FACTORS THAT IMPACT ASSIGNED FEMALE AT BIRTH SEXUAL MINORITY INDIVIDUALS' HEALTH CARE EXPERIENCES: A QUALITATIVE DESCRIPTIVE STUDY

Dissertation

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Doctor of Philosophy

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by

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The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

FACTORS THAT IMPACT ASSIGNED FEMALE AT BIRTH SEXUAL MINORITY INDIVIDUALS' HEALTH CARE EXPERIENCES:

A QUALITATIVE DESCRIPTIVE STUDY

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Abstract

The purpose of this qualitative descriptive study was to identify factors that impact the health seeking behaviors of young, assigned female at birth (AFAB) sexual minority individuals. This understudied population is less likely to engage in health care services and health screenings as compared to their cisgender counterparts. Purposive sampling was used to recruit ten AFAB sexual minority individuals between 18-30 years of age who lived, attended school, and sought health care services in the Chicago metropolitan area. One overarching theme and two main themes emerged from data acquired through individual interviews: overarching theme “the right questions”; main themes (1) lack of trust in health professionals; (2) the need for better sexual health education. An important finding was that assigned female at birth sexual minority individuals want to be asked about their sexual orientation, sexual behavior, and gender identity. Participants wanted to be able to share their sexual orientation and gender identity with health professionals so they could receive appropriate care, accurate information, and feel comfortable sharing aspects about their life. Participants also desired the ability to have a relationship with health professionals that did not include awkward conversations or feeling judged. Additionally, the results suggested that general and health sciences curricula should include content about diverse sexual and gender minority populations. The addition of this type of education might increase the awareness of the person seeking care and the health care professional to the health needs of assigned female at birth sexual minority individuals. Such instruction might also normalize individuals with diverse sexual orientations and gender identities. Findings have important implications for education

and clinical practice. Novel strategies are needed to enhance health-seeking behaviors, and thereby the health outcomes, of the AFAB sexual minority population.

CHAPTER I

INTRODUCTION

Assigned female at birth (AFAB) sexual minority individuals are at increased risk for adverse health outcomes compared to their cisgender heterosexual peers (Horn & Swartz, 2019; Kann et al., 2016). AFAB sexual minority individuals are an understudied population and are at higher risk for heart disease, cancer, suffer from depression and anxiety, and less likely to seek preventative health services than their heterosexual peers (Garland-Forshee et al., 2014; Strutz et al., 2015; Trinh et al., 2017; U.S. Department of Health and Human Services, 2019). Adolescent AFAB sexual minority individuals have an increased incidence of sexually transmitted infections, alcohol and drug use, and sedentary lifestyle. These adolescents have earlier initiation into sex and report more sex partners than their heterosexual peers (Charlton et al., 2019; Kann et al., 2016, 2018). Despite these risks, research shows that AFAB sexual minority individuals are less likely to have an annual health exam and screenings than their heterosexual peers (Blosnich et al., 2014; U.S. Department of Health and Human Services, 2019). Lack of engagement in preventative health care is associated with a higher risk for long term complications due to late identification of STIs, breast cancer, and cervical cancer (Centers for Disease Control and Prevention, 2019; Solazzo et al., 2017; United States Department of Health and Human Services Office on Women's Health, 2017).

Background

A majority of the lesbian, gay, bisexual, transgender, questioning, intersex, asexual, and queer identifying community (LGBTQIA+) population in the United States are AFAB, 5.1%, compared to only 3.9% assigned male at birth (Newport, 2018). Even

though AFAB individuals being the majority group, 70% of the National Institutes of Health Research funding is used to study men who have sex with men (MSM) and transgender women. In comparison, only 10% to 14% of funds are used on research focusing on AFAB sexual minority individuals or AFAB individuals who have sex with other AFAB individuals (Pharr et al., 2019; Potter, 2019). Health data shows that AFAB sexual minority individuals have more adverse health conditions and are less likely to seek routine care than MSM or heterosexual cisgender women (Blosnich et al., 2014; Dahlhamer et al., 2016; Strutz et al., 2015). While research on HIV and AIDS is essential, it is not the only health concern among LGBTQIA+ individuals, and issues that primarily affect AFAB sexual minority individuals are understudied (Baptiste-Roberts et al., 2017; Corcoran, 2017; Everett, 2013).

Approximately 4.5% of the United States population identifies as a sexual or gender minority (Newport, 2018). In the past decade, policy in the United States concerning LGBTQIA+ individuals has changed significantly. While many policy changes have been for the better, repeal of "Don't ask, don't tell" in 2011(Human Rights Campaign, 2011), and the 2015 Supreme Court decision allowing for same-sex marriage (American Civil Liberties Union, 2015); LGBTQIA+ individuals still lack equality and equity when it comes to access to health care and health information. Contrary to evidence showing inclusive sexual health education leads to improved health outcomes in sexual minority individuals (Charest et al., 2016), only ten states require inclusive topics on sexual orientation to be taught in sex education classes in schools. Seven states require only negative information on homosexuality be taught or are required to put a positive emphasis on heterosexuality (Guttmacher Institute, 2020). Despite the appearances of

advances in social policy, LGBTQIA+ individuals still face discrimination in education, employment, housing, and health care (Agénor et al., 2017, 2019; Centers for Disease Control and Prevention, 2016; Curry, 2017; Kaestle & Waller, 2011; Pharr et al., 2019).

Chicago and Illinois have a rich history of accepting and being aware of sexual and gender minority individuals' needs (Harrington, 2011). In 1924 the Society for Human Rights was founded in Chicago and focused on changing laws that made homosexuality illegal and teaching about the LGBTQIA+ community. In 1961 Illinois became the first state to decriminalize sodomy, and in 1988 the city passed an antidiscrimination law making it illegal to discriminate against someone based on race, disability, and sexual orientation (Harrington, 2011). In 2011, Illinois legalized same-sex unions, and three years later, in 2014, same-sex marriage became legal in Illinois (Wilson, 2014). However, despite its progressive past, inequities based on gender, sexual expression, and orientation are still prevalent in the city and state (Morten et al., 2019).

The Chicago Department of Public Health conducted a community assessment of the LGBTQIA+ community in 2018 (Chicago Department of Public Health, 2018). Approximately 7.5%, 146,000, of Chicago's adult population identify as LGBTQIA+. Participants who identified as a gender or sexual minority were recruited for the assessment. The assessment revealed seven key themes: 1) inequities within the LGBTQIA+ community, 2) high quality, affordable, culturally responsive, and comprehensive health care, 3) employment and underemployment and equity in the job market, 4) support accessing quality human and government services, 5) community safety and violence prevention for all, 6) affordable housing and gentrification, and 7)

resilience and capacity of a participatory, intersectional LGBTQIA+ community (Morten et al., 2019).

The geographic location of health care services is problematic in a city as large as Chicago. While there is a wealth of services for LGBTQIA+ individuals in Chicago's Northside neighborhoods, there is a lack of resources for LGBTQIA+ individuals, specifically AFAB sexual minority individuals on the Southside of the city; with the impression that the resources available are for cisgender gay white males (Morten et al., 2019). AFAB sexual minority individuals have unique health needs that are not being met with the current health care resources in Chicago, causing an increased incidence of long-term health issues (Buchmueller & Carpenter, 2010; Kann et al., 2016; Morten et al., 2019).

Purpose

There is a wealth of information about health-seeking behavior and preventative care practices of heterosexual individuals. However, there is scant literature on the views, perceptions, and experiences of AFAB sexual minority individuals, particularly those who are younger (Baptiste-Roberts et al., 2017; Strutz et al., 2015). The few research studies that have been published report low health risk perceptions of sexually transmitted disease and cancers by the individual and their health care professional (Agénor et al., 2019; Baptiste-Roberts et al., 2017; Branstetter et al., 2017; Jahn et al., 2019); fear of stigma (Arbeit et al., 2016; Flanders et al., 2019; Johnson & Nemeth, 2014; Stover et al., 2014), lack informed health professionals, (Alpert et al., 2017; Dearing & Hequembourg, 2014; Martos et al., 2018; Röndahl et al., 2006), and cost of health care as reasons they do not seek routine care. (Blosnich et al., 2014; Dahlhamer et al., 2016;

Jackson et al., 2016; Nguyen et al., 2018; Reiter & McRee, 2015). However, very little research has been conducted to understand AFAB sexual minority individuals' health care needs and address their barriers to health care. Due to the lack of research with this population and the difference in experiences and needs of AFAB sexual minority individuals compared to heterosexual women or men who have sex with men, it is important to highlight what impacts AFAB sexual minority individuals' health care.

This study aims to explore the barriers to health care faced by AFAB sexual minority individuals by looking at their experiences utilizing care. Through interviews, we hoped to better understand AFAB sexual minority individuals' needs and the factors that impact their decisions to seek, or not seek, routine health exams and engage in preventative health care. Moreover, this study was undertaken in an effort to identify modifiable factors that may increase the uptake of preventive health care services by AFAB sexual minority individuals.

For this study, AFAB sexual minority individuals are defined as individuals assigned female at birth (AFAB) who identify as lesbian or bisexual, or AFAB individuals who have sex with other AFAB individuals (Baptiste-Roberts et al., 2017). Transgender women were intentionally omitted from our definition of AFAB sexual minority individuals because of their unique health needs due to being born male. Sexual minority men were omitted as well because there is a wealth of information on their health needs.

Specific Aims

Specific Aim: Identify the factors that impact AFAB sexual minority individuals' decision to engage or not engage in health-seeking behaviors and receive preventative health care services.

Research Questions

RQ#1: What barriers do AFAB sexual minority individuals face with regard to seeking health care services?

RQ#2: What factors enhance the health care seeking behaviors of AFAB sexual minority individuals.

Significance

The proposed research study is innovative in the following ways: first, the proposed research focuses on young AFAB sexual minority individuals. Previous studies focused on the LGBTQIA+ community as a whole, older lesbians and bisexuals AFAB, or MSM. There are limited studies that focus on young AFAB sexual minority individuals' early health care experiences. Second, most studies on this population are cross-sectional; this study is qualitative and asks what young AFAB sexual minority individuals want to be changed about their health care.

This study has important public health implications because it seeks to understand what impacts a sexual minority woman’s decision to seek health care. Furthermore, the study aligns with the National Institute of Nursing’s mission to enhance research on sexual and gender minority individuals' health and well-being and the Chicago Office of Lesbian, Gay, Bisexual, and Transgender Health’s mission to improve the well-being of and health care delivery to LGBTQIA+ people in Chicago.

This dissertation study is the first step in a program of research that aims to enhance the health outcomes of AFAB sexual minority individuals through the development of culturally, gender, and sexuality competent health care initiatives. Results from this project will contribute to the body of knowledge about the health care experiences of an understudied and underserved population. Findings from this study may inform interventions to enhance the health outcomes of this priority population. In addition, the findings of this study may be utilized in the development of curricula for health sciences students that strive to ensure culturally sensitive care for sexual minority populations.

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Definition of Terms

Asexual—A person who has no sexual attraction for other people.

Bisexual—A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree.

Cisgender—A person whose gender identity aligns with the sex assigned to them at birth.

Gender dysphoria—Distress caused when a person's assigned birth gender is not the same as the one with which they identify.

Gender-fluid—A person who does not identify with a single fixed gender.

Gender identity—How a person feels about themselves inside and expresses through dress, behavior, and appearance A persons gender identity can be the same or different from their sex assigned at birth

Genderqueer—A person who does not identify with a single fixed gender, and sometimes sexual orientation.

Gender transition—A process some people undergo to match their gender identity to their outward appearance. This can include changing names, pronouns, and dress to fit their gender identity. It may also include healthcare needs such as hormones or surgeries.

Heteronormative—A world view that promotes heterosexuality as the normal or preferred sexual orientation.

Homophobia—The fear and hatred of or discomfort with people who are attracted to members of the same sex.

Lesbian—A woman who is emotionally, romantically or sexually attracted to other women. Women and non-binary people may use this term to describe themselves.

Nonbinary—A person who does not identify exclusively as a man or a woman.

LGBTQIA+—An acronym for "lesbian, gay, bisexual, transgender, queer, intersex, asexual and others queer identifying individuals."

Pansexual—A person who has emotional, romantic or sexual attraction to people of any gender or sexual orientation.

Queer—A term used to express a spectrum of identities and orientations that are counter to the mainstream. Queer is often used as a catch-all to include anyone not heterosexual or cisgender. This term was previously used as a slur but has been reclaimed by many parts of the LGBTQ movement.

Questioning—A person who is in the process of exploring their sexual orientation or gender identity.

Sex assigned at birth—The sex (male or female) given to a child at birth based on their external genitalia.

Sexual orientation—An enduring emotional, romantic or sexual attraction to persons of the opposite gender, same gender, both genders, or any gender. Sexual orientation is independent of gender identity.

Transgender—An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

CHAPTER II

BACKGROUND

Background is comprised of two published literature reviews, the first authored by the student and a literature review currently under review

The following publication won the 2019 Journal of School Nursing (JOSN)/SAGE Scholarly Writing Award.

The Role of Policy on Sexual Health Education In Schools: Review

Rabbitte, M. & Enriquez, M. Published in *The Journal of School Nursing*, July 2018

Abstract

Teen pregnancy and sexually transmitted infections are leading public health problems in the United States. While abstaining from sexual intercourse is the best way to avoid these conditions, abstinence only education (AOE) programs in schools have been shown ineffective in delaying sexual initiation or decreasing the teen pregnancy rate. Conversely, comprehensive sex education (CSE) programs have demonstrated the ability to decrease teen pregnancy and delay initiation into sex. However, federal funding continues to primarily support AOE programs, and a majority of states favor AOE in schools, rather than CSE. The purpose of this review was to examine the role of policy on sexual health education, which can have an impact on the health and well-being of adolescents. The review provides school nurses with information to help them educate parents and administrators to the negative repercussions of AOE, so they can advocate for policy change.

Keywords: policies/procedures, health education, teen pregnancy/parenting, family life/sexuality, school nursing

According to the 2015 Youth Risk Behavior Survey, 41.2% of teens in the United States reported ever having sexual intercourse and 30.1% had been sexually active in the 3 months prior to the survey (Center for Disease Control [CDC], 2015). Teen pregnancy and sexually transmitted infections (STIs) are leading public health problems in the United States (Office of Disease Prevention and Health Promotion, 2017). While abstinence is the only 100% effective way to prevent these potential problems, over 40% of students are not practicing abstinence. Moreover, studies show that abstinence only education (AOE) programs are not effective in reducing sexual risk-taking behaviors (Society for Adolescent Health and Medicine [SAHM], 2017). Comprehensive sex education (CSE) teaches medically accurate and age-appropriate information about abstinence and contraceptives and also addresses the psychosocial, emotional, physical, and mental aspects of sexuality (Sexuality Information and Education Council of the United States [SIECUS], 2009). CSE programs show the most promise in helping reduce risky sexual behaviors (Advocate for Youth, 2012).

Sexual health education in U.S. schools has changed significantly over the past 50 years as a direct result of federal and state legislation and funding. Beginning in the 1960s, in response to the sexual revolution, federal legislation on sexual health education became more progressive. In 1966, the U.S. Department of Education, to address the growing issue of teen pregnancy, funded 645 agencies throughout the United States to develop sexual health education programs. While there were no stipulations on the type of sexual health education required, CSE that emphasized birth control was included in many of the curricula. In 1971, President Nixon supported the implementation of CSE in all public schools, emphasizing sex as a healthy part of life, and giving students access to

the information required to make informed healthy sexual decisions (Huber & Firmin, 2014).

The promotion and expansion of CSE was halted in the 1980s in response to the HIV epidemic and efforts of the religious right (Huber & Firmin, 2014). Legislation was enacted encouraging states to discard CSE and adopt AOE (Carr & Packham, 2017). In 1981, the Adolescent Family Life Act was passed with a primary goal to promote chastity and self-discipline; in 1996, the welfare reform law enacted Title V of the Social Security Act that provided grants to states that adopted AOE and its tenets (Lerner & Hawkins, 2016). In order to receive a grant, the curricula needed to cover the eight points of AOE (https://www.acf.hhs.gov/ fysb/resource/aegp-factsheet; U.S. Department of Health and Human Services, 2017). The grants grew substantially between 1996 and 2006, with many states adopting abstinence programs to obtain federal funding. It is estimated that over US$2 billion has been spent on AOE in the United States (Donovan, 2017). This trend continued until 2010 when President Obama cut funding to AOE and increased funding to programs that supported CSE (Kaiser Foundation, 2002; Weiser & Miller, 2010). Currently, there are still more federal funding opportunities available to AOE programming than to CSE (Lerner & Hawkins, 2016).

While the U.S. government has promoted AOE in schools, leading health and educational organizations have supported CSE (WHO, 1993). The United Nations Educational, Scientific and Cultural Organization (UNESCO) and the World Health Organization (WHO) view CSE as a human right, with the objective to provide accurate, realistic information and life skills in a nonjudgmental way to help adolescents make informed decisions. Information should be free of stigma and reviewed regularly for

inaccuracies (UNESCO, 2015; WHO, 2010). The CDC (2014) recommends comprehensive education delivered by trained instructors that provides information on the benefits of abstinence but also discusses 16 critical sexual health topics including communication, HIV and STI transmission risks, contraceptives, decision-making skills, and the efficacy of condoms. The SAHM (2017), released a position paper addressing the problems with AOE, recommending it be abandoned due to the lack of evidence of efficacy. Failures identified in the position paper included not meeting the needs of youth in sexual minority, being in violation of the sexual and reproductive rights of youth, and the negative impact of the program's misinformation.

The purpose of this review was to examine the role of policy on sexual health education. Further, this review provides an understanding about continued governmental support for AOE in the United States, despite the fact that leading health and educational organizations promote CSE. A systemic review of studies published between 2000 and 2017 was conducted to evaluate the role of federal policy and funding on sexual health education in U.S. public schools.

Literature Search

The review was conducted according to the Preferred Reporting Items for Systemic Review and Meta-Analysis (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, & the PRISMA Group, 2009). The search was conducted using four online databases: CINAHL, PubMed, Scopus, and EBSCO. The search strategy for CINAHL was as follows: Limits were set to include research articles published in English in peer-reviewed academic journals, age restriction set to "all child," and major heading of "sex education." The search date was set from January 2000 to December 2017. The reason

for the 2000 start date was to give programs established and funded by the 1996 Title V Welfare Reform Act the opportunity to be implemented, evaluated, and published. Subject age was restricted to “all child” to eliminate articles that included college-age individuals. The combinations of the search terms used were “sexual health education” and “policy” and “schools”; “sexual health education” and “policy”; and “sex education policies.” The same searches were conducted in each of the other databases. The process is illustrated in Figure 1. The initial searches yielded a total of 548 articles; 497 articles could be excluded after reading the title or abstract, and 51 articles were viewed in full text. Articles reviewed addressed sexual health education policy and its influence on primary and secondary school education; articles that analyzed parents, students, and staff opinions of sexual health education policy; and articles that addressed policy recommendations by trusted health organizations. After reading the full text articles, 26 articles were excluded for the following reasons: 3 articles were editorials; 10 were not set in the United States; 2 discussed only elementary school programming; 6 addressed program implementations, not policy; and 6 addressed individual school or district policies. Hence, a total of 25 articles were included in the review (Table 1).

Figure 1

PRISMA diagram showing search and screening process, and selection of studies for inclusion in review.

