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# "Render a service worthy of me": A qualitative study of factors influencing access to LGBTQ-specific health services

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## ARTICLE INFO

## ABSTRACT

For a half-century, LGBTQ-specific health services have sought to address the unmet health care needs of LGBTQ people in the U.S. However, there is a dearth of research examining factors that influence LGBTQ care-seekers' reasons for choosing LGBTQ-specific services and their experiences accessing care. This interview-based study explored factors that facilitate and inhibit access to LGBTQ-specific health services among a sample of 40 LGBTQ adults in a major U.S. city. Using framework analysis, emergent themes were organized into supply- and demand-side factors, guided by Levesque et al.'s (2013) framework for patient-centered health care access. Supply-side factors included provider empathy and affirmation, provider knowledge, comprehensive care, and provider-based stigma. Demand-side factors included care-seeker's willingness for self-disclosure, care-seeker beliefs placing primacy on health needs over LGBTQ identities, contentment with general providers, a lack of knowledge for service identification, and perceptions of ability to pay. Social aspects of care seeking were also identified, including desires for social belonging, collective self-esteem, and community solidarity. Findings suggest opportunities to enhance the fit between health care policy, LGBTQ-specific provider characteristics, and care-seeker needs, particularly for multiply-marginalized LGBTQ communities.

## 1. Introduction

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations experience marked health and mental health disparities compared to non-LGBTQ communities (Centers for Disease Control and Prevention, 2015; Hatzenbuehler, 2014; Pachankis et al., 2021; Puckett et al., 2017). For example, compared to their non-LGBTQ counterparts, lesbian and bisexual cisgender women have higher rates of breast and cervical cancers as well as obesity (Brown et al., 2015; Caceres et al., 2019; Institute of Medicine, 2011), and gay and bisexual cisgender men, as well as transgender women, have higher rates of sexually transmitted disease and HIV infection (Baral et al., 2013; CDC, 2015). Additionally, LGBTQ populations have higher rates of substance misuse, mental distress, and depressive symptoms, which are all risk factors for poor health (Day et al., 2017 Demant et al., 2017; Plöderl and Tremblay, 2015). Enhanced access to health care may reduce such disparities; however, literature suggests that LGBTQ communities continue to face multilevel barriers to accessing quality affirmative health care (Goldhammer et al., 2018; Lerner & Robles, 2017; Meyer et al., 2020; Romanelli & Hudson, 2017;

Stroumsa et al., 2019).

LGBTQ people experience various barriers to accessing health care, stemming from both the qualities or characteristics of the care-seeker and of the provider, services offered, and health care systems, more broadly. For example, LGBTQ people may feel hesitant to disclose information related to their sexual and/or gender identities to providers, negatively impacting health and health care outcomes (Redfern & Sinclair, 2014; Romanelli & Hudson, 2017). These hesitancies to openly engage with providers may be rooted in past experiences or the anticipation of healthcare provider-based stigma (Cahill et al., 2017), discrimination (Chapman et al., 2012; Durso & Meyer, 2013), and microaggressions (Shelton & Delgado-Romero, 2011). Such incidents of health care discrimination cause harm not only by exposing LGBTQ care-seekers to stress, but also by disrupting the current care-seeking episode and shaping future care-seeking behaviors (Burgess et al., 2008; Romanelli & Lindsey, 2020; Romanelli, et al., 2018). Both consequences block opportunities for clinical intervention, support services, and education, ultimately worsening long-term health outcomes.

LGBTQ care-seekers may also face financial and geographic barriers

to care, often linked to system-level problems (Blosnich, 2017; Martos et al., 2017). For example, among LGBTQ adults, financial barriers stem from inadequate insurance coverage (e.g., a higher proportion of sexual minority adults are insured through individually-purchased plans with greater out-of-pocket costs; Nguyen et al., 2018; Blosnich, 2017), employment in low-wage or part-time jobs without benefits (Baker et al., 2014; Durso et al., 2013), and high rates of unemployment (Conron & Goldberg, 2018). Transportation and transportation cost barriers are especially salient for rural, low-income, and adolescent LGBTQ individuals and connected to the geographic clustering of LGBTQ-specific health services in urban enclaves (Hudson, 2018 Martos et al., 2017; 2019). Kattari et al. (2020) found that over 35% of their transgender and gender diverse sample had to travel over 25 miles to access a knowledgeable provider. Limited outreach efforts by providers to the LGBTQ community also constrain knowledge of how to identify affirmative provider options for LGBTQ care-seekers (Romanelli & Hudson, 2017). LGBTQ care-seekers with multiply-marginalized identities (e.g., those who are poverty-impacted, rural dwelling, disabled, aging, people of color) experience exacerbated barriers to care related to cost, transportation/geography, discrimination, and availability of affirmative services (Fredriksen-Goldsen, Emlet, et al., 2013; Fredriksen-Goldsen, Kim, et al., 2013; Green et al., 2020; Romanelli & Hudson, 2017; Romanelli & Lindsey, 2020; Zeeman et al., 2019).

Although sexual and gender minority populations share many common barriers to accessing health care, there are also distinct patterns in experiences specific to certain groups within the LGBTQ umbrella. In a study of barriers to care described by a sample of LGBTQ-identified participants, transgender participants were more likely to identify barriers stemming from system-level issues such as lack of availability of affirmative providers and *trans*-specific clinics, while cisgender LGBQ participants mostly identified individual-levels barriers such as difficulties with open engagement in care (Romanelli & Hudson, 2017). Other research has similarly found that transgender care-seekers have cited challenges finding adequately-trained providers, support groups, and substance use treatment relative to their LGBQ cisgender peers (Lambda Legal, 2010). Transgender care-seekers are also more likely to report negative effects from disclosing their identity to their provider compared to LGBQ cisgender counterparts (Macapagal et al., 2016). Transgender people report health care discrimination at higher rates (Casey et al., 2019; Kcomt, 2019), including with greater frequency and intensity than their cisgender LGBQ peers (Kcomt, 2019). Increased issues with availability of affirmative services and providers and exposure to health care discrimination among transgender care-seekers may lead to higher levels of forgone care (and ultimately, worse health outcomes). Indeed, research has found that transgender care-seekers have higher rates of forgoing and delaying needed care relative to their LGBQ cisgender peers (Giblon & Bauer, 2017; Macapagal et al., 2016).

