus better quality, care largely due to providers being more personable.

Many participants also spoke about being intentionally selective about their health care providers in order to foster comfort and relatability. When looking for a provider, nearly all participants reported preferring to receive care from a woman, and many added that they preferred a provider who also identified as LGBTQ+ or who was at least "LGBTQ+ informed," meaning knowledgeable about LGBTQ+ health. Participants leveraged resources including LGBTQ+ peers and online search tools (e.g., insurance portals, provider profiles) where they looked for indicators such as mention of having attended specialized LGBTQ+ health trainings. For example, Dylan described leveraging his social network as a resource:

> And I also try to ask around for recommendations in my network, like, 'hey, Who's your doctor? Are they taking new patients? Oh, this person is not taking new patients? I might, okay, who else do you recommend? Do you know anybody else? Does your doctor know anybody else who's informed about this sort of thing?' And also, I've never done this, but it's a strategy I kind of tuck in the back of my mind, where if I have been seeing a therapist for a while, I will ask them if they know any doctors who might be good for me. Or like trans friends, or people in my network are our therapy, like their therapists, they can ask their therapists if they know any doctors who might be trans and queer informed.

Moreover, most, though not all, participants of color, as well as a few White participants, preferred seeing a provider of color. However, a few noted preferring not to see a provider of the same race as themselves. For example, Hayden described preferring a woman of a different race than herself because she felt Black providers assumed they had the same experiences as, and thus could relate to, Hayden. Her previous experiences with Black providers coupled with her experiences with male providers and being a survivor of sexual violence informed her preference for women providers who were not Black.

While many participants mentioned preferring and actively seeking out providers with particular demographic characteristics, Dylan uniquely mentioned an alternative they consider when evaluating whether a provider is likely to be “trans informed in some way”:

> I try to see, like, you know, if in their profile, they talk about, like, having worked with LGBT people, or being anywhere on the queer spectrum themselves. If I can't find that, I try to look for other qualities like has this person been in the Bay Area their whole life, did this person go to medical school in SF or Oakland or related. Because I think, like, I guess, for me, that increases their likelihood that they've ever **met** a trans or queer person in life. Yeah. And like, if they've grown up in the Bay Area and are practicing medicine, in Oakland or San Francisco, the probability of not being weird, you know, conservative, moderate people is fairly high for me. Because, you know, growing up in a certain area, you tend to adopt those values and keep them. But I guess I look for, if not specific, LGBT related certifications, or experiences I tend to go for like, you know, things that tell me about their value set, like maybe, you know, you were trained here, so might be more progressive, or you have, you know, maybe or, or the alternative, like, oh, you're maybe you're an immigrant, but you have- you were trained in the Bay Area, so like, you know, that not everyone is like you because weren't raised in America and you know what it's like to be othered… if I get someone that went for like, no, Kentucky or Alabama or Minnesota or some- Missouri, I become a little guarded. And like if I see that someone went from Medical School in a country whose values I'm not familiar with, I just I just pass them over because I just don't want to take the risk. They're probably fine people, I don't want to.

Despite the distinctive nature of Dylan’s comment, the strategy resulted from limitations highlighted by many others. There was a disconnect between qualities participants were looking for and being able to identify providers with those qualities. This disconnect stemmed from the limited information available online about providers, which limited participants’ ability to identify providers with certain demographic characteristics and clearly informed the strategy that

Dylan had developed. Additionally, due to structural discrimination, the number of LGBTQ+ and providers of color are limited.

Patient-provider collaborations and cultural health capital

While participants spoke of various strategies that they used to navigate care encounters, they also called attention to how providers' actions during patient encounters inform how interactions unfold. Principally, providers' actions inform the severity of the power differential between patients and providers as well as mobilization of the aforementioned navigation strategies and cultural health capital. Emily, a questioning, Latinx immigrant from El Salvador who was a nurse herself, described how she interacts with her patients:

> Yeah, I really try to, like, listen to my patients… And if they need something, I'm really proactive about like advocating for them to whoever I need to, just making sure that they get it and that they're, that they're, that they're part of their care….

These qualities–close, active listening, advocating for patients', and engaging patients in their care decisions–were nearly universally mentioned as qualities that participants looked for in their health care providers. As depicted by participants' stories, these qualities helped minimize the patient-provider power differential and facilitate open communication, thereby forging productive collaboration between patients and providers.

Several participants spoke of the responsibility they felt providers had to initiate conversations with their patients, thereby creating space in the conversation for patients to share information or ask questions, rather than the burden to speak up falling solely, or even primarily, on patients. When I asked Esther, a bisexual Latina woman who was pregnant at the time of her interview, whether she discusses sexual behavior with her provider, our exchange proceeded as follows:

> **Esther:**
> That feels embarrassing. Sometimes I have questions and I want to bring things up and I just know I don't know…It's just so hard sometimes to talk about, especially when you go in such a rigid place like a hospital to talk about those things. And it's so bright in there…there's nowhere to hide, you know, it's you just can't hide your faces there. It's so bright, they can see every single thing…sometimes I just wish I could ask like, is this safe to do with this?...just ideas that I have about sex and whether those are normal…
>
> **Interviewer:**
> … what would make that more comfortable? What would make you feel more comfortable having those conversations?
>
> **Esther:**
> …I need structure. Like, I know I can talk, but I, I don't know how to start. So it's helpful if you start, if I'm given questions or given ideas or topics. And what I mean by that, or what I hope by that, you know, an ideal world, it's, it's not just, you know, this laminated paper that you have to check off boxes on, which is usually the case at the doctor. And then they like, look at it for two seconds. And that's it. This would be a conversation, right. Like, words are being used.

For Esther and many others, initiating conversations with providers, particularly conversations related to sexual behavior and health, was challenging, but participants anticipated, or had experienced situations in which, providers' initial prompting led to a more open dialogue. Indeed, this prompting is likely to particularly enhance encounters with patients who are less likely, or have less cultural health capital, to speak up otherwise.