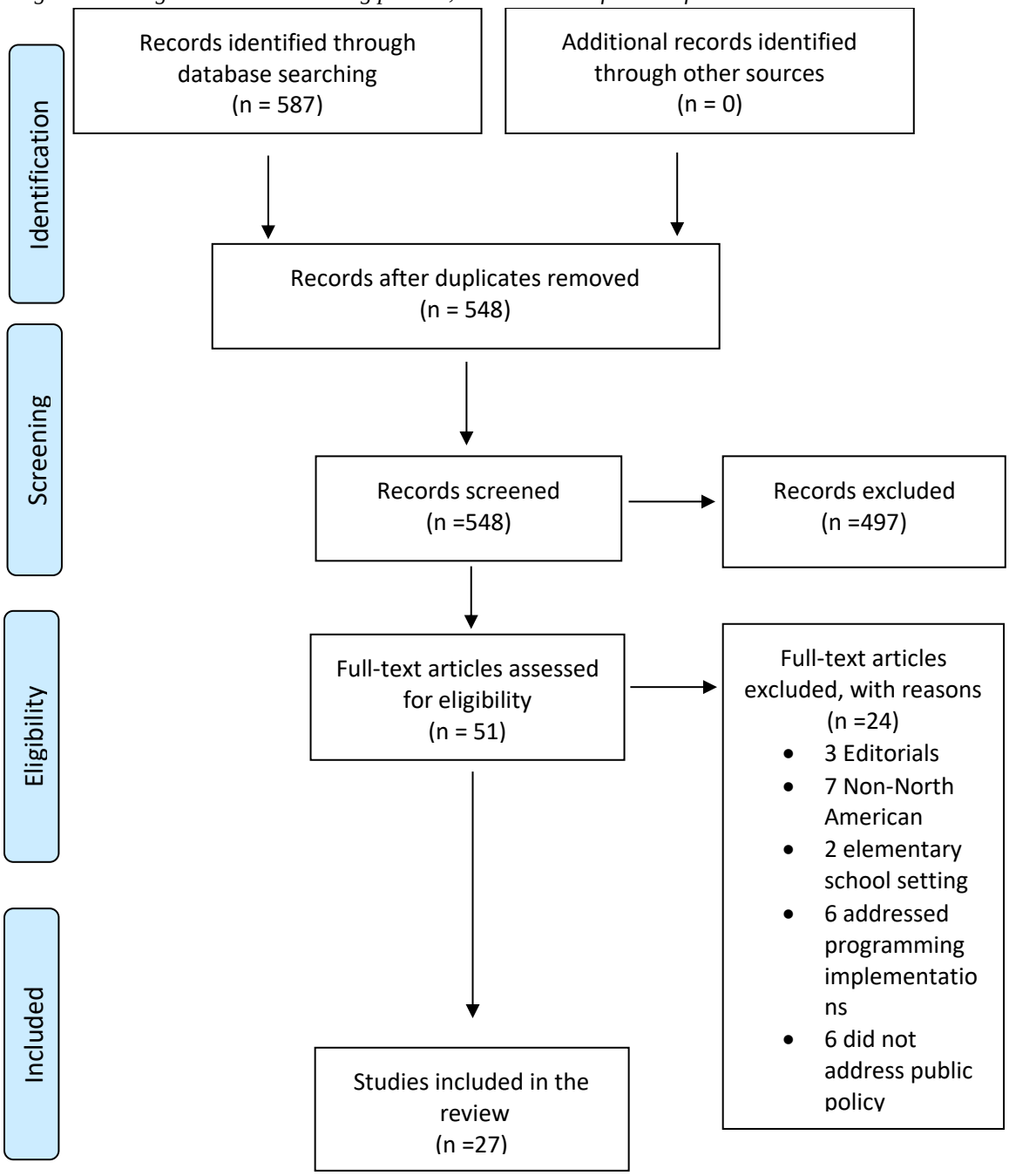

Table 1

Review of Studies Related to Sexual Health Education Policy in Schools

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Baker, J.O.; Smith, K.K.; Stoss, Y.A. (2015)	To determine how the religious makeup of a state's population affects the sexual health education policies of that state.	Information was gathered from multiple sites Pew Religious Landscape Survey Religious Congregation and Membership Survey Politicians	Pew Religious Landscape Survey on scriptural literalism, service attendance, and levels of theism. n=35,957 2000 Religious Congregations and Membership Study was used to assess religious adherence and evangelical adherence. n=3,142 Interviews regarding political alliance right n=400 politicians	States with self-reported high levels of theism are more likely to have sexual health education that stresses abstinence only and states with low levels of theism are more likely to have sexual health education that covers contraceptives. Policy change in states with abstinence only education may be more successful if done through a public health model as opposed to a separation of church and state model.
Bleakley, A.; Hennessy, M., Fishbein, M. (2006)	To determine if public opinion on sexual education aligned with policy.	National representation of randomly selected adults	Cross-sectional survey n=1096 randomly drawn from the Annenberg National Health Communication Survey	Policy does not match public opinion. Most polled were in favor of comprehensive sex education that includes abstinence but also contraceptives and condom use, whereas the federal government supports abstinence only education.

Table 1, continued.

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Bleakley, A.; Hennessy, M.; Fishbein, M. (2010)	To determine what factors influence public opinion on sexual health education policy.	National representation of randomly selected adults	Structural equation modeling n=1096 randomly drawn from the Annenberg National Health Communication Survey	Religion and political beliefs were key factors in whether someone supported or opposed CSHE. CSHE advocates should focus CSHE programs efficacy and value as a public health model when trying to institute policy change.
Carr, J.B.; Packham, A. (2017)	To examine the casual effects of state mandated abstinence only education on teen pregnancy and STI rate.	States policies were gathered from the Guttmacher reports. Birth data was gathered form National Center for Health statistics, Division of Vital Statistics Natality Files; state level STD data and abortion rate obtained from CDC.	Difference-in-difference design Treatment groups: 5 states that changed sexual health education from no content requirements or comprehensive education to a curriculum that stressed abstinence. Control group were the 21 states that did not change policy	State policy change did not significantly affect teen birth and abortion rates. However, STD rates were affected, increasing in states that adopted abstinence policies.

Table 1, continued.

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Chevrette, M., & Abenhaim, H.A. (2015)	To examine whether state level policies had an effect on teen birth and abortion rates.	Guttmacher Institute, National Vital Statistics System, CDC	Cross-sectional study looked at all 15-19 y/o who delivered in the U.S. in 2008 to see if there was a relationship between birth rate and state policy.	State level sex education policy did not affect teen birth rates.
Constantine, N.A., Jerman, P., & Huang, A.X. (2007)	To determine parental preferences for sexual health education	Randomly chosen adults from California who identified themselves as parents.	Random digit dial searched of California parents were surveyed n=1,284 parents	89% supported CSE while only 11% supported AOE. School board and politicians should consider parental opinion when creating sexual health education policy.
Donovan, M.K. (2017)	Examines the trend of funding for AOE and CSE	n/a	n/a	Although funding has been allocated to CSE over the past decade current administration and conservative politicians are threatening to cut funding to CSE and increase AOE funding.

Table 1, continued.

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Eisenberg, M.E., Bernat, D.H., & Bearinger, L.H., Resnick, M.D. (2008)	To determine parental preferences for sexual health education	Randomly chosen adults form Minnesota who identified themselves as parents.	Telephone survey of parents from all 8 of Minnesota's legislative districts that asked n=1, 605 parents of school age children in Minnesota	89% supported CSE. Parents should express their opinions to administrators and politicians
Eisenberg, M.E., Bernat, D.H., & Bearinger, L.H., Resnick, M.D. (2009)	To determine parental support for sexual health education that includes condoms	Randomly chosen adults form Minnesota who identified themselves as parents.	Computer assisted cross sectional phone survey n=1,605 parents of school age children in Minnesota	86% supported education that included condoms.77% supported showing how to use condoms in the classroom. Parents should express their opinions to administrators and politicians
Ito, K.E., Gizlice, Z., Owen-O'Dowd, J., Foust, E., Leone, P.A., Miller, W.C. (2006)	To determine if the state sex education policy matched parental opinion.	Randomly chosen adults from North Carolina who identified themselves as parents.	Computer assisted cross sectional phone survey n=1306 parents of North Carolina school children in grades k–12	86% supported CHSE , 80% thought teaching how to use condoms was important, 57% thought classroom demonstration of how to use a condom was important, 74% thought teaching where to obtain birth control was important, 90% felt parents and healthcare officials should determine content of sexual health education, 7% supported politicians being responsible for sexual health education content

Table 1, continued.

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Jozkowski, K.N.; Crawford, B.L.(2016)	To provide recommendations to these states to help improve the sexual health of teens by reducing teen pregnancy and STI rates.	Data collected from the CDC , Guttmacher Institute, National Assembly on School Based Health Care, National Campaign to Prevent Teen and Unplanned Pregnancy	n/a	States with abstinence only education or no mandated sexual health education have higher rates of pregnancy, birth and STIs compared to other states. Sexual health education policies are based on politician personal feelings and unfounded beliefs and not on scientific data. Make comprehensive sex education available to all students and provide only evidence based, medically accurate information. Amend policy regarding sexual health education in schools to align with scientific findings Improve access to sexual health services in school and community base clinics. State funding should be allowed to be used to purchase condoms and contraceptives in school-based health clinics.

Table 1, continued.

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Kaiser Foundation. (2002)	Examines sexual health education policy at all levels. Looks at scientific evidence on the effectiveness of AOE and CSE.	Data collected from the CDC, Guttmacher Institute, National School Boards Association, Kaiser Foundation, Health Resources and Service Administration, Surgeon General of the United States, SEICUS	n/a	
Kantor, L., & Levitz, N. (2017)	To determine if views on sex education differed based on a person's declared political party.	n/a	91 item parent questionnaires administer to a random sample picked through Gfk Inc. n= 1,633 parents of 9-21-year-old	Regardless of political affiliation parents support CSE in schools. Policy makers and school official should be made aware of parent choices regarding their children's sexual health education.

Table 1, continued.

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Kohler, P.K., Manhart, L.E., Lafferty, W.E. (2008)	To determine the role sex education plays in sexual initiation and teen pregnancy	National Surveys of Family Growth Cycle 6 survey	Cross-sectional survey n=1,719	Teens who received CSE were less likely to report pregnancy than those with no sex ed, AOE did not reduce teen pregnancy or sexual activity. Teaching about contraceptives did not increase risk of STD or sexual activity in teens.
Landry, D.J., Darrach, J.E., Singh, S., & Higgins, J. (2003)	To examine the content of and factors associated with sex education in different geographic areas of the U.S.	Alan Guttmacher Institute, Advocates for Youth, 1995 National Survey of Family Growth,	National survey n=1,657 teachers and nurses of grades 7-12 who are responsible for teaching sex education	Content varied by region, AOE was more common in the South than in the Northeast and teaching about the ineffectiveness of contraceptives was less common in Northeast than other regions. Schools should include medically accurate information in sex education.
Lerner, J.E., & Hawkins, R.L. (2016)	Examines Title V of the Welfare Reform Act and how the ineffectiveness of AOE education impacts teens.	n/a	n/a	AOE policy has poorer outcomes and is less effective than CSE. Using CSE with abstinence education combined with the theory of Reasoned Action Model.

Table 1, continued

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Lindberg, L.D., Maddow-Zimet, I., & Boonstra, H. (2016)	To examine the number of adolescents receiving sex education.	National Surveys of Family Growth	Survey 2006-2010 15-19-year-old n=2,284 female n=2, 378 males 2011-2013 15-19-year old's n=1,037 female n=1,088 male	Decrease in reported female receipt of formal education on contraceptives, STIs, and HIV and a decrease in males receiving instruction on contraceptives. Parents not talking to teens about contraceptives.
Malone, P., & Rodriguez, M. (2011)	Looks at history and effectiveness of AOE and CSE in the U.S.	CDC	n/a	CSE is more effective than AOE. Supports CSE over AOE. Focus should be on providing youth with information they need to protect themselves.

Table 1, continued

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Millner, V.; Mulekar, M.; Turrens, J. (2015).	Investigate parental attitudes of abstinence-plus education in a large metropolitan school district. Opinions were compared based on whether the participant lived in a zip code with high teen pregnancy rate or not.	Randomly selected citizens of Mobile County Alabama with school age children	Computer- Assisted Telephone Interviewer (CATI) system Included 36 substantive questions an 6 demographic questions. Adapted from North Carolina phone study. n= 522 randomly selected in Mobile County in areas with high incidence of teen pregnancy	A majority of the parents surveyed were in favor of abstinence plus sexual health education in schools. Sex ed should focus on the needs of the population served, not the conservative views of the politicians.
Society for Adolescent Health and Medicine. (2017)	Policy statement from the Society for Adolescent health on abstinence only until marriage (AOUM) policies	n/a	n/a	AOUM programs are flawed, not evidenced based, and interfere with an adolescent right to complete and accurate health information. Education should be evidenced based and provided by health educators and healthcare providers. Government programs supporting AOUM policies should be abandoned.

Table 1, continued

Reference	Study purpose/topic	Sources of information	Study design/sample	Key findings/recommendations
Stanger-Hall, K.F., & Hall, D.W. (2011)	Examine AOE and its impact on teen pregnancy and birth rates.	Education Commission of the States, CDC National Vital Statistics, Council for Community and Economic Research, National Center for Education Statistics, Guttmacher Institute,	Looked at relationship between teen pregnancy and birth rates and state policy on sex education.	AOE as a policy is ineffective in decreasing the teen pregnancy rate and teen birth rate increases as the emphasis on AOE increases. Parents and policy makers need to advocate for CSE.
United States House of Representatives Committee on Government Reform-Minority Staff Special Investigations Division. (2004)	To examine AOE programs.	n/a	n/a	AOE programs contained medically inaccurate information, perpetuated gender stereotypes and infused religious belief through curricula.
Weiser, D.A., & Miller, M.K. (2010)	To examine whether sex education policy and funding match public opinion and health agency recommendations.	Information collected from CDC, World Health Organization, federal reports, The Kaiser Foundation,	n/a	Policy and funding does not match opinion and evidence-based research that CSE is better than AOE. Federal, State and local government should advocate for CSE.

Table 1, continued

World Health Organization. (2010)	Looks to define terms in sexual health programming and recommendations on developing programming.	UNESCO, UNAIDS, UNFPA, WHO, Advocates for Youth	n/a	
Yang, Z., & Gaydos, L.M. (2010)	Examined teen birth rate compared to demographics and policy at the state level.	Birth rate data from National Center for Health Statistics, U.S.A.	State level data of births from 2000-2006 was analyzed and compared to policy and demographics.	AOE programming caused an increase in teen birth rate. Policy should be changed to promote contraceptive access and use. Education should also target the cultural needs of teens.

AOE= abstinence only education AOUM= abstinence only until marriage education CSE= comprehensive sexual education CSHE= comprehensive sexual health education STI= sexually transmitted disease n/a = not applicable

Current State Policies

While most teens report having received some form of sexual health education in school, the content of the programming varies widely. According to the CDC (2015), fewer than 50% of high school students and only 20% of middle school students receive instruction on all 16 essential topics of CSE recommended by the CDC. One study reviewed reported a decline in the receipt of formal instruction in schools on methods of birth control, saying no to sex, STIs, and HIV (Lindberg, Maddow-Zimet, & Boonstra, 2016). Another study examined differences in content presented to students based on geographical region in the United States (Landry, Darrach, Singh, & Higgins, 2003). Teachers in the South were less likely to instruct on CSE and more likely to instruct on AOE and the ineffectiveness of contraceptives than teachers in the Northeast (Landry et al., 2003). However, the problem of curriculum content does not seem to be restricted by geography. There was no reporting by districts to the state about exactly what is taught for both AOE and CSE (Malone & Rodriguez, 2011).

The federal government does not mandate a specific type of sexual health education program. Policy adopted at the state level and implemented by individual districts in the state dictate program type (Malone & Rodriguez, 2011). The Guttmacher Institute (2017) has published a summary of state policies regarding sex education. Only 24 states mandate sex education, and just 13 states require that the information taught be medically accurate. If sex education is taught in a state, 26 states require abstinence be the emphasis, 18 require highlighting the importance of sex only in marriage, and 12 require discussion of sexual orientation. Of note is the fact that three states require that only negative information is provided with regard to sexual orientation. Even in states

that have no mandate, AOE is the number one curriculum being taught (Guttmacher, 2017).

Program Effectiveness

To evaluate the efficacy of programs, researchers have examined teen sexual health outcomes (Jozkowski & Crawford, 2016). Three studies focused on teen birth or abortion rates to determine whether there was a difference between states that offered AOE compared to states that offered CSE (Chevrette & Abenhaim, 2015; Stanger-Hall & Hall, 2011; Yang & Gaydos, 2010). One study found no difference in teen birth or abortion rates based on policy, but two found increased teen birth rate in states that had AOE (Chevrette & Abenhaim, 2015; Stanger-Hall & Hall, 2011; Yang & Gaydos, 2010). Researchers provided evidence that as AOE monies increased in a state so did the birth rate (Stranger Hall & Hall, 2011; Yang & Gaydos, 2010). Another study examined data on teen health outcomes in five states that switched from no policy to AOE and found no difference in teen birth and abortion rates (Carr & Packham, 2017). Of note, after changing to AOE, there was a 10% increase in STI rates (Carr & Packham, 2017). Another study in this review reported that such an increase in STI rates is likely due to the negative or false information presented in AOE regarding contraceptives and their failure rate (Weiser & Miller, 2010). This misinformation was felt to lead adolescents into falsely believing that condoms do not work, leaving them at greater risk of pregnancy and STIs (Weiser & Miller, 2010). The empirical evidence does not support the notion that AOE delays sexual initiation or reduces pregnancy and abortion rates (Chevrette & Abenhaim, 2015). On the contrary, the lack of information on safe sex, or

misinformation provided, inhibits adolescents from making informed responsible safe sex decisions (Weiser & Miller,2010).

The content of AOE has come under scrutiny in the recent past. Legislators have known since 2004 that AOE could cause harm. U.S. Congressman Henry Waxman examined abstinence curricula and found that 80%contained false information, the curricula inaccurately presented the effectiveness of contraceptives and risks of abortion, contained scientific errors, blurred the lines between religion and science, and treated male and female stereotypes as scientific fact (U.S. House of Representatives Committee on Government Reform-Minority Staff Special Investigations Division, 2004). This misinformation inhibits an adolescent's ability to make an informed decision on sexual behavior and ultimately puts them at greater risk of STIs and pregnancy (Weiser & Miller, 2010).

Many parents are concerned that CSE will increase an adolescent's sexual activity and cause early sexual initiation (Kohler, Manhart, & Lafferty, 2008). To determine whether these concerns were justified, researchers surveyed 1,719adolescents throughout the United States. Results showed that 9.4%of adolescents surveyed had never received sexual health education, 23.8%received AOE, and 66.8%receivedCSE (Kohler et al., 2008). Adolescents who received CSE did not have increased sexual activity or early initiation to sex and had a lower risk for pregnancy than those who received AOE or no education (Kohler et al., 2008).

It appears that AOE has a negative impact on adolescent health. Teen pregnancy and STI rates are higher in states that mandate an emphasis on AOE. In the 10 states with the highest teen birth rates, 7 stress abstinence in their sexual health education and 6

states focus on the importance of sex only within the context of marriage (CDC, 2018; Guttmacher Institute, 2017). Conversely, in the states with the 10lowest teen birth rates, only 3 mandate abstinence be emphasized (CDC, 2018; Guttmacher Institute, 2017). With regard to STI rates, the same pattern is seen. In the 10 states with the highest reported gonorrhea rates, 9 require an emphasis on abstinence education, as opposed to the 10 lowest where only 3 require such an emphasis (CDC, 2017; Guttmacher Institute, 2017). By focusing on AOE, youth are missing critical information that can help them make better sexual health decisions.

Factors Influencing Policy

States have consistently adopted sexual education programming that is in contrast to public health officials' recommendations (CDC, 2015). The reason for such decisions that go against scientific evidence may be the availability of grant money for AOE. In the fiscal year 2008, US$177 million was allocated in the federal budget for AOE grants to states with no funding for CSE programs. In 2010, Title V was amended to include the Personal Responsibility Education Program, a program aimed at teaching adolescents about abstinence and contraception (Donovan, 2017). Since the amendment funding to AOE has decreased and CSE has increased, many states are still not adopting CSE programming (Guttmacher, 2017).

Other factors can impact the type of sexual health education policy that a state implements, such as political affiliation, religiosity, and conservative or liberal views (Baker, Smith, & Stoss, 2015; Bleakley, Hennessy, &Fishbein, 2010; Kaiser Foundation, 2002; Kantor & Levitz,2017). Religious and political views have been cited as two key factors in determining whether a person is in favor of CSE (Bleakley et al., 2010).

Liberals are more likely than conservatives to support CSE and democrats more likely in favor of sex education that provides birth control, STIs healthy relationships, and sexual orientation information than republicans (Constantine, Jerman, & Haung, 2007; Kantor & Levitz, 2017). Previous research has demonstrated that states with self-reported high levels of theism are more likely to have sexual health programming that focuses on abstinence, and states with low levels of theism are more likely to have CSE (Baker et al., 2015).

Opinions on Policy

Despite the federal impetus for AOE, most American citizens support CSE (Constantine et al., 2007; Kantor &Levitz, 2017). Numerous studies have been conducted using random surveys and all show overwhelming support for CSE (Bleakley, Hennessy, & Fishbein, 2006; Constantine et al.,2007; Eisenberg, Bernat, Bearinger, & Resnick, 2008, 2009; Millner, Mulekar, & Turrens, 2015). One study surveyed1,602 parents in Minnesota regarding CSE and condom instruction. The Minnesota study found that 89.3%of parents supported CSE, 86%agreed information on condoms should be taught, and 59%agreed condoms should be made available to high school students who ask for them (Eisenberg et al., 2008, 2009). Four cross-sectional studies using telephone surveys have been conducted to assess public opinions about sexual health education. Two studies were conducted in areas with AOE, one in a state with CSE (Itoet al., 2006), and one was a national survey (Millner et al.,2015). In all four studies, the majority of individuals surveyed supported CSE and opposed politicians determining sexual health education content in schools (Bleakley et al.,2006; Constantine et al., 2007; Ito et al., 2006; Millner et al.,2015). In summary, with regard to CSE and AOE, the literature

shows that policy does not match public or parental opinion. All studies reviewed showed overwhelming support for CSE, even in areas where AOE is the policy of the state.

Discussion

This review focused on the state of policy influence on sexual health education in U.S. schools and based on literature published from 2000 to 2017. In general, the American public and parents support comprehensive sexual education in schools. However, the reality is that most U.S. schools provide abstinence only programs.

Parents should be aware of the type of sexual health education that their children are receiving. Parents living in a state, or if children are attending a school, with an AOE policy, then parents could work with administrators and policy makers to change to CSE. There is a need for politicians and policy makers to start listening to parents and public health organizations to improve the type and quality of sexual health programming offered in schools.

Public opinion and research, not personal opinion, needs to guide policy. For example, Texas has one of the highest teen birth rates in the country, 37.8 births per 1,000 teenage girls compared to 24.2 births per 1,000 teenage girls in the United States, yet they mandate AOE programs because the politicians choose to follow their beliefs, not the needs of their constituents (Smith, 2010). Moreover, CSE has helped decrease the teen birth rate in other states (Stranger-Hall, &Hall, 2011; U.S. Department of Health and Human Services,2016). Better teen outcomes can be achieved if parents, schools, and policy makers realize the success of CSE and work with public health organizations to create and implement high-quality CSE (Jozkowski & Crawford, 2016). Efforts need to be made to stop allocation of Title V monies to programming that has been shown to be

misleading and unsuccessful (U.S. House of Representatives Committee on Government Reform-Minority Staff Special Investigations Division, 2004). Funding should instead be invested in CSE that meets the 16 CDC (2014) critical sex education topics (https://www.cdc.gov/healthyyouth/data/profiles/pdf/16_criteria.pdf). Much literature exists to support the notion that current sex education policies should be adjusted to match public opinion and the recommendations of public health agencies (Bleakley et al., 2006; Constantine et al., 2007; Itoet al., 2006; Millner et al., 2015). Sex education needs to be holistic; contain information on abstinence as well as contraceptives and STI; and provide information to meet the mental, physical, emotional, and psychosocial needs of sexuality in an adolescent (SIECUS, 2009).