Overall, LGBTQ care-seekers may not be able to access care that fits their needs, in turn lowering treatment satisfaction, an indicator often used as a proxy for receipt of quality care and correlated with treatment adherence (Zolnierek & Dimatteo, 2009) and future treatment receipt (Fenton et al., 2012). Growing evidence suggests that sexual (Blosnich, 2017; Fish et al., 2021) and gender minorities (Ferrucci et al., 2021) report lower satisfaction with the care they receive within the U.S. healthcare system relative to heterosexual and cisgender comparisons. Transgender people, for example, experience lower care-seeker satisfaction based on a lack of provider knowledge about transgender-specific health care (Goldhammer et al., 2018; Lerner & Robles, 2017) and experiences with provider-based stigma, such as gender insensitivity, displays of discomfort or avoidance, or refusal to provide care (Ferrucci et al., 2021; Goldhammer et al., 2018; Howard et al., 2019; Kosenko et al., 2013). As satisfaction is a predictor of health care utilization (Fenton et al., 2012), it is critical to understand factors that increase access to quality care that fits LGBTQ care-seekers' needs.

## 1.1. LGBTQ-specific health services

Early community-based models of LGBTQ-specific health care emerged to address the unmet health care needs of LGBTQ people within a post-Stonewall socio-political landscape (Martos et al., 2018). The availability LGBTQ-specific health services, or health services tailored to the needs of LGBTQ people, corresponds with the LGBTQ Health Movement and the proliferation of LGBTQ community centers in the U.S. (Forstein, 2013). In 1971, Fenway Community Health Center became the first organization to offer LGBTQ-specific health services, a model that rapidly expanded with the inception of other LGBTQ community health centers within major metropolitan cities (Centerlink & MAP, 2018). Types of LGBTQ-specific services may include: general medical care, pharmacy services, counseling, addiction counseling, wellness, and STD/HIV services (Centerlink & MAP, 2018). While primarily rooted in LGBTQ community centers (Martos et al., 2018), LGBTQ-specific services are also available within hospitals, private practice, substance abuse treatment, among other settings (Centers for Disease Control and Prevention, 2020; Williams & Fish, 2020).

A small body of empirical research has investigated the characteristics of care-seekers who access LGBTQ-specific health services (Fish et al., 2019; Holmes & Beach, 2020; Martos et al., 2019). For example, data from a nationally-representative survey of 1,534 LGB people indicated several individual-level factors that contributed to past utilization of LGBTQ-specific services, including increases in the lifetime diagnoses of physical health conditions, proximity to LGBTQ community health centers, and perceived health status (Martos et al., 2019). Demographic differences in LGBTQ-specific service utilization may also be present. While bisexuals may be underrepresented in accessing these services (Holmes & Beach, 2020; Martos et al., 2019), care-seekers assigned male at birth and those with lower income show greater likelihood of accessing LGBTQ-specific services (Fish et al., 2019; Martos et al., 2019). Previous research contributes to a greater understanding of how care-seeker characteristics predict LGBTQ-specific health care service access; however, questions of how both care-seeker and service characteristics determine access remain under researched.

## 1.2. Theoretical framework

In the current study, our analytical process drew on Levesque et al.'s (2013) conceptualization of patient-centered health care access as a series of opportunities to "identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health services, and to actually be offered services appropriate to the needs for care" (p. 4). These opportunities for the care-seeker are dependent on both supply-side (i.e., provider/service characteristics) and demand-side (i.e., care-seeker characteristics) dimensions of accessibility. According to this model, health care service access is dependent on care-seekers' abilities to: 1) perceive a need for care; 2) seek care; 3) reach care; 4) pay for care, and; 5) engage in care. In turn, a care-seeker's abilities interact with the provider/service characteristics of: 1) approachability; 2) acceptability; 3) availability; 4) affordability, and; 5) appropriateness. The Levesque et al. (2013) model specifies that only the care-seeker characteristic of ability to engage and corresponding provider/service characteristic of appropriateness occur in the phase of health care utilization. Comparatively, all other care-seeker abilities and provider/service dimensions occur in prior phases of the access continuum related to opportunities to identify, seek, and reach care (Levesque et al., 2013).

Within this framework, we might consider how access to quality, affirming health care might be beneficially impacted by both care-seeker characteristics and LGBTQ-specific service characteristics. For example, a care-seeker's *ability to perceive* a need for LGBTQ-specific services may be influenced by their knowledge about the local availability of such care. Outreach efforts by LGBTQ-specific services, particularly for harder to reach care-seekers, reflects one way to enhance knowledge and in-turn

the *approachability* of one's services, the supply-side dimension linked to *ability to perceive* (demand side; Authors own, 2017). Additionally, the *acceptability* and *appropriateness* of LGBTQ-specific services might exceed that of general providers as many of these services have been built by and for LGBTQ communities to reduce personal and social barriers to care-seekers' *ability to seek* and *ability to engage* in affirming health care experiences. Although some dimensions of access may be facilitated by LGBTQ-specific services, these places of care may not accessible to every care-seeker, for example, for reasons related to service *availability and accommodation* (e.g., inhibiting care-seekers' *ability to reach* needed services) and *affordability* (e.g., inhibiting care-seekers' *ability to pay* for health care). Indeed LGBTQ-specific services and FQHC LGBTQ-specific health centers serving low-income care-seekers are sparsely distributed throughout the U.S., often only found in urban enclaves (Hudson, 2018; Martos et al., 2017; 2019). Ultimately, when the characteristics of services clash with those of the care-seeker, access to care is inhibited (Levesque et al., 2013).

### 1.3. Current study

The current study explores supply- and demand-side access-related factors influencing LGBTQ community members' reasons for choosing or not choosing LGBTQ-specific health services, and their experiences and perspectives in accessing such services. This study was guided by the following questions:

Research Question 1: What reasons do participants identify for choosing or not choosing LGBTQ-specific health services?

Research Question 2: What factors, experiences, and perspectives shape these reasons?

Research Question 3: How do these factors, experiences, and perspectives contribute to their ability to access health services?

## 2. Materials and methods

In accordance with a phenomenological approach (Moustakas, 1994), in-depth interviews were used to explore the subjective experiences and perspectives of LGBTQ community members related to accessing LGBTQ-specific health services.