Esther, like others, emphasized the importance of building productive collaborative partnerships between patients and providers. When asked about the qualities she looks for in providers, Esther described providers as having a responsibility to be aware of how they are engaging with patients and to tailor the encounter to the individual and their unique situation and concerns:

> awareness of who they are and where they are and who they are talking to, or who are they, you know, providing services to. Because, you know, we come in with our own experiences as patients and as clients and, and we, though we understand that, you know, even the provider themselves have their own identity and have their own, you know, life …I feel [the provider] like has the responsibility to really be aware and to be conscientious of who they are and how they talk to people…I look for a provider or

> someone who is, who is going to respond and complement my, my concerns, my worries, my questions, you know, what I'm coming in with. And that's kind of hard, you know, like, you can't just match a provider on a patient. But we have to be adaptable. And then in that way, try to match or complement whoever you're talking to.

She drew on her experiences with her current OB to depict the types of partnerships to which she was alluding:

> …so my OB right now, you know, I'm pregnant. So I, I've been seeing my OB for a while now. Or very often, I should say. And I'm a very worrisome person, just in general and even more so now that I'm pregnant. And I feel like a lot of the times when I've had other providers, first of all, I haven't had a consistent OB up until now because I've been, I've been seeing the same one because of my pregnancy. But I feel like they've– most of the time, we've kind of just– they laugh at my worries or my concerns, because…they know the science behind everything. And they know, you know, the facts…And so I've had people laugh…making light of my worry. In my current provider, she's gotten to know me, and she sits down, and doesn't make it feel like she's in a rush. And she really hears my questions and really helps me understand why I'm even worried about the things that I'm worried about. And then tries to give me information because I love information and then helps me.

As Esther's example with her OB illustrates, providers play an integral role in encouraging and facilitating patients' involvement in their own care and thus greatly inform how patients navigate healthcare.

Several participants highlighted that part of building a successful collaboration entailed providers recognizing that patients bring their own knowledge and expertise into their clinical encounters based on their lived experiences. While participants recognized that providers possess a particular type of specialized knowledge, they also argued their lay knowledge could and should be used to inform their care. One interviewee, Maria, described how she felt LGBTQ+ sexual health challenged the traditional tension between lay and expert knowledge:

> I think I kind of expect…doctors to be culturally incompetent in the sense that most cishet people are really clueless when it comes to queer things. I'm not saying that that's ideal, but...it would make no sense to be like 'Oh, most people in my life are clueless about this, but this doctor is really well informed.'

Here Maria argues that society as a whole is not knowledgeable about queer culture, so clinicians should not be held to a different standard. Maria, as well as a few others, expressed rather low expectations for clinicians when it came to being knowledgeable about queer health. Instead, what they found frustrating was that rather than clinicians acknowledging when they were less knowledgeable or uncertain about something, clinicians often *pretended to know*, attempting to maintain the power division between lay and expert knowledge. However, what interviewees really hoped for was a provider who "is aware of what they know and don't know, and they're not afraid to admit when they don't know something, because you can't know everything" (Maddie).

Given U.S. healthcare historically has been, and continues to be, a White-centric, racist institution in which the majority of providers are White, building successful person-centered, patient-provider collaborations may be particularly important for LGBTQ+ patients of color. Avery, an Asian lesbian woman, described feeling out of place when they sought health care:

> I think that the way that I present and the identities that I hold, however, that influences the way that I feel at, say, like a supermarket. It's the same as if I'm in a doctor's office. So like, um, I get really uncomfortable if I'm in a room full of White people. Like I get really uncomfortable if I'm in a group full of like White men and like cis[gender] men. And so like similar, you know, that is true across any environment if like I'm surrounded by a type of person that I am not comfortable around…but obviously like being in a healthcare– health environment, like if I'm in a doctor's office where I'm perhaps in a state of heightened vulnerability that I wouldn't otherwise be in like a grocery store, you know, it, it magnifies it of course…healthcare is not a realm where I feel empowered to like ask for those things that I want or need…And in my experience, it's a thing that I have, like I, I tolerate and have to go through every, every so often.

As Avery suggests, due to the heightened power differential, patients of color may feel less empowered than White patients yet, as suggested by various participant experiences such as those shared by Hayden and Papi, patients of color often have to put in more work (i.e., self-advocacy) in order to receive the care that they are seeking.

Further, Papi shared an experience which suggested that providers might be more responsive to, and foster more enhanced collaborations with, some patients compared to others. In speaking about a specific provider who best represented the qualities that Papi looks for in a provider, Papi shared how their relationship, and interactions, had evolved over time:

> The first time I started asking her questions, she just answered me, like, quickly, but then when I started asking more questions, and she started explaining more, and I showed her that I understood her responses, that was when she was like, ‘oh,’ like, almost like the eyebrow raised like, ‘oh, oh, okay.’ You know, ‘this one has questions.’ And I know at first she kind of actually wanted to rush me through it. But after that, every appointment that I had, I scheduled it with her. Because she would explain stuff to me. And after that, she just anticipated that I was going to ask her questions, so she would tell me things, and then she would put her clipboard down and look up me and be like, ‘Alright, so what questions do we got,’ you know. Just basically anticipating that it was going to be a dialogue. And so she already knew the relationship was, was not going to be just heard, you know…maybe they're used to having patients that are passive, I don't know. But maybe we have opportunities instead where we change that, or we engage people more instead of just expecting the patient or the doctor to both be perfect…

While at first the provider “answered quickly,” with time her approach shifted–she took the time not only to answer Papi’s questions but also to explain (unprompted) questions about their care. Papi suspected that using biomedical language similar to the provider gave them more credibility in the eyes of the provider:

> **Interviewer:**
> And when you when you said that you showed her that you understood what she was saying …was there anything in particular that you think you did that made her realize, like, ‘Okay, this person is, is really getting it and is going to, like, want to engage in this dialogue?’
>
> **Papi:**
> I feel like, I'm not really sure what it was that I said, you know, that I did. Um, you know, but but I know that, that when I reflected back to her that I understood what she was saying, it was like that, I think it was because I understood, like some some things about how my body works, that she also understands what the same words, you know, and then the same framework. And since I was able to be like, ‘Oh, yes, I know what you're talking about. Yes.’ And I reflected that back to her. She was like, ‘Okay, this person and I…we can speak– we can understand each other’…and I think because I had that understanding, she knew that I was willing to that I wanted to engage my body in this way, right with this understanding.

