Published in final edited form as:
Qual Health Res. 2022 January ; 32(1): 121–134. doi:10.1177/10497323211050051.

"Making a Way Out of No Way:" Understanding the Sexual and Reproductive Health Care Experiences of Transmasculine Young Adults of Color in the United States

Madina Agénor[1,2,3], **Dougie Zubizarreta**[4], **Sophia Geffen**[5], **Natasha Ramanayake**[6], **Shane Giraldo**[7], **Allison McGuirk**[8], **Mateo Caballero**[9], **Keosha Bond**[10]

[1]Department of Behavioral and Social Sciences, Brown University School of Public Health, Providence, RI, USA

[2]The Fenway Institute, Fenway Health, Boston, MA, USA

[3]Center for Health Promotion and Health Equity, Brown University School of Public Health, Providence, RI, USA

[4]Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, MA, USA

[5]Johns Hopkins University School of Nursing, Baltimore, MD, USA

[6]Department of Psychology, Suffolk University, Boston, MA, USA

[7]Department of Sociology, Simmons University, Boston, MA, USA

[8]Department of Counseling Psychology, University of Wisconsin at Madison, Madison, WI, USA

[9]Department of Communication Studies, Northeastern University, Boston, MA, USA

[10]Department of Community Health and Social Medicine, City University of New York School of Medicine, New York, NY, USA

Abstract

Research focusing on the specific and unique sexual and reproductive health care experiences of transmasculine young adults of color are extremely scarce. We conducted five focus group discussions with 19 Black, Latinx, Asian, Native, and other transmasculine individuals of color aged 18–25 years in the greater Boston area. Using thematic analysis, we found that transmasculine young adults of color experienced cissexism, heterosexism, and racism in accessing and utilizing sexual and reproductive health services. These multiple forms of discrimination undermined participants' receipt of high-quality sexual and reproductive health information and care from competent health care providers who shared their lived experiences. Participants relied on support from their lesbian, gay, bisexual, transgender, and queer peers to obtain needed sexual and reproductive health resources and minimize harm during clinical

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Corresponding Author: Madina Agenor, Department of Behavioral and Social Sciences, Brown University School of Public Health, Box G-S121-4, Providence 02912, USA. madina_agenor@brown.edu.

Supplemental Material
Supplemental material for this article is available online.

Declaration of Conflicting Interests
The authors declared no potential conflict of interest with respect to the research, authorship, and/or publication of this article.

encounters. Multilevel interventions are needed to promote access to person-centered and structurally competent sexual and reproductive health care among transmasculine young adults of color.

Keywords

transgender health; young adults; sexual and reproductive health; health care disparities; discrimination; cissexism; racism; heterosexism

Introduction

Research on the sexual and reproductive health of transmasculine people—especially transmasculine people of color, including but not limited to Black, Native, Latinx, and Asian individuals—is very limited (Agénor et al., 2021; Reisner & Murchison, 2016; Stephenson et al., 2017). Transmasculine people include transgender men (i.e., men who were assigned female at birth) and gender diverse (e.g., non-binary, gender fluid, gender non-conforming, and genderqueer) individuals who were assigned female at birth (AFAB) and identify with masculinity (Fenway Health, 2021; University of California San Francisco, 2020). The few studies focusing on the sexual and reproductive health of this marginalized and underserved population show that transmasculine individuals can experience unintended pregnancy (Hoffkling et al., 2017; Light et al., 2014, 2018; Obedin-Maliver & Makadon, 2016; Stark et al., 2019) and acquire HIV and other sexually transmitted infections (STIs; Clark et al., 2016; Reisner & Murchison, 2016; Stephenson et al., 2017) from sexual partners of various genders and sexual orientations (Bauer et al., 2012; Reisner et al., 2014; Scheim et al., 2017).

Additionally, research suggests that transmasculine individuals may face unique sexual and reproductive health challenges (Bauer et al., 2012; Reisner & Murchison, 2016; Stephenson et al., 2017). Indeed, as a result of pronounced social and economic marginalization stemming from cissexism (i.e., gender identity-related bias, prejudice, and discrimination toward transgender and gender diverse people) at both the structural and interpersonal level (James et al., 2016; Lombardi, 2009; White Hughto et al., 2015), transmasculine individuals experience high levels of participation in sex work and exposure to sexual violence (Bauer et al., 2012; Reisner & Murchison, 2016; Stephenson et al., 2017)—both of which have been linked to unintended pregnancy, HIV and other STIs, and cervical cancer (Bauer et al., 2012; Cipres et al., 2017; Coker et al., 2009; Spade, 2015).