### 2.1. Sample

The study used purposive and snowball sampling techniques to identify participants. Participants were recruited by posting informational flyers about the study on-location or online at 12 LGBTQ-specific organizations in New York City (NYC) that are known to serve diverse segments of the LGBTQ population. The flyers provided a brief description about the study purpose, inclusion and exclusion criteria, compensation details, and contact information for prospective participation. Additionally, snowball sampling was used to recruit potential participants who did not access LGBTQ-specific services or who were difficult to reach. Snowball sampling techniques included the provision of researcher business cards and study flyers to participants upon interview completion, which they were instructed to share with other potential participants. Eligibility for participation included identification as LGBTQ (or another non-cisgender, non-heterosexual identification) and being at least 18 years old. Prospective participants engaged in phone screening interviews to determine eligibility and to schedule in-person interviews, as appropriate.

The final sample consisted of 40 LGBTQ-identified adults living in New York City. Table 1 displays sample characteristics by race/ethnicity, gender, sexual identity, socioeconomic status, ability, and age. Participants were between 21 and 68 years old (M = 45; SD = 14), with the majority identifying as African American or Black (62.5%), cisgender female (47.5%), bisexual (47.5%), and poor (55.0%). Five (12.5%) participants identified as non-cisgender and non-heterosexual. The majority of participants (60.0%) reported past utilization of LGBTQ-specific health

**Table 1**
Sociodemographic characteristics of participants (N = 40).

| Characteristics | n | % | M (SD) |
|---|---|---|---|
| Race | | | |
| African American/Black | 25 | 62.5 | |
| Latina/o | 12 | 32.0 | |
| Asian American | 2 | 5.0 | |
| Native American | 2 | 5.0 | |
| White | 2 | 5.0 | |
| Mixed Race | 1 | 2.5 | |
| Gender | | | |
| Cisgender Woman | 19 | 47.5 | |
| Transgender/Gender Nonconforming | 11 | 27.5 | |
| Cisgender Man | 10 | 25.0 | |
| Sexual Identity | | | |
| Bisexual | 19 | 47.5 | |
| Gay | 9 | 22.5 | |
| Straight/Heterosexual | 5 | 12.5 | |
| Lesbian | 4 | 10.0 | |
| Other | 3 | 7.5 | |
| Socioeconomic Status | | | |
| Poor | 22 | 55.0 | |
| Low Income | 8 | 20.0 | |
| Middle Income | 3 | 7.5 | |
| Other (e.g., Homeless, Retired) | 7 | 17.5 | |
| Living with a Disability | 18 | 45.0 | |
| Has Accessed LGBTQ-Specific Health Services | 24 | 60.0 | |
| Age (Range = 21–68) | | | 45.0 (14.0) |

services. Forty-five percent of participants identified as living with a disability. Sociodemographic information was gathered during the interview by participant completion of a written questionnaire. Totals may equal more than 100% due to rounding error and some participants indicating membership in more than one social category.

### 2.2. Interview procedure

From August to October 2016, 40 semi-structured, one-time in-depth interviews lasting approximately 90 min were conducted by the second author in a private office in the University. The interview guide included domains such as perceptions of health, structural barriers, and the role of LGBTQ-specific services. The interview guide consisted of open-ended questions such as: "What impact have LGBTQ specific care providers had on your overall health?" and "Can you tell me why you chose to visit an LGBTQ-specific care provider?" The interview guide was pilot-tested with an LGBTQ-identified person of color known to two of the authors; subsequent feedback informed adjustments on the framing and sequencing of questions. The Human Subjects division at [blinded for peer review] provided ethical approval for this study (IRB-FY2016-581, Health Reimagined: Making Meaning of Health in LGBTQ Communities). Informed consent was gathered prior to the start of the interviews. Cash compensation of $40 was provided for participation. Upon completion of the interviews, debriefing memos were written to capture observations, such as specific to participants' nonverbal characteristics and emergent themes (Padgett, 2006). The interviews were audio-recorded and transcribed verbatim.

### 2.3. Data analysis

Data were examined using framework analysis techniques, including: (a) familiarization with the data, (b) identifying a thematic framework, (c) indexing and pilot charting, (d) summarizing data, and (e) mapping and interpretation (Ritchie & Spencer, 1994; Ward et al., 2013). All authors reviewed the data sources to extract sections pertinent to this study. Data were analyzed using Atlas.ti. Inductive, open-coding was used to identify patterns, and initial codes were organized into a framework of categories and themes. This framework was then applied deductively to the data and further refined. Each author reviewed codes, themes, and framework in an iterative process; memos and debrief meetings were

used to document analytic insights, assumptions, and decisions, thus creating an audit trail (Patton, 2002).

### 2.4. Quality and credibility

Several strategies were used to enhance the quality and credibility of this study. Authors engaged in critical reflexivity practices about how our positionings, points of privilege and disadvantage, and biases influenced the research process. The research team consisted of three scholars with doctoral-level social work degrees, with one having a previous history of clinical practice at an LGBTQ-specific service organization. Our positionalities included: a Japanese-American queer cisgender woman, a white queer non-binary scholar, and a mixed-queer cisgender woman who benefits from White privilege. Given our "insider" status based on social positionalities and research/practice focus areas as well as our "outsider" status based on positions of privilege, we engaged in reflexive discussion about how our positionalities, perspectives, training, and related assumptions might impact our framing of the research questions, selection of theory and methods, interviewer-interviewee interpersonal dynamics, and analytical processes. Additionally, we maintained an audit trail during the analytic process and used peer debriefings to check for researcher biases and subsequent over- or under-emphasized points. Furthermore, given the phenomenon of interest related to the experience of health inequities within a vulnerable population, we engaged with participants with a respectful, transparent, and affirming approach at every touch point of the process (Davies & Dodd, 2002).

### 3. Results

Participants discussed a combination of factors across the access continuum that facilitated or inhibited access to LGBTQ-specific health services. We categorize each factor within the supply-side provider/service characteristics and demand-side care-seeker abilities as outlined in Levesque et al.'s (2013) framework of patient-centered health care access (see Table 2).