Thus, having these skills–the cultural health capital–to reflect the provider's language and show a commitment to active engagement in their care enhanced the collaboration between Papi and their provider.

In another instance, Maria, a queer Latina woman, was seeking STI testing and had disclosed to the clinician that she only had sex with cisgender women, at which point the clinician said she did not need STI testing. However, Maria was insistent. She was particularly concerned about herpes, which she felt would impact her sex life. Therefore, she lied in order to get the tests that she wanted, stating that she had engaged in sex with a man and that she had sores around her mouth. She knew this would fit some of the criteria the clinician was looking for in order to be willing to give her the tests. However, Maria also acknowledged that not everyone would have the knowledge and skills–the cultural health capital–to be able to navigate a situation such as this.

DISCUSSION

This study examined strategies beyond avoidance of care that LGBTQ+ people AFAB use to navigate health care encounters in order to receive needed care and/or combat oppressive assumptions, practices, and policies. While studies have identified numerous barriers to care and examined the sexual health care experiences of LGBTQ+ people AFAB, it is important to recognize patients as active agents in interpersonal exchanges between patients and providers. I found that participants utilized a variety of covert and overt approaches to obtain needed care services and to navigate cissexism, heterosexism, racism, and fatism as well as misinformation in the clinic. Understanding strategies that patients use will help develop new, and improve existing, programs, practices, and policies in order to advance LGBTQ+ health equity and ensure that LGBTQ+ people AFAB receive quality, person-centered care.

Many findings from the present study are similar to, and build upon, prior studies that reported strategies LGBTQ+ people AFAB use in navigating care encounters and resisting stigma (Agénor et al. 2022a, Carpenter 2021, Paine 2018, Seelman and Poteat 2020). Similar to past studies, LGBTQ+ adults AFAB actively sought information in order to fill in gaps in their health knowledge, a strategy that often emerged as a result of the limited availability of LGBTQ+-inclusive information in formal sex education settings and a lack of knowledge among providers. Participants sought information largely online and through members of their social network, who provided both informational and emotional support, particularly for trans and nonbinary participants (Agénor et al. 2022a, Eiduson et al. 2021, Seelman and Poteat 2020, Taylor 2013). While this speaks to the integral role of social support in sexual health care for LGBTQ+ people AFAB, it also speaks to the need for improved provider knowledge and more comprehensive and inclusive sex education.

Further, this study found that LGBTQ+ individuals AFAB intentionally select their care providers by seeking information about providers and clinics through their own research and by word of mouth from their social network (Taylor 2013). Participants intentionally sought care from clinics and/or providers that best aligned with the qualities they looked for in providers, often seeking care from providers who shared a marginalized identity(ies) with participants (Agénor et al. 2022a). For several participants, this meant seeking care from LGBTQ+ specialized or community-based clinics. While many participants noted that they would prefer to receive care from LGBTQ+ providers or women of color, most described having a provider who was a woman and, in a few instances, specifically a woman of color. Despite being in the Bay Area, participants described having difficulty identifying and/or accessing LGBTQ+ or Black or Latinx providers, similar to another study (Carpenter 2021).

Consistent with prior studies (Carpenter 2021, Seelman and Poteat 2020), this study also found that individuals intentionally control what information they do and do not share with providers for a variety of reasons. Most prominently, LGBQ+ individuals manage whether or not they share their sexual orientation and trans and nonbinary individuals whether or not they disclose their gender identity in order to prevent anticipated discrimination and denial of care. Further, by looking for reactions (e.g., body language, eye contact) after disclosure and evaluating the clinic environment, participants described how they evaluated the presence (or absence) of microaggressions in clinical settings (Sue 2010).

Finally, participants had also developed advocacy and resistance strategies, including advocating for themselves, advocacy from others, and direct resistance to oppressive practices and policies. This included challenging heterosexist and cissexist practices, such as Fern's example of challenging the blood bank policy, as well as challenging incorrect information provided by providers, such as that sex between cisgender women poses no STI transmission risk (Scherzer 2000). These findings are consistent with prior studies that found that LGBTQ+ individuals AFAB engage in self-advocacy in order to improve care for themselves as well as advocacy efforts to improve care, and promote equity, for LGBTQ+ people as a whole (Agénor et al. 2022a, Scherzer 2000, Seelman and Poteat 2020).

Limitations

These findings should be interpreted in light of several limitations. The results reflect the lived realities of a convenience and snowball sample comprised of individuals living in the San Francisco Bay Area, specifically. Due to COVID-19, recruitment was conducted primarily online, which may have systematically excluded people with limited technology access due to socioeconomic or other reasons who would have otherwise wanted to participate. Nearly all participants were currently enrolled in health insurance and had previously sought sexual health care, so the findings may not capture the experiences of uninsured individuals or those who have not sought sexual health care. This may have partially resulted from study recruitment materials which characterized the study as focused on sexual health and thus may have led to a sample of respondents more willing to discuss sexual health.

