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## “Little Red Flags”: Barriers to Accessing Health Care as a Sexual or Gender Minority Individual in the Rural Southern United States—A Qualitative Intersectional Approach

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### Abstract

Sexual and gender minorities (SGM) experience unique challenges when accessing sexuality and gender-affirming, safe health care services in the rural, southern United States. An identified gap in the literature is an intersectional, community-based approach to assessing the obstacles SGM individuals with intersecting identities experience when navigating comprehensive health services in the rural southern communities in the United States; therefore, the present study utilized qualitative inquiry with an intersectional lens to describe these obstacles. We analyzed qualitative data from in-depth, semi-structured individual interviews with SGM individuals ( $N = 12$ ).

Common themes emerged that highlighted the compounding effects of the sociopolitical climate of the geographical area, religious attitudes towards SGM, and the experience of racism. Our

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#### Author Contributions

L. Joudeh was responsible for conceptualizing the study, developing methodology, conducting research procedures, data curation, formal analysis, funding acquisition, writing the original draft, and overseeing manuscript revision. O. Harris was responsible for project supervision, funding acquisition, supporting data analysis, as well as contributing to the original draft and the revised version of the manuscript. E. Johnstone contributed to conceptualizing the study, developing methodology, recruiting participants, validating research themes, and revised versions of the manuscript. S. Heavner-Sullivan contributed to conceptualizing the study, developing methodology, recruiting participants, validating research themes, and revised versions of the manuscript. S. K. Propst contributed to study conceptualization and design and revised versions of the manuscript.

#### Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

#### Data Accessibility Statement

The datasets used for this analysis are available from the authors upon request.

findings can inform health professions' academic curriculum, provider and support staff training, and implementation of policy that focuses on creating a diverse and inclusive health care delivery experience.

### Keywords

community-based participatory research; gender identity; intersectionality; race; religion; rural; sexuality identity; southern United States

Despite the fact that the southern United States has the highest proportion of sexual and gender minorities (SGM) compared to other regions in the United States, SGM individuals in the South have limited access to health care and negative health care experiences (Eaton et al., 2014; Hasenbush et al., 2014; Stepleman et al., 2019). For this study, gender minority is defined as individuals whose gender identity is different from their sex assigned at birth, and sexual minority is defined as someone whose sexual orientation is not heterosexual (VandenBos & American Psychological Association, 2015). Research shows that SGM individuals in the South are less likely to be insured and are more likely to avoid medical care due to costs, compared to SGM individuals in other parts of the country (Gonzales & Blewett, 2013; Hasenbush et al., 2014; Kates et al., 2018). When SGM individuals in the southern United States do engage with the medical system, they often experience discrimination and stigma from medical providers, due in part to their SGM identities (Austin, 2013; Quinn et al., 2015; Stepleman et al., 2019).

Lack of access to high-quality culturally sensitive and inclusive health care leads to negative health outcomes (McKay, 2011). For example, lesbian and bisexual women are less likely to have timely Pap smears due to providers' perceptions of their sexual risk factors (Buchmueller & Carpenter, 2010; Solazzo et al., 2017). Black SGM individuals face unique disparities due to racism, gender identity/expression, and sexual orientation stigma and discrimination (Whitfield et al., 2014). For example, Black SGM experience both racism and SGM stigma, which hinders access to HIV pre-exposure prophylaxis and antiretroviral therapy (ART), both key components for meeting the U.S. Health and Human Services goal of *Ending the HIV Epidemic* (EtHE) in the United States by 2030 (Cahill et al., 2017; Eaton et al., 2014). SGM individuals may have different variations of risk for HIV, where some are at higher risk than others, which may place them outside of the EtHE goals. However, apart from HIV, many SGM with intersecting identities experience various degrees of stigma and discrimination, which results in significant disparities in health.

It is well documented in the literature that SGM individuals in the South face challenges when accessing health care. A limitation in this literature is that most studies are either conducted in urban environments or the environment in which the studies are conducted is not stated (Barefoot et al., 2014; Rosenkrantz et al., 2016). The few studies that compared health care access for SGM individuals in urban vs. non-urban settings have found differences in health care experiences. One study revealed that non-urban individuals in the South who identified as lesbian were less likely to tell their health care provider their sexual orientation compared to those in urban areas (Buitron de la Vega et al., 2019). Another study in rural New Mexico reported that fear of anti-SGM bias influenced SGM individuals who

attempted to access health care (Willging et al., 2006). Furthermore, a 2014 literature review on lesbians in the South demonstrated that, for lesbians living in rural areas, the need to remain invisible or navigate harmful perceptions from rural residents negatively impacts their mental health (Barefoot et al., 2014).

Religion, more specifically Christianity, is another factor that influences the lives of SGM in the rural South. The religious dogma rooted in some Christianity sects' teachings are more often part of the pervasive stigma and discrimination SGM persons experience in rural settings, which may be different for those living in urban areas (Giano et al., 2020). For African American men who have sex with men (MSM) in the Deep South, religiosity—defined based on how a person adheres to their religion—impacts the homonegativity African American MSM face and their safer sex practices, which negatively impacts their sexual health decision making (Smallwood et al., 2017). Given the gap in literature regarding the unique challenges of identifying as an SGM in the rural southern United States and the goal of ending the HIV epidemic by 2030, understanding the barriers to accessing medical care, such as HIV treatment and prevention services, for this marginalized population must be a key public health priority.