Sexual and reproductive health care, including HIV and STI testing, cervical cancer screening, and contraceptive care, plays an important role in the prevention, detection, and treatment of various sexual and reproductive health outcomes (Keller & Sonfield, 2019). However, studies show that transmasculine people face pronounced barriers to sexual and reproductive health services, including high levels of poverty and unemployment, limited access to health insurance and a regular source of care, and a lack of health care providers and systems with expertise in transgender health (Agénor et al., 2021; Gonzales & Henning-Smith, 2017; James et al., 2016; Lombardi, 2001; Reisner & Murchison, 2016; Rollston, 2019; Stephenson et al., 2017). Other barriers include pervasive gender identity-related discrimination at the structural (e.g., laws, policies, norms, and practices) and interpersonal (e.g., patient-provider communication) level in the health care system, including health insurance, as well as in society more generally (Agénor et al., 2021; Gonzales & Henning-Smith, 2017; James et al., 2016; Lombardi, 2001; Reisner & Murchison, 2016; Rollston, 2019; Stephenson et al., 2017; White Hughto et al., 2015). These social, economic, and health care barriers may in turn lead to avoidance of or delayed care, a lack of health care provider recommendation of needed services, and mistrust of health care providers' recommendations among transmasculine individuals (Agénor et al., 2021; Gonzales & Henning-Smith, 2017; James et al., 2016; Kcomt et al., 2020; Lombardi, 2001; Rollston, 2019)—thus resulting in low levels of HIV and STI testing (Bauer et al., 2012; James et al., 2016; Scheim et al., 2016; Scheim & Travers, 2017), cervical cancer screening (Agénor et al., 2016; Peitzmeier et al., 2014; Rollston, 2019), and contraceptive care (Agénor et al., 2020 ; Gómez et al., 2020; Cipres et al., 2017; Stark et al., 2019) in this marginalized population.

With a few notable exceptions (Bauer et al., 2012; Scheim & Travers, 2017; Xavier et al., 2005), the limited research examining sexual and reproductive health care among transmasculine people has relied on samples of predominantly white individuals (Reisner & Murchison, 2016; Stephenson et al., 2017). However, intersectionality—an analytic tool rooted in Black feminist theory and practice (Collins, 2000; hooks, 1981; The Combahee River Collective, 1977)—underscores that multiply marginalized individuals' specific and unique lived experiences, including their health and health care experiences, are shaped by multiple intersecting social positions (e.g., race/ethnicity, gender identity, social class, and sexual orientation) and interdependent power relations (e.g., racism, (cis)sexism, classism, and heterosexism) rooted in past and present systems of oppression (e.g., white supremacy, patriarchy, capitalism, and colonialism) (Bowleg, 2012; Collins & Bilge, 2016; Crenshaw, 1989; Crenshaw, 1991; Davis, 1981; hooks, 1981; The Combahee River Collective, 1977).

Therefore, existing findings on transmasculine individuals' sexual and reproductive health care experiences may not reflect the unique needs, concerns, and preferences of Black, Latinx, Native, Asian, and other transmasculine people of color, who face specific barriers to sexual and reproductive health services as a result of not only cissexism but also racism (TM Health Justice: LA, 2021; Williams et al., 2019). Further, although young adults are at disproportionately elevated risk of HIV and STIs and unintended pregnancy (Centers for Disease Control and Prevention, 2016), no study of which we are aware has specifically examined sexual health care among transmasculine young adults in particular, and only a few have focused on reproductive health care among transmasculine people in this age group (Agénor et al., 2020; Gómez et al., 2020). Thus, to address these notable gaps in the scientific literature, we designed a qualitative research study exploring Black, Latinx, Native, Asian, and other transmasculine young adults of color's experiences accessing and utilizing sexual and reproductive health services, including HIV and STI testing, cervical cancer screening, and contraceptive care, using focus group discussions.

Methods

Participant Recruitment

Guided by a purposive sampling strategy (Marshall, 1996; Maxwell, 2005; Patton, 2002), we recruited individuals who self-identified as a person of color, including but not limited to Black, Latinx, Native, and/or Asian; were assigned female at birth (AFAB); self-identified as transmasculine, including but not limited to a transgender man or a masculine gender diverse (e.g., non-binary and gender fluid) person; were between 18 and 25 years of age; and resided in the greater Boston area. Using maximum variation sampling (Marshall, 1996; Maxwell, 2005; Patton, 2002), we recruited participants from diverse gender identity and racial/ ethnic backgrounds in order to capture the perspectives and experiences of a broad range of transmasculine young adults of color. We recruited participants between October 2018 and May 2019 by sharing study flyers with community-based organizations, community health centers, college student groups, email listservs, and Facebook groups that serve transmasculine young adults of color in the greater Boston area.

Additionally, participants were asked to disseminate the study flyer to individuals in their social networks who may be eligible for and interested in the study using a chain referral sampling strategy. Further, we shared information about our study with our personal and professional networks, who then shared this information with transmasculine individuals who may be interested in participating (Ellard-Gray et al., 2015; Marshall, 1996; Maxwell, 2005; Patton, 2002; Sadler et al., 2010). Lastly, drawing on the principles of community-based participatory research, we also convened and collaborated with a Youth Community Advisory Board (YCAB) composed of three transmasculine young adults of color who helped us identify potential recruitment sites and partners and disseminated the study flyer within their peer social networks (Israel et al., 2013; Newman et al., 2011; Sadler et al., 2010). Potential study participants were screened for eligibility using a demographic questionnaire.

Data Collection

We conducted mini focus group discussions ($N = 5$) with 3 to 5 transmasculine young adults of color each ($n = 19$) to elicit detailed and nuanced information on their sexual and reproductive health care experiences and their multilevel social determinants (Krueger, 2015). We chose to conduct mini focus groups to allow members of this multiply marginalized population—whose needs, concerns, and experiences are often ignored—ample time to share their perspectives on a variety of sensitive topics, which are often more easily discussed in smaller groups that facilitate rapport and comfort (Krueger, 2015). All focus group participants provided written informed consent at the start of each group.