Furthermore, no Native respondents and three Black respondents were included in the sample. Thus, given the characteristics of this sample, the results may not capture the experiences of the most marginalized individuals, such as Black trans and nonbinary individuals (Agénor 2019). This limited my ability to examine how multiple forms of social identity and inequality might simultaneously inform how people navigate clinical encounters. Finally, participants are more likely to have recalled extreme experiences and, as a result, the strategies identified are unlikely to be a comprehensive list. Future studies should conduct observations of patient-provider interactions for a more comprehensive and nuanced understanding of the strategies used and how power plays out, and is resisted, by both patients and providers in encounters between LGBTQ+ individuals AFAB and providers, with particular attention to how multiple systems of oppression inform the unfolding of clinical encounters.

Implications

While these findings demonstrate resilience on the part of LGBTQ+ patients, adaptive strategies to obtain needed health services and to receive quality, person-centered care free from stigma and discrimination should not be necessary. Yet, because U.S. healthcare is founded upon and upholds heterosexism, cissexism, racism and White supremacy, classism, and fatism, LGBTQ+ patients often need to fight to receive needed services. Participants' experiences speak to the need for enhanced trainings focused on topics including LGBTQ+ health and structural competency among providers (Donald, DasGupta, Metzl et al. 2017, Downey and Gómez 2018, Metzl and Hansen 2014), but also underscore the fact that educational trainings are insufficient to address the stigma and discrimination that patients experience (Dean, Victor and Guidry-Grimes 2016). Additional structural changes are needed in health care, including ensuring organizations' context (e.g., structure, operations, practices) and environment are welcoming to patients from diverse sexual orientation identity and racial/ethnic backgrounds (DeMeester, Lopez, Moore et al. 2016) and organizational commitment and accountability for improving hiring and retention practices to enhance the diversity of providers and meet the need for providers who shared lived experiences of socially marginalized patients (DeMeester et al. 2016, Donald et al. 2017, Peek, Lopez, Williams et al. 2016, Prather, Fuller, Jeffries IV et al. 2018).

An important contribution of this study is its explicit discussion of power in the clinic, with an emphasis on patient-provider power dynamics. Findings speak to the power of medical authority (Filc 2006) and the gatekeeping role that providers play, with the power to grant or deny services, medications, and medical procedures to patients. As a result, in certain contexts–such as when requesting gender affirming hormones–many participants felt pressured to acquiesce to providers' requests in order to obtain care, thereby conforming with, and thus reproducing the power differential between patients and providers (Peitzmeier, Bernstein, McDowell et al. 2019).

This pressure–and thus a reduced likelihood to resist stigma and discrimination–may be particularly felt by the most socially marginalized and those with limited access to resources that might enable them to seek care elsewhere (Poteat et al. 2013). Indeed, in some cases social position and access to resources informed how participants navigated encounters and their degree of success in obtaining needed services and/or challenging oppressive practices or policies

(Carpenter 2021). Although LGBTQ+ individuals AFAB often advocate for themselves, and for LGBTQ+ rights as a whole, in health care settings, some are more able, and some are more willing, to challenge or resist stigma and discrimination, and their efforts have varying levels of success. These findings point to the fact that a complex array of factors, including type of health services being sought, cultural health capital, gender identity, race/ethnicity, and sense of self, shapes how patients navigate clinical encounters. While this is a major contribution of this study, due to data limitations and the complexities of care navigation processes, I was limited in my ability to examine how these factors *interact* to shape care navigation and whether strategies implemented varied by sexual orientation identity, race/ethnicity, and gender identity, an important area for future inquiry.

Participants also described and demonstrated that, in the face of stigma and discrimination and lack of provider knowledge, it is particularly important that providers recognize and value patient knowledge–embodied but in many cases also biomedical. LGBTQ+ individuals AFAB exhibited extensive knowledge about their bodies, LGBTQ+ sexual health, and how to navigate stigma and discrimination in clinical settings as well as embodied expertise based on their lived experiences. As Maria alluded to, this knowledge, while different from the expertise of providers (Popay and Williams 1996), has a particular value given limited knowledge of LGBTQ+ health among many providers. Unfortunately, providers typically overlook the value of lay knowledge, which may be particularly problematic for populations that historically have had negative experiences in clinical settings, such as LGBTQ+ individuals and people of color, as it could exacerbate health care avoidance.

Relatedly, findings also point to the fact that, even in the context of systemic stigma and discrimination, productive collaborations (Filc 2006) and the exchange of cultural health capital

(Chang, Dubbin and Shim 2016, Shim 2010) can lead to mutually satisfying interactions between LGBTQ+ patients AFAB and providers. These productive collaborations were most often forged in clinics offering specialized LGBTQ+ health services and community-based clinics, which provided more person-centered care. Given many of these clinics are under resourced and such clinics are limited in number, financial and logistical support is needed to support existing clinics and to create additional facilities of this nature. This would help minimize barriers and improve the quality of sexual health care provided to LGBTQ+ people AFAB by better meetings their needs and centering their experiences (Harb, Pass, De Soriano et al. 2019, Howard, Lee, Nathan et al. 2019, Seelman and Poteat 2020).

Finally, efforts to leverage, but simultaneously seek to change, the culture of medicine may help to mitigate stigma and discrimination and promote health equity. For example, given medicine's role in defining sexuality and sex/gender (Paine 2018), sustained major changes to sexual history assessments along with changes to make sex ed curricula comprehensive could help redefine societal sexuality and gender norms, making them more inclusive. Meanwhile, challenging the lay-expert divide might help empower patients, forge productive patient-provider collaborations, and, ultimately, combat oppression in the clinic (Wilkerson 1994:330).

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CHAPTER 5: Conclusion

SUMMARY AND KEY FINDINGS

In this dissertation, I examined how stigma impacts the sexual health and gender affirming care experiences of LGBTQ+ people assigned female at birth and how they navigate clinical encounters. This study, informed by the fields of sociology and public health and theoretical frameworks of intersectionality, stigma, and structural and social determinants of health, was motivated by sexual health care inequities among LGBTQ+ people assigned female at birth and limitations of existing studies on the topic. Specifically, this project considered how multiple dimensions of social inequality simultaneously shape sexual health and gender affirming care experiences. Further, given existing studies overwhelmingly represent the experiences of White LGBTQ+ people, the qualitative portion of this study sought to recruit a sample comprised predominantly of LGBTQ+ people of color.