Research programs that are designed using a community-based participatory research (CBPR) approach to understand these complex issues can be beneficial in that they allow the researchers to work directly with community stakeholders, such as SGM individuals, health care providers, and local organizations to identify a research question that addresses the needs of a specific community and to design study procedures that are inclusive and respected by community members (Israel et al., 2012; Wallerstein & Duran, 2010). The Kellogg Foundation Community Health Scholars Program defines CBPR as an approach that “equitably involves all partners...with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities” (Wallerstein & Duran, 2010, p. S40). Using a CBPR approach to study the specific factors that affect access to care in the rural southern United States can foster more participation from racial and ethnic minorities and increase the opportunity for translational science (Nueces et al., 2012; Wallerstein & Duran, 2010). CBPR studies that employ an intersectional approach can further amplify community needs in research procedures and outcomes (Agénor, 2020; Israel et al., 2012).

Originally generated and advanced by Black feminist theorists (Crenshaw, 1989), intersectionality is a critical theoretical and normative framework that illuminates how structural forms of power and privilege intersect to produce and reinforce social inequalities (Bowleg, 2012). An intersectional approach to studying health care access in the rural South is essential as it highlights how structural forms of power and privilege overlap to create and reinforce inequalities (Bowleg, 2012). An intersectional approach acknowledges that people's multiple identities affect how they move through the world in a complex fashion—not merely an additive fashion (Windsong, 2018). As a lens through which to approach social justice-oriented research and analytic methodological approaches, intersectionality offers a holistic perspective with which researchers and clinicians can examine how power and privilege are differentially structured for groups at different intersectional sociodemographic positions (Bauer & Scheim, 2019). Thus, we now know any one identity

a person might hold intersects with their race, gender, sexuality, and socioeconomic class. Therefore, both someone's gender and race uniquely affect an individual's experiences as an SGM, and gender and race cannot be analyzed as two different entities (Crenshaw, 1989; Turan et al., 2019). In the literature, for example, intersectionality has been used to explore the intersection of race and HIV prevention (Bowleg et al., 2013; Logie et al., 2011) as well as mental and reproductive health for incarcerated individuals (Kelly et al., 2018).

In light of the recent killings of unarmed Black men in the United States and the racial justice protests in the summer of 2020, there has been a renewed focus on diversity, equity, inclusion, and the centering of anti-Blackness violence in the health care profession (Landry et al., 2021). The SARS-CoV-2 or coronavirus disease 2019 (COVID-19) global pandemic has further revealed the racial disparities that exist in the medical system—with Black and Latinx Americans dying at disproportionately higher rates than their White counterparts (APM Research Lab, 2021; Harris et al., 2020). A more targeted approach to addressing barriers to care for racial and ethnic minorities requires a renewed focus on the role of sociocultural and environmental factors that increase negative health experiences and outcomes (Kates et al., 2018; Rosenkrantz et al., 2016). Emerging literature on experiences of SGM in the southern parts of the United States who are racial and ethnic minorities has begun to highlight the significance of racial and ethnic discrimination in increasing health disparities among SGM; this has led to negative health outcomes (Cahill et al., 2017; Eaton et al., 2014). However, additional research is needed to further examine how beneficial an intersectional approach to health care delivery can be for those with intersecting identities in the rural South. Given the deep-rooted prejudices and discrimination that exist in the rural South toward SGM individuals, an interrogation of how these prejudices affect access to health care is urgently needed. In this context, the purpose of this intersectional qualitative CBPR study was to describe the experiences of sexual and gender minorities accessing health care services in the rural southern part of the United States. We also describe how those experiences were shaped based on geographical location, religious dogma, and race and racism.

## METHODS

This qualitative study on the barriers to care resulting from the geographical location, religious attitudes, and race and racism in the rural southern United States emanates from a broader qualitative study on the experience of clients accessing services from, and providers working in, a mobile community health center (MCHC) in rural South Carolina. In addition to including providers in the broader study, we also asked clients and providers about their experiences with linkage to care from the MCHC to other health care providers and facilities outside of the MCHC facility. However, the focus of this paper is on the barriers experienced by clients when accessing health care at the MCHC or other health care facilities within the community. The lead author collaborated with the MCHC, using a CBPR approach to design, develop, and execute all aspects of the research endeavor. We used semi-structured individual interviews to understand the lived experiences of SGM individuals accessing medical services in the rural South. The study received oversight approval from the Institutional Human Subjects Review Board of the University of California, San Francisco Human Research Protection Program (Study #20-30440).