### 3.1. Supply-side factors influencing access to LGBTQ-Specific services

Nineteen participants (47.5%) highlighted provider/service (supply-side) characteristics as informing their reasons for accessing LGBTQ-specific health services, including themes specific to provider empathy and affirmation, provider knowledge, and comprehensive care offerings. Applied within Levesque et al.'s (2013) model, the themes of provider empathy and affirmation and provider knowledge correspond with the dimension of *appropriateness*, with the technical and interpersonal skill sets of the providers tailoring to the health- and identity-specific needs of LGBTQ care-seekers. The theme of comprehensive care also corresponds with Levesque et al.'s (2013) dimension of *appropriateness* with these health services aligning with the integrated needs of LGBTQ care-seekers. All three themes (i.e., provider empathy and affirmation, provider knowledge, comprehensive care) fall within the healthcare utilization

**Table 2**
Supply- and demand-side factors influencing access to LGBTQ-Specific health services.

|  | Supply-Side Factors | Demand-Side Factors |
| --- | --- | --- |
| Access Facilitators | Provider empathy/ affirmation Provider knowledge Comprehensive care | Willingness for self-disclosure Social belonging Collective self-esteem Community solidarity |
| Access Inhibitors | Provider-based stigma | Primacy of health needs over LGBTQ identity Contentment with general provider Lack of knowledge for service identification Perceptions of ability to pay |

phase of the Levesque et al. (2013) model of health care access. On the other hand, three participants (7.5%) highlighted experiences with provider-based stigma as a primary reason for not accessing LGBTQ-specific health services. Applied within Levesque et al.'s (2013) model, provider stigma represents the dimension of acceptability, in this case, with an incongruence between provider beliefs and care-seeker positionalities inhibiting opportunities to seek LGBTQ-specific services.

#### 3.1.1. Supply-side factors that facilitate access

**Provider Empathy and Affirmation.** Seventeen participants (42.5%) identified provider-based empathy and affirmation of LGBTQ identities as reasons for accessing LGBTQ-specific services. Specifically, several emphasized an empathic LGBTQ-affirming approach as critical for cultivating provider-care-seeker rapport, with one participant explaining: "… the sensitivity of LGBT is main to me. If you're not understanding where I'm coming from then you're not going to feel what I'm feeling."

Another participant emphasized the need for affirmative care in light of the vulnerabilities already inherent within the health care-seeking process: "When you're dealing with cleaning yourself up…you want somebody who's going to accept you're LGBT."

Some participants described their expectations for affirmative care within LGBTQ-specific health services, with one participant noting:

> You're not here to judge me. You're here to service me. Render a service worthy of me. Why am I worthy of that service? Because I'm a human being.

**Provider Knowledge.** Twelve participants (30.0%) discussed provider knowledge as a primary reason for accessing LGBTQ-specific services. One participant pointed out the benefits of health care with an LGBTQ-specific service provider who is knowledgeable about transgender health needs: "I need hormones…surgery. I'd rather go here because they already know…you don't have to educate doctors." In other words, provider knowledge alleviated this care-seeker's burden of having to educate providers about transgender health needs. Another participant emphasized how provider knowledge about LGBTQ health also encompassed an understanding of LGBTQ lifestyles and behavioral considerations that may be secondary to primary health needs. This participant discussed how his provider offered guidance to address needs related to medication management, sobriety, and sexual health:

> They let me know that, as a gay person, you got to keep yourself up. You got to stay on medication. You can't drug and drink…be out there partying…can't be promiscuous. Those are the things you need to hear. And a lot of other doctors won't tell you that.

Some participants pointed out that provider knowledge about LGBTQ health supports increased access to informational resources. For example, a participant explained that LGBTQ-specific healthcare services have provided "a lot of education on positive HIV, and PrEP, and safe sex…and nutrition." Another participant indicated that greater access to sexual health-related information has helped her to modify sexual health behaviors: "It taught me how to handle myself sexually…risk factors of not actually getting myself harmed or sick." These findings suggest provider knowledge within LGBTQ-specific healthcare services benefited quality of care as well as care-seekers' development of sustainable health-promoting behaviors.

**Comprehensive Care.** Comprehensive care was discussed as the availability of multiple service offerings, such as safe sex, addiction treatment, counseling, psychiatry, medication management, nutrition, well-being, and sexual health. Nine participants (22.5%) perceived engaging with a provider that can meet multiple service needs as a facilitator to accessing LGBTQ-specific services. For example, in describing the comprehensive services offered by LGBTQ-specific services, one participant explained:

> It doesn't focus just on trans hormone therapy. It also focuses on STD

testing, housing, career development…on trying to help the community.

Another participant discussed how they currently utilize LGBTQ-specific services for reasons beyond medical needs, noting, "They have meetings there now, so if I'm not going there for my health, I go there for meetings." These responses highlight preference for the consolidation of services with a trusted LGBTQ-specific service provider.

### 3.1.2. Supply-side factors that inhibit access

**Provider-Based Stigma.** Three participants (7.5%) discussed experiences with provider-based stigma as a barrier to accessing LGBTQ-specific services. Stigmatizing experiences, while described by participants largely through accounts of interpersonal interactions, were related to the erasure of LGBTQ identities, stigmatizing experiences with clinical and administrative systems, as well as exposures to cultural/ideological violence and other systems of oppression. A transgender female participant described her experience with anti-transgender stigma within LGBTQ-specific health services by saying, "Even though my doctor's gay, I don't think he was fully understanding the whole trans thing." A bisexual participant described her perspective about anti-bisexual stigma within LGBTQ-specific health services for HIV/AIDS-related prevention and care: "I'm bisexual. No matter what it's 'gay men.' And it's so profound… it's like you're invisible." One transgender participant described her belief that LGBTQ-specific health services "discriminate against heterosexual people." Two out of three of these participants, both of whom were transgender women of color, added that they no longer utilize LGBTQ-specific services for this reason.

### 3.2. Demand-side factors influencing access to LGBTQ-Specific services

Thirteen participants (32.5%) highlighted personal characteristics as influencing their access to LGBTQ-specific health services, including the specific themes: willingness for LGBTQ identity self-disclosure, social belonging, collective self-esteem, and community solidarity. Applied within Levesque et al.'s (2013) model, the theme of willingness for LGBTQ identity self-disclosure corresponds with care-seekers' *ability to engage* by active and transparent participation in their treatment process. Twelve participants (30.0%) highlighted community-level factors as informing their reasons for accessing LGBTQ-specific health services. As applied within Levesque et al.'s (2013) model, the community-level themes correspond with the *ability to engage* whereby the benefits of LGBTQ social connectivity appear to motivate care-seekers' participation within their LGBTQ-specific service utilization. All four themes (i.e., willingness for LGBTQ identity self-disclosure, social belonging, collective self-esteem, and community solidarity) fall within the healthcare utilization phase of the Levesque et al. (2013) model of health care access.