Through its concurrent focus on the micro and macro levels, this dissertation, in part, demonstrates how–at the macro-level–institutional practices and policies and–at the micro-level–providers' interactions with individual patients reproduce and reinforce systems of oppression, thereby maintaining inequality. In this way, this project helps to unearth how stigma is a fundamental cause of sexual health care inequalities among LGBTQ+ people assigned female at birth (Hatzenbuehler, Phelan and Link 2013). However, it also sheds light on how individual patients and how, together, patients and providers can resist manifestations of stigma and oppression in the clinic.

Specifically, in Chapter 2, I examined interpersonal and structural factors that inform sexual health and gender affirming care seeking and quality of care among a racially/ethnically diverse sample of LGBTQ+ people assigned female at birth. Consistent with prior studies

(Agénor, Geffen, Zubizarreta et al. 2022a, Agénor, Zubizarreta, Geffen et al. 2022c), I found that experienced and anticipated discrimination in clinical settings as well as structural factors impacted care seeking and quality of care. Specifically, participants reported experiences of interpersonal sexism, cissexism, and racism as well as, in a few cases, of being stigmatized due to weight or prior mental health or substance use. Structural factors included resource-related factors common to the general population, principally cost, insurance, and limited time during clinical encounters, as well as structural discrimination that specifically impacts LGBTQ+ populations, including medical gatekeeping, insurance coverage of gender affirming care, the cissexist nature of sexual and reproductive health, limited access to providers knowledgeable about LGBTQ+ health, and a lack of access to LGBTQ+ providers, which similarly impacts patients of color who have limited access to providers of color. However, some participants also reported experiences of inclusive, affirmative, and person-centered care which promoted sexual health care seeking and quality care interactions.

In this chapter, I argued and demonstrated how the impacts–positive and negative–from the aforementioned factors are especially consequential in the context of sexual health and gender affirming care given the stigma associated with these types of care, the particular position of vulnerability that these care interactions often place patients in, and the importance that most participants placed on provider awareness of patients' LGBTQ+ identity(ies) in these care contexts. Further, the impacts are heightened for multiply stigmatized populations who may experience multiple types of stigma and discrimination. Findings particularly pointed to the importance of mitigating medical mistrust and building trust between patients and providers, which, it would be remiss not to mention, requires combatting stigma and discrimination in healthcare settings, to facilitate health care utilization and optimize care experiences among LGBTQ+ populations.

Next, in Chapter 3, I utilized secondary survey data from the National Survey of Family Growth to focus in on a specific component of sexual health care: receiving a sexual history assessment. I examined racial/ethnic and sexual orientation identity differences in having received a sexual history assessment from a medical provider in the last 12 months. In this chapter, I analyzed five different dichotomous outcome measures: having been asked about sexual orientation or sex of sexual partners, number of sexual partners, condom use, or types of sex engaged in and having been asked about any (i.e., one or more) of the aforementioned four outcome measures. Driven by existing stereotypes and in line with some of my findings in Chapter 2, I hypothesized that Black heterosexual, Latina heterosexual, Black bisexual, and Latina bisexual women would report higher odds, while White lesbian women would report lower odds, of having received a sexual history assessment compared to White heterosexual women. Additionally, I hypothesized that Black and Latina bisexual women would report the highest odds of having received a sexual history assessment.

Results were largely consistent with my hypotheses, with some variation by outcome measure. Black heterosexual, Latina heterosexual, White bisexual, Black bisexual, Latina bisexual, and Black or Latina bisexual women had higher odds of having received any sexual history assessment compared to White heterosexual women. Black bisexual women had the highest predicted probability of having received a sexual history assessment, and Black heterosexual women, not, as hypothesized, Latina bisexual women, generally had the second highest predicted probability.

Finally, in Chapter 4 I examined strategies that a racially diverse group of LGBTQ+ people assigned female at birth use to navigate sexual health care in order to obtain needed services and, in some cases, resist stigma and discrimination. Strategies developed and mobilized included conforming to biomedicine and provider recommendations; advocacy and resistance; stigma management; seeking information and support; and intentional selection of healthcare. My analysis also considered whether specific strategies were more likely to be mobilized by certain groups or under certain conditions, finding that controlled information sharing specifically emerged in conditions under which participants feared potential denial of care. Further, participants tended to mobilize strategies that conformed to asymmetrical patient-provider power relations under these conditions. Additionally, seeking information and support was a strategy especially leveraged by trans and nonbinary participants.

Findings pointed to how power relations are reproduced in the clinic and ways that patients resist stigma and oppression in order to obtain needed care and/or to advocate for the LGBTQ+ community as a whole. Further, this chapter demonstrated the role of providers in shaping how patients navigate care, shedding light on the potential for person-centered patient-provider collaborations to optimize LGBTQ+ patient care experiences. This entails creating space for, and empowering patients to, speak up during clinical encounters, thus contributing to the mobilization of their cultural health capital, and also recognizing the knowledge and expertise that patients bring to encounters, thereby challenging the traditional lay-expert divide. Building successful person-centered, patient-provider collaborations might be particularly important for LGBTQ+ patients of color given the heightened power differential they likely experience compared to White patients in clinical settings. However, findings also gesture to the role of cultural health capital in the reproduction of health care inequalities, as providers might be more responsive to, and foster more enhanced collaborations with, patients who have the skills that providers value (Dubbin, Chang and Shim 2013, Shim 2010).