Implications for School **Nursing Practice**

Sex education in schools is a matter of public health, not areligious or political one (Baker et al., 2015; Bleakley et al.,2006). CSE Is much more than just handing out condoms. If implemented correctly, sex education teaches students about anatomy and physiology, healthy relationships, hygiene, positive self-image, how to handle uncomfortable situations, and about health resources available to them. School nurses are in a unique position to play a critical role in policy change with regard to sex education. As public health professionals, school nurses have the responsibility to advocate for legislation that enhances the sexual health and well-being of their students. School nurses should take the lead in raising aware-ness among parents, teachers, administrators, and staff about the successes of CSE on teen sexual health outcomes. Strategies for raising awareness might include such activities as school presentations at parent teacher's association, faculty, school board, and community meetings to draw attention to the issue

and gain support. Further, school nurses can seek political sponsors to make proposals, rally cosponsors for support, and give testimony to the effectiveness of CSE programming (Maryland & Gonzalez, 2012).

Conclusion

This review indicated that U.S. government officials are endorsing AOE while leading health and educational organizations clearly support CSE. There is strong published evidence with regard to outcomes of sexual health programs. AOE programs have been shown to be detrimental to teen sexual health outcomes (Weiser & Miller, 2010; Yang &Gaydos, 2010). Conversely, CSE programs have been shown to decrease teen birth rates and meet the educational needs of teens who are already sexually active or in the sexual minority (Malone & Rodriguez, 2011; Stranger-Hall & Hall, 2011). Yet, policy makers continue to allocate funding for AOE in schools (Donovan, 2017). Factors that play a role in policy, such as conservative political and religious, must be considered. A majority of the public has voiced support for CSE, even when identifying as religious and conservative (Bleakley et al., 2010; Constantine et al., 2007; Kantor & Levitz, 2017). Policy needs to change to match parent opinion and public health recommendations. Sex education in schools should provide adolescents with medically accurate information and the skills needed to make informed decisions regarding their sexual behaviors.

Future research should focus on strategies to empower parents and voters to address mandates for AOE. While the studies in this review examined opinion versus policy and suggested making educational choice known to politicians and administrators, there was no direction provided or strategies given about how to change policy (Constantine et al., 2007; Eisenberg et al., 2008, 2009). Effective interventions are

needed that can help parents and citizens work to change policy and advocate to help forge the path for CSE.

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SEX EDUCATION IN SCHOOL, ARE GENDER AND SEXUAL MINORITY YOUTH INCLUDED?: A DECADE IN REVIEW

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Abstract

Comprehensive sexual health education increases sexual health knowledge and decreases adverse health outcomes and high-risk behaviors in heterosexual youth but lacks information relevant to gender and sexual minority youth. Universal access to comprehensive sexual health education that includes information relevant to gender and sexual minority individuals is lacking in the United States, leading to poor health outcomes for gender and sexual minority youth. The purpose of this review was to examine sexual health education programs in schools in the United States for the inclusion of information on gender identity and sexual orientation. The review provides information on current programs offered in schools and suggestions to make them more inclusive to gender and sexual minority youth.

(LGBTQ+, sex education, sexual health, gender minority, sexual minority)

Introduction

Gender and sexual minority youth (GSMY), youth who do not identify as heterosexual or their gender identity are non-binary, have increased sexual risk behaviors and adverse health outcomes compared to their heterosexual and cisgender peers (Kann et al., 2016; Rasberry et al., 2017, 2018). According to the 2017 YRBS youth that identified as a sexual minority (lesbian, gay, bisexual, or another non-heterosexual identity or reporting same-sex attraction or sexual partners) reported increased sexual partners, earlier sexual debut, the use of alcohol or drugs before sex, decreased condom and contraceptive use than their heterosexual peers (Rasberry et al., 2018). Comprehensive sexual health education increases sexual health knowledge and decreases adverse health outcomes, sexually transmitted infections (STIs), HIV, and pregnancy and high-risk behaviors in heterosexual youth, age of sexual initiation, the number of sex partners, sex without protection, sex while under the influence of drugs and alcohol (Bridges & Alford, 2010; Mustanski, 2011; Sexuality Information and Education Council of the United States (SIECUS)., 2004; Steinke et al., 2017). Research conducted with heterosexual adolescents shows comprehensive sexual health education, medically accurate material that includes information on STIs, HIV, pregnancy, condoms, contraceptives as well as abstinence and sexual decision making, increases sexual health knowledge and decreases adverse health outcomes, STIs, HIV, and pregnancy and high-risk behaviors (Bridges & Alford, 2010; Mustanski, 2011; Sexuality Information and Education Council of the United States (SIECUS)., 2004; Steinke et al., 2017). Most GSMY report receiving some form of sexual health education in school ranging from comprehensive to abstinence-only, however GSMY-inclusive sexual health education, education that includes

information on all genders and sexual orientations, is out of reach for a majority of youth in the United States (Charest et al., 2016; Human Rights Campaign, 2015; Kosciw et al., 2018; Steinke et al., 2017). Not having access to GSMY-inclusive sex education, GSMY lack the information they need to understand their sexuality and gender concerns and to make informed sexual decisions (Charest et al., 2016; Steinke et al., 2017).

Most teens, 70%, report receiving some form of sexual health education in school; while the content varies widely, from abstinence-only to comprehensive, it is primarily penile-vaginal in nature (Human Rights Campaign, 2015; Lindberg et al., 2016). Universal access to comprehensive and GSMY-inclusive sexual health education is lacking in the United States and can lead to poor health outcomes for GSMY (Human Rights Campaign, 2015). Currently, only 27 states mandate sexual health and HIV education (Guttmacher Institute, 2020). Seventeen states require discussion of sexual orientation, with only 10 requiring information to be inclusive of gender and sexuality, and seven mandating only negative information be provided on homosexuality and positive information solely be provided on heterosexuality (Guttmacher Institute, 2020). These laws intended to prohibit the promotion of homosexuality, deny SGMY the sexual health information they need and serve to further stigmatize them for their gender identity and sexual orientation (Gay, Lesbian and Straight Education Network (GLSEN), 2018).

Significance of the Topic

Despite the effectiveness of comprehensive sexual health education in increasing sexual health outcomes in heterosexual youth, little research has been done on its effects on GSMY (Human Rights Campaign, 2015; Kosciw et al., 2018; Steinke et al., 2017). The sex education offered in schools primarily describes penile-vaginal intercourse and

does not include information on oral, anal, or manual intercourse or ways to practice safe sex with these types of sexual activity. Less than 7% of GSMY in the United States report receiving sexual health education that was inclusive of both gender and sexual minorities (Charest et al., 2016; Human Rights Campaign, 2015; Kosciw et al., 2018; Steinke et al., 2017). Many GSMY look to the internet or pornography for information on sex, leading to misinformation or an unrealistic expectation of intercourse and relationships (Arbeit et al., 2016; Charest et al., 2016; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Roberts et al., 2019).

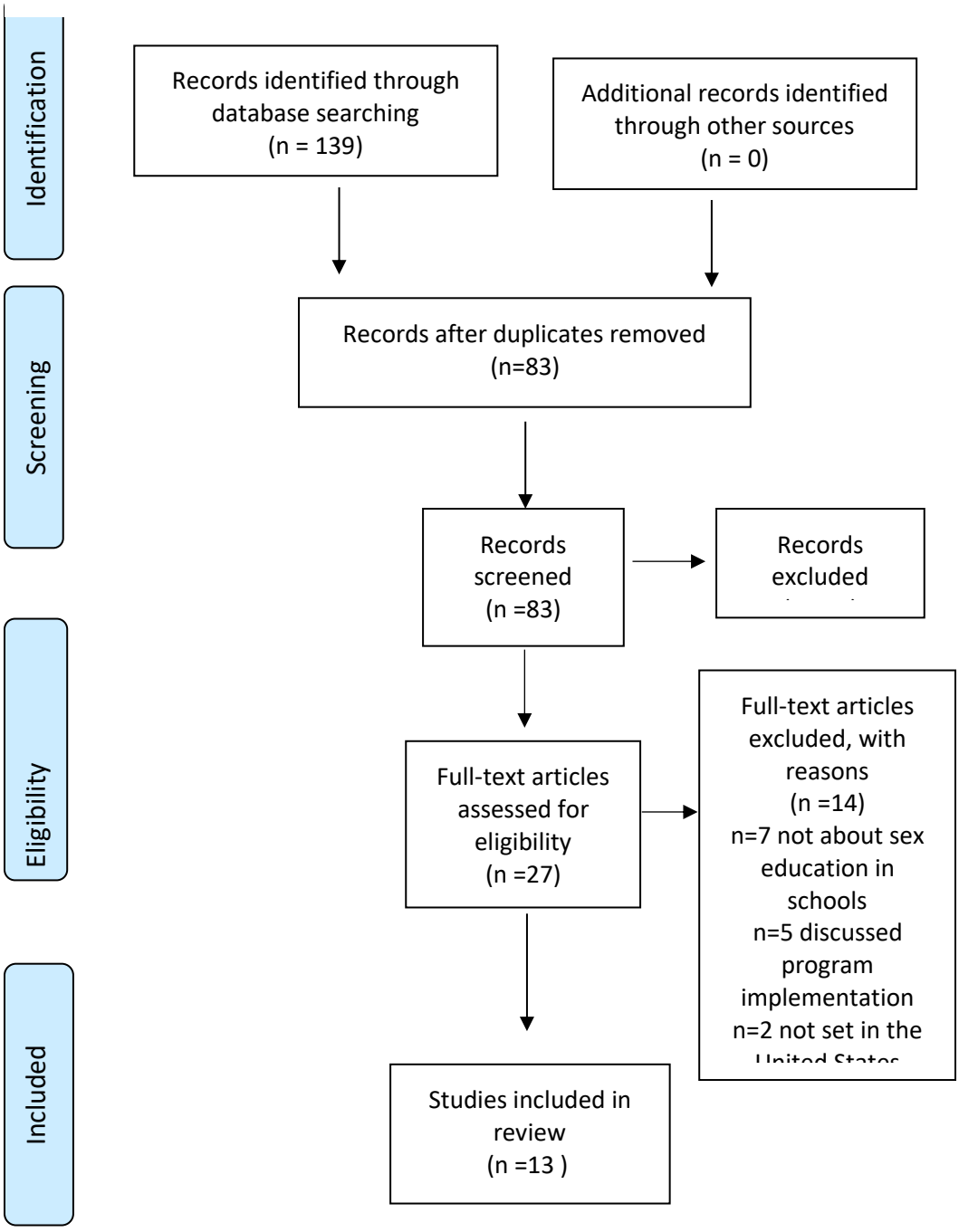
Teens and young adults account for 21% of all new HIV cases in the United States, with 81% of newly diagnosed cases attributed to young men who have sex with men (Centers for Disease Control and Prevention (CDC), 2019). Lindley & Walsemann, (2015) conducted a study of teens in New York and found that GSMY youth had between a two to seven times higher chance of being involved in a pregnancy than their heterosexual peers. According to the Centers for Disease Control and Prevention (2018), young men who have sex with men have a higher incidence of gonorrhea, chlamydia, and syphilis compared to women and men who have sex with women only. The 2017 YRBS report revealed that GSMY reported significantly higher incidences of forced sex, dating violence, suicidal thoughts, attempted suicide, bullying, alcohol and drug use, earlier initiation into sex, more sexual partners, and were also less likely to use condoms during sexual intercourse than their heterosexual peers (Kann et al., 2018; Rasberry et al., 2018). To improve sexual health outcomes in GSMY, they need to receive sexual health education that is comprehensive and inclusive to all genders and sexual orientations at an early age.

The purpose of this review was to examine the sexual health education programs in public and private schools in the United States for the inclusion of information on gender identity and sexual orientation. Further, this review provides an understanding of the sexual health education needs of GSMY, how it is reflected in the programs offered to young adults, and what changes could be made. A review of studies published between 2010 and 2020 was conducted to evaluate the inclusion of gender and sexual minority information in sexual health education offered in schools.

Literature Search

The review was conducted according to the Preferred Reporting Items for Systemic Review and Meta-Analysis (PRISMA) guidelines (Moher et al., 2009). The search was conducted using three online databases: CINAHL, PubMed, and Scopus. The search strategy for CINAHL was as follows: limits were set to include research articles published in English in peer-reviewed academic journals, age restriction set to “all child” major heading “sex education” and “sexual health”. The search date was set from January 2010 to March 2020. The reason for the 2010 start date was to get the latest information on sexual health education programs. The combinations of the search terms used were “sex education” and “sexual minority”; “sexual health education” and “sexual minority”; “inclusive” and “sex education” and “school”; “LGBT” and “sex education”. The same searches were conducted in each of the other databases. The process is illustrated in Figure 2.

Figure 2.
PRISMA diagram showing search and screening process, and selection of studies for inclusion in the review.



The initial searches yielded a total of 83 articles after duplicates were removed; 56 articles could be excluded after reading the title or abstract due to location or not discussing sex education in the primary or high school setting, 27 articles were viewed in

full text. After reading the full-text articles, 14 articles were excluded for the following reasons: seven did not discuss sex education programs in school, five discussed program implementations, and two were not set in the United States. A total of 13 peer reviewed articles were included in this review (Table 2).

Table 2.

Review of Studies Related to Inclusive Sexual Health Education.

Author	Purpose/topic	Type of study/sample	Key findings/recommendations
Arbeit et al. 2016Arbeit, M. R., Fisher, C. B., Macapagal, K., & Mustanski, B. (2016).	To analyze bisexual female youth perspectives on their experiences. To analyze bisexual female perspectives of their experiences accessing sexual health information and services provided by schools and health providers.	Mixed methods: n= 40 cisgender sexual minority females divided into 6 focus groups	Practitioners should include nonjudgmental questions regarding bisexuality into contraceptive and sexual health practices involving young females. Schools need to provide inclusive sex education.
Bodnar, K., & Tornello, S. L. (2019)	To explore how exposure and timing of sex education were associated with sexual health outcomes.	Quantitative; 2002 to 2013 collections of the National Survey of Family Growth n=5, 141 young women	Exposure to sex education resulted in poorer outcomes for sexual minority women. Sex education should be presented earlier and be inclusive.
Gowen, L. K., & Winges-Yanez, N. (2014).	To investigate the sexual health education experiences of LGBTQ youth and gather suggestions for improving the inclusiveness of sexuality education curricula.	Qualitative ; n=5 semi-structured focus groups containing 30 LGBTQ adolescents	LGBTQ youth see current sex education as exclusive, not inclusive. Schools and policymakers need to make sure inclusive education is available to all youth.
Haley, S. G., Tordoff, D. M., Kantor, A. Z., Crouch, J. M., & Ahrens, K. R. (2019)	To use information from transgender and nonbinary youth and their parents to understand deficits in sexual health education and give recommendations for a comprehensive inclusive curriculum.	Qualitative; n=21 (n=11 transgender/nonbinary youth, n=5 parents of transgender/nonbinary youth; n=5 healthcare providers)	Most information taught in schools was irrelevant to transgender/nonbinary youth. Education needs to be inclusive and gender-affirming.
Hall, K. S., McDermott Sales, J., Komro, K. A., & Santelli, J. (2016)	To analyze the content of school-based sex education policies in the United States.	Commentary	There were no consistent policies regarding sex ed in schools. Abstinence-only education was the prominent form of education taught. Few states mandated inclusive teaching and some mandated only negative information on homosexuality be taught. Sex education should be evidence-based.

Table 2, *continued*.

Author	Purpose/topic	Type of study/sample	Key findings/recommendations
Hobaica, S., & Kwon, P. (2017).	To explore sex-ed policies and curriculum to determine if they could be adapted for sexual minority students.	Qualitative; n=12 sexual minority individuals who received sex ed in school	Sex education was heteronormative and did not address the needs of sexual minority individuals potentially causing poorer physical and mental health outcomes. Education should be inclusive and be taught earlier.
Hobaica, S., Schofield, K., & Kwon, P. (2019).	To explore the experiences of trans students in sex education.	Qualitative; n=11 transgender individuals who received sex ed in school	Most information taught in schools was cisgender and irrelevant to transgender/nonbinary youth. Education needs to be offered earlier and be gender-affirming to help prevent risky sexual behavior and gender dysphoria.
McCarty-Caplan, D. (2015).	To explore policy limitations and demonstrate how comprehensive sex education perpetuates the heteronormative nature of sex education in a way that continues to marginalize and harm LGB individuals.	Commentary	Comprehensive sex education programs do not provide substantial support for lesbian, bisexual, and gay individuals.
Pingel, E. S., Thomas, L., Harmell, C., & Bauermeister, J. (2013).	To investigate the sexual health education experiences of sexual minority young men and gather suggestions for improving the inclusiveness of sexuality education curricula.	Qualitative; n=30 young gay, bisexual, and questioning men who had experience with school-based sex education.	Most information on sexual minorities was excluded from the sex-ed taught in school. Many youths looked to the internet for sexual health information to fill the gap. Sexual health education should be inclusive.
Proulx, C. N., Coulter, R. W. S., Egan, J. E., Matthews, D. D., & Mair, C. (2019)	To explore whether LGBTQ inclusive sex education is associated with adverse mental health and school-based victimization.	Quantitative; 2015 Youth Risk Behavior Survey and 2014 School Health Profiles n=47,730 sexual minority youth.	Inclusive sex education had a protective effect against suicidal thoughts and plans. LGBTQ youth had lower odds of being bullied as the percentage of schools in the state offered inclusive education. States should offer inclusive education.
Rasberry, C. N., Condron, D. S., Lesesne, C. A., Adkins, S. H., Sheremenko, G., & Kroupa, E. (2017).	The purpose of this study was to help inform the development of school-centered strategies for connecting sexual minority young men with HIV and STD prevention services.	Mixed methods; n=415 web-based questionnaires and n=32 interviews of Black and Latino young sexual minority men.	School nurses were the people youth most talked to about STIs, HIV, or condom use, but they would not talk to them about personal attraction. Many youths felt school staff lacked knowledge on LGBT issues. School nurses and staff need additional training on LGBT issues.

Table 2, *continued*.

Author	Purpose/topic	Type of study/sample	Key findings/recommendations
Roberts, C., Shiman, L. J., Dowling, E. A., Tantay, L., Masdea, J., Pierre, J., Lomax, D., & Bedell, J. (2019)	To conceptualize the barriers LGBTQ+ students of color face in learning about sexual health education in school.	Qualitative; n=27 LGBTQ students of color between the ages of 15-19	Students reported receiving heteronormative sex education that was inadequate to their needs and left them feeling unrepresented, unsupported, stigmatized, and bullied. Students filled these gaps by seeking information from external sources. Schools need to provide inclusive information.
Steinke, J., Root-Bowman, M., Estabrook, S., Levine, D. S., & Kantor, L. M. (2017).	To better understand what young people want from digital sexual health interventions.	Qualitative; n=92 gender and sexual minority youth	Education taught in schools was inaccurate and insufficient. Most participants looked for information online. Content and delivery of online sexual health information should be inclusive.
LGB= lesbian, gay, and bisexual STD= sexually transmitted disease LGBTQ+= lesbian, gay, bisexual, transgender, queer, plus other gender and sexual minorities			

Current Education Offered

Heteronormative Information

A majority of the research reported the content of the sexual health education offered in schools was heteronormative, the belief that heterosexuality and binary gender are the norms, and the intercourse discussed was penile-vaginal intercourse (Arbeit et al., 2016; Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Haley et al., 2019; K. S. Hall et al., 2016; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017; Steinke et al., 2017). The lessons primarily consisted of information about puberty, the dangers of sex, penile-vaginal intercourse, STIs, and pregnancy; information the GSMY in the studies reported as irrelevant to them (Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013; Roberts et al., 2019). Of the 13 studies, eight mentioned students being taught about external condoms, one mentioned internal condoms, 1 discussed students being shown a condom demonstration and none reported information being given on dental dams or finger condoms. (Arbeit et al., 2016; Gowen & Winges-Yanez, 2014; Haley et al., 2019; K. S. Hall et al., 2016; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017; Roberts et al., 2019). In seven of the studies, participants reported their questions regarding gender identity or sexual orientation went unanswered in class. This was due to the teacher ignoring the question, the teacher lacking the information to answer, or the teacher not being allowed to answer due to school and state policy (Arbeit et al., 2016; Gowen & Winges-Yanez, 2014; Haley et al., 2019; K. S. Hall et al., 2016; Hobaica et al., 2019; Hobaica & Kwon, 2017; Mahdi et al., 2014; Pingel et al., 2013; Steinke et al., 2017).

Supplying only heteronormative education contributed to poorer mental outcomes for GSMY. Non-heterosexual, non-binary, and gender-nonconforming individuals and their behavior were often pathologized in the education presented, leading to internalized homophobia, increased depression, increased anxiety, and self-loathing in GSMY (Arbeit et al., 2016; Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013; Steinke et al., 2017). The exclusion of information about gender and sexual minorities made GSMY feel confused about how they were feeling, made them feel something was wrong with them and made them feel like they did not exist (Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017; Roberts et al., 2019). Lack of GSMY-inclusive information also led to an increase in bullying of GSMY in schools from both students and teachers (Arbeit et al., 2016; Gowen & Winges-Yanez, 2014; W. J. Hall et al., 2019; McCarty-Caplan, 2015; Roberts et al., 2019). Numerous studies described a decrease in bullying of GSMY in schools with GSMY-inclusive education, potentially due to a normalizing non-heterosexual, non-binary, and gender-nonconforming individuals, (Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Proulx et al., 2019; Roberts et al., 2019).