In contrast, 17 participants (42.5%) highlighted personal characteristics as reasons to not access LGBTQ-specific services. Identified themes included a belief in the primacy of health needs over LGBTQ identity, contentment with their current general provider, a lack of knowledge for service identification, and perceptions of their ability to pay for care. As applied within Levesque et al.'s (2013) model, the themes specific to a belief in the primacy of health needs over LGBTQ identity and contentment with their current general provider correspond with an ability to perceive. In this case, care-seekers' varied perceptions of their health needs inhibited their motivations to even seek LGBTQ-specific services, such as related to a lack of knowledge for service identification (ability to seek) and perceptions of ability to pay for care.

### 3.2.1. Demand-side factors that facilitate access

**Willingness for LGBTQ Identity Self-Disclosure.** Five participants (12.5%) discussed a greater willingness for LGBTQ identity self-disclosure within LGBTQ-specific services compared to general services. Participants identified that expectations of LGBTQ identity affirmation and adherence to confidentiality policies contributed to their willingness for self-disclosure. For example, a participant pointed out a preference for receiving care in a stigma-free, safe space for self-disclosure, with confidence of "total confidentiality." Another participant highlighted that willingness for self-disclosure corresponds with perceiving the benefits as outweighing the risks: "… empowerment in a true sense of the word. They're not there to shame me. I feel better just being honest."

**Social Belonging.** Ten participants (25.0%) shared that LGBTQ-specific health services provide a sense of belonging with the LGBTQ community. In particular, three participants emphasized the bond they experience within LGBTQ-specific health services, described as being "part of a family" with others who are "under the same umbrella." One participant described the emotional connection she feels with other community members within the healthcare services, by saying, "It's just a feeling of comfort. It's just like, mentally, you're feeling like…they get me. There are people like me in this world. I am not alone." Yet another emphasized that LGBTQ-specific healthcare services provide them with socialization opportunities outside of traditional LGBTQ venues such as bars and nightclubs: "… it's the people…we just bond together, and that's where I get more help…because there are so many spaces that are not inviting, like gay clubs." Overall, these perspectives highlight the social benefits that LGBTQ-specific services provide beyond the provision of health care.

**Collective Self-Esteem.** Five participants (12.5%) discussed how involvement in LGBTQ-specific healthcare services improved their self-valuation by route of group affiliation (Luhtanen & Crocker, 1992). For example, a participant articulated how being in an LGBTQ-affirmative health care service positively impacted their sense of identity: "The biggest thing for me is meeting some great people and changing the narrative about myself and what it means to be part of my community." Similarly, another participant emphasized how her involvement within an LGBTQ-specific health services "… taught me how to handle myself sexually, to not harm myself or get sick; empowered me to be comfortable with who I am."

**Community Solidarity.** Four participants (10.0%) described utilization of LGBTQ-specific health services as part of demonstrating solidarity with one's community. For example, one participant shared that utilizing LGBTQ-specific health services was part of a commitment to "… shop in your own community. That is how you keep your village going." Similarly, another participant highlighted the mutually-supportive approach within LGBTQ-specific services whereby providers and care-seekers "have each other's back," The benefits of solidarity were described by a participant who expressed her belief that "it was the community that was going to help me get back on my feet," Yet another participant described a preference for services that are "within the LGBT community," noting, "They're for us. They're there to provide us with the health and care that we need. These responses highlight how decisions to seek and utilize LGBTQ-specific services are informed by the extent to which participants identify as part of and assume responsibility for serving the LGBTQ community.

### 3.2.2. Demand-side factors that inhibit access

**Primacy of Health Needs over LGBTQ Identity.** Eight participants (20.0%) articulated a belief that their specific health needs took precedence over their desire to seek LGBTQ-specific services. For example, one participant noted that when it comes to her health, "it doesn't really matter what doctor we go to." Specific to the primacy of a health needs over LGBTQ identity, a participant expressed her perspective that a provider's "… profession comes first," while another similarly expressed that the quality of professional care was more important than having a provider with whom she could identify with based on sexual identity: "I don't really care if my doctor's gay or not. All I care about is that he's a good doctor." One participant with an epilepsy condition separated her health- and identity-needs entirely, noting, "… when you're thinking about LGBT, you think about it's a sexual thing. So epilepsy and sexual identity have nothing to do with each other." These sets of beliefs disconnected health and LGBTQ identity, ultimately inhibiting access to

LGBTQ-specific health services.

**Contentment with Current General Provider.** Thirteen participants (32.5%) shared that they are aware of LGBTQ-specific health services, however, felt satisfied with the care they were already receiving at general non-LGBTQ-specific services. Several participants shared that they consider their general providers to be LGBTQ-affirmative and/or self-identifying as LGBTQ. For example, five participants described their decisions to utilize general HIV-specific services that are inclusive to LGBTQ people, with one participant sharing, "It's not necessarily only for gay people. But most of the people is gay …" When describing her general provider, another participant added: "I've never heard them be disrespectful or rude to anybody because they may be gay and stuff like that." Another participant expressed her choice to remain with her long-standing general provider:

> My doctor has been my doctor for 15 years ….they service anybody, whether you're straight, bisexual, gay... They don't judge, they're just there to help a client to get healthy.

**Knowledge for Service Identification.** Two participants (5.0%) explained that they had never sought LGBTQ-specific health services based on a lack of knowledge for service identification. When asked about experiences with LGBTQ-specific services, one participant shared, "I didn't know they had specific doctors like that." Another participant noted being aware of LGBTQ-specific services, but not knowing how to access them: "I don't know how, to be honest." More research is needed to clarify this finding as a care-seeker's lack of knowledge might also reflect services' limited outreach as a barrier.

**Perceptions of Ability to Pay.** Two participants (5.0%) cited insurance considerations as reasons they have not utilized LGBTQ-specific services. One participant shared a perspective of feeling disempowered in the process of selecting services, noting, "… the way my insurance is, they pick my doctor for me." Another participant stated that not having insurance impacted their decision to not seek LGBTQ-specific services, without consideration to the availability of insurance/benefits navigation services that these locations frequently offer to support un/under-insured care-seekers. These responses again highlight a need to clarify how perceptions of their ability to pay for LGBTQ-specific services may reflect system-level deficits in adequately outreaching and informing un/under-insured LGBTQ consumers.