As a whole, these findings contribute to a growing body of literature focused on LGBTQ+ health. While much existing literature has examined barriers to care, which were examined as part of this project as well, rather than conceptualizing these solely as barriers, I considered how these "barriers" are reflective of, and reproduce, social inequality more broadly. This is true of both how I understood structural factors as well as how I understood patient-provider interactions. Indeed, by combining population-level quantitative work (Chapter 3) with qualitative data from interviews I conducted with a racially/ethnically diverse sample of LGBTQ+ individuals assigned female at birth (Chapters 2 and 4), I gained more nuanced insight into individuals' health care experiences, demonstrating how micro-level interactions are co-constitutive of macro-level processes and phenomenon. Thus, a major contribution of this work is its explicit attention to how multiple systems of power and oppression manifest and are reproduced at multiple levels to impact the health care experiences of LGBTQ+ people assigned female at birth.

IMPLICATIONS

The findings from this dissertation speak to the fact "that multiple interventions across levels are necessary to dismantle systems of power" (Sievwright, Stangl, Nyblade et al. 2022:S359). Interventions needed to promote sexual health equity for LGBTQ+ people assigned female at birth range in both scale and scope. For example, there is a need for more inclusive clinic environments that use gender neutral colors and in which diverse identities, including, but not limited to, LGBTQ+ and people of color, are represented (Dean, Victor and Guidry-Grimes 2016, DeMeester, Lopez, Moore et al. 2016). Additionally, although findings regarding the impacts of provider trainings are mixed (e.g., Maina, Belton, Ginzberg et al. 2018, Morris, Cooper, Ramesh et al. 2019, Stroumsa, Shires, Richardson et al. 2019), interview participants suggested, and findings point to, the importance of LGBTQ+ health training for providers. While permanent changes to make medical education curriculum inclusive of LGBTQ+ health and topics related to sexuality and gender more broadly would hopefully enhance provider knowledge, even more fundamentally it raises awareness about the *importance* of these topics. Indeed, as Cruz (2021:4) argues, "The true driver of health care inequities is the *deprioritization of gender and sexuality* as manifested within curricular priorities, which then shapes how future health care workers think of their work."

However, the aforementioned changes are insufficient to address sexual health inequities among LGBTQ+ people assigned female at birth. Rather, they would merely help mitigate harms currently being committed. As suggested by fundamental cause theory, in order to achieve health equity, fundamental causes themselves, rather than mechanisms linking fundamental causes to health inequalities, must be addressed (Link and Phelan 1995). While at the surface, and, indeed, perhaps in the short term, it may seem fruitful to address mechanisms, health inequalities will persist due to the emergence of new mechanisms. As Phelan and Link (2015:312) argue,

> An important implication of the theory is that health inequalities resulting from a fundamental cause cannot be eradicated by addressing intervening mechanisms, because enduring inequalities in knowledge, money, power, prestige, and beneficial social connections ensure that mechanisms are reliably replaced.

In order to combat stigma and discrimination, structural interventions aiming to dismantle systems of power and oppression are needed. Indeed, Sievwright et al. (2022:S357) argue that interventions designed to address intersectional stigma, "must expand beyond an emphasis on individual attributes (i.e., stigmatized identities or health conditions) by including components that both (a) seek to dismantle the systems of privilege and power that drive intersectional stigma and (b) mitigate the harms caused by those systems." In turn, there is evidence that reducing power differentials can reduce health inequalities (Hatzenbuehler et al. 2013).

Healthcare is built to serve the privileged and further disadvantage stigmatized and marginalized groups (Wilkerson 1994, Yearby, Clark and Figueroa 2022). Therefore, changes to institutional conditions (Cruz 2021) and the culture of medicine are needed to mitigate harms caused by healthcare as an institution. For example, health systems must commit to hiring LGBTQ+ providers and providers of color and, importantly, work to support and retain these providers, including by working to ensure healthcare is free of bias and discrimination not only for patients but for employees as well (DeMeester et al. 2016, Peek, Lopez, Williams et al. 2016, Prather, Fuller, Jeffries IV et al. 2018).

Further, efforts are needed to challenge the lay-expert divide by providing person-centered care. Patients must feel empowered, and provided a platform, to speak up during care encounters. This may be particularly important for multiply stigmatized patients, such as LGBTQ+ patients of color, who likely experience a more pronounced patient-provider power differential compared to White patients. One key, although insufficient, step toward providing person-centered care is structural competency training for providers and a shift in medicine toward greater consideration of the role of upstream factors in determining health outcomes. However, it is also important to acknowledge the constraints under which health care providers work, as system constraints, particularly the amount of time providers have with each patient, shape how they approach care provision (Dubbin et al. 2013).

Finally, there is a need to change the discourse around sex, sexuality, and sex/gender definitions and norms as implemented in, and implemented beyond, healthcare. As discussed in Chapter 2 as well as in prior literature, the phrasing of sexual history questions typically upholds the notion that “sex” refers to penis-in-vagina sex between a cisgender man and a cisgender woman. Likewise, while there have increasingly been calls for comprehensive sex education that includes topics related to sexuality and gender, we have simultaneously seen school bans of books containing LGBTQ+ and sexualized content. This contributes to the stigmatization of people who do not adhere to these norms and makes invisible or erases their experiences. Recognizing the power of discourse (Foucault 1990), changes to make the phrasing of sexual history questions not centered around penis-in-vagina sex and changes to make sex education comprehensive would help to shift the discourse around sex, sexuality, and sex/gender.

NEXT STEPS AND FUTURE RESEARCH DIRECTIONS

An abbreviated version of Chapter 3 of this dissertation was published in *Women's Health Issues* in March 2022. After additional revisions, I plan to submit Chapter 2 to *Social Science and Medicine*. After making revisions to reduce the content of and re-format Chapter 4, which is currently in chapter rather than peer-reviewed article format, and perhaps consider breaking it into multiple peer-reviewed articles, I will decide where to position this paper (or these papers).