Incomplete and Inaccurate Information

The negative impact an incomplete sex education had on GSMY health was a common theme in the literature (Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013). Many of the lessons taught in school only covered the “mechanics” of penile-vaginal intercourse and the problems that can occur from that action, with few reporting

receiving lessons about other types of sex (anal, oral, manual, masturbation), healthy relationships, consent, or the enjoyment of sex (Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Roberts et al., 2019). No studies reported information being taught on transgender identity, non-binary identity, or use of proper pronouns (Haley et al., 2019; Hobaica et al., 2019; Roberts et al., 2019).

Several authors discussed inaccurate information being offered to students in schools (Haley et al., 2019; K. S. Hall et al., 2016; Hobaica et al., 2019; Hobaica & Kwon, 2017). Hobaica and Kwon (2017) reported in 2016 only 20 states required sexual health information provided to students in school to be medically accurate. Inaccurate information given to youth included inflated failure rates of condoms and birth control, inaccurate information on the transmission of STIs, and inaccurate representation of gender and sexual minority individuals (Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Roberts et al., 2019; Steinke et al., 2017). Lack of information and inaccurate information contributed to GSMY making uninformed decisions about sex, leading to increased sexual experiences, increased number of partners, non-consensual sexual experiences, unprotected sex, sex while intoxicated, STIs, and pregnancy (Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017).

Timing of Information

The timing of education being offered to students occurred in middle school and high school (Bodnar & Tornello, 2019; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017). For some GSMY this information came too late to be helpful. Sexual minority youth report earlier initiation into sex and many received sex education after

they had already become sexually active leading to early risky sexual behaviors and pregnancy (Arbeit et al., 2016; Bodnar & Tornello, 2019; Haley et al., 2019; Hobaica & Kwon, 2017). Gender minority and non-binary individuals recommended that information about gender and puberty start as early as 1st and 2nd grade to help with the problems associated with gender dysphoria.

Recommendations

There were many recommendations included in the literature on how to make sexual health education more inclusive and appropriate for GSMY. To be relevant to all students, sexual health education must be inclusive of all genders and sexual orientations and it is important that affirming gender and sexuality inclusive language and pronouns are used when describing different subgroups of GSMY (Arbeit et al., 2016; Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013; Rasberry et al., 2017; Roberts et al., 2019; Steinke et al., 2017). It is important that the education provided be medically accurate and cover different types of sex acts, not just penile-vaginal intercourse, include information on the type of protection needed to have safe sex based on the sexual act being performed, and local resources where it can be obtained (Arbeit et al., 2016; Bodnar & Tornello, 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013; Roberts et al., 2019). Education should also include information on medical and non-medical gender-affirming interventions, information on relationships, consent, and reputable resources for healthcare and sexual health information (Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013; Roberts et al., 2019). There was a reported need for inclusion of historical gender and sexual minority individuals in the

core curriculum. This would allow GSMY to have role models and would allow others could see gender and sexual minority individuals in a different light (Hobaica et al., 2019; Hobaica & Kwon, 2017; Pingel et al., 2013).

Discussion

This paper reviewed how sexual health education has been presented in schools over the past ten years. All studies reported participants receiving some form of sexual health education in school. However, the education presented was almost exclusively heteronormative and exclusive to GSMY needs leaving them feeling left out and lacking the information they needed to better understand themselves and make informed sexual health decisions (Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017).

School administrators need to be aware of the specific sexual health needs of GSMY and tailor education to meet the needs of all the students, not only cisgender, heterosexual students. Providing comprehensive GSMY-inclusive education improves the physical and mental health outcomes of all youth and decreases bullying of GSMY in school (Hobaica et al., 2019, 2019; Human Rights Campaign, 2015; Proulx et al., 2019; Roberts et al., 2019). GSMY-inclusive education has been shown to decrease negative mental health outcomes and bullying by normalize the LGBT experience (Gowen & Winges-Yanez, 2014; Proulx et al., 2019; Roberts et al., 2019) and potentially decrease pregnancy and STI rates, and increase the use of condoms and the age of sexual debut (Haley et al., 2019; Hobaica et al., 2019; Pingel et al., 2013). If school administrators are unable to provide GSMY-inclusive sex education due to policy at the local or state level, it is important to offer vetted outside resources for students and to work with politicians

to change these stigmatizing laws (W. J. Hall et al., 2019; Human Rights Campaign, 2015; Steinke et al., 2017).

The needs of students should take precedent when creating sexual health education programs. Administration, faculty, and staff should be educated on the needs of GSMY. Curricula presented to students in schools must be evidence-based and facilitated by trained LGBT (lesbian, gay, bisexual, and transgender) affirming educators (Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Human Rights Campaign, 2015; Steinke et al., 2017).

Limitations

This review is not without limitations. The search databases used were health and medical and not educational in nature due to the author examining the physical and mental health aspects of sex education on GSMY. The number of articles included was small and more may have been included had educational databases been used. MeSH terms were not used in the search as they had a limiting effect on the results. Lastly, there is very little research on the long-term benefits of GSMY-inclusive sex education in the United States. One of the reasons for this is there is no consistent sex education offered to students, with instructional content often being based on state, local, mandate or teacher preference.

Conclusion

This review indicated that schools are still presenting sexual health education exclusive of gender and sexual minority needs. Sex education is a public health necessity, allowing individuals to make informed decisions concerning their sexual health and wellbeing, and GSMY are being overlooked, leading to poorer mental and physical health

outcomes (Gowen & Winges-Yanez, 2014; Haley et al., 2019; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017; Roberts et al., 2019). Sex education in schools needs to be medically accurate, affirming, and reflect all genders and sexual orientations to help reduce health disparities and increase the quality of life for GSMY. Future research should focus on strategies to implement comprehensive and GSMY-inclusive sex education in schools to evaluate its impact on the health and wellness of all youth.

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FACTORS THAT IMPACT THE HEALTH-SEEKING BEHAVIORS OF AFAB SEXUAL MINORITY INDIVIDUALS: A REVIEW

(Manuscript to be submitted Spring 2021)

Abstract

Assigned female at birth (AFAB) sexual minority individuals are at higher risk for adverse health outcomes when compared to their heterosexual peers. This group is more likely to be overweight/obese, drink alcohol and smoke, acquire sexually transmitted infections, suffer from depression and anxiety, and develop heart disease and cancer than AFAB heterosexual women. However, they are less likely to seek preventive health services and screenings. Results from this review indicated that AFAB sexual minority individuals forgo health services for several reasons, including underestimating health risk, fear of stigma, and scarcity of health professionals trained in providing inclusive care and services to AFAB sexual minority individuals. Potential strategies are provided to enhance health care services uptake and reduce health disparities in this population.

Keywords: lesbian, bisexual, women, gender and sexual minority; health care, disparities

Introduction

Assigned female at birth (AFAB) sexual minority individuals are individuals who are attracted to or have sex with other AFAB individuals (Jahn, Bishop, Tan, & Agénor, 2019). AFAB sexual minority individuals have health needs that are different than AFAB heterosexual women and transgender women. Compared to AFAB heterosexual individuals, AFAB sexual minority individuals are at significantly higher risk for health disparities (Horn & Swartz, 2019; Kann et al., 2016). AFAB sexual minority individuals are at greater risk for heart disease, stroke, and certain types of cancer (Baptiste-Roberts et al., 2017; Horn & Swartz, 2019; Quinn et al., 2015; Trinh et al., 2017). This group of individuals are more likely to be overweight or obese, smoke, abuse alcohol, suffer from depression and anxiety, and less likely to seek preventative health services than their heterosexual peers (Gonzales & Henning-Smith, 2017; Horn & Swartz, 2019; Newlin Lew et al., 2018; Pharr et al., 2019; Strutz et al., 2015; Trinh et al., 2017; U.S. Department of Health and Human Services, 2019). Moreover, adolescent AFAB sexual minority individuals have an increased risk for sexually transmitted infections (STIs), alcohol and drug use, sedentary lifestyle, earlier initiation into sex, increased rate of unwanted pregnancy, and more sex partners (Charlton et al., 2019; Kann et al., 2016, 2018). Despite these known risks, AFAB sexual minority individuals are less likely to seek and receive sexual health screenings when compared to their heterosexual peers (Agénor et al., 2017; Everett et al., 2019; Substance Abuse and Mental Health Services Administration, 2012; U.S. Department of Health and Human Services, 2019).

According to a 2017 Gallup poll, 4.5% of Americans identify as lesbian, gay, bisexual, or transgender (LGBT), with the majority identifying as AFAB, as opposed to

assigned male at birth (5.1% and 3.9%, respectively) (Newport, 2018). Despite AFAB individuals being the majority in the LGBT community, 86% of the National Institutes of Health Research funding is used to study men who have sex with men while less than 14% of funds are used in studies involving lesbian, bisexual AFAB individuals (Coulter et al., 2014; Pharr et al., 2019; Potter, 2019). In 2019, most of the National Institute of Health funds awarded through the *Sexual and Gender Minority Research Office* were used to study HIVAIDS in men who have sex with men and transgender women (National Institutes of Health, 2020). The importance of HIV and AIDs research is undeniable; however, it is not the only health concern that faces the LGBT community.

AFAB sexual minority individuals are a subgroup of the LGBT community, and they are significantly understudied (Baptiste-Roberts et al., 2017). Health data shows that AFAB sexual minority individuals have more adverse health conditions and are less likely to seek routine care than men who have sex with men or heterosexual women (Charlton et al., 2018; Everett, 2013; Everett & Mollborn, 2014; Strutz et al., 2015). There is a paucity of research focusing on AFAB sexual minority individuals (Coulter et al., 2014; Everett, 2013; Potter, 2019). The majority of health behavior research conducted with the LGBT population has focused on MSM and transgender women (Coulter et al., 2014; National Institutes of Health, 2020). There is a need to examine the unique health needs and health-seeking behaviors of AFAB sexual minority individuals, as this group is different from other LGBT groups (Baptiste-Roberts et al., 2017; Corcoran, 2017; Everett, 2013).

Objective

This review was conducted to better understand the health needs and health-seeking behaviors of AFAB sexual minority individuals, specifically the utilization of preventive health services. The lack of engagement in preventative health care is associated with a higher risk for long term complications due to unmet health needs, including late identification of STIs, breast cancer, and cervical cancer (Everett & Mollborn, 2014; Pharr et al., 2019; Polek & Hardie, 2017; Strutz et al., 2015). Findings from this review may inform strategies to create targeted health initiatives to enhance health outcomes, increase health-seeking behaviors, and increase the uptake of preventive health care services among AFAB sexual minority individuals.

Methods

Eligibility Criteria

The review was conducted according to the Preferred Reporting Items for Systemic Review and Meta-Analysis (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). The search consisted of three online databases: PubMed, Scopus, and CINHAL. Limits were set to include articles published in English in peer-reviewed academic journals. The search date was set from January 2010 to the present, and the location was the United States. The time frame was chosen because the Affordable Care Act was enacted in March 2010, allowing young adults to stay on their parent's health insurance longer, thereby increasing the number of young adults with access to health care coverage and services (Centers for Medicare & Medicaid Services, 2013). The location of the United States of America was chosen for insurance reasons as well. Including other countries that have socialized medicine and free access to health

care could confound the results. AFAB sexual minority individuals, in this review, were defined as individuals assigned female at birth (AFAB) with same-sex attraction who identify as lesbian or bisexual, or other AFAB woman-identified individuals who have sex with AFAB individuals. Transgender women were excluded from this review. They have different health needs because they are biologically male.

Search Strategy

The following combinations of the search terms were used in all databases: “sexual minority women” and “health care”; “sexual minority women;” and “health care” not “gay” not “transgender”; “lesbian” and “health care” not “gay” not “transgender”; “assigned female at birth” and “health care” not transgender"; “health care disparities” and “sexual minority women”; “health care disparities” and “bisexual”; “health care disparities” and “sexual orientation”. The initial searches yielded a total of 373 articles; there were 338 after duplicates were removed; 259 articles could be excluded after reading the title or abstract, and 79 articles were viewed in full text. Primary reasons for exclusion were the articles focused on MSM, HIV, and AIDS, or were set in a country other than the United States of America. Articles reviewed addressed sexual health services and screenings, health disparities in AFAB sexual minority individuals, health-related interactions between sexual minority women and health professionals, and health promotion.

Study Selection

After reading the full-text articles, 59 articles were excluded for the following reason: 23 were not about AFAB sexual minority individual’s health care, nine were not set in the United States, six were about teaching health professionals, eight focused on

specific racial minority groups, four focused on particular diseases or conditions, three used data more than fifteen years old, one focused on older adults, and one was a literature review (see Figure 3). A total of 20 articles were included in the review (see Table 3).

All articles included in this review were conducted in the United States: four articles reported on qualitative studies, seventeen were cross-sectional quantitative studies, with fourteen of those taking data from large cross-sectional studies. Six of the articles addressed health disparities faced by AFAB sexual minority individuals, five addressed health care utilization, four discussed disclosure of identity to health professionals, three addressed STIs in sexual minorities, two addressed HPV, and one addressed pregnancy.

Figure 3.

PRISMA diagram showing search and screening process, and selection of studies for inclusion in review.

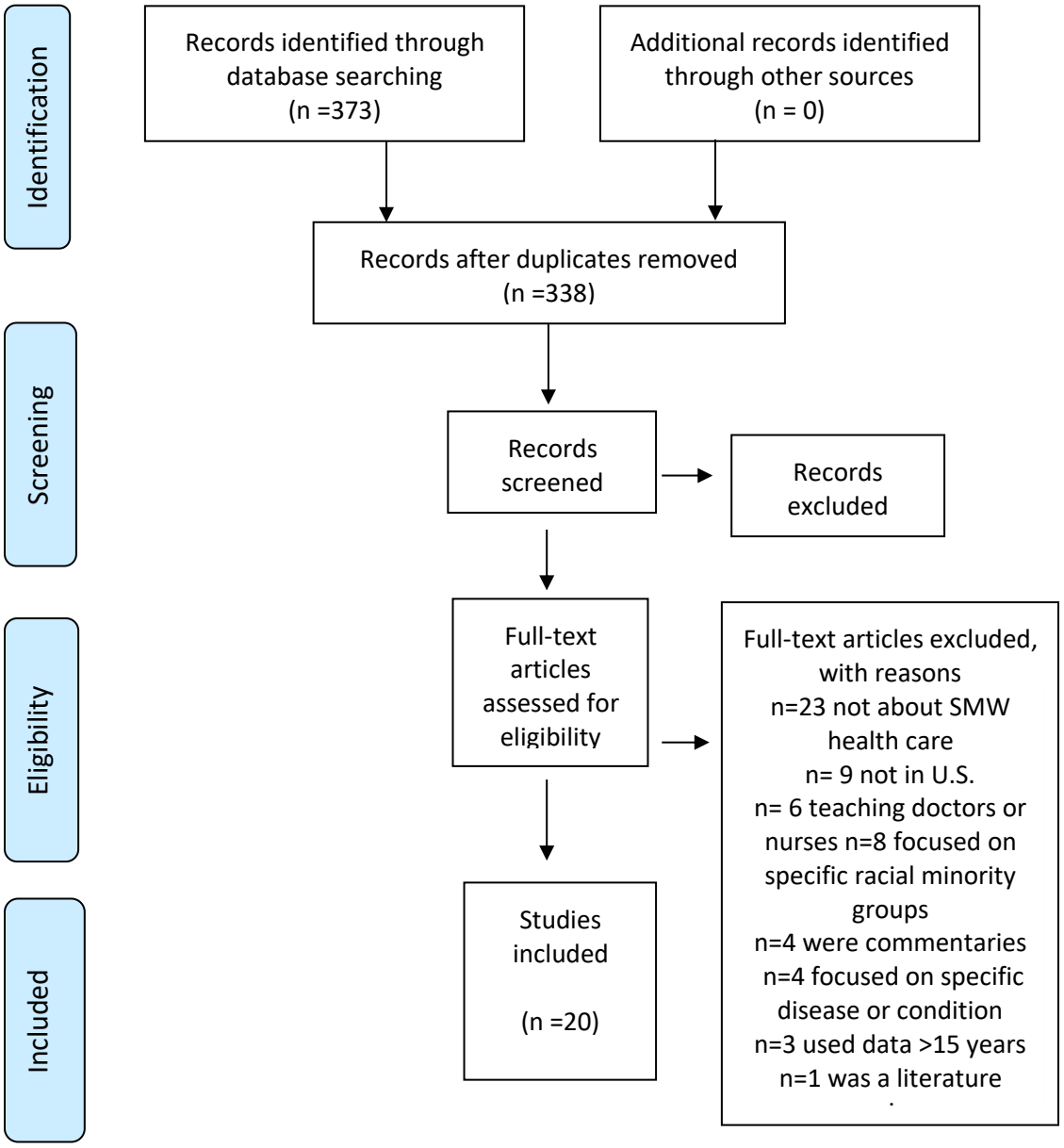

Table 1.

Review of Studies Related to Sexual Minority Women Health Seeking Behaviors

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Agénor, M., Jahn, J. L., Kay, E., Bishop, R. A., Peitzmeier, S. M., Potter, J., & Austin, S. B. (2019). Human papillomavirus risk perceptions among young adult sexual minority cisgender women and nonbinary individuals assigned female at birth.	To explore HPV risk perception ad factors that influence those perceptions in SMW	In-depth interviews	Qualitative n=29	Women in the study as well as health providers perceived SMW as having a lower risk of HPV due to perceptions the HPV is linked to having penile vaginal sex. SMW need more accurate healthcare information.	Findings not generalizable due to participants having college education and private health insurance. Unable to assess risk perception prior to HPV vaccination.
Agénor, M., Muzny, C. A., Schick, V., Austin, E. L., & Potter, J. (2017). Sexual orientation and sexual health services utilization among women in the United States.	To examine the associations between sexual behavior, sexual identity and STI testing in the past year.	2011-2013 and 2013-2015 waves of the National Survey of Family Growth	Cross sectional multivariate regression n=11300 U.S. women aged 15-44 16% identifies as bisexual	Bisexual women were more likely to have had an STI test in the past year. Women with only female partners were less likely than both to have had an STI test in the past year; were less likely to have had a pap test in the past 3 years. Health care facilitates should collect inclusive information of sexual partners	Data is self-reported and could not be conformed with the individuals health records . Data is cross sectional, so researchers were unable to establish links between predictors, covariates and outcomes.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
			1.6% identified as lesbian	and identity using non-heteronormative language. Need for programs to promote use of sexual health services to female only partners	
Baldwin, A., Dodge, B., Schick, V., Herbenick, D., Sanders, S. A., Dhoot, R., & Fortenberry, J. D. (2017). Health and identity-related interactions between lesbian, bisexual, queer and pansexual women and their healthcare providers.	To explore factors related to identity disclosure, potential differences and similarities between sexual identity groups , including queer and pansexual.	Online surveys with open and closed ended items. Information collected in one phase	Cross sectional Mixed methods n=354 AFAB sexual minority individuals	Reasons cited for disclosure relevance to visit; always disclosed (with lesbians being a majority of the always disclosing); Being asked by provider or paperwork . Language used to ask was key (9.8%).n=reported never being asked on forms or by staff and never being asked by provider . Bisexual women were 6.2 times less likely than lesbians to disclose.	Due to the nature of the questionnaire researchers were unable to probe participants for clarification.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Charlton, B. M., Gordon, A. R., Reisner, S. L., Sarda, V., Samnaliev, M., & Austin, S. B. (2018). Sexual orientation-related disparities in employment, health insurance, healthcare access and health-related quality of life: A cohort study of US male and female adolescents and young adults.	To investigate sexual orientation-related disparities in employment and healthcare.	Growing Up Today Study	Cross sectional n=9914 18-32 years old	SM men and women were twice as likely to be unemployed and uninsured than their heterosexual peers. 40.4% of cohabitating SMW were unemployed compared to 21.8% SMW and 25.5% hetero. Bisexual women were at higher risk of being uninsured than heterosexual women (RR 3.76 (95%CI 2.42 to 5.85)More research needs to be conducted on sexual minority subgroups.	Cohort had a high social status and study findings may not be generalizable to the LGBT community. Data was cross sectional and limited on some of the variables. Other factors not included in study may affect HRQL.
Charlton, B. M., Nava-Coulter, B., Coles, M. S., & Katz-Wise, S. L. (2019). Teen pregnancy experiences of sexual minority women.	To describe teen pregnancy among sexual minority women to determine potential risk factors.	Sexual Orientation, Gender Identity, and Pregnancy Experiences (SLOPE) study	Qualitative n=10	All pregnancies were unintentional, and half were the result of a sexual assault. There is a need for targeted health promotion regarding pregnancy and SMW. More research should be done to explore reasons for pregnancy among SMW.	Small sample size findings may not be generalizable to all SMW.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Everett, B. G. (2013). Sexual orientation disparities in sexually transmitted infections: Examining the intersection between sexual identity and sexual behavior.	To examine STI distribution by gender, sexual identity and sexual behavior	National Longitudinal Survey of Adolescent Health Wave III and IV	Cross sectional n=13,715; n=7,392 females; n=6,323 males	STI risk is elevated in heterosexual WSW and bisexual women whereas heterosexual MSM did not have a greater likelihood of reporting an STI. Gay identified WSW reported lower STI compared to heterosexual women. Providers need to look at identity, orientation, and behavior when providing care	Study limited to specific types of identity. Study included physician diagnosed STI and may be biased toward those seeking STI testing.
Everett, B. G., Higgins, J. A., Haider, S., & Carpenter, E. (2019). Do sexual minorities receive appropriate sexual and reproductive health care and counseling?	To role of recent sexual partner and the type of information provided to SMW	National Survey of Family Growth 2006-2015	Cross sectional n=20, 703 women	83% of bisexual women and 17% of lesbian's reported male partner in the past 12 months. Lesbian women were less likely to receive script for contraception or receive contraception counseling but were more likely to receive an STD test. Providers need to look at identity and behavior when providing sexual health services.	Data is cross sectional and time order may be off, changes in pap guidelines during study, long term BC outside of implant or IUD was not considered, data did not consider discussion outside of those noted, condom consult does not