Focus groups were conducted between February and May 2019 in Boston, MA using a semi-structured focus group discussion guide (Krueger, 2015). The discussion guide included open-ended questions and probes pertaining to the following topics: sources of sexual and reproductive health information, sexual and reproductive health beliefs and risk perceptions, and sexual and reproductive health care attitudes, needs, preferences, and experiences. Focus group discussion guide questions included: “Tell me about a time when your transmasculine status, race/ethnicity, or other aspects of your identity affected your health care," "Tell me about your experience discussing HIV and STIs with health care providers since identifying as transmasculine," and "Tell me about your experience getting tested for HIV and STIs since identifying as transmasculine." The guide was informed by the scientific literature on sexual and reproductive health among transmasculine individuals and reviewed by members of the YCAB, who provided oral and written input and feedback from their perspectives. The guide was also reviewed by members of a sexual orientation and gender identity and expression (SOGIE) health equity research working group, which includes experts in transgender health, lesbian, gay, bisexual, transgender, and queer (LGBTQ; Fenway Health, 2021) adolescent and young adult health, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) sexual and reproductive health.

All focus groups were conducted in person by LGBTQ people of color at a transgender-inclusive social justice organization, LGBTQ youth community-based organization, or LGBTQ community health center, which helped facilitate participant comfort and promote group rapport and discussion. Focus groups were conducted in English and audio-recorded. Focus groups lasted between 93 and 111 minutes (mean: 99 minutes). At the end of each focus group, participants completed a brief demographic survey to help contextualize qualitative research findings. Participants received a $45 gift card for their time. All research activities were approved by the Social, Behaviora, and Educational Research Institutional Review Board at Tufts University.

Data Analysis

Audio-recordings of the focus groups were transcribed verbatim by a professional transcription company and entered into Dedoose (version 8.3.19, Manhattan Beach, CA) for analysis. Focus group transcripts were analyzed using a template style approach to thematic analysis that involved both deductive and inductive coding using a codebook (Crabtree & Miller, 1992, 1999; King, 2018). Data analysis began with immersion in the data, followed by codebook development and refinement. The codebook was developed collaboratively among research team members and included both deductive codes based on the scientific literature and focus group discussion guide and inductive codes based on the focus group transcripts. Two independent coders each applied the codebook to two focus group transcripts to test its fit to the data. Codes were then merged, refined, and discarded, and the revised codebook was applied independently by each coder to all five transcripts. Coding discrepancies were discussed and resolved by consensus, and the codebook was further refined and reapplied to the data based on ongoing research team discussions (Crabtree & Miller, 1992, 1999; Deterding & Waters, 2018; Fereday & Muir-Cochrane, 2006; King, 2018; MacQueen et al., 1998).

For the present manuscript, coded text fragments pertaining to participants' sexual and reproductive health care experiences were clustered into themes and sub-themes (Bradley et al., 2018; Deterding & Waters, 2018; Fereday & Muir-Cochrane, 2006; King, 2018; Vaismoradi & Snelgrove, 2019). Relevant quotes were organized according to the theme(s) and sub-theme(s) to which they pertained using a data analysis matrix, which allowed for further refinement and comparison across and within focus groups and participants by gender identity and race/ethnicity (Miles et al., 2014). Memo writing and regular research team meetings were also used to facilitate the identification and refinement of themes and sub-themes (Birks et al., 2008). Focus group transcripts were then reviewed to ensure that all relevant coded excerpts were included in the analysis, study findings accurately represented the data, and all relevant themes had been identified (Braun & Clarke, 2006).

Results

Participant Demographic Characteristics

Study participants ranged in age from 18 to 25 years, with a mean age of 22 years. Most participants identified as non-binary (37%; $n = 7$) in terms of gender identity, queer (42%; $n = 8$) in terms of sexual orientation identity, and Black (58%; $n = 11$) in terms of race/ethnicity. Further, most participants were working full-time (47%; $n = 9$), and the majority had some college education or more (84%; $n = 16$) and were enrolled in a private health insurance plan (63%; $n = 12$). Additionally, the majority of participants received care at a community health center (63%; $n = 12$) and from a Nurse Practitioner or Registered Nurse (74%; $n = 14$; Supplementary Table).

Theme 1. Cissexism-, Heterosexism-, and Racism-Related Barriers to Accessing Sexual and Reproductive Health Care

Transmasculine young adults of color faced notable barriers to accessing sexual and reproductive health care related to not only cissexism but also heterosexism (i.e., sexual orientation-related bias, prejudice, and discrimination towards LGBQ and other sexual minority individuals) and racism. These barriers included the labeling of sexual and reproductive health care as “women’s health care,” which undermined and negated participants’ experiences as transmasculine individuals, and fears and prior experiences of gender identity, sexual orientation, and racial discrimination. Lastly, transmasculine young adults also reported facing a lack of availability of and access to affirming and knowledgeable sexual and reproductive health care providers who shared their lived experiences at the intersection of gender identity and cissexism, sexual orientation and heterosexism, and race/ethnicity and racism.