## Setting

The MCHC is a clinic that focuses on serving SGM communities in rural South Carolina. All services at the MCHC are free of charge. Prior to the COVID-19 pandemic that began in March 2020, they offered in-person services once a month in alternating local towns across the state. The medical team traveled to different towns to offer services closer to where their clients lived or worked, and they also provided taxi vouchers to help reduce the cost of traveling to and from the designated MCHC location. The medical team operated out of local organizations and businesses that volunteered their spaces to support the MCHC mission. The MCHC offers mental health screenings, physical health screenings, HIV testing and education, sexually transmitted infection (STI) testing, assistance with signing up for state benefits and legal name changing (for transgender individuals), and a safe space for young people to drop in and meet other SGM persons. At each MCHC session, there are about six to 12 volunteers, including licensed mental health providers, nurses, physicians, phlebotomists, social workers, HIV counselors, health professional student volunteers, and non-medically affiliated community volunteers. The volunteers either identify as SGM or are allies to the SGM community. The MCHC serves between five and 50 clients per month.

## Participants

Participants were recruited between June and August of 2020. MCHC clients were eligible to participate in the study if they were at least 18 years of age, had used the MCHC in an in-person setting at least once since June 2019, and could complete study procedures in spoken English. Health care services were defined as mental health services; physical health screenings and exams; and HIV/AIDS testing, counseling, and supportive services. Clients were screened for participation interest and eligibility, and then were provided a verbal consent over a virtual platform. Due to the COVID-19 pandemic, all interviews were conducted electronically via a secure video platform.

The authors took an intersectional approach to ensure we involved, engaged, and recruited diverse communities—paying close attention to how race, gender, and sexual orientation interacted together to uniquely affect the experiences of participants who held multiple marginalized identities from these three categories (Logie et al., 2011). For example, we analyzed how being a Black SGM person affects access to care as opposed to only looking at how being Black or being an SGM person affects access to care. Because the MCHC serves a largely lower income community, we did not prioritize engaging specifically low-, medium-, or high-income communities.

## Procedures

We utilized some elements of CBPR in this study to ensure that the community was represented in this research to the fullest extent possible and that their unique voices were heard throughout every stage of the research process (Nueces et al., 2012; Wallerstein & Duran, 2010). The lead author collaborated with co-authors, who represented multiple intersectional identities and diverse research expertise, to ensure the study followed and adhered to a culturally appropriate participant-centered research approach. The lead author and MCHC representatives—the MCHC director and two clinical volunteers, who are also co-authors—met monthly for the first 6 months to identify community needs and design the

research methods and data collection instruments. After obtaining institutional review board approval, our team met once a week during the recruitment and interview phase of the study. Research questions, procedures, and materials were created in conjunction with the MCHC representatives. Participant recruitment was done in partnership with the MCHC representatives.

The lead author recruited participants in conjunction with the MCHC representatives, using a client database, purposive sampling, and snowball sampling (Kristensen & Ravn, 2015; McLafferty, 2004). The lead author made recruitment materials for an MCHC representative to disseminate via email to clients and made several posts on the MCHC's public social media platforms. Individuals interested in the study contacted the lead author via text message, email, or phone call to be screened for study eligibility. To ensure we had individuals representing racial, ethnic, and gender minority groups, our team sent individual recruitment emails to Black, Indigenous, and other persons of color as well as transgender and nonbinary clients. All screened potential participants were given an opportunity to share study-related recruitment information along with the lead author's contact information throughout their networks. To maintain confidentiality, the MCHC representatives were kept blinded to screened individuals and consented participants.

Study information was shared over the initial contact medium. If individuals expressed interest in participation, a phone call or video call was set up to go through screening questions. Screening questions included: (a) age at time of study participation, (b) last date they used the in-person MCHC, (c) services they accessed at the MCHC, and (d) comfort with completing an interview and questionnaire in English. Individuals who were screened and eligible for the study were invited to participate in the study. As a result of the COVID-19 pandemic, the consenting process and individual interview formats were adjusted to respect established social distancing and public safety guidelines. Therefore, the lead author obtained verbal consent from all the participants over a virtual platform, and all interviews were conducted in a confidential, virtual setting using a video conferencing platform. After consenting and beginning study procedures, all participants were remunerated with a \$35.00 gift card for their time. The lead author, a native to a rural southern region, who assisted in building rapport, conducted all the individual interviews (Anthias, 2002; Kristensen & Ravn, 2015; Milner, 2007; Rose, 1997).

## Measures

A demographic and health care access survey was administered to all participants prior to being invited to participate in an in-depth semi-structured individual interview. Participants were asked to provide general information about their age, gender, sexual orientation, race, income, health insurance status, highest level of education, primary care access, MCHC services received, and MCHC satisfaction. The interview guide was created in partnership with the MCHC representatives. See Table 1 for the interview content areas and sample questions. The interview guide was created prior to the interviews with input from the MCHC representatives to allow for systematic sequencing of the content and flexibility in facilitated deviations to less sensitive topics (Krueger, 2014); however, the lead author adapted contents of the interview based on the person's individual experiences. For example,

if a client stated they never received a medical referral from the MCHC, that portion of the interview was adapted to explore if the client would have wanted to receive a referral and how they would have wanted to receive that referral.