## 4. Discussion

Framed within a patient-centered access framework (Levesque et al., 2013), this study contributes qualitative data that provides a deeper understanding of supply- and demand-side factors influencing LGBTQ care-seekers' access to LGBTQ-specific services. This study identified several themes of supply-side (i.e., provider cultural sensitivity, provision of comprehensive services) and demand-side (i.e., willingness for self-disclosure, social belonging, collective esteem, community solidarity) contributors to LGBTQ-specific health care service access. Novel within these findings were the themes related to the community-level benefits (i.e., social belonging, collective self-esteem, community solidarity) of LGBTQ-specific service utilization which facilitated access. All of the supply- and demand-side factors participants described as facilitating access to LGBTQ-specific services were contextualized within the healthcare utilization phase of Levesque's model. In other words, these care-seekers had already identified, sought, and reached LGBTQ-specific services.

On the other hand, our findings suggest that some barriers exist to enhancing care-seekers' some participants' access to LGBTQ-specific services. Notably, all participants who reported not using LGBTQ-specific services reported an issue that manifested early on the continuum of health care access, creating a barrier to the care-seeker's perceptions of needs or desire for, seeking of, or utilization of LGBTQ-specific services. For example, on the supply-side, provider-based stigma affected participants' lack of desire or need for LGBTQ-specific services, while on the demand-side, it was the primacy of health over identity and contentment with current providers that were described as the most influential factors.

### 4.1. A closer look at gender

Analysis by gender identity revealed that transgender (n = 9) and cisgender (n = 10) participants discussed supply-side factors as influencing their access to services. Of note, the majority (81.8%) of transgender participants emphasized provider empathy, affirmation, knowledge, and comprehensive services as important drivers to their LGBTQ-specific service access and utilization. This finding supports previous literature pointing to affirmative and knowledgeable care as a supply-side characteristic that is of central importance to transgender people when accessing health care services (Lerner & Robles, 2017; Zeeman et al., 2019). Our study found that transgender (n = 6) and cisgender participants (n = 6) evenly comprised participants who discussed the benefits of social connectivity as part of LGBTQ-specific service utilization. However, all of the 5 participants who discussed opportunities for LGBTQ identity self-disclosure were cisgender, corroborating previous research indicating that challenges with self-disclosure may be a central concern of LGBTQ cisgender care-seekers (Romanelli & Hudson, 2017).

Specific to supply-side factors inhibiting access, two of the three participants who reported experiencing provider-based stigma identified as transgender, aligning with literature illuminating transgender care-seekers' vulnerability to stigmatizing health care experiences (Ferrucci et al., 2021; Goldhammer et al., 2018; Howard et al., 2019). Alternatively, cisgender participants comprised all of the participants (n = 12) who discussed demand-side factors related to their abilities to perceive a need, seek, and pay for LGBTQ-specific services. The absence of transgender participants (the majority of whom identified as also women of color) within this category is surprising, considering literature discussing LGBTQ multiply marginalized people as having added systems-level barriers to accessing care, such as related to insurance, cost, and accessibility (James et al., 2016; White Hughto et al., 2017). However, our findings may be explained by the efforts of LGBTQ-specific services in New York City to attenuate these barriers for transgender communities of color (Romanelli & Hudson, 2017).

### 4.2. Supply-side factors influencing access to LGBTQ-Specific services

Our findings of the supply-side factors influencing access to LGBTQ-specific services support the Levesque et al. (2013) conceptualization of health care access as informed by the *appropriateness* of the fit of services with the care-seeker's needs. For example, we found that inclusive, knowledgeable care delivered by empathetic and affirming providers was a major factor driving participants' access to LGBTQ-specific services. Another theme that emerged was that of the *appropriateness* of LGBTQ-specific services based on their offering centralized access to comprehensive care in response to the high risk of co-occurring substance use, mental health issues, and medical multimorbidity among LGBTQ people (Evans-Polce et al., 2020; Pachankis et al., 2021). In addition to health care, participants indicated that an advantage of receiving care through LGBTQ-specific services includes access to legal, housing, and employment resources, which is of particular relevance to multiply-marginalized LGBTQ community members (Hudson, 2018). Historically, LGBTQ-specific services have always been responsive to the emerging needs of the community. Most recently, in response to the COVID-19 pandemic, some LGBTQ-specific health services added new offerings, such as diagnostic and antibody COVID-19 testing, vaccinations, vaccine education and outreach, remote behavioral health, medication delivery, and public benefit navigation (Callen-Lorde, 2020, 2021). These findings align with the core intents of the LGBTQ Health Movement to provide LGBTQ people with safe and affirmative health

care environments that can comprehensively serve their unique health needs (Forstein, 2013; Hudson, 2018; Martos et al., 2017).

Our results suggest that for three participants, the *acceptability* of LGBTQ-specific services, particularly specific to the congruence of provider beliefs with care-seeker positionalities, was not guaranteed. Notably, two of the three participants who discussed experiencing provider-based stigma were transgender women of color. This finding corresponds with previous research accounting for provider-based stigma against transgender people (Grant et al., 2011; Hines et al., 2014; Howard et al., 2019; Hudson, 2019; Poteat et al., 2013) as an explanatory factor for the underutilization of health services by transgender people (Hughto & Pachankis, 2018; Lerner & Robles, 2017; Romanelli et al., 2018; Whitehead et al., 2016). While transgender care-seekers may identify their health care needs, factors such as the expectation of provider-based stigma may influence their decisions to delay or not seek care (Giblon & Bauer, 2017; Macapagal et al., 2016). Beyond extending provider education (see Section 4.6.3 for more), attention to enhancing care-seekers' motivations to seek and abilities to identify, reach, and obtain transgender-affirmative services, in light of their past stigmatizing experiences and related rejection sensitivity, is an important takeaway. More research is needed on transgender people of color's experiences with stigma at the intersections of racism and cissexism within LGBTQ-specific services (Howard et al., 2019).

### 4.3. Demand-side factors influencing access to LGBTQ-Specific services

As with previous research, our results indicate a greater willingness for self-disclosure within LGBTQ-specific services which cultivate a safer environment for some LGBTQ people (Burton et al., 2020; Taylor et al., 2020). Outside of these settings, prior stigmatizing experiences may hinder LGBTQ persons' willingness for self-disclosure based on rejection sensitivity (Rood et al., 2016; Sutherland, 2021), despite the importance of a care-seeker's *ability to engage* in their health assessment and treatment processes (Utamsingh et al., 2017; Whitehead et al., 2016). Ultimately, this presents a double bind for LGBTQ care-seekers, whereby non-disclosure may avert stigmatizing exposures, while potentially sacrificing quality of care.