Sexual and Reproductive Health Care Labeled as “Women’s Health Care” for (Presumed) Cisgender, Heterosexual Patients—Several participants in our study described being deterred from accessing sexual and reproductive health care, especially gynecological care, because of its narrow focus on pregnancy, use of the term “women’s health” to describe reproductive health, and a lack of sensitivity towards the needs of patients from diverse gender identity and sexual orientation backgrounds and attention to transgender-specific concerns (e.g., testosterone use). For example, referring to gynecologists and explaining why they were reluctant to seek gynecological care, a Black, Native, and multiracial agender individual stated: “Because they think about pregnancy. And I’m like, ‘There’s no way I’m getting pregnant at all.’ And just not thinking [about] the possibility that your clients are not straight.” Moreover, gynecologists’ lack of knowledge in transgender health and the need for transmasculine patients to then educate providers on their sexual and reproductive health needs and concerns was also a deterrent to seeking gynecological care for some participants. For example, a Latinx transgender man noted: "I've never been to the ob/gyn. And the reason I haven't gone at all is because I'm very afraid of it being awkward and having to explain things or what T [testosterone] does."

Similarly, gynecology's focus on genitals gendered as female by the health care system in particular and society in general led several participants to avoid gynecological care altogether due to fears and past experiences of gender dysphoria. For example, an Asian non-binary participant noted: "This is why I haven't gone to a gynecologist. Because I don't want to […] think about genitals because genitals are gender. And that's kind of the crux of it. And if you're going to gynecology, you're there for your genitals, you know?" Similarly, a Black gender non-conforming participant stated: "For a long time having to talk to my doctor about sexual health stuff always gave me violently bad dysphoria. That's probably the reason why I still refuse to see a gynecologist. Because just the thought of it gives me violent dysphoria." In contrast, a Filipino transgender man recommended: "In an ideal world, we just would not have gendered doctors [or] services that are 'only women go there' or 'men go there,' but these are the services that are provided and this is what you get when you come here."

Fears and Prior Experiences of Cissexism and Racism in Sexual and Reproductive Health Care Settings—Several participants described delaying or avoiding gynecological care as a result of fears and prior experiences of cissexism and racism in sexual and reproductive health care settings. For example, a Black, white, and multiracial demi-girl participant explained: "The worst part is just not knowing if they're going to regard me the right way. Like acknowledge me how I want to be acknowledged. Whether it's my pronouns and my name or just the way they're looking at me or are asking questions. That's always something I have to worry about and anticipate or prepare myself for. […] It's usually not to the extent of feeling mocked or ridiculed but sometimes it is, and I just kind of have to prepare myself for like, 'Oh these people are judging me when I walk in the door.'" Moreover, referring to experiencing cissexism in the particularly vulnerable context of gynecological care, an Asian non-binary participant noted: "She would misgender me every time I went in for surgery stuff or like check-up stuff. And I never felt comfortable correcting her because I was always half naked with my foot in the stirrups."

Further, similarly to a few other participants, a Black and Latinx non-binary participant described encountering racist stereotypes and assumptions while seeking sexual and reproductive health care at a LGBTQ health clinic, which in turn led them to avoid seeking further care: "When I think about those interactions that I've had, particularly at places where people have recommended. […] And you go to those places […], and it's always something to imply that I'm hypersexual, that I'm a drug addict, or anything like that. That can only be my race…especially in LGBTQ center places. And I think that's the other thing. Because the space is so specifically centered on LGBTQ health, I think that's where that level of disappointment really came in." Moreover, a white, Black, and Latinx non-binary participant described discontinuing their care as a result of prior and fears of future experiences of racism at the facility: "I didn't want to go back to them because it was very obvious how they thought of me. And they probably wouldn't have treated me the same as they treated the other people that were going there because the place that this happened

[…] in was not diverse so I just knew how they thought of people who were Black and brown. So I was just like, 'I just don't want to go to you guys anymore.'"

Lack of Access to Affirming and Knowledgeable Sexual and Reproductive Health Care Providers With Shared Lived Experiences—Overall, study participants preferred receiving sexual and reproductive health care from affirming providers who were not only knowledgeable about transgender health but also shared their lived experiences in relation to gender identity and cissexism, sexual orientation and heterosexism, and/or race/ethnicity and racism. However, most transmasculine young adults of color in our study reported experiencing notable challenges to identifying trans-competent and -identified sexual and reproductive health care providers. For example, a Black agender participant explained: "I'm very particular about who I see. […] On my time off, I would go on the website and look up who seems to be trans-friendly. And that's how I found a [reproductive health organization] […] that had a very trans-friendly nurse practitioner that put in my implant 4 years ago." They continued: "I have to be very meticulous and very careful of who I choose because I have anxiety around medical professionals. And I don't want that to be fueled even more when I have to educate someone, you know?" Further, referring to receiving care at a LGBTQ health clinic, a Black, Latinx, and white non-binary participant noted: "The doctors, they know about trans stuff, but most of them aren't trans. But when I go to other people [providers at LGBTQ youth community-based organization], they are trans, so they have been through it before and know different ways of getting through it."