### Data Collection and Analysis

Due to the COVID-19 pandemic and multiple limitations on travel, all study-related activities were conducted virtually. The virtual setting for screening, consenting, and interviewing participants provided greater access in terms of who could participate in the study (e.g., clients who did not have access to transportation) and greater flexibility in when interviews could take place (e.g., early mornings and late evenings). Although qualitative data collection historically requires face-to-face engagement or field observation, the virtual approach to qualitative interviewing adhered to COVID-19 social distancing requirements and offered the researcher an opportunity to engage with participants in an unconventional way (Opdenakker, 2006). The descriptive quantitative data, which included demographic data, were collected virtually using the survey software REDCap. The interviewer read the survey questions to the participant, and the participants verbally answered. The interviewer filled out the survey based on the participant's response.

The lead author and second author conducted the qualitative data analysis. However, consultations with other members of our team were frequently sought, with the intent to clarify findings and reach consensus on disagreements. The qualitative data were managed using the computer software ATLAS.ti. Interviews were audio and video recorded and professionally transcribed via a UCSF IRB-approved service. The transcriptions were de-identified and given a numeric identifier. Our analysis of the qualitative data included an iterative stepwise process. It included code development, extraction, generation of a codebook, code consolidation, and tagging or coding large portions of text that represented key thoughts or ideas into categories, which resulted in the construction of participants' collective narrative into thematic statements (Miles & Huberman, 1994). This iterative analysis process continued concurrently with participant interviews, but coding continued until saturation was achieved, which resulted in the conclusion of all study interviews due to the lack of new data (Ando et al., 2014; Morse, 2007; Sandelowski, 2001; Watkins, 2012). Code development involved an open-coding technique, in which large sections of text were labeled under a code if they illustrated a collective narrative or concept (Braun & Clarke, 2006). The tagging of key concepts was necessary to assess key thoughts and ideas within the data (Miles & Huberman, 1994; Patton, 2014). After the initial code list was created, the lead author assessed code overlap and consolidated similar codes. The final list of codes retained in the codebook was central to the investigation. Those codes were then clustered into categories—and all new categories were presented as thematic statements (Ando et al., 2014; Patton, 2014).

Another component of the analysis included consultation with individuals familiar with the study population. Once the initial thematic statements were generated, the lead and second authors presented the themes with exemplar quotes to the MCHC representatives. These experts and community partners also enhanced rigor and validity of the findings reported in this study through frequent meetings throughout the analysis process to review the codebook



and ensure that codes were valid and consistently used (Burla et al., 2008; Miles & Huberman, 1994). Additionally, to assist with member checking, meetings with collaborators and key stakeholders also involved discussing themes and exemplar quotes, reviewing the data to determine accuracy and provide feedback or support around revising the thematic statements, and resolving any disagreements with consensus agreement on the findings (Burla et al., 2008; Miles & Huberman, 1994). The results presented in this article describe the barriers SGM persons experienced when accessing health services in rural South Carolina.

## RESULTS

### Sample Characteristics

The sample characteristics of study participants ( $N = 12$ ) are displayed in Table 2. The age range was 24 to 35 years, and the mean age was 27 years. The majority of participants had an annual income less than \$60,000. Fifty-eight percent ( $n = 7$ ) of participants had a 4-year bachelor's or graduate level degree. Race, sexual orientation, and gender identity were asked via three open-ended survey questions. Forty-two percent ( $n = 5$ ) of the participants identified as Black, 50% ( $n = 6$ ) identified as White, and 8% ( $n = 1$ ) identified as Hispanic. Ninety-two percent ( $n = 11$ ) of participants had a non-heterosexual sexual orientation, and participants were evenly split between cisgender ( $n = 6$ ) and transgender or nonbinary ( $n = 6$ ) gender identity. A binary question of whether the participant had a primary care provider (yes/no) was included in the demographic survey. Of the 12 participants, seven (58%) reported that they had a primary care provider. Of the participants that did not have a primary care provider, three had employee-based insurance, one was privately insured, and one was uninsured.

In the following sections, we first describe clients' perspectives on how their geographical location, religious attitudes, and race or racism affects their experiences in accessing SGM affirming health care services. Within these experiences, we highlight how religion, a by-product of the participant's geographical location, influences the care SGM individuals receive and how clients view religiously influenced care. Then, we discuss how the effects of racism further impact the experiences of Black SGM participants within this rural geographical location. Pseudonyms are used throughout this report to protect participants' anonymity.

### Geographical Location

Participants reported hesitancy in accessing care due to the sexual and gender discrimination they faced living in a rural southern state in the United States. Participants mentioned their geographical location as one of the reasons they cannot access culturally congruent care. One participant described this experience of hesitancy in accessing care:

Especially in the South... even going to a doctor in an established like health care clinic or hospital, you can get people who don't really empathize or understand what you're going through...there are assumptions that are being made that people have based on their experiences or their own prejudices.

(Jamila)

Another participant expounds on this by sharing a similar sentiment and stated how SGM individuals could experience harm from accessing care:

The politics of the region, it makes it difficult...for myself and friends of mine who are trans to find affirming care... or going to medical providers that would be able to treat us in the way we needed to be treated without making it some sort of traumatizing experience.