Our results point to community-level drivers (i.e., social belonging, collective self-esteem, community solidarity) to accessing and actively engaging in LGBTQ-specific services. This finding suggests that, for LGBTQ care-seekers, the ability to engage in health care treatment processes may relate, not just to an individual motivation and capacity for participation, but also social factors that may enhance such motivation and capacity. Thus, we build on Levesque et al.'s (2013) conceptualization of caregiver support as one social illustration of a care-seeker's ability to engage, by pointing to how, for LGBTQ care-seekers, this may additionally involve the support of other LGBTQ community members/care-seekers. This aligns with research discussing the importance of informal care networks from within the LGBTQ community for LGBTQ care-seekers who are more likely to experience rejection by their families of origin (Carastathis et al., 2017; Hudson & Romanelli, 2020).

Connectedness to the LGBTQ community plays an essential role in the lives of many LGBTQ people, the benefits of which range from a sense of belonging, knowledge sharing, identity affirmation, collective self-esteem, socialization, social support, and opportunities for LGBTQ social activism (Dunn & Szymanski, 2018; Harner, 2021), helping to buffer the effects of living in a cisheterosexist society (Zimmerman et al., 2015). Further investigation in this area is needed, including exploration of if and how LGBTQ community connectivity impacts care-seekers' treatment satisfaction and outcomes. Attention is also needed to examine how service providers can and are unlocking the potential of community-based interventions to drive outreach, visibility, and engagement efforts among more difficult to reach multiply-marginalized LGBTQ communities. Additionally, we urge interrogation of how intra-group stigma within the LGBTQ community might impact minoritized racial/ethnic or non-monosexual community members'

motivations to access LGBTQ-specific health services in light of research indicating that people of color (Battle et al., 2017) and bisexuals (Gray & Desmarais, 2014) may feel less connected to the LGBTQ community.

Consistent with Levesque et al.'s (2013) model of access, our findings indicate that the *ability to perceive* a need for LGBTQ-specific health services was a key factor for participants who chose to not access such care. Up to a third of participants discussed not perceiving a need for LGBTQ-specific services either related to their contentment with their general provider or their beliefs that separated health-specific needs and LGBTQ identity-specific needs. Our findings suggest that socio-structural processes beyond the fit of the care-seeker and provider/service may inform LGBTQ care-seekers' access to LGBTQ specific services (e.g., the centrality of their sexual and/or gender identities relative to other identities, such as ethnicity).

Despite expansions in the availability of LGBTQ-specific services nationwide, particularly in major cities (Martos et al., 2017), four participants indicated that they have not accessed LGBTQ-specific services due to their perceptions of a lack of *ability to seek* or *ability to pay* for such care. Specifically, the two participants who discussed a lack of knowledge about the availability of LGBTQ-specific services were bisexual, African American, and self-identified as poor. Further consideration of how access-related factors such as service identification are impacted by the intersection of care-seeker characteristics and service provider characteristics is necessary (Romanelli & Hudson, 2017). While the current study involved participants based in New York City, a city with several LGBTQ-specific health services (Centerlink & MAP, 2018; Hudson, 2018; Martos et al., 2017), problems with LGBTQ-service identification in this city have been documented (Martos et al., 2018), including a dearth of affirmative services in under-resourced neighborhoods populated predominantly by people of color Romanelli & Hudson, 2017. Our findings suggest that in order to promote care-seekers' knowledge and reach of LGBTQ-specific services, service providers should enhance service visibility and outreach efforts to multiply-marginalized LGBTQ people (Romanelli & Hudson, 2017).

### 4.4. Limitations

Interpretation of our results must be considered in the context of the study's limitations. To begin, this study's findings are not generalizable to all LGBTQ communities. Participants self-selected into the study through participant referrals or after viewing information about our study at one of the 12 LGBTQ-specific service locations, and so were more likely to be connected to the LGBTQ community. Analysis of responses by recruitment strategy (i.e., in-person at LGBTQ-specific services or by participant referral) might have provided greater understanding of the networks of LGBTQ community members who participated in this study. The experiences of LGBTQ community members who do not actively engage in the LGBTQ community may not be represented in our findings. These community members may hold alternative perspectives about or barriers to accessing LGBTQ-specific services. Access to and the subsequent ability to form perspectives on LGBTQ-specific services can be dependent on service availability and identifiability. Finally, as the study was conducted in an urban location with a large and visible LGBTQ community and multiple LGBTQ-specific services, this study should be replicated in rural and suburban locations across the U.S. (Martos et al., 2017).

Other limitations were related to the interview process. For example, the interview did not ask in-depth questions about participants' use of LGBTQ-specific health services, such as specific to duration and frequency of use, and types of services accessed. These factors could contribute to a better understanding of participants' care-seeking behaviors and impressions of the benefits of utilizing LGBTQ-specific services. In addition, a single in-person interview was conducted leaving little time to build trust and rapport between interviewer and interviewees, potentially restricting participants' willingness to discuss sensitive topics related to their health and health care experiences. Further, any disparate social identities of the interviewer and

participants could have affected the questions asked and the responses given. It is possible, for example, that the interviewer consciously or unconsciously failed to ask certain questions based on their assumed familiarity of or lack of knowledge about some aspects of the community. Finally, the interview did not require participants to disclose personal health information. This might have allowed a comparison of health outcomes between participants who did and did not utilize LGBTQ-specific services, ultimately deepening our understanding of the benefits of utilizing tailored health services.

## 5. Implications

Taken together, the results hold research, policy, and practice implications for the enhanced utilization of LGBTQ-specific health services.

### 5.1. Research

The current research accounted for participants' multiple positionalities; however, a formal intersectional analysis was not completed, nor did we include analyses about the centrality with which they held their sexual and gender identities. Future research should consider not only the influence of participants' positionalities on access patterns, but the resulting experiences of power and oppression that differentiate their ability to access or not access LGBTQ-specific health services. Intersectional experience is particularly salient when considering the varied ways in which supply- and demand-side factors influence LGBTQ community members' access to LGBTQ-specific services. For example, this might include exploration of gendered racial disparities in care-seeker abilities related to health literacy, cultural values, housing security, and social capital, among other factors. Research should also center inquiry on the extent to which service providers are adapting outreach, accommodations, and costs to facilitate engagement among multiply-marginalized LGBTQ groups.