Although most transmasculine young adults of color expressed a preference for health care providers who shared their lived experiences, a few participants described how obtaining sexual and reproductive health care from a provider with similar marginalized social positions did not guarantee affirming, person-centered care. For example, a Black and Latinx non-binary participant explained: "Even when I think about my doctor of color, who I specifically chose because she was a doctor of color. […] And you know, I show up here, and she's trying to give me an IUD (intrauterine device). […] And in the same procedure to then be asked several times, 'Well, are you sure you're not pregnant?' It's really one of those things where I was like, 'That's not my queerness. That's not my gender. That is 100% my race. And your assumptions about people who look like me.'" Moreover, a Black, Native, and multiracial agender participant stated: "They were like, 'do you have protective sex?' And I'm like, 'No.' […] And one of the questions they didn't ask was, was I queer. And the doctor was queer. […] And they were like, 'Well, we have to talk to you about not using protection during sex.' And I'm like, 'I'm gay.' […] 'There's no way I'm getting pregnant at all.' And they were like, 'Oh.' […] They were not thinking [about] the possibility that [their] clients are not straight."

Theme 2. Experiences of Cissexism, Heterosexism, and Racism During Sexual and Reproductive Health Clinical Encounters

Participants also described experiencing cissexism, heterosexism, and racism—which were overlapping and mutually constitutive and undermined high-quality patient-provider communication and the receipt of relevant sexual and reproductive health services—in the context of HIV/STI and pregnancy risk assessment and testing during sexual and reproductive health clinical encounters.

Cissexism—Most participants discussed how, during sexual risk assessments, health care providers often incorrectly assumed that they were not at risk of acquiring HIV and STIs and therefore did not need HIV or STI testing based on their female sex assigned at birth. For example, a Black non-binary person noted: “Mostly people don’t really think about HIV and assigned female-at-birth people in general. And so, usually, if they think of people who contract HIV, they’ll think of men who have sex with men, and they’ll think of transgender women. But they don’t really think about, for example, cisgender women or trans men.” Moreover, a Black agender participant observed: “I think the fact that no one has ever talked to me about HIV is kind of just an indicator. I get the feeling sometimes that when I go talk to someone who’s not experienced, that they don’t really…they’re not grouping me with men who like men. And so, then, it just doesn’t occur to them [to test me for HIV] even though I have been in relationships with cis [gender] men who like men in the past. So they’re at risk, which puts me at risk. But it’s like, ‘Oh, but you’re not…’”

Further, a few participants described how health care providers made cisnormative (i.e., based on the belief that all people are cisgender) assumptions about their body parts based on their female sex assigned at birth, which in turn led to a “one size fits all” pregnancy risk assessment and inappropriate reproductive health information and care. For example, a Black, Latinx, and white non-binary participant explained: “They just don’t realize that there’s so many different types of trans bodies, and they really haven’t done their research into that. Because there’s AFAB people who have had hysterectomies, or they’re on birth control, or they’re trans. And then there’s AMAB [assigned male at birth] people who had their testicles taken off or they had bottom surgery. And they just never really think about the difference in risk assessments there.”

In contrast, several participants recommended that, during sexual and reproductive health risk assessments, health care providers avoid making assumptions by asking participants directly about their own and their sexual partners’ body parts and using degendered or gender-affirming, person-centered language. For example, a Black agender participant noted: “She would be like, ‘Have you slept with someone with a penis lately?’ And I was like, ‘No.’ And she’s like, ‘Okay, have you slept with people who have vaginas lately?’ And I was like, ‘Yeah,’ and I was like, ‘Thank you so much.’ And she made that entire procedure more bearable when she asked those questions so degendered.” Similarly, an Asian non-binary participant mentioned: “I actually had a really good conversation with my PCP recently about Pap smears […] and she asked, ‘Do you have specific names for parts of your body that you would like me to use?’ Which was really pleasantly surprising.”

Heterosexism

Patient-Provider Communication.: Additionally, many participants described that, in conjunction with cissexism, they also experienced heterosexism during encounters with health care providers in the context of sexual and reproductive health care. In particular, several participants reported that health care providers often assumed that they were not at risk of acquiring STIs because their sexual partners were cisgender women or transgender or non-binary AFAB individuals, which in turn curtailed meaningful patient-provider communication about sexual risk. For example, with regard to patient-provider STI communication, an Asian transmasculine individual observed: “It’s very limited. And there’s no conversation about protection. Because I think they’re like, ‘Oh, your risk factors [are] low.’ And there’s no conversation about anything about risk or anything beyond that. They find out [my partner is] a cis[gender] woman, and they’re like, ‘Oh, you’re fine.’” Similarly, an Asian non-binary participant noted: “They [HIV/AIDS organization] give out free hormone injection supplies, and they do a risk assessment in order for you to get the supplies. And they’re like, ‘have you had vaginal or anal sex in the past year?’ And I said, ‘with like a body part, or a toy or what?’ And they said, ‘someone with a penis,’ and I said, ‘no.’ And they said, ‘okay the sexual part of the risk assessment is done, moving on.’”

