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Factors that Impact Assigned Female Sexual Minority Individuals Health Care Experiences: A Qualitative Descriptive Study

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ABSTRACT

This qualitative descriptive study identified factors that impact assigned female at birth (AFAB) cisgender and non-binary 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 and 30 years of age in the Chicago metropolitan area. Three main themes emerged from data acquired through individual interviews: (1) "ask the right questions"; main themes (2) lack of trust in health professionals; (3) 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. Additionally, the results suggested that general and health sciences curricula should include content about diverse sexual and gender minority populations. Findings have important implications for health education and clinical practice.

KEYWORDS

AFAB health; sexuality education; sexual health; health science sexuality curricula; sexual minority; health care experiences

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.,

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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 (Gutmacher 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 & Wings-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2018).

Reasons AFAB sexual minority individuals avoid seeking health care are multifaceted. Many AFAB sexual minority individuals do not inform healthcare professionals of their sexual orientation due to fear of discrimination (Baldwin et al., 2017; Baptiste-Roberts et al., 2017; Corcoran, 2017; Jahn et al., 2019). Others do not participate in health screening due to the perception that healthcare 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 a sedentary lifestyle, increased body weight, and substance use (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 primarily affecting AFAB sexual minority individuals are understudied (Baptiste-Roberts et al., 2017; Corcoran, 2017; Everett, 2013). Overall, LGBTQIA + individuals lack equality and equity regarding 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 healthcare 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 design inspired by a grounded theory 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 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. The University of Missouri Institutional Review Board approved this study.

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 that 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) living, working, or attending school in the Chicago metropolitan area, (5) having 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. The consent form was entirely read verbatim to each participant to confirm their understanding of the study's nature, purpose, and rights as a participant. Participants knew they could refrain from answering and withdraw from the study at any time. After the interview, the participant received a one-time \$50 Amazon gift card via email or text. Each participant was interviewed once by the PI. All participants agreed to be contacted in the future to check the validity of the results. Interviews were scheduled at a time convenient to the participant using a password protected Zoom meeting link to maintain social distancing practices. The Zoom video recording was disabled during the interviews, and participants could 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 collect the participants' thoughts and feelings while

allowing the PI the flexibility to probe deeper and ask clarifying questions (De Jonckheere & 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. For the purposes of this manuscript and study the acronym LGBTQIA+ is being used because that was the acronym accepted by the participants and the community at the time as being most inclusive. 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 ensure they did not misgender them 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 LGBTQIA+ friendly. Participants received an anonymous link and completed the survey prior to the interview.

Data analysis

The PI analyzed the data 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, initial codes were generated while reading the transcripts and listening to the recording (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. Lastly, the report was written to include the story of 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. The tenth interview revealed no new information, and data collection ceased.

To establish the study's trustworthiness, 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. One participant, who agreed to review the findings through random member checking 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. Three individuals contacted the PI about the study during the second recruitment period in November 2020. 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 to 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 LGBTQIA + 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 1).

Themes

Through thematic analysis, three main themes emerged. The three themes that emerged were: (1) ask the right questions, (2) lack of trust in health care professionals, and (3) a need for better sexual health education

Ask the right questions (Theme 1)

All participants ($n = 10$) reported instances where healthcare professionals did not ask about gender identity, sexual orientation, or sexual behavior. All participants believed healthcare 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 safely 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

Table 1. Demographic data ($n = 10$).

Demographic variable	<i>n</i>	%
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
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	2	22
No	7	78
Has your primary health care provider or their staff ever asked about your sexual practices? $n = 9$		
Yes	8	88
No	1	11
Is your provider's office LGBTQ welcoming?		
Yes	10	100

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 healthcare 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 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 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 up 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 healthcare professional's part and allow an assessment based on actual 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 healthcare 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 healthcare 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 healthcare visits. This assumption led to the participants, or their partners, being misgendered during the exam.

Healthcare 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 healthcare 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.

Also, four participants noted healthcare professionals assumed their sexual behavior based on their stated sexual identity or the gender reported for their partner. None of the health care professionals considered 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 healthcare 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 healthcare 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 2)

Lack of trust in their health care professional was a common concern for many participants. The participants were all asked why they did or did not share their gender or sexuality with their healthcare 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 healthcare professional that they were a lesbian. Another bisexual woman 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 healthcare professionals. Some participants said the interactions affected how much they trusted their healthcare 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 would be 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 healthcare professional. This fear was not unfounded. Two participants reported a breach of confidence. After a health care appointment, the healthcare 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 healthcare 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 should 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 (Theme 3)

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 healthcare professionals. While most participants reported good relationships with their healthcare professionals and being satisfied with their interactions, they did not know how well their healthcare professional was meeting their sexual health needs. Many participants were unaware of what healthcare professionals should and should not be asking. One participant noted, when asked if healthcare professionals should ask about past partners, *"I don't know. I'm not well versed enough to know what is relevant to sexual health."*

Most 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. Participants searched the internet to learn more about diverse genders and sexualities 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 LGBTQIA+ 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 healthcare professionals needed additional education as well. Participants felt that healthcare professionals needed to be more educated on the needs of gender and sexual minority individuals, including assessing health risks more transparently and accurately manner, communicating using nongendered terms, and asking about pronouns, preferred names, and language for body parts. When asked what they thought healthcare 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 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 healthcare 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 healthcare professional because they did not know how the information would be received. If the healthcare 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 healthcare professionals but did not feel comfortable starting the conversation. Participants thought healthcare 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, such as a script or questions on the intake form, at health visits would normalize gender and sexual diversity. In addition, a standardized procedure might alleviate awkward situations and provide the healthcare 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 healthcare professional to provide gender and sexuality-affirming care in a confidential space that did not focus on their sexual orientation and gender identity (Corcoran, 2017; Mosack et al., 2013; Youatt et al., 2017). Individuals whose healthcare professionals provide an affirming environment reported greater trust and have been shown to be more open with their healthcare professionals about their gender, sexuality, and sexual behavior (Everett et al., 2019; Jahn et al., 2019; Johnson & Nemeth, 2014; Mosack et al., 2013; Youatt et al., 2017). The participants in this study who were open with their healthcare 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 healthcare professional and 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 & Wings-Yanez, 2014; Hobaica et al., 2019; Hobaica & Kwon, 2017; Rasberry et al., 2018). ; Heteronormative and gender normative education can lead to internalized homophobia, increased depression, increased anxiety, and self-loathing (Gowen & Wings-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 given about bisexuality and another who was homophobic when they went to college only to realize they were queer. Some 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 LGBTQIA+ 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 healthcare professionals provided about sexual health revolved around pregnancy prevention, with little information on preventing STIs (Jahn et al., 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 factors that impacted AFAB sexual minority individual's health care experiences could be avoided if healthcare 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 focus 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 et al., 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. Additionally, participants received an incentive for their participation in the study. This incentive may have influenced individuals to participate who might not have if there

was no incentive. 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 et al., 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 LGBTQIA + Q 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. They do not have to do this alone. There are several organizations in the United States that offer faculty and staff training on this topic. The National LGBTQIA + Health Education Center, run by the Fenway Institute, and Howard Brown Health in Chicago are two organizations that offer educational programs to healthcare providers and organization to optimize the quality-of-care LGBTQIA + receive. 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. Most 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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