(Tonya)

Participants' narratives revealed a link between being denied affirming care that reflected their intersecting identities and the associated trauma that followed. In a different example, another participant discussed more specifically the challenges they experienced in accessing transgender affirming care in the rural South:

We're in the South, the Bible-Belt. So, it's always conflicting, for some reason, with folks to want to help someone with HRT [hormone replacement therapy], period.

(Ari)

The same participant further described the differences they have experienced with accessing services in the South compared to outside of the South. The latter was an easier, pleasant, and less stratified care experience.

The further you go up North...you're getting...a true list of folks who [provide SGM affirming care]. I was able to get a provider...who specialized in HRT [hormone replacement therapy]. And they were my primary care doctor, too. And so, I didn't have to have the endocrinologist. And then... an OBGYN for this. And then... like three or four different doctors. And I'm like, "Oh, I can see this one doctor for all of my trans needs."

The participant above identified the benefits of having an integrated clinical care model that is patient centered. Their narrative described significant barriers to care for many SGM in regions of the United States that restrict therapies such as HRT or make it impossible to access transgender-specific affirming health care. These experiences are often cited by transgender or gender-expansive individuals as barriers to care. Illustrating this finding, another participant described how they must mentally prepare themselves for any harm that might come from accessing care. This fear stemmed from their previous experiences with medical care in the South:

I think for me the biggest fear often in stepping in a doctor's office is [that] on some level I am vulnerable... how much am I going to have to deal with things that should never be a part of my medical experience? And for me that has in large part been a barrier to care... [I think] those fears are based a lot on the experiences kind of growing up and in this geographic area. Particularly in the South.

(Sydney)

Other participants' narratives demonstrated a link between their geographical location and the barriers they face when accessing care. Individuals identifying as SGM in the southern part of the United States could not show up at any clinic or doctor's office and expect affirming care. Participants depended on friends and resources within the community to find gender-affirming care. One participant described that being in the South made it even more important to use the SGM community as a resource for finding SGM-friendly providers or allies who provide affirming care:

Having somebody that's vetted by a community of LGBT people, and it's like, hey, they're not going to judge you. They're not going to recommend things that might be harmful to you. They're going to come from a place of understanding and just no judgment.

(Jamila)

In describing the narrative above, Jamila further went on to inform us of another situation in which a close friend of theirs went to the prominent hospital in their community in the rural South and experienced discrimination and stigma because of their sexual orientation minority status. They explained:

This person ended up getting diagnosed with a fungal infection. The doctor that they went to was part of a very prominent hospital and insisted that it was HIV and needed to start treatment for HIV without running any tests or anything. There [are] assumptions that maybe people have based on their experiences or their own prejudices.

Participants described negative experiences when accessing health care services from other clinics or hospitals in their communities and favored the treatment they received while accessing services from the MCHC. One client described the MCHC's mission as being integral in enhancing their comfort accessing care:

Because we live in the South and it is very difficult to find like any kind of medical providers, health people or even therapists or counselors that are queer affirming...I think with [the MCHC] there was a level of comfort because I knew their mission, I knew their values. But I also knew that like nobody was going to ask me any intrusive questions. I wasn't going to be profiled or have to deal with any kind of homophobia from the medical community.

(Sydney)

Participants described challenges finding affirming care due to their geographical location, so they exerted extra effort to find affirming care. They depended on vetted community resources such as gay or transgender friendly providers in order to access care that was stigma-free or non-discriminatory.

### **Religious Attitudes**

When discussing their experiences accessing health care and community resources, participants emphasized how religion was an added barrier to finding affirming care, specifically the integration of Christianity into medical care in their geographical area. Participants described that being in the Bible Belt made it more difficult to know whether a

doctor was affirming because Christianity was often tied to anti-SGM beliefs and rhetoric. In one example, the participant tried to use a search engine to find an affirming mental health provider in his rural southern community:

When searching mental health providers..., the top thing that pops up like when you Google “gay mental therapy” is that a lot of it is conversion or Christian-based. I’m looking at that, and that’s not necessarily something I want to do.... I didn’t want a therapist who is judgmental of [my sexual orientation].

(Rodrigo)

Another participant also had similar challenges using online resources to find an affirming mental health provider, and they actively avoided any Christian provider:

Of all of the therapists and counselors who were kind of listed on like Psychology Today, and I had some referrals from friends and stuff like that. Like just winnowing that list down and trying to screen these people to make sure that like they didn’t just put that [they were queer affirming] on their profile and they weren’t bible-thumpers and stuff like that...I just wish there were more [queer-affirming providers].

(Sydney)

Another participant expressed how Christian-centered medical practices made her hesitant because of her past experiences with Christian providers. She offered a detailed explanation of her thought process when navigating the religious aspect of medicine in the southern United States:

I don’t follow a religion or have any sort of religious beliefs, so every time when I see an office or a therapist...incorporate Christian values and things, and it’s almost like a little red flag for me because... interactions I’ve had in the past where... myself and a therapist or a person get along together great on a personal level, and then bringing in... Christian belief or religious teaching or things just makes things awkward and there’s almost [an] abrupt disconnect.