This dissertation focused specifically on the sexual health and gender affirming care experiences of LGBTQ+ people assigned female at birth. However, qualitative interviews covered a range of topics–driven both by additional questions on my interview guide and additional topics brought up by participants–that I was not able to examine in this dissertation. Therefore, I plan to continue to analyze this data and write several additional manuscripts to submit for peer-review publication. For example, I plan to continue my analysis of data related to identity formation to develop a manuscript guided by intersectionality that focuses on identity formation, including factors that inform the ways that LGBTQ+ people assigned female at birth think about and have experienced sexuality and gender. Specifically, this paper will examine resistance to labeling and oppressive norms and expectations as well as resilience strategies participants developed. This study will contribute to a growing body of literature using intersectionality as an analytic tool to understand identity formation processes among multiply marginalized populations (Cerezo, Cummings, Holmes et al. 2020).

Additionally, I will write an article focused on how interview participants conceptualized sexual health and how this compares to popular definitions. In order to optimize the quality and impact of this article, I plan to pursue analysis of documents and/or peer-reviewed publications, which, thus far, were not included in my data and analysis. This will enable me to better compare and contrast participants' conceptualizations of sexual health to others', popular, and academic use of the term and analyze what might contribute to observed similarities and differences.

As I pursue continued analysis and academic writing and dissemination of the data from this project, I also plan to disseminate study findings to interview participants and the local LGBTQ+ community and to follow up with a few participants were particularly interested in the project. I had intended and hoped to engage participants more in the research process prior to submission of my dissertation, however, due to personal circumstances, this ultimately became incompatible with submitting in a timely fashion. As a first step, I plan to generate a summary document based on the findings presented in this dissertation to disseminate to participants via email and to post on my personal website. In this communication, I will let participants know that additional study findings will be posted on my webpage on an ongoing basis. I will also individually reach out to the participants with whom I had discussed following up once I had results to share so that we can reconnect and, if they are interested, discuss their thoughts on the study findings (compensation to be provided), including those presented here as well as those to be included in additional publications that emerge from this data.

I have been gradually building a research program focused on the multilevel determinants of LGBTQ+ health and well-being. My sociological training and this project particularly illuminated the importance of “looking upstream” when examining health inequalities, yet, outside of this dissertation, I have had little opportunity to pursue empirical projects directly related to structural determinants of LGBTQ+ health. Studies have increasingly examined the health implications of state laws and policies, but, in the context of LGBTQ+ health, these studies have largely focused on same-sex marriage, specifically, yet a wide array of laws related to sexual orientation and gender identity likely influence LGBTQ+ health (Agénor, Pérez, Solazzo et al. 2022b). Therefore, in order to fill this critical gap in the literature as well as to expand my research portfolio, I hope to engage in projects leveraging data on state policies, for example, examining how state laws related to sex education, sexual orientation, and gender identity impact sexual health-related outcomes, such as utilization of sexual health care services. This research is critical to understand how laws and policies contribute to LGBTQ+ health inequities and, at the opposite end of the spectrum, how laws and policies can promote LGBTQ+ health and well-being in order to advocate for laws and policies that will promote social and health equity for LGBTQ+ people (Agénor et al. 2022b).

CONCLUSION

Hoskin, Blair, and Jenson (2016) sampled participants of various sexual and gender identities, including cisgender, heterosexual people, and found that “The most commonly cited concern among cisgender heterosexual individuals related to receiving negative news about their health, while sexual and gender minorities in this sample were primarily concerned with how their minority identities changed their experience of navigating the healthcare system." The findings from this dissertation speak to the fact that being able to attend a medical appointment without concern for how one will be treated and thereby being able to focus solely on the reason(s) for the appointment is a privilege in the U.S. (Hoskin et al. 2016:286). Indeed, while this dissertation identified various strategies that LGBTQ+ people assigned female at birth use to obtain needed health care services, these strategies should not be necessary but rather result from inequality. Radical changes are needed both inside and outside of healthcare in order to mitigate ongoing harm as quickly as possible and, longer term, combat oppression in order to promote access to quality, person-centered health care free from bias and discrimination for all.

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Appendix A. Adjusted odds of receiving a sexual history assessment from a medical care provider in the last 12 months by race/ethnicity and sexual orientation identity among sexually active[a] U.S. women aged 15-44 years (N=11,460)