A few participants with transgender women sexual partners also explained how patient-provider communication about pregnancy and HIV and STI risk was undermined by providers’ conflation of their sexual partners’ assigned sex at birth, gender identity, and sexual anatomy. For example, a Black gender non-conforming participant with cisgender and transgender women sexual partners discussed how providers made incorrect assumptions about the sex of their sexual partners (i.e., AFAB and AMAB)— and, in turn, their sexual risk—based on their gender identity (i.e., women): “I’m like, ‘I’m attracted to women.’ And they’re like, ‘Oh, so AFAB people?’ I’m like, ‘Women.’ And they’re like, ‘AFAB people.’ I’m like, ‘Women.’ It was so frustrating. I literally just didn’t go back. […] Because I felt so uncomfortable that I had to explain to this doctor three times that me saying that I was attracted to women didn’t mean that I was only having sex with AFAB people.” Moreover, a few participants also noted how providers made erroneous assumptions about their sexual partners’ sexual anatomy by relying solely on their assigned sex at birth for this information, which in turn led to inaccurate assessments of their sexual and reproductive health risk. For example, a Latinx and Native transmasculine participant explained: “I put down that I had had sex with someone who is AMAB, and I was like, ‘But I know I’m not pregnant.’ She was like ‘Why?’ I was like ‘Well, that person had gotten her testicles removed, so she wasn’t a sperm producing person.’”

Sexual and Reproductive Health Services Receipt.: Several transmasculine young adults of color with AFAB sexual partners discussed how health care providers made erroneous assumptions about their need for various sexual and reproductive health services based on the sex of their sexual partners. Of note, participants described how health care providers perceived them to be at low risk of acquiring HIV and STIs because they had AFAB sexual partners, which in turn undermined their ability to obtain a HIV or STI test. For example, a Black gender non-conforming person noted: “I feel like my doctors have all told me that I don’t need [HIVand STI testing] because of my sexual orientation. Especially as an AFAB person who’s attracted to other AFAB people. They were like, ‘Oh, so you don’t need it.’” Similarly, a Black, Latinx, and white non-binary individual mentioned: “My PCP [primary care provider] has asked, ‘what are your partners?’ AFAB, AMAB, stuff like that. But I feel like one thing is when I say both my partners are AFAB, they don’t really technically think I need to get tested [for HIV and STIs].” In contrast, a few participants mentioned how health care providers wrongly assumed that they could be pregnant and therefore needed to take a pregnancy test, even though they only had AFAB sexual partners. An Asian/Pacific Islander non-binary participant described: “I’ve had weird experiences when I go to the ER [emergency room], where they make you take pregnancy tests for certain reasons. And I’m like, ‘I’m literally not pregnant because I have a long term, AFAB partner. There’s no way I could be pregnant.’ And they’re like, you can’t get this done if you don’t take the pregnancy test.”

As a result, several participants with AFAB sexual partners mentioned having to advocate for themselves to receive the sexual and reproductive health care they needed. For example, an Asian non-binary participant with AFAB sexual partners stated: “I just want to get tested because a lot of people I’ve slept with have slept with men, cis men. But […] I’ve only ever gotten tested because I’m like, ‘Hey can you test me?’ And then they’re like, ‘Oh, well, your risk factors are low,’ and I’m like, ‘Yeah. Can you still test me?’” In contrast, some participants noted that they actively searched for health care providers who were knowledgeable about LGBTQ sexual and reproductive health so that they could easily receive the services they needed. A Latinx transgender man noted: “I got lucky that any doctor I’ve went to so far, because I scoped them out, they will automatically ask me, ‘Do you want to get HIV testing?’ Even if I mentioned, ‘All my partners are assigned female at birth,’ they’ll be like, ‘Do you want to get tested?’ Because my particular doctor understands that anyone can get an STI, so I’m lucky for that.”

Racism—Several transmasculine young adults of color, especially Black participants, discussed how racism undermined their access to high-quality sexual and reproductive health information and care. For example, a Black, white, and multiracial demi-girl individual noted: “It seems that only people of color and LGBT people and LGBT people of color are the ones getting STDs. But we’re the ones not getting the right care. We’re the ones that aren’t having the best access to treatment or to knowledge.” Moreover, a few participants noted how racist assumptions that Black people, especially dark-skinned Black individuals and Black AFAB people, were hypersexual undermined the sexual health care that Black transmasculine people received. For example, a Black gender non-conforming participant noted: “I am lucky that, as a light-skinned Black person, I don’t deal as much with hypersexualization in health spaces. But I think that Black, especially Black transgender people, should be able to go into a health space and be able to ask for sexual health services and testing without, ‘Oh, so you’ve been [having sex].’ That always seems to happen.”

Of note, several participants situated the influence of racism on transmasculine young adults of color’s sexual and reproductive health care experiences in historical context. For example, a Black non-binary participant explained: “I can understand the history of why a lot of people don’t trust health care providers, especially people of color and especially women of color. Because doctors and health care providers haven’t always had the interest of people of color in their sights. It’s always an afterthought for them. Or it’s actively racist policies. Like when people think they’re getting vaccines, and they’re actually being sterilized. Or using a woman of color’s body without consent for medical science.” In contrast, participants recommended that health care providers receive critical training in recognizing and addressing racism in sexual and reproductive health care. For example, an Arab and multiracial non-binary participant suggested: “It’s critical teaching physicians about the racialized history of STI stigma and research. There’s the Tuskegee trials and all these [awful things] that doctors don’t know about. […] And so, trying to mitigate that by actually giving explicit and race critical and gender critical education to physicians.” Further, a Black gender non-conforming participant recommended: “I think that people should be trained to not assume that [Black people are hypersexual]. Or at least have critical thinking skills and know not to do that. That’s a big ask because not everyone has critical thinking skills, but at least to make that part of the training to disassociate racial biases from sexual health treatment.”