(Sabrina)

The same participant went on to further explain why she did not want to have Christian-based mental health services:

Why go see this person who’s going to judge my mental health and how I act who also may be basing their judgments...off of some sort of teaching or thing that I don’t entirely believe in.

However, Sabrina’s experience with Christianity was not always negative, but there was still hesitancy in seeking Christian-based care:

[I’ve had an] intentional Christian community and it was great and accepting and affirming, and then I’ve also interacted with different people on campus or different professors who are Christian and very much the opposite...It’s always...a grab bag, and I don’t know what I’m going to get, and I don’t know if I’m prepared for it.

Although some participants explained a proactive avoidance of Christian-based medical providers, one participant was in the process of trying to find a more affirming provider using the MCHC network. A visual reminder of their provider's Christian-centered care was a catalyst for seeking out a new provider:

I was trying to find a more affirming doctor because the doctor I had been going to... they had a little table with a little flower and a little sign that said, "This is a Christian loving environment." And at that day I realized, I need to get a new doctor.

(Taylor)

Participants expressed a prevalence of Christian-centered care in their rural southern communities. The integration of Christianity into medical care made it more challenging for participants to find affirming care. In some cases, participants established care in a Christian-based medical practice only to have to search for more affirming providers at a later time.

### The Experience of Race and Racism

The participants who identified as Black in this study cited racism and lack of racial representation as significant barriers to accessing care in the rural South. The racism reported was not necessarily unique to the geographical location in which participants lived, but the location in the South further compounded the barriers Black SGM individuals face when navigating the health care system. One participant described multiple staff with discriminatory views at their clinic:

The therapists available were all passively homophobic, passively racist, or actively homophobic or actively racist, which made...the top therapy treatment kind of difficult and kind of hard to get a sense of like how I actually felt.

(Lilly)

This participant found care in a more diverse setting that was affirming, safe, and offered them an opportunity to be their authentic self. However, even at the safer location, the participant described the space as not being racially diverse.

There was...a little bit of like a White superstructure of like people that all knew each other at the event, which made it feel a little bit like a cool kids' club in some ways.

They're all very nice, but it was a little hard to interface on a person-to-person level.

Black participants were often in White-centered environments, which negatively impacted their engagement with their medical care. Because White-centered spaces are dominant in these rural southern communities, improvement in the racial make-up of spaces was on the top of participants' minds when discussing how their community resources could improve. Several participants emphasized the need for more Black representation in health care spaces. One participant detailed what the environment felt like to them:

I don't think there's enough resources for LGBT teens, or trans people, or people of color, really...it also seems to be like there is some - it really seems to be heavily... centered around...a cis White male...perspective or enjoyment.

(Eric)

The lack of racial and gender representation in the rural health care setting was also identified as a barrier to care. Another Black participant described frustration when trying to find care that would make her feel safe. She described regretting going to one non-Black medical provider due to the dismissive nature of the medical visit. She also felt a big disconnect between her and the non-Black provider. Some described representation as a way of seeking allies and trust. For example, the benefit of having representation in the medical space was illustrated in one participant's reflection of being in a medical environment with Black health care providers:

When it comes down to Black folks and, especially Black queer and trans folks, just to be able to see those faces [is a cool thing]. I saw multiple faces...So that was affirming for me to know that...I could see... someone that looked like me, and that they were in this environment and this space. And that they were trusted allies.

(Ari)

This example illustrated the value of racial or ethnic representation in the clinical or hospital environment. Participants suggested that having racial representation can provide affirming care and serve as potential passive intervention through role modeling.

## DISCUSSION

This qualitative study provides strong evidence supporting the notion that SGM individuals' concern for potential discrimination as well as past experiences of discrimination based on interlinking factors, such as geographical location (rural South), regional religious attitudes (e.g., homophobia and transphobia), and anti-Black racism negatively affects access to affirming medical care. Participants expressed navigating multiple layers of discrimination while trying to find affirming providers within their communities.

For many participants, living in the southern United States was seen as a primary barrier to care. The geographical location was reported to be anti-SGM, and the added context of racism and intersecting identities further amplified those experiences. Our findings are supported by previous research suggesting that people in the southern United States have more negative attitudes toward SGM individuals compared to residents of other geographical areas and that Southern culture affects SGM stigma (Herek, 2002; Norton & Herek, 2013; Stepleman et al., 2019). Our study results corroborate previous findings that highlight the experiences of stigma and discrimination among SGM in the South (Baunach et al., 2009).

Religion, which is a major part of the experiences of many persons living within sections of the United States that are considered the "Bible Belt," serves as a discriminatory anchor for homophobia and transphobia (Prairie et al., 2018; Wilson et al., 2014). In our study, we also found negative religious attitudes that participants encountered when trying to access affirming medical care, which alienated the community and drove them further away from

health care services and preventative care. In fact, some participants reported having to travel long distances or rely on peer referrals to SGM-friendly providers in order to access affirming care. These experiences also align with the existing literature showing that nurses' and doctors' religious attitudes impact the level of care provided to SGM individuals (Prairie et al., 2018; Wilson et al., 2014).