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
				SMW may benefit from non-contraceptive benefits of BC. Providers should ask about orientation to improve trust. Research needed to develop scripts that are informative and inclusive for all women.	address safe sex needs of many SMW, data did not provide for discrimination in clinical setting.
Everett, B. G., & Mollborn, S. (2014). Examining Sexual Orientation Disparities in Unmet Medical Needs among Men and Women.	Examines disparities in unmet medical needs by sexual orientation in adulthood.	National Longitudinal Study of Adolescent Health	Cross sectional n=13,810	SMW report more unmet medical needs including access and use than heterosexual women and SMM. No differences found between SMM and heterosexual men. Public health policy should continue to develop inclusive health centers for sexual minority populations especially SMW.	Unable to access gender identity or reasons for unmet needs.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Gonzales, G., & Henning-Smith, C. (2017). Health disparities by sexual orientation: Results and implications from the Behavioral Risk Factor Surveillance System.	To examine differences in sexual orientation and health outcomes and health risk factors.	Behavioral Risk Factor Surveillance System	Cross sectional n=308, 546 (n=8290 lesbian, gay or bisexual participants) n=300, 256 heterosexual participants)	SM men and women had higher odds of mental distress and depression than their heterosexual peers. SM also faced higher odds of poor physical health, activity limitations, chronic con-conditions, obesity, smoking, and binge drinking. HCP need to continue collecting data on sexual orientation in order to identify and address causes of sexual orientation-based disparities.	Info is self-reported which can lead to recall bias, reporting sexual orientation may lead to selection bias, participants were limited to noninstitutionalized adults with a land line or cell phone who were comfortable revealing their sexual orientation so it may be missing individuals from vulnerable populations. Study only included participants form 27 states.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Horn, K., & Swartz, J. A. (2019). A comparative analysis of lifetime medical conditions and infectious diseases by sexual identity, attraction, and concordance among women: Results from a national U.S. survey.	To compare the odds of having 10 medical conditions/infectious diseases among women, assessing for differences associated with sexual identity, sexual attraction, and the degree of concordance between sexual identity and attraction	2015-2017 National Survey on Drug Use and Health (NSDUH)	Cross sectional n=67,648	Bisexual and lesbian women had more asthma and COPD than heterosexual women. Women who identified as bisexual had significantly higher odds of having cancer and hepatitis and any STI in the past 12 months than heterosexual women. Physicians need education about sexual minorities and how best to care for them. Providers need to create a welcoming space to make disclosure easier.	Cross sectional data, Younger participants, especially those with a co-occurring mental illness or substance abuse issues, might not manifest adverse health consequences until later life. Additionally, self-report could generate under- or over-reporting of illness and risk. Data does not include sexual behavior measures.
Jahn, J. L., Bishop, R. A., Tan, A. S. L., & Agénor, M. (2019). Patient-provider sexually transmitted infection prevention communication among young adult sexual minority	Explore SMW experiences discussing health issues with hcp and to elucidate how patient provider communication experiences influence STI prevention	29 in-depth interviews	Qualitative n=29 English speaking; AFAB; identify as female and lesbian, bisexual or queer; aged 18-36.	Heteronormative assumption inhibits participants willingness to disclose. Most health conversations focused on pregnancy and contraception. Providers lacked information or were misinformed on needs of SMW. Provider bias based on sexuality,	Unable to determine if communication differed between races other than White, Asian, and Black and individuals without college education because they were not in study.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
cisgender women and nonbinary assigned female at birth individuals.			n=14 white n=15 people of color n=9 self-identified as other than heterosexual women aged 18-24 years old.	gender and race caused participant mistrust. Providers should affirm patient's sexuality/gender and expand sexual history conversations to ask about past partners gender, practices, identity. Providers must educate themselves on needs of SMW when it comes to STI, pregnancy, cervical screening and safer sex practices.	
Johnson, M. J., & Nemeth, L. S. (2014). Addressing health disparities of lesbian and bisexual women: A grounded theory study.	To understand how LB women experience healthcare delivery systems.	Individual in-depth interviews	Qualitative n=9 self-identified as other than heterosexual women aged 18-24 years old.	Participants identified disclosure and HCP attributes as being important parts of the healthcare experience. Most providers deliver heteronormative care. Healthcare environments should encourage disclosure of sexuality and gender.	Population was mostly white college students and may not be representative of population.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Kaestle, C. E., & Waller, M. W. (2011). Bacterial STDs and perceived risk among sexual minority young adults. *Guttmacher Institute*.	To explain how sexual minority status relates to sexual health risk perception and sexual health risk among young sexual minority adults.	Wave 3 of the National Longitudinal Study of Adolescent Health	Cross sectional n=14,322	Bisexual women had higher incidence of STI than heterosexual women. Sexual minority status had no effect on male incidence of STIs. Females who reported only same sex relationships perceived their STI risk as low. Practitioners must make sexual minority young adults aware of their STI risk.	Cross sectional data precludes inference. Sexual minority status was measured in multiple ways across the years.
Mosack, K. E., Brouwer, A. M., & Petroll, A. E. (2013). Sexual identity, identity disclosure, and health care experiences: Is there evidence for differential homophobia in primary care practice	The purpose of this study was to explore how sexual minority women's (SMW) health care experiences compared with those of their heterosexually identified counterparts	Anonymous, self-administered, written survey	Cross sectional n=420 n=354 LGB or queer, n=66 heterosexual women	SM women utilization of healthcare was similar to heterosexual women. However, they were less likely to report being satisfied with their HCPs. Those who disclosed sexual minority status reported had increased satisfaction with their HCPs and greater comfort discussing their sexual health. HCP should encourage sexuality disclosure.	The providers SMW choose are most likely those who are affirming of their sexual orientation.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Newlin Lew, K., Dorsen, C., Melkus, G. D., & Maclean, M. (2018). Prevalence of obesity, prediabetes, and diabetes in sexual minority women of diverse races/ethnicities: Findings From the 2014-2015 BRFSS Surveys.	To assess the weighted prevalence and odds ratios of obesity, prediabetes, and diabetes by (1) female sexual orientation (lesbian, bisexual, and straight) with racial/ethnic (	2014-2015 Behavioral Risk Factor Surveillance	Cross sectional n= 136,878	Lesbian and bisexual women, relative to straight women, had a significantly increased likelihood for obesity when controlling for demographics. providers should provide culturally competent care that addresses sexuality as well as ethnicity and race.	Disclosure of sexual orientation may have been influenced by race/ethnicity or concern of heterosexism. Other measures associated with disclosure, discrimination, psychological stress, and behavioral risk factors were not included
Pharr, J. R., Kachen, A., & Cross, C. (2019). Health disparities among sexual gender minority women in the United States: A population-based study.	To understand disparities in access to healthcare, preventive care, and health risk behaviors of lesbian and bisexual women compared to their straight counterparts and to each other.	2016 Behavioral Risk Factor Surveillance System data.	Cross sectional n=9,016	Lesbian and bisexual women were more likely to report depression, smoking, and heavy/binge drinking compared to straight women. They were also less likely to have received a pap test. Bisexual women were more likely to report depression and poorer health and have a higher risk for depression and worse general health. Health promotion	Causation cannot be determined due to cross sectional data. Participants were excluded if they did not have a land/cell phone line or were institutionalized. Results may not be generalizable to the population as a whole.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
				programs and interventions must be tailored to account for the unique stressors SM women encounter and associated negative health outcomes.	
Polek, C., & Hardie, T. (2010). Lesbian women and knowledge about human papillomavirus.	To explore the association between lesbians' knowledge of HPV cancer risk with age, education, and openness with a woman's healthcare provider; and the relationship between lesbians' knowledge of female-to-female HPV transmission with age, education, and openness with one's physician	35-question survey, modified from the Delaware Breast Cancer Coalition National Health Interview Survey.	Cross sectional n=96 self-identified lesbian, bisexual or transgender. Quantitative Descriptive correlational survey.	A third of respondents did not know HPV could be contracted through female to female contact and did not know it posed a cancer risk. Targeted health promotion for all women on routine health screenings, vaccinations, and relative risk for the development of diseases and education for those providing care.	Data is cross sectional. Sexual orientation was self-reported and may not be accurate as previous studies have shown many women who identify as heterosexual have sex with women.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Strutz, K. L., Herring, A. H., & Halpern, C. T. (2015). Health disparities among young adult sexual minorities in the U.S.	To compare health care access and outcomes of sexual minority young adults and heterosexual young adults.	National Longitudinal Survey of Adolescent Health Wave IV	Cross sectional n=13, 088 (6,020 men and 7,068 women) between the ages of 24-32	Sexual minority women were more likely to rate health as poor, had elevated odds of asthma, depression, anxiety, ADHD, and lifetime STIs, yet had lower odds of receiving examination or dental care. More research needs to be done on the multidimensionality of SM status and how policy and influences health outcomes.	Reporting bias due to stigma of sexual minority status. Information is self reported and cannot take into consideration of undiagnosed conditions.
Trinh, M.-H., Agénor, M., Austin, S. B., & Jackson, C. L. (2017). Health and healthcare disparities among U.S. women and men at the intersection of sexual orientation and race/ethnicity: A nationally representative cross-sectional study.	To examine the interplay between race and sexual orientation on health outcomes	2013–2015 National Health Interview Survey data	Cross sectional n=91,913	Sexual minorities have higher incidence of negative health behaviors and adverse health outcomes, but these differed by race. More research needs to be done explain and eliminate health disparities.	Due to cross sectional data researchers only had access to one dimension of gender sexuality and would not capture people who did not identify as male or female or gay, lesbian, or bisexual.

Table 3, *continued*.

Reference	Purpose/topic	Source	Design	Key findings/recommendations	Limitations
Youatt, E. J., Harris, L. H., Harper, G. W., Janz, N. K., & Bauermeister, J. A. (2017). Sexual health care services among young adult sexual minority women.	To explore factors influencing a young SMW to seek routine sexual health care services.	2011 cross-sectional, web-based survey of YSMW's health behaviors	Cross sectional n=471	Only 35 % of participants were "out" to their provider. Disclosure was associated with increased receipt of sexual health services. SMW should be encouraged to come out to providers to increase sexual health services.	Small sample size and homogeneity may limit the ability to generalize findings. Due to cross sectional data researchers do not know if disclosure preceded receipt of services. Findings do not account for variables that were not included in study but may have affected the findings.
SMW= sexual minority women LGB=lesbian, gay, and bisexual HPV=human papillomavirus STI= sexually transmitted infection HCP=health care provider, SM=sexual minority BC=Birth control					

Findings

Lack of knowledge about health risks was one of the main factors associated with underutilization of health care. AFAB sexual minority individuals underestimated their risk of human papillomavirus, STIs, breast cancer, and other chronic diseases (Agénor et al., 2017; Everett, 2013; Horn & Swartz, 2019; Jahn, Bishop, Tan, & Agénor, 2019; Kaestle & Waller, 2011). Insufficiently targeted health promotion campaigns aimed at AFAB sexual minority individual' health and lack of health professionals educated on the needs of AFAB sexual minority individuals were common themes found in the literature (Agénor et al., 2017, 2019; Charlton et al., 2019; Everett, 2013; Everett et al., 2019; Kaestle & Waller, 2011; Newlin Lew et al., 2018; Pharr et al., 2019; Polek & Hardie, 2017; Trinh et al., 2017).

Underestimation of Risk

A secondary analysis of Wave 3 of the National Longitudinal Study of Adolescent Health Data (Kaestle & Waller, 2011) determined that AFAB sexual minority individuals diagnosed with a bacterial infection had a 98% probability of thinking they were at very low risk for STIs compared to only 71% of heterosexual females with the same characteristics. AFAB sexual minority individuals who identified as lesbian are screened less often than those that identify as bisexual or heterosexual (Agénor et al., 2017; Youatt et al., 2017). STIs are common in young AFAB individuals regardless of sexual orientation and gender of sex partners (Jahn et al., 2019; Kaestle & Waller, 2011). While having penile-vaginal sex increases the risk of acquiring an STI, there is documentation of female-to-female transmission of chlamydia, gonorrhea, syphilis, bacterial vaginosis,

and HIV (Agénor et al., 2017; Centers for Disease Control and Prevention, 2016; Kaestle & Waller, 2011).

AFAB sexual minority individuals perceive a low risk for acquiring human papillomavirus (HPV) (Agénor et al., 2019; Everett et al., 2019; Pharr et al., 2019; Youatt et al., 2017). In multiple studies measuring HPV risk perception, a majority of AFAB sexual minority individuals reported the belief that having a partner that is assigned female at birth put them at low risk for HPV infection, that HPV risk was related to the sharing of genital fluids, and that HPV could only be transmitted via penile-vaginal sex (Agénor et al., 2019; Pharr et al., 2019; Polek & Hardie, 2017; Youatt et al., 2017). Low-risk perception is believed to be one of the reasons AFAB sexual minority individuals were less likely to have had a pap test in the past three years when compared to heterosexual women (Agénor et al., 2019; Pharr et al., 2019) or received one or more doses of the HPV vaccine (Polek & Hardie, 2017; Youatt et al., 2017).

Other areas of underestimation of risk are breast cancer and chronic health conditions. AFAB sexual minority individuals are more at risk for breast cancer than their heterosexual peers due to fewer full-term pregnancies, increased incidence of binge drinking, and a higher incidence of being overweight or obese (Mattingly et al., 2016; Newlin Lew et al., 2018). However, they do not obtain mammography screenings as often as heterosexual women (Corcoran, 2017; Mattingly et al., 2016). AFAB sexual minority individuals have higher incidences of negative coping behaviors, including lack of exercise, increased body weight, smoking, and drinking, increasing their risk for developing chronic health conditions (Gonzales & Henning-Smith, 2017; Pharr et al., 2019; Trinh et al., 2017). These risky behaviors may be associated with minority stress,

chronic stress faced by members of stigmatized groups due to discrimination and prejudice faced in their environment (Gonzales & Henning-Smith, 2017; Newlin Lew et al., 2018; Pharr et al., 2019). This chronic stress can lead to internalized homophobia and unhealthy coping mechanisms.

Stigma Associated with Sexual Minority Status

Despite changes in the social acceptance of sexual and gender minority individuals in the U.S., AFAB sexual minority individuals continue to experience stigma related to their sexuality when trying to access health care (Baldwin et al., 2017; Corcoran, 2017; Everett et al., 2019; Jahn, Bishop, Tan, & Agénor, 2019). Unlike visible minority individuals, AFAB sexual minority individuals may need to "come out" to their health professional to make their minority status known (Johnson & Nemeth, 2014; Strutz et al., 2015; Youatt et al., 2017). Due to past "bad" experiences or fear of the reaction of the health professional and staff, many AFAB sexual minority individuals choose not to disclose their sexuality because they fear poor treatment (Corcoran, 2017) or undue attention being placed on their sexual orientation (Youatt et al., 2017). Lack of disclosure causes the individual to withhold information that might be important to the health professional in providing care and can strain the relationship between the individual and the health professional (Baldwin et al., 2017; Johnson & Nemeth, 2014). Individuals whose health professionals know about their sexuality were more likely to receive pap screenings, HPV vaccinations (Youatt et al., 2017), and report better health care interactions (Mosack et al., 2013). Corcoran (2017) reported that AFAB sexual minority individuals were more likely to report discrimination in health care than men who have sex with men. AFAB sexual minority individuals may face increased

discrimination over other groups because they are at the intersection of gender and sexuality (Everett, 2013; Trinh et al., 2017).

Shortage of Health Professionals Trained in Providing Inclusive Care

The shortage of health professionals trained in providing inclusive care was another reason AFAB sexual minority individuals avoid seeking care (Horn & Swartz, 2019; Jahn, Bishop, Tan, & Agenor, 2019). Johnson and Nemeth (2014) reported that AFAB sexual minority individuals' satisfaction with health services increased their likelihood of participating in health screenings and was positively affected by the health professional's knowledge of AFAB sexual minority individuals' issues. Many health professionals do not see sexual orientation as relevant information to gather (Pharr et al., 2019). However, knowing the individual's sexual orientation and practices allows a clearer picture of the individuals to whom they provide care and their needs and allows for more targeted care (Everett, 2013; Trinh et al., 2017).

Heterosexual Assumption

Heterosexual assumption is when health professionals do not ask about sexual orientation or behaviors and assume the individual is heterosexual (Jahn, Bishop, Tan, & Agénor, 2019). Heterosexual assumption can cause the individual to feel uncomfortable, can cause anxiety and insecurity, and can limit the positive communication between the individual and the health professional (Baldwin et al., 2017; Charlton et al., 2018; Jahn, Bishop, Tan, & Agénor, 2019; Johnson & Nemeth, 2014; Roberts, 2018; Youatt et al., 2017). Several studies reported that AFAB sexual minority individuals want their health professionals to make the first move when it comes to asking about sexual orientation or

sexual practices (Baldwin et al., 2017; Horn & Swartz, 2019; Jahn, Bishop, Tan, & Agenor, 2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Youatt et al., 2017).

Health Professional Knowledge

Lack of health professionals knowledgeable about the health risks faced by AFAB sexual minority individuals and their health risk behaviors was a recurring theme in this review (Agénor et al., 2019; Everett, 2013; Everett et al., 2019; Gonzales & Henning-Smith, 2017; Jahn, Bishop, Tan, & Agenor, 2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Newlin Lew et al., 2018; Pharr et al., 2019; Youatt et al., 2017). Health professionals who treat individuals based on their sexual orientation label are not providing complete care. Many individuals who identify as sexual minorities may have past or continued sexual contact with individuals assigned male at birth (Everett et al., 2019). A majority of AFAB sexual minority individuals, over 75%, reported penile-vaginal sexual contact at some point in their life, with 5-28% of AFAB sexual minority individuals reporting assigned male at birth sexual partners in the past year (Charlton et al., 2019; Everett et al., 2019). Failing to ask about past sexual activity or current sexual acts and assuming an AFAB sexual minority woman is not engaging in penile-vaginal sex puts them at risk for pregnancy and STIs due to missed teaching or screening opportunities (Charlton et al., 2018, 2019; Everett et al., 2019).

The few qualitative studies in this review revealed many AFAB sexual minority individuals were provided incorrect health information from their health professionals regarding their sexual health. One study reported a participant was told she did not need to see a gynecologist because she was in a same-sex relationship (Jahn, Bishop, Tan, & Agénor, 2019). In another study, a woman was told she didn’t need a pap test because

she wasn't having sex with men (Agénor et al., 2019). Another qualitative study related how a health professional did not know how to respond when a female seeking care revealed she had a female partner after being asked what birth control she was using; missing an opportunity to discuss dental dams or offer other sexual health screening and prevention (Johnson & Nemeth, 2014).

Discussion

This review focused on the health-seeking behaviors of AFAB sexual minority individuals and examined what impacts their decision to seek care. A majority of the articles included in this review were quantitative and used cross-sectional data, making it impossible to establish links between predictors, covariates, and outcomes. Quantitative research makes it difficult to understand and address social contexts and determinants of health. More research needs to be conducted to understand better what barriers to health care exist for AFAB sexual minority individuals and how they impact their decision to seek care. The limited amount of literature on AFAB sexual minority individuals coupled with most of it being quantitative limits what is known about their experiences. To encourage AFAB sexual minority individuals to seek care, the following areas of health care need to be addressed: health professionals should educate themselves and their staff on the needs of sexual minorities (Corcoran, 2017; Everett, 2013; Everett et al., 2019; Horn & Swartz, 2019; Jahn, Bishop, Tan, & Agénor, 2019), targeted health promotion campaigns need to created addressing the health needs of AFAB sexual minority individuals (Agénor et al., 2017; Kaestle & Waller, 2011; Pharr et al., 2019; Polek & Hardie, 2017), and AFAB sexual minority individuals must feel comfortable enough to disclose their sexuality to their health professional (Baldwin et al., 2017; Horn & Swartz,

2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Polek & Hardie, 2017; Youatt et al., 2017).

Assuming that AFAB sexual minority individuals who identify as a lesbian or are bisexual in a same-sex relationship do not participate in penile-vaginal intercourse puts the woman at risk for not receiving appropriate health care (Baptiste-Roberts et al., 2017; Centers for Disease Control and Prevention, 2016; Youatt et al., 2017). Using correct language and asking about gender, sexual orientation, and behavior on intake forms or at the beginning of the visit made the individual feel the doctor was accepting, decreased fear and anxiety about the visit, improved communication between the individual and health professional, and increased service utilization (Jahn, Bishop, Tan, & Agénor, 2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Quinn et al., 2015; Youatt et al., 2017).

The CDC (2016) reported that although the risk of transmitting HSV-2 from female to female was low, the risk of transmitting HSV-1 through oral-genital sex was high. Individuals should be screened for STIs based on sexual behavior and risk factors, not sexual orientation (Centers for Disease Control and Prevention, 2016). Same-sex sexual behavior does not free a woman from the risk of HPV. Of the AFAB sexual minority individuals who reported never having sex with a man, 26% had antibodies for HPV-16 and 42% for HPV-6 (CDC, 2016). The CDC recommends that all AFB individuals, no matter their sexual orientation, receive routine pap exams starting at age 21 and be offered the HPV vaccine (Baptiste-Roberts et al., 2017; Centers for Disease Control and Prevention, 2016, 2019; Jahn, Bishop, Tan, & Agénor, 2019).