Theme 3. Social Support from LGBTQ Peers Facilitates Sexual and Reproductive Health Information and Care

Participants relied on social support from their LGBTQ peers, including in-person and online communities, friends, and romantic partners, to navigate their access to and utilization of sexual and reproductive health resources. In particular, LGBTQ peers helped facilitate access to appropriate and affirming sexual and reproductive health information and services and mitigate violations to bodily autonomy in the context of sexual and reproductive health care among transmasculine young adults of color.

Support for Accessing Sexual and Reproductive Health Information and Care—Several participants discussed relying on their LGBTQ peers for instrumental support in the context of sexual and reproductive health, including relevant sexual and reproductive health information that addresses their needs, concerns, and lived experiences. For example, an Asian non-binary individual noted: “I feel like the queer community at large, at least the ones that I’ve been a part of, are very vocal about the importance of [STI testing]. And that’s primarily where my education’s come from, from the community, not from a doctor, not from online, regarding STIs.” They continued: “I mean, for a lot of queer and trans people, it’s like, if we don’t protect each other, who will?” Similarly, a Latinx transgender individual observed: “And then, I also found out [about HIV and STIs] through a squad…so I was lucky to grow up in New York City and have a squad of homies who knew about STIs and stuff.” Further, referring to a community-based organization led by and for LGBTQ young people, which they described as their primary source of sexual and reproductive health information, a Black non-binary participant explained: “We learn about STIs at [LGBTQ youth community-based organization] and how to best use protection and what to do when you contract an STI and how to handle it, how to talk to partners.”

Moreover, a few participants also described relying on their LGBTQ peers, either in person or online, for referrals to accessible and trans-competent sexual and reproductive health care providers and services. For example, an Asian non-binary participant mentioned: “I think I found the health care providers through word-of-mouth and also Facebook groups like Queer Exchange Boston.” Similarly, a white, Black, and multiracial non-binary person noted: “And like a lot of people…I was in Philly…I guess it’s Queer Exchange Philly. Yeah…It was great. I was so happy that they still existed. Like, everyone posted about it [HIV and STI testing]. So I knew that it was free, and that it would be easy.” Further, a

Black transgender man explained: “As far as the trans community that I’m involved with, I think testing has been pretty talked about. Like a lot of the LGBTQ groups that I’m either in on Facebook or gone to a social, there’s always something about testing. I feel like it’s become a bigger thing now, which is good.”

Support During Sexual and Reproductive Health Clinical Encounters—Several participants described how their friends and partners helped mitigate violations to their bodily autonomy during sexual and reproductive health care encounters, especially contraceptive care visits, by engaging in advocacy on their behalf, providing reassurance and comfort, and facilitating self-advocacy. For example, a Black, Latinx, and white non-binary individual explained how their partner advocated for them during an emergency medical visit: “The same thing happened with my IUD [intrauterine device]. They didn’t believe that I had one, and I was just passing out. My partner had to come with me again at that point, and they had to explain my body to the doctor because the doctor just did not understand what was going on. They were just like, ‘I don’t know how you got an IUD.’ […] So, it took almost 2 hours after my first initial pass-out to them actually taking it out.” Similarly, a Black and Latinx non-binary participant noted: “Having someone in the room while my doctor tried to force an IUD on me, that was great for me because it just made me realize that I didn’t dissociate and hallucinate the whole experience.” Lastly, a Black, Native, and multiracial non-binary participant recommended: “People act better when they know people are watching them. And so I tell people, ask your friends to go with you to the doctor. If you’re comfortable enough, having someone there with you gives you that confidence to stand up for what you know you need.”

Discussion

Guided by intersectionality, which focuses on the lived experiences of multiply marginalized groups and underscores that individuals’ lived experiences are shaped by multiple intersecting social positions (e.g., gender identity, sexual orientation, and race/ethnicity) linked to interdependent power relations (e.g., cissexism, heterosexism, and racism) that are rooted in past and present systems of oppression (e.g., white supremacy, patriarchy, capitalism, and colonialism; Bowleg, 2012; Collins & Bilge, 2016; Crenshaw, 1989; Crenshaw, 1991; Davis, 1981; hooks, 1981; The Combahee River Collective, 1977), the present study builds on the existing scientific literature in several important ways. First, our research findings build on those of the few other (quantitative) studies that have examined sexual and reproductive health services use among transmasculine people of color (Bauer et al., 2012; Scheim & Travers, 2017; Xavier et al., 2005) by providing nuanced and in-depth information on the complex ways in which cissexism, heterosexism, and racism simultaneously shape not only HIV testing but also STI testing, cervical cancer screening, and contraceptive care in this multiply marginalized population. Additionally, our study results extend those of prior qualitative and mixed-methods research studies examining the sexual and reproductive health care experiences of predominately white transmasculine individuals by focusing on the unique and specific experiences of transmasculine young adults of color at the intersection of cissexism, heterosexism, and racism.