In addition to the discriminatory attitudes and practices of providers and the health care system toward those identifying as SGM, Black study participants expressed having to navigate racism in White-dominated health care spaces. This finding is consistent with the literature around the experiences of racism and homophobia among Black MSM in the South (Cahill et al., 2017; Eaton et al., 2014), and our study's focus on a rural area—a population that is often understudied—expands on this body of knowledge. Further, previous research has shown that racism from health care providers is a major barrier to accessing health care services, further eroding confidence in the medical institutions for many Black Americans, specifically those who are sexual or gender minorities (Agénor et al., 2015; Ben et al., 2017; Cahill et al., 2017; Schwei et al., 2014). Our findings highlight many of these experiences and indicate these experiences discourage SGM communities from accessing vital treatment and preventative health services.

Because racism negatively affects care delivered to marginalized communities with intersecting identities (Bailey et al., 2017; Ben et al., 2017; Richardson & Norris, 2010), there is a need for health profession training programs that center on the experiences of racial and ethnic minority SGM. Studies have shown that exposure to SGM content in health professional education can reduce provider stigma and discrimination towards marginalized communities (Parameshwaran et al., 2017; White et al., 2015). Furthermore, a health profession curriculum that discusses racism—not race—as a cause of disease and racial health disparities can help alleviate racism that occurs in the medical field (Williams et al., 2019). However, this alone will not be enough to address the issue of access to affirming care for SGM individuals living in rural southern communities, especially as most providers are not recent graduates of health profession schools (Association of American Medical Colleges, 2019; Young et al., 2019). Continuing health profession education should also make anti-racist and SGM-inclusive health care training a priority for all providers.

These programs must be different from historical cultural competency training, which does not consider intersecting experiences or identities. To achieve concrete health outcome goals, such as the one proposed by the U.S. Health and Human Services in the EtHE by 2030 plan for America, research has shown that health programs and outreach initiatives that integrate intersectionality will increase our understanding of the multi-level factors impacting the lives of SGM individuals with intersecting identities, thus improving access to services like HIV prevention and treatment services for marginalized sexual and gender minorities—more specifically, Black SGM individuals (Cahill et al., 2017; Eaton et al., 2014; Turan et al., 2019). One important step toward achieving an intersectional care delivery model that centers on equity and inclusion is to expose nursing, medical, and other health profession students to curriculum that highlights an intersectional approach to care. The curriculum should be nuanced in that it illustrates how racism and anti-SGM actions and

beliefs, among other factors of injustice and discrimination, interact to affect access to vital health care services, such as HIV pre-exposure prophylaxis.

In addition, diversifying the health care workforce is an opportunity to improve the experiences of racial and ethnic sexual minorities when accessing health care services. Previous research has suggested attitudes around medical mistrust are diminished if patients engage with members of the medical team who look like them (King et al., 2004). Our data suggesting that Black participants had improved care experiences and outcomes if they had a Black provider demonstrate these findings (Ma et al., 2019; Smith et al., 2018). This also illustrates that in order to provide services that are equitable and inclusive, community clinics and hospital systems must recruit and retain a diverse pool of health care providers.

Finally, while patient-physician race concordance has been shown to improve care experiences and outcomes, we suggest that recruiting and retaining Black health care providers in the South is only part of the solution to anti-racist and SGM-inclusive health care delivery provisions (Ma et al., 2019; Smith et al., 2018). It is also important for all health care providers, regardless of race, to implement an anti-racist and SGM-affirming approach to their work such that racial, sexual, and gender health disparities are eliminated. The following will contribute to a more anti-racist/SGM-inclusive health care system:

- having medical providers and staff actively identify and assess how racism functions in their clinical environments (Jones, 2018),
- providers advocating for increased access to medical care regardless of socioeconomic status (Williams & Cooper, 2019),
- reflection on how SGM stigma and discrimination impacts mental and physical health, and
- prioritization of an interprofessional approach to address patients' environmental risk factors for illness (Williams & Cooper, 2019).

Our study illustrates how regional political and religious attitudes as well as racial make-up of an area affect how SGM individuals navigate and experience their medical care. As it stands, individual organizations, such as the MCHC, try to fill in care gaps, but our study shows that that is not enough to provide the affirming, safe, and comprehensive care that people deserve.

## LIMITATIONS

This study has several limitations. First, our findings are limited to this sample of rural SGM community participants. Second, participants were all clients of the MCHC and openly identified as SGM. SGM individuals who do not access care from an SGM-centered clinic or might not be open about their SGM identity status might have different experiences when accessing health care services. Furthermore, all the participants spoke English as their primary language; therefore, further research is needed to explore the experiences of non-native English-speaking SGM individuals living in the rural southern United States. Third, the COVID-19 pandemic limited our ability to employ a complete CBPR approach due to limitations in travel, social distancing guidelines, and jurisdictional shelter-in-place orders.