Implications for Practice

To decrease health disparities in AFAB sexual minority individuals, we must increase their access to and engagement in preventive care. Health professionals should educate themselves on AFAB sexual minority individuals' needs and create safe, inclusive environments to access care. Public health officials should create targeted health promotion campaigns explicitly aimed at AFAB sexual minority individuals. Lastly, sexual and gender minority health should be added to the health science curriculum in order to educate future generations of health professionals.

Conclusion

AFAB sexual minority individuals are a diverse group with varied risk behaviors and sexual practices (Centers for Disease Control and Prevention, 2016). The reasons AFAB sexual minority individuals forgo care are multiple and complex. Many individuals who seek care do not disclose their sexual identity to their health professionals or do not receive appropriate screenings. Health professionals need to ask all individuals, regardless of their reported orientation, about their sexual behaviors as well as their sexual orientation (Baptiste-Roberts et al., 2017; Everett, 2013; Everett et al., 2019; Jahn, Bishop, Tan, & Agenor, 2019; Johnson & Nemeth, 2014; Youatt et al., 2017). Asking about behaviors will decrease the risk of missing important health risk information.

Due to the scarcity of research on AFAB sexual minority individual's health care experiences, determining the causes of underutilization of care is complicated. Most of the authors offered recommendations on improving care to AFAB sexual minority individuals, but no research has been done to see if those recommendations are effective.

Further research needs to be conducted with AFAB sexual minority individuals and health professionals to better understand AFAB sexual minority individuals' health care experiences.

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CHAPTER III

RESEARCH DESIGN AND METHODS

Study Objectives and Research Design Overview

The purpose of this qualitative descriptive study was to identify the factors that impact the decision of young AFAB sexual minority individuals to engage, or not engage, in health-seeking behaviors and receive preventative health care services. The study explored the aspects influenced by interaction between the health professional and the person seeking care to identify modifiable factors that may enhance the health care seeking behaviors of AFAB sexual minority individuals. Poor provider interactions have been identified as a factor in AFAB sexual minority individual's decision to seek health care (Baptiste-Roberts et al., 2017; Corcoran, 2017). Although other studies have identified health disparities and barriers to seeking health care faced by older AFAB sexual minority individuals, it was determined from the review of the literature, that little is known about what factors impact young AFAB sexual minority individual's decision to seek care. This is an important research question to answer because the early receipt of regular preventative health care services can prevent chronic disease, detect disease earlier, and increase future health (Centers for Disease Control and Prevention, 2009; Ozer et al., 2012). This study is the first step in a program of research that aims to enhance the health outcomes of AFAB sexual minorities through the development of culturally, gender, and sexuality specific health initiatives, including informing the development of health sciences curricula.

Specific Aims

Specific Aim: Identify the factors that impact the decision of AFAB sexual minority individuals to engage, or not engage, in health-seeking behaviors and receive preventative health care services.

Research Questions

RQ#1: What barriers do AFAB sexual minority individuals face with regard to seeking health care services?

RQ#2: What factors enhance the health care seeking behaviors of AFAB sexual minority individuals.

Methodology

A qualitative descriptive approach was used for this study. This approach focuses on the who, what, and where of an experience and was appropriate for studying a poorly understood phenomenon (Sandelowski, 2000). Qualitative description is less theoretical than other approaches (Kim et al., 2017; Magilvy & Thomas, 2009; Sandelowski, 2000); thus, it allowed for a clear understanding of the participants' experience (Bradshaw et al., 2017; Sandelowski, 2010). Qualitative descriptive design is a useful method when studying the experiences of the person seeking care and health professional interaction in healthcare (Neergaard et al., 2009). This design was the most appropriate for the study due to its focus on the personal health care experiences of AFAB sexual minorities.

Participant Selection

There is no set rule for the appropriate sample size to use in a qualitative descriptive study (Bradshaw et al., 2017; Kim et al., 2017). Samples in qualitative

descriptive studies are typically smaller than in other qualitative designs due to the researcher's intense contact with participants (Bradshaw et al., 2017; Kim et al., 2017; Magilvy & Thomas, 2009). Initially, it was anticipated that approximately 20 participants would be recruited and interviewed to have the maximum variation of sexual orientation and race to understand better the similarities and differences in experiences, motivators, and barriers to health care of the different subgroups. (Agénor et al., 2017; Arbeit et al., 2016; Poteat, 2012; Winn, 2012).

Exclusion of Under 18, Assigned Male at Birth, and AFAB Transgender Individuals

Excluded from the study were individuals assigned male at birth, AFAB transgender individuals, those under 18 or over 30. Persons under the age of 18 were excluded for two reasons: 1) they would require parental consent to participate, which could create an ethical concern due to disclosure of sexual orientation or identity; and 2) fear of exposure could lead to low recruitment and inaccurate information being collected from participants (Mustanski, 2011; Schrager et al., 2019). Individuals assigned male at birth were excluded because a large portion of the research done on LGBT individuals is conducted on this group (National Institutes of Health, 2020). Lastly, AFAB transgender individuals were excluded due to their unique health needs associated with their transition.

Eligibility Criteria

The study's primary criteria for participation were for individuals to be AFAB and identify as a sexual minority. For the study, a sexual minority was defined as an individual who does not identify as heterosexual or is attracted to or has sexual contact with another AFAB (Centers for Disease Control and Prevention, 2019). Individuals

AFAB were chosen because there is a paucity of research focusing specifically on them and their health care experiences (Baptiste-Roberts et al., 2017; Coulter et al., 2014; Everett et al., 2019).

Setting

An additional criterion for inclusion was for the participant to reside, go to school, or work in the Chicago metropolitan area. Chicago was chosen because health resources available for sexual minority individuals vary broadly based on geographic location in the city. There is a considerable disparity between services available on the Southside of Chicago versus those available on the city's Northside. A recent study conducted by the City of Chicago found that funding for and availability of health services target towards sexual minorities was limited outside of Chicago's Northside neighborhoods (Morten et al., 2019). Lastly, Chicago was chosen because the PI is familiar with the city and has connections with schools, universities, and health care agencies in the city.

Procedure

Recruitment

Due to the Covid-19 pandemic, recruitment was conducted through the social media platforms Facebook, Instagram, and Twitter and with snowballing. Targeted ads were purchased through Facebook and shared on Instagram and Twitter. The ads featured information on the study and a dedicated phone number and email address interested individuals could use to obtain additional information. Filters for the targeted ads on Facebook were set to 1) Chicago area plus 25 miles; 2) ages 18-30; 3) gender women. Detailed interests included: 1) LGBT community; 2) LGBT culture; 3) LGBT social movements; 4) LGBT pride; 5) lesbian pride; 6) lesbian, gay, bisexual, transgender

community center; 7) gay, lesbian, bisexual, transgender, straight alliance; 8) the gay, bisexual, and transgender community center; 9) bisexual community; 10) bisexual pride flag; and 8) Rainbow pride.

The ads ran from July 21 through July 31, 2020, and from November 2-7 on Facebook and were shared on Instagram and Twitter. According to Facebook metrics, the ad reached a total of 2484 individuals and had 69 post engagements. A Facebook post engagement is when someone reacts, comments, saves or shares a post (Facebook, 2021).

Snowball sampling was another valuable tool used in the recruitment of eligible participants as well. After each interview was complete and the recording ceased, the PI asked the participant to think of friends or acquaintances who might meet the eligibility criteria and be interested in the study. The PI asked the participants to forward study information, the social media ad, or the contact information with the potential participant or share the Facebook ad on their social media page.

During the initial recruitment period of July 2020, 16 individuals reached out for information regarding the study. Potential participants were given information about the study using a script (see Appendix A). The following screening questions were used to confirm eligibility: (1) what gender were you assigned at birth? (2) What is your gender identity? (3) do you have sex, or are you attracted to other individuals assigned female at birth? (4) What is your age? (5) Do you live, work, go to school, or seek care in the Chicago metropolitan area? After confirming eligibility, an interview date/time was scheduled via Zoom. All 16 individuals met eligibility criteria, but only 13 agreed to schedule an interview. Of the 13 that scheduled interviews, only nine completed the interview. During the second recruitment period in November 2020, three individuals

contacted the PI interested in the study. All three met the eligibility criteria, but only one agreed to be interviewed. In total, ten interviews were conducted. Each participant was contacted the day before their scheduled interview, via their chosen contact method, to remind them of the interview and send them the consent for review.

Protection of Human Subjects

Institutional Review Board

An application for full board approval was applied to the Health Sciences Institutional Review Board (IRB) at the University of Missouri. The IRB was provided with the proposal, research protocol, informed consent with waiver of documentation form, recruitment script (Appendix A); interview guide (Appendix B), and demographic questions (Appendix C). All research personnel completed CITI and HIPAA training. Participants were informed of the minimal risk involved, their rights to refuse to answer questions, ability to revoke consent, and withdraw from the study at any time.

Informed Consent

Each interested participant was sent a copy of the informed consent and offered a copy of the interview protocol. Informed consent was obtained from each participant prior to the interview. To confirm understanding of the nature and purpose of the study and their rights the consent form was read to each participant in its entirety. Participants were aware that they could refrain from answering any question and withdraw from the study at any time.

Risk to Subjects

Risks associated with participation in this study were low. Potential risks included psychological discomfort due to the personal questions in the interview and the loss of

confidentiality. To mediate the risk of psychological discomfort, participants were informed their participation was voluntary and they could leave the study at any time. They were also allowed to preview the interview guide ahead of time to make an informed decision about their participation. To protect the anonymity of the participants they were informed they could choose a pseudonym to be used during the interview process. All participants were assigned a code number that was used to label each recording and transcript. Audio recordings and deidentified transcripts were kept securely in the PI's password protected Box account. Any identifying information was kept in a separate secure password protected file.

Data Collection

Demographic Data

Demographic data were collected electronically using a Qualtrics survey, an online data management software that securely facilitates data collection. The PI has access to Qualtrics through their affiliation with the University of Missouri. Participants answered questions on age, racial and ethnic background, sexual identity, gender identity, education, level of income, insurance status, sexual practices, health care access, whether they had a primary care provider, length of time they have had the provider, practitioner knowledge of sexual practices, practitioner practice of asking about sexual practices, and whether they thought their practitioner's office was LGBT friendly (see Appendix C). Participants completed the survey before the interview.

The Interview Protocol

Open ended semi-structured interview questions allow the researcher to collect data on the participants thoughts and feelings, while allowing them the flexibility probe

deeper and ask clarifying questions (DeJonckheere & Vaughn, 2019). The interview protocol for this study included questions such as: "Describe to me a good healthcare experience you've had.", "Can you tell me about a bad experience?", "What could have been done to make it better?". The interview included questions about past experiences, openness about sexuality with family, friends, and providers, how or if providers asked about sexual behavior and orientation, what they look for in a provider, and what they would change about health care (see Appendix B).

When creating the interview protocol, advice was sought from members of the LGBT community to ensure the appropriate language was used. Even with this consultation, the interview protocol had to be amended with IRB to contain language more inclusive to nonbinary individuals. Prior to the interview, each participant was asked what their preferred name and pronouns were and if they could identify their gender and sexual orientation in their own words. The PI asked these questions to show respect to the participant and make sure they did not misgender the participant or make assumptions about their gender or sexuality.

Data Collection Procedures

The primary data collection technique was individual interviews (approximately 30 to 60 minutes in length). Each participant was interviewed once by the PI; all informants agreed to be contacted in the future to check the validity of the results. The interviews were semi-structured, informal, and consisted of open-ended questions and carried out in a conversational nonjudgmental manner. All of the interviews were conducted by a heterosexual cisgender female nurse researcher with expertise working with adolescent's sexual health and public health. An interview guide containing

questions, vetted by the PI's committee, on healthcare experiences was used (See Appendix B).

Due to the Covid-19 pandemic, all interviews were scheduled using the teleconferencing platform Zoom at a time convenient to the participant. Before starting the interview, the PI read the consent form to the participant, answered their questions, and verbally consented them, as approved by IRB, for participation in the study. The interviews were recorded using Zoom audio and a hand-held digital recorder. The Zoom video recording was disabled during the interviews, and participants had the option to keep their cameras off to maintain participant privacy. At the completion of the interview, the participant received a one-time payment of a $50 Amazon gift card through email or text. The incentive monies were provided through a small grant from Sigma Theta Tau Alpha Omicron Chapter.

During the interview, the PI took field notes of the participant's behavior, tone, and language. After the interview was completed, the file was assigned a code, identifying information was removed, and all voice recordings and field notes, were uploaded the PI’s secure Box account. Audio recording were transcribed verbatim using Zoom transcription service and Otter.ai. The transcribed interviews were reviewed for errors and corrections were made as necessary. The files were then uploaded into Dedoose, a web-based application for organizing and analyzing qualitative data.

Interviews continued until saturation occurred and no new categories emerged (Doyle et al., 2020). Saturation was reached at nine participants. An additional participant was recruited and interviewed to verify saturation. No new information was revealed from the tenth interview, and data collection ceased.

Data Analysis

Data from the demographic survey was analyzed in Qualtrics using descriptive statistical analysis. The transcribed interviews were analyzed using Dedoose qualitative software. The qualitative data for this study was analyzed using thematic analysis. Thematic analysis is a qualitative research analysis method that identifies and analyzes recurring patterns (themes) within the data (Braun & Clarke, 2006; Vaismoradi et al., 2013).

Braun and Clark's six phases of thematic analysis were used to analyze the data (Braun & Clarke, 2006). Each step of the analysis is designed to keep the researcher embedded in the data allowing for a rigorous examination. First, following each interview the PI familiarized herself with the data by listening to the recordings and taking notes on the participant's behavior. Information gathered from the interviews was used to guide the questions in the subsequent interviews. After the recordings were transcribed, the transcripts were read to ensure accuracy and so the PI could become familiar with their contents (Braun & Clarke, 2006; Flanagan et al., 2019; Vaismoradi et al., 2013). Next, while reading the transcripts and listening to the recording, initial codes were generated (Braun & Clarke, 2006). Dedoose was used to organize codes and participant quotes. After the data was coded, the PI reviewed the codes looking for recurrent themes and grouped them under main themes and sub-themes. The initial themes were reviewed and refined to determine if they fit. A thematic map was developed to assist with analyzation. Next, themes were named, and a detailed description of each theme was developed. Lastly, the report was written to include the story the data provided within and across themes (Braun & Clarke, 2006; Flanagan et al., 2019).

Trustworthiness

Lincoln and Guba's (1985) model of "trustworthiness" will be used to define rigor in this research project. Lincoln and Guba's (1985) model addresses four criteria of trustworthiness relevant to qualitative research: credibility, transferability, dependability, and confirmability. These criteria are comparable to the quantitative concepts of internal validity, external validity, reliability, and objectivity (Bradshaw et al., 2017; Cypress, 2017; Rolfe, 2006; Thomas & Magilvy, 2011).

Credibility

Ensuring trustworthiness in qualitative research requires adherence to the criteria put forward by Lincoln and Guba (1985). The first criterion, credibility, similar to internal validity, focuses on the truth value of the research and is the accurate representation of the participants' experiences (Cypress, 2017; Krefting, 1991; Prion & Adamson, 2014; Thomas & Magilvy, 2011). Credibility was achieved through the following strategies: prolonged engagement with the participants and the data, member checking, peer examination, and reflexivity (Cypress, 2017; Krefting, 1991; Thomas & Magilvy, 2011).

Transferability

The second criterion to establish trustworthiness is transferability. Transferability refers to the ability of the findings to be relevant and applicable to other contexts (Bradshaw et al., 2017; Krefting, 1991; Noble & Smith, 2015; Nowell et al., 2017; Thomas & Magilvy, 2011). Strategies used to assist with transferability included purposive sampling, providing an in-depth description of the sample, and a deep description of the participants (Bradshaw et al., 2017; Koch, 1994; Krefting, 1991).

Dependability

Dependability is the third criteria for trustworthiness, and it focuses on increasing the likelihood that another researcher can replicate the findings (Bradshaw et al., 2017; Cypress, 2017; Krefting, 1991). In order to ensure dependability in this qualitative study, the PI kept a written audit trail detailing the procedures used in each step of the research process and reasons why changes may have been made (Bradshaw et al., 2017; Cypress, 2017; Krefting, 1991; Thompson & Walker, 1998).

Confirmability

The last criterion of trustworthiness is confirmability. Confirmability establishes the study findings were derived from the data and not the researcher's biases (Cypress, 2017; Noble & Smith, 2015; Thompson & Walker, 1998). Confirmability occurs when credibility, transferability, and dependability are established (Noble & Smith, 2015; Nowell et al., 2017; Thomas & Magilvy, 2011; Thompson & Walker, 1998). The steps used to ensure confirmability included reflexivity, member checking, peer examination, audit trails with detailed notes about how themes and subthemes were developed, and providing a rich description of the demographics of the study participants (Bradshaw et al., 2017; Cypress, 2017; Nowell et al., 2017; Thomas & Magilvy, 2011; Thompson & Walker, 1998)**.**

Member Checking

Member checking and peer examination involve sharing the results with participants and peers to determine if interpretations are correct (Koch, 1994; Lincoln & Guba, 1985; Nowell et al., 2017; Thomas & Magilvy, 2011). Researchers must be aware

that member checking can have its pitfalls; it feeds into the idea that there is one fixed reality (Morse et al., 2002; Sandelowski, er 1993).

One participant agreed to review the findings to determine if the interpretations were correct. A summary of the findings was sent to the participant, they responded.

> I think that your findings are about in line with how I feel about the matter. I don't know how much I talked about the need for inclusive sex ed – of course I think it's necessary, but I was lucky enough to actually get a pretty decent and comprehensive sex ed from my high school. The same goes for the issue of privacy when asking about personal issues in front of parents – my pediatrician always asked my mom to leave the room before asking me about my sex life (as well as if I drank/smoked/engaged in other risky habits). However, I recognize my experience with both of those issues is not a typical one, and I definitely agree with what the other participants said*!*

Reflexivity

Reflexivity refers to the ability of the researcher to think, reflect, and pull away from the research to look at how the researcher's biases may be affecting the study (Cypress, 2017; Koch, 1994; Krefting, 1991; Noble & Smith, 2015; Thomas & Magilvy, 2011). Throughout the research study the PI kept a journal to create an audit trail, kept field notes, and consulted with their advisor while interpreting the data.

Summary

The goal of this chapter was to outline the research method used to answer the research questions. Chapter III included the research design, research methodology, participant selection, procedures, protection of human rights, informed consent

procedures, data collection procedures, data analysis procedures and methods for establishing trustworthiness.

Chapter IV is a manuscript that reports the findings of the dissertation study.

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CHAPTER IV

FACTORS THAT IMPACT THE HEALTH CARE EXPERIENCES OF ASSIGNED FEMALE AT BIRTH SEXUAL MINORITY INDIVIDUALS

(Manuscript to be submitted Spring 2020)

Abstract

This qualitative descriptive study identified factors that impact assigned female at birth (AFAB) sexual minority individuals' decision to engage, or not engage, in health-seeking behaviors and receive preventative health care services. AFAB sexual minority individuals were asked to describe their health care experiences to determine modifiable factors that could improve their intention to seek care and improve their health care experiences. Purposive sampling was used to recruit AFAB sexual minority individuals between 18-30 years of age who lived, attended school, and sought health care services in the Chicago metropolitan area. One overarching theme and two main themes emerged from data acquired through individual interviews: overarching theme “the right questions”; main themes (1) lack of trust in health professionals; (2) the need for better sexual health education. An important finding was participants wanted to be asked about their sexual orientation, sexual behavior, and gender identity. Participants wanted to be able to share their sexual orientation and gender identity with health care professionals so they could receive appropriate care, accurate information, and feel comfortable sharing aspects about their life. Participants also desired to have interactions with health care professionals that did not include awkward conversations or feeling judged. Additionally, the results suggested that general and health sciences curricula should include content about diverse sexual and gender minority populations. The addition of this type of

education might increase the awareness of the person seeking care and the health care professional of the health needs of AFAB sexual minority individuals. Such instruction might also normalize individuals with diverse sexual orientations and gender identities. Findings have important implications for health education and clinical practice. Novel strategies are needed to enhance health-seeking behaviors, and thereby the health outcomes, of the AFAB sexual minority population.

Introduction

Health data shows that assigned female at birth (AFAB) sexual minority individuals have more adverse health conditions and are less likely to seek routine care than men who have sex with men (MSM) or heterosexual cisgender women (Blosnich et al., 2014; Dahlhamer et al., 2016; Strutz et al., 2015). AFAB sexual minority individuals are at higher risk for heart disease, cancer, mental health diagnosis and are less likely to seek preventative health services than their heterosexual peers (Garland-Forshee et al., 2014; Strutz et al., 2015; Trinh et al., 2017; U.S. Department of Health and Human Services, 2019). Adolescent AFAB sexual minority individuals have an increased incidence of sexually transmitted infections (STIs), alcohol and drug use, and sedentary lifestyle. Lack of engagement in preventative health care is associated with a higher risk for long term complications due to late identification and delayed treatment of sexually transmitted infections (STIs), breast cancer, and cervical cancer (Centers for Disease Control and Prevention, 2019; Solazzo et al., 2017; United States Department of Health and Human Services Office on Women's Health, 2017).

Evidence shows comprehensive, inclusive sexual health education leads to improved health outcomes in young gender and sexual minority individuals (Charest et al., 2016; Human Rights Campaign, 2015; Steinke et al., 2017). However, only eleven states require inclusive topics on sexual orientation to be taught in high school, and six states require only negative information be provided on homosexuality or are required to put a positive emphasis on heterosexuality (Guttmacher Institute, 2020). Providing sexual health education that is limited or exclusively heteronormative and gender normative, and exclusive to the needs of LGBTQIA+ individuals, deprives them of the information

needed to make informed sexual health care decisions (Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017).