Outcome	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Any sexual history assessment[b]				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**1.99 (1.74, 2.29)**	**1.63 (1.41, 1.88)**	**1.68 (1.46, 1.94)**	**1.67 (1.45, 1.92)**
Latina heterosexual	**1.59 (1.35, 1.88)**	**1.38 (1.17, 1.63)**	**1.48 (1.25, 1.76)**	**1.53 (1.29, 1.82)**
White bisexual	**1.81 (1.38, 2.37)**	1.29 (0.97, 1.71)	1.31 (0.99, 1.74)	**1.34 (1.01, 1.80)**
Black bisexual	**2.96 (1.97, 4.43)**	**1.87 (1.26, 2.79)**	**2.02 (1.36, 3.00)**	**1.97 (1.33, 2.93)**
Latina bisexual	**2.30 (1.58, 3.37)**	1.46 (0.96, 2.23)	**1.54 (1.01, 2.35)**	**1.65 (1.08, 2.54)**
White lesbian	1.31 (0.83, 2.07)	0.95 (0.59, 1.52)	0.97 (0.60, 1.54)	1.01 (0.64, 1.58)
Black or Latina lesbian	**1.77 (1.10, 2.87)**	1.10 (0.66, 1.85)	1.13 (0.67, 1.89)	1.16 (0.71, 1.90)
Sexual orientation or sex of sexual partners				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**1.97 (1.67, 2.33)**	**1.61 (1.36, 1.90)**	**1.58 (1.34, 1.88)**	**1.58 (1.34, 1.87)**
Latina heterosexual	**1.31 (1.10, 1.56)**	**1.31 (1.09, 1.58)**	**1.30 (1.08, 1.58)**	**1.35 (1.12, 1.64)**
White bisexual	**1.57 (1.19, 2.07)**	1.08 (0.80, 1.46)	1.07 (0.79, 1.44)	1.09 (0.81, 1.48)
Black bisexual	**2.82 (1.89, 4.20)**	**1.80 (1.23, 2.63)**	**1.79 (1.23, 2.62)**	**1.78 (1.22, 2.59)**
Latina bisexual	**1.71 (1.06, 2.76)**	1.14 (0.71, 1.82)	1.13 (0.71, 1.82)	1.22 (0.75, 1.98)
White lesbian	**1.82 (1.09, 3.06)**	1.31 (0.76, 2.25)	1.33 (0.78, 2.28)	1.38 (0.81, 2.36)
Black or Latina lesbian	**3.21 (1.96, 5.25)**	**2.14 (1.27, 3.60)**	**2.11 (1.26, 3.53)**	**2.19 (1.33, 3.60)**
Number of sexual partners				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**1.75 (1.50, 2.04)**	**1.44 (1.23, 1.68)**	**1.42 (1.21, 1.66)**	**1.41 (1.21, 1.65)**
Latina heterosexual	**1.68 (1.41, 2.01)**	**1.50 (1.26, 1.80)**	**1.53 (1.28, 1.84)**	**1.58 (1.31, 1.89)**
White bisexual	**1.54 (1.19, 1.97)**	1.12 (0.87, 1.45)	1.13 (0.88, 1.46)	1.15 (0.89, 1.49)
Black bisexual	**2.90 (1.91, 4.39)**	**1.94 (1.28, 2.93)**	**1.97 (1.30, 3.00)**	**1.94 (1.28, 2.93)**
Latina bisexual	1.44 (0.94, 2.19)	0.95 (0.60, 1.50)	0.96 (0.61, 1.53)	1.02 (0.64, 1.62)
White lesbian	0.79 (0.46, 1.34)	0.58 (0.33, 1.02)	0.58 (0.33, 1.02)	0.60 (0.34, 1.06)
Black or Latina lesbian	0.99 (0.65, 1.52)	0.65 (0.42, 1.00)	0.64 (0.41, 0.99)	0.65 (0.42, 1.01)

Outcome	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Condom Use				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**2.21 (1.90, 2.56)**	**1.78 (1.53, 2.08)**	**1.83 (1.56, 2.15)**	**1.82 (1.55, 2.14)**
Latina heterosexual	**1.65 (1.42, 1.92)**	**1.45 (1.22, 1.71)**	**1.54 (1.30, 1.82)**	**1.58 (1.34, 1.87)**
White bisexual	**1.47 (1.12, 1.93)**	1.03 (0.78, 1.36)	1.04 (0.79, 1.38)	1.06 (0.80, 1.41)
Black bisexual	**3.28 (2.20, 4.89)**	**2.07 (1.40, 3.06)**	**2.21 (1.51, 3.24)**	**2.18 (1.49, 3.19)**
Latina bisexual	**2.47 (1.64, 3.72)**	1.58 (0.98, 2.54)	**1.66 (1.04, 2.64)**	**1.77 (1.11, 2.82)**
White lesbian	**0.49 (0.25, 0.97)**	**0.34 (0.17, 0.66)**	**0.35 (0.18, 0.69)**	**0.36 (0.19, 0.70)**
Black or Latina lesbian	0.74 (0.46, 1.18)	**0.44 (0.27, 0.73)**	**0.45 (0.28, 0.75)**	**0.46 (0.28, 0.76)**
Types of sex				
White heterosexual	1.00	1.00	1.00	1.00
Black heterosexual	**2.52 (2.11, 3.01)**	**2.02 (1.70, 2.41)**	**1.88 (1.56, 2.26)**	**1.88 (1.57, 2.26)**
Latina heterosexual	**1.88 (1.58, 2.24)**	**1.70 (1.42, 2.03)**	**1.61 (1.33, 1.94)**	**1.65 (1.37, 2.00)**
White bisexual	**2.15 (1.61, 2.86)**	**1.49 (1.10, 2.02)**	**1.44 (1.05, 1.97)**	**1.46 (1.07, 2.00)**
Black bisexual	**4.57 (2.93, 7.12)**	**2.90 (1.88, 4.48)**	**2.72 (1.76, 4.20)**	**2.73 (1.76, 4.22)**
Latina bisexual	**2.35 (1.37, 4.03)**	1.50 (0.88, 2.56)	1.43 (0.85, 2.41)	1.52 (0.89, 2.59)
White lesbian	0.75 (0.42, 1.32)	**0.53 (0.30, 0.93)**	0.52 (0.29, 0.93)	**0.54 (0.30, 0.96)**
Black or Latina lesbian	**1.69 (1.01, 2.85)**	1.06 (0.62, 1.80)	1.00 (0.58, 1.70)	1.02 (0.60, 1.73)

Note. Bolded values refer to p-values <0.05. Model 1 is adjusted for survey wave only. Model 2 adds demographic factors (i.e., age, place of residence, nativity, and relationship status) to Model 1. Model 3 adds socioeconomic factors (i.e., educational attainment, household federal poverty level, and employment status) to Model 2. Model 4 adds health care factors (i.e., health insurance status, usual source of care) to Model 3. All models are adjusted for survey wave and account for the survey's complex sampling design.

[a] Sexually active women include those who reported opposite-sex or same-sex sexual contact in the last year, including vaginal, oral, or anal sex.

[b] Any sexual history assessment is based on a "yes" response to one or more of the four questions (sexual orientation or sex of sexual partners, number of sexual partners, condom use, types of sex) about whether a doctor or medical provider asked the respondent about their sexual behaviors in the last 12 months.

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