Our findings underscored the importance of community-level connectivity among our participants. Future research should investigate if and how social belonging, collective self-esteem, and LGBTQ community solidarity impact the health outcomes of people receiving care at LGBTQ-specific health services. Finally, future studies should seek to compare health outcomes between care-seekers who receive LGBTQ-specific services versus general health services. This might include longitudinal examination of the comparative effects of treatment within LGBTQ and general services across different LGBTQ segments as well as by race/ethnicity and gender. Such research would gather valuable data with the potential to inform policy efforts to expand funding for LGBTQ-specific health services, particularly in under-reached locations and for under-served populations.

### 5.2. Policy

It is important to acknowledge how structural disadvantage often precludes LGBTQ communities' participation in the health care system and that access to LGBTQ-specific services might attenuate these barriers. Many LGBTQ people avoid seeking health care in anticipation of discrimination (Fish et al., 2021; Romanellet al., 2018. The Patient Protection and Affordable Care Act (ACA) promotes LGBTQ communities' participation in the health care system through the establishment of protections which prohibit discrimination on the basis of race, color, national origin, disability, age, and sex (inclusive of gender identity, sex stereotyping, and termination of pregnancy) by health care providers (Baker, 2012; Baker & Krehely, 2011; Lewis, 2017). Protections for transgender people under the ACA have been under particular threat, with efforts by the Trump Administration to exclude gender identity from the definition of "sex." While it has been subject to continuous threat of repeal, the U.S. Supreme Court upheld the ACA in 2021, with the Biden Administration restoring transgender protections under the ACA. However, numerous U.S. state legislatures are proposing or passing bills that would limit the rights of transgender people to receive protections from discrimination specific to gender-affirming services. Furthermore, the formation of the Conscience and Religious Freedom Division in the U.S. Department of Health and Human Services endangers non-discrimination protections by shielding providers who refuse to treat certain population segments, including LGBTQ community members (Chavkin et al., 2018; Gostin, 2019; Raifman & Galea, 2018).

The cumulative effects of state and federal policy challenges to LGBTQ health care protections threaten to exacerbate LGBTQ health disparities as help-seekers may: 1) be exposed to extraneous discrimination; 2) forgo needed and essential care because they fear poor treatment, and; 3) be hesitant to openly discuss their care needs with providers due to diminished trust and safety (Gostin, 2019; Raifman & Galea, 2018). In addition, health disparities may increase based on an increased workload of providers willing to pick up the caseload of those who refuse care, leading to long waitlists for affirmative providers (Chavkin et al., 2018). LGBTQ-specific services may become overburdened with care-seekers seeking assured safety. Because of their limited resources and availability, it is essential that expanded funding become available to support current and establish new LGBTQ-specific health services.

### 5.3. Practice

Given the benefits of LGBTQ-specific services described by study participants, it is necessary to broaden their availability, including in rural locations that have fewer quality and inclusive health care options for LGBTQ people who have greater health disparities compared to urban and suburban LGBTQ people (Rosenkrantz et al., 2017). This expansion of services may be particularly important for multiply-marginalized members of the LGBTQ community, such as the two bisexual African American study participants who indicated that they did not know LGBTQ-specific health services even existed. Our research suggests a need for LGBTQ-specific services to make explicit efforts to enhance outreach and accessibility efforts, in particular, for transgender, bisexual, Black/African-American, and poverty-impacted LGBTQ communities (Romanelli & Hudson, 2017). Such outreach efforts might include initiatives to increase care-seekers' health literacy in light of our findings around misperceptions that LGBTQ-specific services are singularly focused on sexual health and unwilling to reduce barriers to payment.

As nearly a third of participants discussed community-level factors as informing their access to LGBTQ-specific health services, organizations might consider community-based interventions to facilitate greater awareness and utilization of their services. This might include partnering with local LGBTQ social establishments (e.g., book stores, coffee shops) to host events aimed at raising awareness of the available LGBTQ-specific services. Additionally, organizations might develop social media campaigns that both build awareness and generate referrals through various digital platforms. Finally, corresponding to the finding about participants perceiving LGBTQ-specific service access as part of a demonstration of community solidarity, there is an opportunity for LGBTQ-specific services to foster enhanced collaborations that support the initiatives of other organizations that serve the LGBTQ community's broader needs, such as related to housing, immigration, suicide prevention, or victim advocacy.

Based on participant accounts of experiences with provider-based stigma, even within LGBTQ-specific health services, there is a pressing need for mandatory organization-wide trainings and enhanced LGBTQ health-related curriculum in medical and nursing education, particularly related to transgender health needs (Goldhammer et al., 2018; Obedin-Maliver et al., 2011). Educational institutions should emphasize curricula that teaches students basic LGBTQ community terminology, appropriate clinical interview questions, and the importance of assessing and addressing one's own biases—which have been connected to providers' increased knowledge, ability, and willingness to provide care to LGBTQ care-seekers (Rutherford et al., 2012; Stroumsa et al., 2019). A

systematic review examining the effect of LGBTQ health care educational content and training on health care students and providers showed short-term improvements to their LGBTQ-specific health care knowledge and practice skills (Sekoni et al., 2017). In light of current educational shortcomings, it is essential that providers who seek to specialize in LGBTQ-specific care gain knowledge by proactively seeking out workshops with LGBTQ health-related content (Rutherford et al., 2012). Fostering a diverse and inclusive health care workforce and implementing a comprehensive response to eradicating barriers to accessing such care are crucial to providing all LGBTQ people with the best possible health care.

## Funding

## Ethics approval

New York University's Institutional Review Board (IRB) approved the study protocol (RB-FY2016-581, Health Reimagined: Making Meaning of Health in LGBT Communities). All procedures performed involving human participants were in accordance with the ethical standards of this review board.

## Consent to participate

Informed consent was obtained from all participants of the study.

## CRediT roles

**Sara Matsuzaka:** Formal analysis; Project administration; Validation; Visualization; Writing - original draft; Writing - review & editing. **Meghan Romanelli:** Data curation; Investigation; Project administration; Validation; Visualization; Writing - original draft; Writing - review & editing. **Kimberly D. Hudson:** Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Writing - review & editing.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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