Reasons AFAB sexual minority individuals avoid seeking health care are multifaceted. Many AFAB sexual minority individuals do not inform health care professionals of their sexual orientation due to fear of discrimination (Baldwin et al., 2017; Baptiste-Roberts et al., 2017; Corcoran, 2017; Jahn, Bishop, Tan, & Agenor, 2019). Others do not participate in health screening due to the perception that health care professionals do not understand the health risks of AFAB individuals (Agénor et al., 2019; Charlton et al., 2011; Everett et al., 2019; Mattingly et al., 2016; Newlin Lew et al., 2018; Pharr et al., 2019; Youatt et al., 2017). There is a common misconception among AFAB individuals, and some health care professionals, that AFAB sexual minority individuals have no risk for STIs, including human papilloma virus (HPV), due to the assumption that these infections cannot be transmitted between two AFAB individuals and/or that AFAB sexual minority individuals do not participate in penile-vaginal intercourse (Agénor et al., 2019; Centers for Disease Control and Prevention, 2016; Charlton et al., 2011; Kaestle & Waller, 2011). AFAB sexual minority individuals are also at higher risk for chronic health conditions and breast cancer due to fewer full-term pregnancies and negative coping behaviors, including sedentary lifestyle, increased body weight, and substance use increases AFAB sexual minority individuals' risk for developing chronic health conditions (Gonzales & Henning-Smith, 2017; Mattingly et al., 2016; Newlin Lew et al., 2018; Pharr et al., 2019; Trinh et al., 2017).

AFAB individuals make up a majority of the LGBTQIA+ population in the United States; however, less than 15% of the National Institutes of Health Research funding is awarded to researchers focusing on AFAB sexual minorities (Pharr et al., 2019; Potter, 2019). Specific health issues that primarily affect AFAB sexual minority individuals are understudied (Baptiste-Roberts et al., 2017; Corcoran, 2017; Everett, 2013). Overall, LGBTQIA+ individuals lack equality and equity when it comes to access to health care and health information (Baptiste-Roberts et al., 2017; Corcoran, 2017).

There is a lack of qualitative research addressing young AFAB sexual minority individual's health care experiences and there are significant gaps in the literature. Identifying barriers to health care and determining what factors impact AFAB sexual minority individuals' health care experiences is vital in increasing their uptake of preventative care services. This study addresses the gaps in the literature and provides a foundation for further research, education, practice, and policy change.

Methods

A qualitative descriptive approach was used for this study. This approach focuses on the who, what, and where of an experience and was appropriate for studying the poorly understood phenomenon of young AFAB sexual minority health care experiences (Sandelowski, 2000). Qualitative description is less theoretical than other approaches (Kim et al., 2017; Magilvy & Thomas, 2009; Sandelowski, 2000); thus, it allowed for a clear understanding of the participants experience (Bradshaw et al., 2017; Sandelowski, 2010). Qualitative descriptive design was specifically chosen because it is a useful method when studying the experiences of the person seeking care-professional interaction in healthcare (Neergaard et al., 2009). This design was the most appropriate for

identifying the factors that impact the decision of a purposive sample of young AFAB sexual minority individuals to engage, or not engage, in health-seeking behaviors and receive preventative health care services. This study was approved by the University of Missouri Institutional Review Board.

Sample and Setting

Purposive sampling was used to recruit participants for this study as participants needed to meet specific inclusion criteria (Magilvy & Thomas, 2009; Sandelowski, 2000). Due to the Covid-19 pandemic, recruitment was conducted only through the social media platforms Facebook, Instagram, and Twitter and snowballing. Targeted ads were purchased through Facebook and shared on Instagram and Twitter. The ads featured information on the study and a dedicated phone number and email address interested individuals could use to obtain additional information. Snowball sampling was another valuable tool used in the recruitment of eligible participants. After each interview was complete and the recording ceased, the PI asked the participant to think of friends or acquaintances who might meet the eligibility criteria and be interested in the study (Ellard-Gray et al., 2015). The PI asked the participants to consider forwarding study information, the social media ad, or the contact information to other potential participants or share the Facebook ad on their social media page.

Inclusion criteria included 1) English speaking, 2) self-identify as an AFAB sexual minority, 3) 18- 30 years of age, 4) live, work, or attend school in the Chicago metropolitan area, 4) have sought healthcare in the past year. Exclusion criteria included 1) assigned male at birth, 2) under 18 and over 30 years of age, 3) AFAB transgender individuals due to their unique health needs.

Procedure

Individual interviews, approximately 30 to 60 minutes in length, were conducted between August and November 2020. Interviews were conducted via videoconferencing (i.e. Zoom). Informed consent was obtained from each participant prior to the beginning of the interview. To confirm understanding of the study's nature and purpose and their rights as a participant, the consent form was read verbatim to each participant in its entirety. Participants were aware that they could refrain from answering any question and withdraw from the study at any time. At the completion of the interview, the participant received a one-time $50 Amazon gift card via email or text. Each participant was interviewed once by the PI and all participants agreed to be contacted in the future to check the validity of the results. To maintain social distancing practices, interviews were scheduled at a time convenient to the participant using a password protected Zoom meeting link. The Zoom video recording was disabled during the interviews, and participants had the option to keep their cameras off to maintain participant privacy. Interviews were semi-structured, informal, and consisted of open-ended questions and carried out in a conversational nonjudgmental manner. The interviews were conducted by a heterosexual, cisgender female nurse researcher with expertise working with adolescents, sexual health, and public health. In total, ten interviews were completed. All interviews were audio-recorded and transcribed verbatim using transcription software and checked for accuracy by the PI.

The interview protocol for this study included open-ended semi-structured questions to allow for collecting the participants' thoughts and feelings while allowing the PI the flexibility to probe deeper and ask clarifying questions (DeJonckheere & Vaughn,

2019). The interview protocol included questions such as: "Describe to me a good healthcare experience you've had.", "Can you tell me about a bad experience?", "What could have been done to make it better?". The interview included questions about past experiences, openness about sexuality with family, friends, and providers, how or if providers asked about sexual behavior and orientation, what they look for in a provider, and what they would change about health care.

When creating the interview protocol, advice was sought from members of the LGBTQIA+ community to ensure the appropriate language was used. Even with this consultation, the interview protocol had to be amended with IRB to contain language more inclusive to nonbinary individuals. Before the interview, each participant was asked what their preferred name and pronouns were and if they could identify their gender and sexual orientation in their own words. The PI asked these questions to show respect to the participant and make sure they did not misgender the participant or make assumptions about their gender or sexuality.

Demographic and Health Data

Demographic and health data were collected via an online survey using Qualtrics, a secure data management software that securely facilitates data collection. Demographic and health data collected included age, racial and ethnic background, sexual identity, gender identity, education, level of income, insurance status, sexual practices, health care access, whether they had a primary care provider, length of time they have had the provider, practitioner knowledge of sexual practices, practitioner practice of asking about sexual practices, and whether they thought their practitioner's office was LGBT friendly. Participants received an anonymous link and completed the survey prior to the interview.

Data Analysis

The data was analyzed by the PI using Braun and Clark's six phases of thematic analysis (Braun & Clarke, 2006). Each step of the analysis was designed to keep the researcher embedded in the data allowing for a rigorous examination. Following each interview, the PI familiarized herself with the data by listening to the recordings and taking notes on the participant's behavior. Information gathered from the interviews was used to guide the questions in the subsequent interviews. After the recordings were transcribed, the transcripts were read to ensure accuracy (Braun & Clarke, 2006; Flanagan et al., 2019; Vaismoradi et al., 2013). Next, while reading the transcripts and listening to the recording, initial codes were generated (Braun & Clarke, 2006). Dedoose was used to organize codes and participant quotes. After the data was coded, the PI reviewed the codes looking for recurrent themes and grouped them under main themes and sub-themes. The initial themes were reviewed and refined to determine if they fit. A thematic map was developed to assist with analysis. Next, themes were named, and a detailed description of each theme was developed (see Table 2). Lastly, the report was written to include the story the data provided within and across themes (Braun & Clarke, 2006; Flanagan et al., 2019). Interviews continued until saturation occurred and no new categories emerged (Doyle et al., 2020). Saturation was reached at nine participants. An additional participant was recruited and interviewed to verify saturation. No new information was revealed from the tenth interview, and data collection ceased.

To establish the trustworthiness of the study, following the thematic analysis of the data, the PI shared results with another researcher who had expertise in conducting qualitative studies and with one participant. Through random member checking, one

participant who agreed to review the findings determined that the interpretations were correct (Koch, 1994; Lincoln & Guba, 1985; Nowell et al., 2017; Thomas & Magilvy, 2011). A summary of the findings was sent to the participant. Feedback was used to establish the study's confirmability and credibility (Noble & Smith, 2015; Nowell et al., 2017; Thomas & Magilvy, 2011; Thompson & Walker, 1998).

Findings

During the initial recruitment period of July 2020, 16 individuals inquired about the study. The following screening questions were used to confirm eligibility: (1) what gender were you assigned at birth? (2) What is your gender identity? (3) do you have sex, or are you attracted to other individuals assigned female at birth? (4) What is your age? (5) Do you live, work, go to school, or seek care in the Chicago metropolitan area? After confirming eligibility, an interview date/time was scheduled via Zoom. All 16 individuals met eligibility criteria: nine enrolled in the study and completed the interview. During the second recruitment period in November 2020, three individuals contacted the PI about the study. All three met the eligibility criteria: one agreed to be interviewed. In total, ten individuals participated in the study, with each completing one individual interview.

Participants in this study ranged in age from 18-22 years old (M_{age} 20.1 years), all were assigned female at birth (AFAB), and all self-identified as a sexual minority. Six of the participants identified their sexual orientation as bisexual, three as lesbian, and one as queer. Three participants reported having sex with women only, five with both men and women, one was not sexually active at the moment, and one was interested in any gender. Eight of the participants identified as women, one as nonbinary or agender, and one as genderqueer. The sample's racial makeup consisted of four White, four Asian, one Black,

and one Mestiza. Nine had health insurance, and one did not. Two were high school graduates, five completed some college, and three completed a four-year degree.

When looking at their past health care experiences, nine participants had a primary care provider, and one did not. The majority (80%) of participants had been seeing the same primary care provider for over one year. Two participants reported that their health care provider was aware of their sexual orientation, and eight reported their provider was unaware. Two participants said their provider asked about their sexual orientation, and eight reported never being asked. Eight participants reported being asked about sexual practices, and two reported never being asked. All participants reported that their primary care provider's office was LGBT welcoming. Most (90%) of the participants engaged in health-seeking behavior and reported seeing a health care provider in the previous 12 months for something other than an illness. Over half of the participants (60%) sought regular mental health services (Table 4).

Table 4.

Demographic and Health Data (n=10)

Demographic variable	n	%
Age		
18	1	10
19	2	20
20	4	40
21	1	10
22	2	20
Sexual identity		
Lesbian	3	30
Bisexual	6	60
Queer	1	10
Do you have sex with		
Women only	3	30
Men and Women	5	50
Other: interested in any gender, not sexually active at this time	2	20
Describe your gender identity		
Female	8	80
Nonbinary/Agender	1	10
Genderqueer	1	10
Race		
White	4	40
Asian	4	40
Black	1	10
Mestiza	1	10

Table 4, *continued.*

Demographic variable	n	%
Do you have health insurance?		
Yes	9	90
No	1	10
Annual income level		
Less than $10,000	6	60
$10,000-$19,999	2	20
$30,000-$39,999	1	10
More than $100,000	1	10
Education level		
High school graduate	2	20
Some college	5	50
Four-year degree	3	30
Do you have a primary care provider?		
Yes	9	90
No	1	10
Have you sought care for something other than an illness in the past 12 months?		
Yes	9	90
No	1	10
Years with provider n=9		
<1 year	2	22
1-3	2	22
4-5	2	22
>10	3	33
Is your primary provider aware of your sexual orientation? n=9		
Yes	2	20
No	7	70
Has your primary health care provider or their staff ever asked about your sexual orientation? n=9		
Yes		
No	2	22
	7	78
Has your primary health care provider or their staff ever asked about your sexual practices? n=9		
Yes		
No	8	88
	1	11
Is your provider's office LGBTQ welcoming?		
Yes	10	100

Themes

Through thematic analysis, one overarching theme and two main themes emerged. The overarching theme, the right questions, ran through all of the interviews and centered on the questions participants were asked by their health care professionals, and the feedback participants received in response. The two themes that emerged were: 1) lack of trust in health care professionals, 2) a need for better sexual health education (Table 5).

Table 2.

Themes

Overarching Theme	The Right Questions		
Theme		Lack of trust in Health care professionals	Better Sexual Health Education

The Right Questions (Overarching Theme)

All participants (n=10) reported instances where health care professionals did not ask about gender identity, sexual orientation, or sexual behavior. All participants believed health care professionals should ask these types of questions. Further, participants felt that asking such questions would improve care. Asking about gender and sexuality would allow the person seeking care to share the information in a safe way and signal to the person seeking care that the health care professional is open to people from diverse genders and sexualities.

> So, I think asking questions about your sexual identity. Even if the answer doesn't matter as much, it might set sort of a precedent. Oh, if they're asking me this, it means that they acknowledge that non-cis people exist, and it's okay if I talk about my life in that regard. Or like, something happened with my partner, and I want to talk about it, but I don't know if my doctor will react strangely and negatively, so I think that those questions can just set a precedent of comfort overall in the doctor's office

And another participant stated,

> At some point, the beginning, asking, but also like, just because there are, bi people or pan people and stuff like, like what I do when I don't know, what

> somebody's partner's, gender is I just use they, or avoid using pronouns until I hear them use a pronoun or a name, and then I just start using that. And it's not; it's not that hard to talk about someone's significant other without using pronouns, or with or just using they.

How and when health care professionals should ask about sexual orientation, gender, and behavior differed amongst participants. While all felt it was important for health care professionals to ask to alleviate potential awkward situations and provide proper care, they disagreed on how it should be asked. Nearly all participants (n=9) said asking about gender identity, sexual orientation, and behavior should be done at the beginning of the assessment. Still, some wanted it to be asked on a form, while others thought it should be asked verbally during the course of the assessment. Asking the questions via completing a form would allow the participant to share their gender identity, sexual orientation, and sexual behavior in a "low stakes way" without having to "find the words" to verbalize these answers aloud. Others felt it was more natural to be asked during the course of the assessment using a standardized script.

> It would probably startle me the first time I found it just because it's never there, and I'm just like, why do they want to know, but It would also just be nice to have that like it's a simple check so I don't have to bring it off and I don't have to figure out the words they could just like I can just quickly decide, and then I'm like, this has been done.

Overall, participants (n=8) reported that having a standardized way to ask about sexuality, preferred pronouns, gender identity, and sexual behavior would improve care. Asking would eliminate any assumptions made on the health care professional's part and

allow an assessment based on actuals risks and behaviors. Many felt that the conversation about sexual orientation and gender identity should start in the pediatrician's office. For example, when asking about behaviors such as drugs, alcohol, and sexual behavior, the pediatrician could then ask about the person seeking care's identity and sexuality. Participants reported this type of conversation would "normalize" gender and sexuality differences, give young people a trusted source of information, "provide an extra layer of support".

Every participant reported awkward interactions with a health care professional that could have been avoided had the health care professional asked the "right questions". Assumption of gender, sexual orientation, and sexual behavior was a problem brought up by all participants. Everyone interviewed reported instances where health care professionals assumed sexual activity based on the assumption that the person seeking care was a heterosexual, cisgender female. While only two participants identified as nonbinary or genderqueer, none reported being asked about their gender identity during health care visits. This assumption led to the participants, or their partners, being misgendered during the exam.

Health care professionals also assumed the sexual behavior of the participants. Eight participants reported being asked if they were sexually active; however, only two were asked the types of people with whom they had sexual contact. None reported being asked the types of sexual activities in which they engaged. Participants commented that they would like health care professionals to be more open and understanding when asking about sexual orientation and sexual behavior, *"I'm having sex with men"* is not the only correct answer to the "who are you having sex with?" question. As one participant noted

> Whenever you're not straight, and you tell somebody, they're like, oh, why is that? Like, why are you bi? Why are you pan or whatever? You have to explain yourself, which is stupid. And I just wish people would just accept it and then move on with their lives.

Additionally, four participants noted health care professionals assumed their sexual behavior based on their stated sexual identity or the gender reported for their partner. None of the health care professionals took into account the possibility of the partner being transgender. *"Just because I'm not having sex with men doesn't mean I'm not having sex with people with penises."* Two of these participants felt their health care professional assumed they were promiscuous due to their bisexuality without asking them about their sexual behavior and activities or assessing them for risk.

> So I think it would make sense, maybe even though it might seem more invasive. I think it makes more sense for them to be like, have you participated in this act, you know, at least that makes more sense to me medically because the other questions just struck me as moralistic.

For over half of the participants (n=6), "Is there any possibility you could be pregnant?" was the follow-up question to "are you sexually active?" If the participant answered "no," some health care professionals moved on, but others pressed and asked if the participant was sure. If they replied they were lesbian, the typical response was, "oh, you don't need a pregnancy test then." None of the participants reported being educated on the sexual health risks associated with sexual activity between two AFAB individuals or on measures to avoid contracting STIs. When asked why health care professionals cared more about pregnancy than STI, one participant responded

> Oh, you can't get pregnant, so it's fine… they're sort of dismissive or flippant about what sex between two AFAB people or like two vulvas…, it's just not regarded as anything worth worrying about, I mean, even though STIs can be transmitted between two people of the same biological makeup.

Lastly, participants reported that health care professionals only asked about "current" sexual partners and practices but not past behavior that could affect current health. Sexuality is "fluid," and some AFAB individuals are in "transitive phases" as to how they identify. Many of the participants had past sexual experiences with people assigned male at birth, even though they currently identify as lesbian. According to one participant, "I slept with a dude a month ago, but I'm not sleeping with dudes now."

Lack of Trust in Health Care Professional (Theme 1)

Lack of trust in their health care professional was a common concern for many of the participants. The participants were all asked why they did or did not share their gender or sexuality with their health care professional and why they thought other AFAB sexual minority individuals did not share their gender and sexuality. A common response was trust. All participants reported incidences in which they did not share their sexual orientation, sexual behavior, or gender identity with their health care professional because they did not trust that the response would be positive. When asked why they would prefer to let their health care professional assume they were cisgender or heterosexual instead of communicating to them their gender identity or sexual orientation, they reported past uncomfortable interactions with health professionals or their staff after reporting their sexual orientation or gender identity. One participant was asked if they were "experimenting" with their sexuality when they informed their health

care professional that they were a lesbian. Another, who is bisexual, experienced a rude comment from a nurse, a lecture she felt was "stigmatizing" from the doctor, and was made to feel as if she was promiscuous due to "the diversity of her partners." Participants reported being "confused" by the interactions with their health care professionals. Some participants said the interactions affected how much they trusted their health care professionals and staff, caused them to doubt their feelings and actions, and influenced their intention to share information about their sexuality, sexual behavior, and gender identity with other health care professionals. One participant was told by the health care provider,

> Bisexuality isn't really a thing. And you're either straight or you're gay. And if you're bisexual, you're just confused… I like forced myself to be straight for a while, which has affected my more recent relationships with females, just because I wasn't very accepting of it at first.

Participants were also leery about sharing information on gender identity and sexual orientation because they did not trust the information kept private and confidential. While all participants were open about their gender identity and sexual orientation with friends, many were not open about the gender identity or sexual orientation with their family. Fear of this information being shared casually with their family, amongst staff, or outside of the clinical setting was another reason the participants reported refraining from sharing it with their health care professional. This fear was not unfounded. Two participants reported a breach of confidence. After a health care appointment, the health care professional shared information with their family that they thought was shared in confidence. Fear of disclosure was reported by another participant

who said she would not see a gynecologist in her small town specifically due to fear of having her sexuality disclosed.

Due to the participants' young ages, many of them still saw their pediatricians for primary care. While most reported having a good relationship with their pediatrician, three participants reported not being given a safe, private space to share information. Instead of being assessed in private, the participants reported their mothers were allowed in the room during the exam. Their mothers' presence caused them to withhold information from their health care professionals and not ask questions regarding sexual health.

> They'll need to be more considerate of that stuff. But I think like, especially with pediatricians and things. Like young queer teens exist, trans teens and kids exist, and while they may not always be comfortable like talking about it in front of their parents…And so they would ask my mom to leave the room.

While all of the participants reported they would share information about their gender and sexual orientation if asked, many felt that their gender or sexual identity was not relevant to their overall health. Most reported that if they were going in for general concerns, like a sprained ankle, their sexuality or gender identity would not make a difference in the care they received, and they saw no reason to share it with the health care professional. However, participants stated they would not share the information if they thought their care would be negatively impacted. *"I would definitely lie about it if I felt like I could be, I would be judged."*

Participants also reported that if they sought care for a gynecological issue, sexual health concern, or mental health issue, they would share the information. Nearly all

participants (80%) felt that sharing gender and sexual orientation was essential to those receiving mental health services. Participants who were engaged in mental health services and shared their gender identity and sexual orientation with their therapist reported it improved the care they received and how they felt about their gender identity and sexuality.

> It felt like it was more important than I have been treating it, I guess because I hadn't come out to anybody here, I was just like it wasn't a whole ordeal. You know, like, it's not like a thing anymore.