Although the majority of the authors on this manuscript represent the study population or are from the community, further exploration of these topics that includes all the elements of CBPR should be included in future studies. Despite these limitations, the purposive sampling and CBPR approach yielded confidence that participants represented a range of SGM experiences related to accessing medical care in the rural southern United States.

## RECOMMENDATIONS AND IMPLICATIONS

Our study findings suggest the need for a robust intersectional approach to health care that targets individual-, community-, and societal-level factors that contribute to poor health among SGM individuals in rural southern communities. Deeper exploration of these topics using mixed-methods research may provide further information that supports the development of clinical and training guidelines that improve SGM health care delivery. Moreover, multi-level interventions that are geared towards community stakeholders, health care workers, and other support staff are desperately needed to mitigate the negative impact of homophobia, transphobia, stigma, and discrimination. More importantly, improving public health facilities, community clinics, and other rural health facilities to make them accessible and welcoming for all patients in need of care, regardless of race, ethnicity, gender identity, or sexual orientation, is necessary.

One way to start working toward accessible and welcoming care for SGM individuals is to improve health profession education through inclusive trainee curriculum, continuing health education courses, and health professional licensure competencies in SGM-specific health care and inclusion practices. Research projects that incorporate a CBPR collaborative approach should be prioritized in these settings to include the perspective, vision, and needs of the community directly affected.

## CONCLUSION

Study participants expressed that regional political and social climate, religious attitudes, and racism were barriers they routinely experienced when accessing health care in the rural southern region of the United States. Health care facilities such as the MCHC mentioned in this report can serve as a catalyst for providing SGM-affirming services to the community, as well as functioning as a setting for providers to practice and implement SGM-inclusive and competent health care under the guidance of experts and with the consent of clients. In addition, sociopolitical factors in the rural South need re-examination, with an enhanced focus on intersecting identities in order to increase SGM individuals' access to safe, comprehensive, and affirming care. Further studies should explore specific steps, training, or policies that health care providers, hospitals, and clinics need to implement in order to create an affirming and discrimination-free environment.

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### KEY CONSIDERATIONS

- When identifying a health care provider, sexual and gender minorities (SGM) individuals in the rural southern United States often weigh whether a provider, clinic staff, and other member of the health care team will be discriminatory based on geopolitical beliefs, religious dogma, or racist practices.
- There is a shortage of affirming, safe health care providers, clinics, and systems in the rural southern United States, which leads to decreased access to health care for SGM individuals.
- Black SGM individuals in the rural South also face additional discrimination and barriers due to their intersecting identities, which is complicated by racism and medical mistrust.
- SGM-specific and anti-racist health care training should be integrated into medical education, continued medical education, and medical staff training, and research focusing on the knowledge gaps and SGM, and racial and ethnic minority needs should inform educational reform.

**Table 1.**

## Sample Questions for Interview Content Areas

Interview Content Areas	Sample Question
Southern United States and SGM Identity	Why do you think people aren't necessarily comfortable going to the doctor?
	What are some obstacles for you when you are trying to follow through with a medical referral?
	What would be helpful for health care providers and offices to do to make people feel comfortable going to see a provider?
	Are there resources in your area that help SGM individuals find resources?
	Why is it challenging to find SGM-specific support resources?
Religious Attitudes and SGM Identity	Why did you seek services at the MCHC?
	Could you describe what your general understandings are of the purpose of the MCHC?
	What were things you want to make sure providers you were referred to were able to do?
	Were there any other community resources available for you when you were trying to find care or follow through with a referral?
	How do you go about finding an affirming provider?
Race and SGM Identity	What are some of the major health care needs of SGM individuals in your area?
	What was challenging about accessing services at the MCHC?
	What do you think would be important for creating a list of affirming providers?
	What worries you the most or has been the hardest to deal with during the COVID-19 pandemic?
	How has your physical and emotional well-being been since the pandemic started?

*Note.* COVID-19 = coronavirus disease 2019; MCHC = mobile community health center; SGM = sexual and gender minorities.

**Table 2.**

## Demographic Characteristics of Study Participants

	<b><i>n</i> (%) Unless Otherwise Noted</b>
Mean age in years ( $\pm$ <i>SD</i> )	27.3 $\pm$ 4.44
Race	
Black	5 (42)
Hispanic	1 (8)
White	6 (50)
Mean annual income	
\$20,000 or less	1 (8)
\$20,001 to \$40,000	4 (33)
\$40,001 to \$60,000	5 (42)
\$60,001+	2 (17)
Sexual orientation	
Queer	3 (25)
Bisexual	1 (8)
Pansexual	2 (17)
Lesbian	2 (17)
Gay	3 (25)
Heterosexual	1 (8)
Gender identity	
Nonbinary	2 (17)
Transgender female	1 (8)
Transgender male	3 (25)
Cisgender female	3 (25)
Cisgender male	3 (25)
Highest level of education	
Some college	4 (33)
Two-year associate degree	1 (8)
Four-year bachelor's degree	6 (50)
Graduate or professional degree	1 (8)