Better Sexual Health Education

All the participants reported having a knowledge deficit regarding sexual health information, even though they all reported receiving some form of sexual health education in school. Several participants commented on the need for better sexual health education and topics related to AFAB health and gender and sexual minority individuals. Participants reported their lack of information on STI risk and prevention, necessary screening, and women's health affected their experiences with health care professionals. While most participants reported good relationships with their health care professionals and being satisfied with their interactions, they did not know how well their health care professional was meeting their sexual health needs. Many participants were unaware of the things health care professionals should and should not be asking. One participant noted, when asked if health care professionals should ask about past partners, *"I don't know. I'm not well versed enough to know what is relevant to sexual health."*

A majority of the participants reported receiving sexual health education in middle and high school that stressed abstinence and was based primarily on topics related

to penile-vaginal intercourse. Only one participant reported learning about sex acts that were not penile-vaginal. To learn more about diverse genders and sexualities, participants searched the internet or asked peers. Many participants reported not receiving vetted information about "different" types of sex acts, the risks involved in participating in the sex act, and measures to counter the risks until they reached college. For many of the participants, it was sobering information that they could have used years earlier. According to one participant:

> It could have been helpful to me growing up to know these things. I think it could be really damaging to a lot of people if they have a lot of sex and don't know how to have safe sex beyond just saying,' guys need to wear condoms when their penises are inside of you, that's not it, that's not it.

Improving the sexual health education offered in primary, middle, and high schools and including information on gender and sexually diverse individuals was a change most participants wanted to see. Having gender and sexually diverse individuals excluded from sexual health education affected how participants felt about the LGBTQTIA+ population and themselves. Inclusive sexual health education goes beyond just teaching about the risks involved in specific sex acts(Hobaica et al., 2019; Hobaica & Kwon, 2017). Inclusive sexual health education would have helped the participants be more accepting of themselves and would have created a friendlier and more welcoming environment for gender and sexual minority individuals.

> Just inclusivity…learning about this, if you don't know anything about something, you're not really gonna ask or bother to care about it. But if they knew that stuff, I guess… it's better to, it's just like better to know, that kind of stuff. So

> you don't accidentally offend somebody or say the wrong thing. That can lead to trouble.

In addition to more comprehensive sexual health education in primary, middle, and high schools, participants thought health care professionals needed additional education as well. Participants felt that health care professionals needed to be more educated on the needs of gender and sexual minority individuals, including assessing health risks in a more transparent and accurate manner, communicating using nongendered terms, and asking about pronouns, preferred names, and language for body parts. When asked what they thought health care professionals needed, one participant responded

> I would say get a bit more training on like, the diverse health and sexuality of a lot of different people and always get a bit of sensitivity training to and training on, like, just how to approach different types of people or have more inclusive healthcare providers that are able to relate personally, with students of diverse, like, backgrounds.

Discussion

This qualitative study identified factors that impact assigned female at birth (AFAB) sexual minority individuals' decision to engage, or not engage, in health-seeking behaviors and receive preventative health care services. Contrary to what has previously been published in the literature, that AFAB sexual minority individuals are less likely to seek regular health care (Agénor et al., 2017; Everett et al., 2019; Substance Abuse and Mental Health Services Administration, 2012; U.S. Department of Health and Human Services, 2019), all of the participants in this study sought out health care. Moreover,

60% of participants were engaged in regular mental health care services. Only one participant reported problems accessing health care related to insurance status, but that did not stop her from seeking regular exams and treatment. Instead, participants reported factors that acted as barriers to the care they received from their health care professionals.

Providing heteronormative and gender normative care exclusive of AFAB sexual minority individuals can lead to awkward interactions, incomplete care, and a breakdown in the relationship between the person seeking care and the health care professional (Alpert et al., 2017; Baldwin et al., 2017; Fredericks et al., 2017). Even though all the participants in this study were open about their gender identity and sexuality with friends, they hesitated to tell their health care professional because they did not know how the information would be received. If the health care professionals do not ask about sexuality, gender identity, and sexual behavior, the onus of disclosure falls onto the person seeking care. Failure to ask about sexuality and gender identity requires the AFAB sexual minority individual to "come out" to their health care professional to make their minority status known (Johnson & Nemeth, 2014; Strutz et al., 2015; Youatt et al., 2017). Putting the responsibility of disclosure onto the person seeking care can cause apprehension and anxiety over how the health care professional would respond. As seen in the literature, many of the participants refrained from disclosing information about their sexuality, gender identity, or sexual behavior because they feared rebuke or mistreatment from their health care professional post-disclosure (Baldwin et al., 2017; Brooks et al., 2018; Corcoran, 2017; Fredericks et al., 2017; Utamsingh et al., 2015).

In this study, the participants wanted to share the information on gender and sexuality with their health care professionals but did not feel comfortable starting the

conversation. Participants thought that health care professionals should initiate questions about gender identity and sexual orientation when they started asking questions about sex and recreational drugs around age 12 or 13. Participants also wanted these questions to be asked at the beginning of the visit to avoid any awkward corrections to be made later. Participants felt that having a standardized procedure to collect gender and sexuality information at health visits would normalize gender and sexual diversity. In addition, a standardized procedure might alleviate awkward situations and provide the health care professional information they need to provide appropriate information and care (Ard & Makadon, 2012; Centers for Disease Control and Prevention (CDC), 2020; Everett et al., 2019; Grasso & Makadon, 2016).

Consistent with the literature, AFAB sexual minority individuals wanted their health care professional to provide gender and sexuality affirming care in a confidential space that did not put undue attention on their sexual orientation and gender identity (Corcoran, 2017; Mosack et al., 2013; Youatt et al., 2017). Individuals whose health care professionals provide an affirming environment reported greater trust have been shown to be more open with their health care professionals about their gender, sexuality, and sexual behavior (Everett et al., 2019; Jahn, Bishop, Tan, & Agénor, 2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Youatt et al., 2017). The participants in this study who were open with their health care professionals about their sexuality and gender identity reported a better relationship with their provider and felt they were provided more individualized care. The open relationship allowed them to speak freely about parts of their life that were important to them, making them feel "seen" by their provider.

Participants felt the sexual health education they received in middle and high school was inadequate. The receipt of sexual health education in the United States is not a guarantee and varies widely (Rabbitte & Enriquez, 2019). Decisions about sexual health education in schools are made at the state level, with the content varying widely from district to district and even school to school based on who is teaching (Guttmacher Institute, 2020). Even if sexual health education is taught in school, most states focus on abstinence-only education with little or no discussion about gender identity and sexual orientation (Charest et al., 2016; Rabbitte, 2020; Rabbitte & Enriquez, 2019; Steinke et al., 2017). Consistent with these findings, most participants reported receiving abstinence-only education in school, with only one reporting receiving information that included gender and sexually diverse individuals.

Not having access to inclusive sexual health education was problematic for the participants. Participants in this study indicated that they did not have the knowledge base to differentiate whether they were receiving appropriate care from their health care professional or not and also did not know what questions to ask. Not having access to health information that was inclusive of all genders and sexualities limited AFAB sexual minority individuals' ability to make informed decisions regarding their sexual health and put them at risk for STI, pregnancy, and other health issues (Charest et al., 2016; Hobaica & Kwon, 2017, 2017; Rasberry et al., 2018; Steinke et al., 2017).

Providing only heteronormative and gender normative education exclusive to AFAB sexual minority individual's needs; can leave sexual minority individuals feeling isolated and confused (Bodnar & Tornello, 2019; Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2017). Heteronormative

and gender normative education can lead to internalized homophobia, increased depression, increased anxiety, and self-loathing (Gowen & Winges-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Steinke et al., 2017). Consistent with the literature, several of the participants reported feelings of anxiety over their sexuality, including one who tried "to be straight" due to inaccurate information she was given about bisexuality and another who was homophobic when they went to college only to realize they were queer. Some of the participants discussed the need for early sexual health education in school to normalize diverse genders and sexual orientations, adding that the education would help young gender and sexual minority individuals become more accepting of themselves and create a more inclusive environment in schools. These perceptions are consistent with results from a recent study that showed a decrease in bullying and adverse mental health issues in LGBT students in schools with inclusive sexual health education (Proulx et al., 2019).

Having a health care professional knowledgeable in the language, culture, and health needs of AFAB sexual minority individuals was something all the participants reported looking for in future health care professionals. Participants reported receiving inaccurate information regarding sexuality, health risks, and screenings from past and current providers. Consistent with the literature, most of the conversations health care professionals provided about sexual health revolved around pregnancy prevention, with little information on preventing STIs (Jahn, Bishop, Tan, & Agénor, 2019; Kaestle & Waller, 2011; Polek & Hardie, 2017). In addition, other participants reported being treated poorly based on stereotypes attributed to lesbian and bisexual individuals (Alpert et al., 2017; Arbeit et al., 2016). Most of the factors that impacted AFAB sexual minority

individual's health care experiences could be avoided if health care professionals received instruction that included content about diverse sexual and gender minority populations.

This study had several notable strengths. First, the development of the stories of young AFAB sexual minority individuals allowed for a deeper understanding of the experience and provided rich and robust data. The specificity of the study population also added to the strength of the study. Few studies exist focusing on young AFAB sexual minority women and their health care experiences. The results of this study are consistent with the body of literature that connects the improved health outcomes in sexual minorities with a health care professional educated on care inclusive of gender and sexual minorities (Baptiste-Roberts et al., 2017; Charlton et al., 2011; Corcoran, 2017; Everett, 2013; Everett et al., 2019; Horn & Swartz, 2019; Jahn, Bishop, Tan, & Agénor, 2019). This study's full strength is that it provides health professionals information on how their actions, language, and education can impact an AFAB sexual minority individual's health care experiences and influence their future decisions.

While this study had a number of strengths, there were also limitations that should be considered when considering the findings. This study was conducted at the height of the COVID-19 pandemic when universities and healthcare centers in Chicago, the initial proposed recruitment sites, were closed. Hence, this was a small study with 10 participants and results cannot be generalized. Recruitment on social media limited the participant pool to AFAB sexual minorities who engaged in social media or were connected to someone who engaged in social media. A larger sample may have possible through face-to-face recruiting strategies. The homogeneity of the participant group was another limitation.

The themes identified in this study have implications for future research and clinical and educational interventions. Results suggest that health care professionals need a standardized system to collect and assess information about sexual orientation and gender identity. Asking the right questions about gender and sexual identity could normalize sharing this information, which could enhance the quality of care and health outcomes for the AFAB population (Centers for Disease Control and Prevention (CDC), 2020; Horn & Swartz, 2019; Jahn, Bishop, Tan, & Agénor, 2019; Johnson & Nemeth, 2014; Mosack et al., 2013). The findings also suggest that health professionals need more education on diverse gender and sexual minority individuals and their needs. There is currently limited content with regard to gender and sexually diverse individuals in the health sciences curricula. For example, baccalaureate nursing programs provide an average of only 2.12 hours of instruction on LGBTQ issues (Lim et al., 2015; Pratt-Chapman, 2020). Part of the reason for the omission of gender and sexuality in health science curricula is the shortage of faculty knowledgeable on gender and sexual minority health (Lim et al., 2015; Luctkar-Flude Marian et al., 2020; Sherman et al., 2021). Health science programs need to develop and implement faculty training programs to integrate information on gender and sexual diversity into the nursing curricula. Lastly, health professionals need to work with lawmakers to change policy to make comprehensive and inclusive sexual health education is available to all (Baker et al., 2015; Bleakley et al., 2006; Guttmacher Institute, 2020; Stanger-Hall & Hall, 2011). Many of the participants discussed how the lack of sexual health education hindered their ability to interact with their health professionals, caused them mental stress and put them at risk for adverse sexual health outcomes. To make informed decisions about health care and sexual

behavior, AFAB sexual minority individuals need to receive the proper education (Charest et al., 2016; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2018).

Conclusion

The findings of this study highlight the need to enhance the health care experiences of young AFAB sexual minority individuals. This group of young people lacked trust in their health care providers and felt that these professionals were ill prepared to meet their needs. Findings suggest that health care professionals need to receive additional training and skill building in order to better care for AFAB sexual minority individuals. The most common topic of discussion was the need for health professionals to ask better questions during health care visits. A majority of participants reported that asking a simple question, such as preferred pronouns, would increase their trust in their provider, make them consider sharing more information about their gender and sexuality, and improve their health care experience. Providing more comprehensive sexual health education in public schools and adding content about the health needs of sexual minority individuals to health science curricula seem warranted. The findings of this study underscore the need for further research, and novel strategies, to enhance trust and improve the interactions between AFAB sexual minority individuals and health care professionals.

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CHAPTER V

IMPLICATIONS FOR FURTHER RESEARCH

Summary and Synthesis of Findings

The purpose of this qualitative descriptive study was to identify factors that impact the health-seeking behaviors of young, assigned female at birth (AFAB) sexual minority individuals. There were two research questions addressed in this study. The first question was to identify barriers AFAB sexual minority individuals face concerning seeking health care services. The second research question this study aimed to answer was to identify factors that enhance the health care seeking behaviors of AFAB sexual minority individuals. Contrary to current literature, this study found that AFAB sexual minority individuals do seek regular health care (Agénor et al., 2017; Everett et al., 2019; Substance Abuse and Mental Health Services Administration, 2012; U.S. Department of Health and Human Services, 2019). All participants in this study engaged in health care services, with 60% seeking regular mental health care services. Instead, participants reported factors that acted as barriers to the care they received from their health care professionals.

The themes identified in this dissertation mirror findings from previous research. Health care professionals are not asking the person seeking care the right questions at health care visits. The omission of questions regarding gender, sexuality and sexual behavior, limits the information available to the health professional when assessing risk and puts a strain on the relationship between the health professional and the person seeking care (Alpert et al., 2017; Baldwin et al., 2017; Fredericks et al., 2017). AFAB

sexual minority individuals expressed doubt and did not trust that their health professionals could provide accurate nonjudgmental care and to maintain confidentiality (Baldwin et al., 2017; Brooks et al., 2018; Corcoran, 2017; Fredericks et al., 2017; Utamsingh et al., 2015).

What was unique about the current study findings was that young AFAB sexual minority individuals identified a need for better sexual health education in school. Participants felt that comprehensive sexual health education could enhance their health care experiences. Participants reported that a lack of knowledge about sexual health and women's health negatively impacted their health care experiences. As discussed in chapter 2, comprehensive and inclusive sexual health education decreases high risk behaviors and increases positive outcomes because it allows individuals to make informed sexual health decisions (Rabbitte, 2020; Rabbitte & Enriquez, 2019). However, comprehensive and inclusive sexual health education and its effect on health care experiences have not been previously described in the literature.

This dissertation study addressed gaps in the literature and contributed to what little is known about young AFAB sexual minority individuals and their health care experiences. All of the participants in this study were satisfied with their health care interactions. However, their health care experiences left them wanting. According to the Agency for Healthcare Research and Quality (AHRQ) (n.d.), health care satisfaction and experiences are two different metrics. Satisfaction means the interaction went as expected, while experience is more multifaceted and looks at ease of access to information, clear communication with health professionals, and ability to access care (Agency for Healthcare Research and Quality, 2021; Berkowitz, 2016). This study

identified key areas that can be targeted to improve the health care experiences of AFAB sexual minority individuals.

Due to the scarcity of research on young AFAB sexual minority individuals, more research needs to be conducted to determine other factors that impact their health-seeking experiences. It is essential to develop effective strategies to engage the population of AFAB sexual minority their preventative health behaviors and screenings. In addition, larger studies need to be conducted to address the unique health care needs of this priority population.

This study focused on AFAB sexual minority individuals that lived in a large urban area with numerous health care facilities and professionals to choose from to provide health care. Additionally, all of the participants had access to health care through their university or their parents' insurance. Future research should include younger participants, uninsured individuals, and participants from non-urban areas who may not have the health care access that the participants in this study did.

Due to the age of the participants, many of the health care experiences discussed involved their pediatrician. Congruent with the literature, most described discussions about sex in the pediatrician's office that were brief, with only one being asked about their gender and sexual orientation (Alexander et al., 2014). The American Academy of Pediatrics published a clinical report in 2004 offering guidance to pediatricians on caring for sexual and gender minority youth (Frankowski & Committee on Adolescence, 2004). The suggestions align with topics the participants reported wanting to receive: providing a confidential space to have the discussion, an informed health professional, the importance of using gender-neutral terms and nonjudgmental language, and placing

information in the office that depicts gender and sexually diverse individuals (Burstein, 2021; Frankowski & Committee on Adolescence, 2004). Future research needs to be conducted with pediatric health professionals to determine if providing care that incorporates providing information on sexuality and gender identity improves long-term mental and physical health outcomes.

Implications for Nursing

Nurses need to work with politicians, community leaders and lawmakers to change policy and make comprehensive, inclusive sexual health education available to all (Baker et al., 2015; Bleakley et al., 2006; Guttmacher Institute, 2020; Stanger-Hall & Hall, 2011). Many of the participants in this study discussed how the lack of information about sexual health impacted their health care experiences. The inability to interact with health professionals has the potential to cause mental stress and put individuals at risk for adverse physical, emotional, and sexual health outcomes. To make informed decisions about health care and sexual behavior all individuals, and particularly sexual minority individuals, need to receive the accurate health education (Charest et al., 2016; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2018).

A key element of creating an inclusive health care environment requires that health care professionals become aware of the best practices for working with AFAB sexual minority individuals. These best practices include: use of inclusive language, open communication, asking questions regarding gender and sexuality and not making assumptions based on appearance, asking questions in a nonjudgmental manner, and provider affirming care (Ard & Makadon, 2012; Felsenstein, 2018; Gay & Lesbian Medical Association, n.d.).

Many sources suggest that health professionals need more education on the care of diverse gender and sexual minority individuals and need to approach the collection of gender and sexual health information (Everett et al., 2019; Horn & Swartz, 2019; Jahn et al., 2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Newlin Lew et al., 2018; Youatt et al., 2017). However, there is currently no standardized or required education on gender and sexually diverse individuals in health sciences curricula, with baccalaureate nursing programs providing an average of only 2.12 hours of instruction on LGBTQ issues (Lim et al., 2015; Pratt-Chapman, 2020). Part of the reason for the omission of gender and sexuality in nursing curricula is the shortage of faculty knowledgeable about gender and sexual minority health (Lim et al., 2015; Luctkar-Flude Marian et al., 2020; Sherman et al., 2021). Potential next steps in this program of research include developing and implementing nurse faculty training programs to train faculty in order to integrate information on gender and sexual diversity into the nursing curricula. In addition, infusing information about gender and sexual minorities throughout the BSN curriculum is warranted.

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APPENDIX A

RECRUITMENT SCRIPT

Hello, my name is Maureen Rabbitte. I am a graduate student at the University of Missouri, Columbia, in the School of Nursing. I am researching AFAB sexual minorities and their experiences with healthcare in Chicago, and I am inviting you to participate because you identify as an AFAB sexual minority.

Participation in this research includes answering demographic information about your age, sexual orientation, education, insurance status, employment, race, and zip code, which should take approximately 5 minutes. It also includes an interview about your healthcare experiences, which will take approximately 30 to 60 minutes. Your total time commitment will be between 55 – 65 minutes.

Participation in this study is voluntary. Your identity as a participant will remain confidential during and after the study. Your identity will be protected by removing all identifying information and replacing it with a random code.

If you have questions or would like to participate, please contact me at 708-232-3022

APPENDIX B

INTERVIEW QUESTIONS

Interview Questions

- Please tell me about a good experience you've had with a health care provider and the health care system?

- Please tell me about a bad experience you've had with health care, a health care provider, and the health care system?

Potential Prompts

- What went well?
- What did not go well?
- Do you discuss your sexual identity/orientation with your family? Friends? Health care providers?

If they do not discuss with the provider:

- Tell me more about the reasons you do not share this information with your HCP*?* Why do you think sexual minority women don't discuss their sexual identity with HCPs?

If the provider is aware of sexual behavior

- Can you tell me how they become aware of your sexual orientation?
- How did they react? Has it changed how they care for you?
- How has disclosing your sexuality has affected your relationship with your provider? How has it affected your health?
- Has your provider addressed any specific health needs based on identifying as a "*how they identify"*?
- What did they do?
- How did that make you feel?

If the provider is not aware of sexual behavior

- Do you think your provider assumes you are heterosexual?
- What are the reasons that it's important for your provider to know about your sexuality?

Past experiences

- Tell me about how your previous experiences with providers impact your current intention to see a healthcare provider?

Future

- What makes you want to see a provider?
- Or refer others to a provider?
- If you had a magic wand, what would you do to change how you access healthcare?
- What questions did I forget to ask?
- Is there anything you want to add that you did not get a chance to say?

Other questions looking at intersectionality:

If someone dropped in from another planet, how would you describe yourself to them?

APPENDIX C

DEMOGRAPHIC QUESTIONS

Demographic	What is your age? (collected as a categorical variable)
	What race do you most identify with? (Black, Hispanic, White, Asian, other)
	How do you identify? (lesbian, bisexual, heterosexual, other)
	Do you have sex with men, women, both, other (select all that apply)?
	Do you have insurance? (yes, no, I don't know)
	What is your annual income (collected as a categorical variable with income ranges)?
Healthcare specific Demographics	Do you have a primary care provider? (yes, no)
	How long have you had them? ___ insert number of years
	Have you sought care for something other than an illness in the past 12 months? (yes, no)
	Are they aware of your sexual orientation? (yes, no)
	Have they ever asked about your sexual orientation? (yes, no)
	Have they ever asked about your sexual practices? (yes, no)
	Is their office LGBT welcoming? (yes, no)

VITA

Maureen Rabbitte was born and raised in Chicago. She earned a Bachelor of Science in Nursing from Saint Xavier University, Chicago in 2001. She earned a Master of Science in Advanced Practice Public Health Nursing from Rush University, Chicago in 2014. She holds two graduate certificates, a certificate in school nursing from University of Illinois Chicago in School Nursing and a certificate as a youth development specialist from University of Missouri. Her research experience is in adolescent sexual health and women's health. She is the coordinator of Inquiry and Innovation the Illinois Association of School Nursing. Maureen is passionate about public health and currently volunteers with the Chicago Medical Reserve Corps. She lives on Chicago with her three teenage children.