Indeed, similar to prior qualitative and mixed-methods research studies conducted among predominantly white transmasculine people (Agénor et al., 2020; Harb et al., 2019; Peitzmeier et al., 2017), cissexism and heterosexism played a critically important role in undermining access to and utilization of sexual and reproductive health care among transmasculine young adults of color. Specifically, our findings indicate that the labeling of sexual and reproductive health care as "women's health care" for (presumed) cisgender, heterosexual patients deterred transmasculine young adults of color from seeking the services they need. Further, we also found that the lack of availability of and access to not only gender-affirming but also transgender-identified sexual and reproductive health care providers also undermined sexual and reproductive health care access and utilization among participants (Agénor et al., 2020; Harb et al., 2019; Peitzmeier et al., 2017).

Second, similarly to the results of prior research (Agénor et al., 2016, 2020; Reisner et al., 2010), we also found that cisnormative and heteronormative health care provider assumptions (namely, that all people are or should be cisgender and heterosexual and that only sex between cisgender and heterosexual individuals "counts" as "real" sex) negatively impacted their receipt of relevant sexual and reproductive health information and services during clinical encounters. Lastly, as other qualitative and mixed-methods research studies conducted among predominately white samples have described (Harb et al., 2019; Seelman & Poteat, 2020), we also found that many participants preferred receiving sexual and reproductive health information and services in community-based settings that explicitly affirmed and centered the lived experiences of transgender and gender diverse individuals and actively used a range of resistance strategies, including LGBTQ peer support, to receive the resources they need and mitigate harm.

Moreover, our study results show that, in addition to cissexism and heterosexism, racism also negatively impacts access to and receipt of relevant, high-quality sexual and reproductive health information and care among transmasculine young adults of color, especially Black transmasculine young adults. Of note, several Black participants reported not receiving person-centered care and avoiding care altogether as a result of racist stereotypes (e.g., hypersexuality), assumptions (e.g., multiple sexual partners), and treatment (e.g., contraceptive coercion) by sexual and reproductive health care providers, including at LGBTQ health clinics. These experiences are linked to the long history of racism in medicine, including gynecology, and reproductive abuse and coercion targeting Black cisgender women and other AFAB individuals since slavery and to this day (Roberts, 1998; Washington, 2008). Indeed, through the institution of slavery and past and present government programs and medical practices, Black cisgender women and other AFAB people have been subjected to medical experimentation, abuse, control, and coercion that have and continue to undermine their reproductive capacity, bodily autonomy, and self-determination (Gómez & Wapman, 2017; Prather et al., 2016, 2018; Roberts, 1998; Washington, 2008). However, our results show that, despite experiencing cissexism, heterosexism, and racism in accessing and utilizing sexual and reproductive health care, transmasculine young adults of color exercise agency and practice resistance through a range of strategies, including seeking support from LGBTQ peers to obtain the care they need and minimize harm.

Our findings should be interpreted in the context of several limitations. First, our sample primarily consisted of individuals who had received at least some college education and were enrolled in a private health plan; thus, findings may not reflect the experiences of transgender and non-binary AFAB people with less than a college-level education or those enrolled in a public health plan or lacking health insurance. Second, focus groups took place in the greater Boston area, thus findings may not be transferable to those who live in geographic areas with other social, political, and health policy climates. Third, focus groups were not stratified by race/ethnicity or gender identity, so findings may have masked differences among racial/ethnic and gender identity subgroups of transmasculine young adults of color. Therefore, additional research focusing on the unique sexual and reproductive health care experiences, needs, and preferences of specific racial/ethnic and gender identity subgroups of transmasculine young adults of color (e.g., Black transgender men and Latinx non-binary AFAB people) is needed.

Despite these limitations, our findings have important implications for promoting access to high-quality sexual and reproductive health care among transmasculine young adults of color. First, medical, nursing, and other clinical education programs should train sexual and reproductive health care providers in the provision of person-centered and structurally competent care that acknowledges and addresses the historical and ongoing joint effect of cissexism, heterosexism, and racism on access to and utilization of sexual and reproductive health care among transmasculine people of color and other marginalized populations (Downey & Gómez, 2018; Epstein et al., 2010; Metzl & Hansen, 2014). Alongside curricular efforts, hiring, supporting, and retaining health care providers and staff who share the lived experiences of transmasculine young adults of color at the intersection of gender identity and cissexism, race/ethnicity and racism, and sexual orientation and heterosexism may also help facilitate the delivery of high-quality sexual and reproductive health information and care to this marginalized and underserved population (Howard et al., 2019).

Second, given many participants' preference for receiving sexual and reproductive health care in community-based settings that center their needs and lived experiences, community-based organizations that serve transmasculine young adults of color should receive the ongoing financial support and technical assistance they need to deliver high-quality sexual and reproductive health services and information, including educational materials created by and for transmasculine young adults of color (Harb et al., 2019; Howard et al., 2019; Seelman & Poteat, 2020). Moreover, the creation of new health care facilities that explicitly center the lived experiences, needs, and preferences of and facilitate access to person-centered and structurally competent sexual and reproductive health care to diverse groups of transgender and non-binary people, including young adults and Black, Native, Latinx, Asian, and other people of color, are also warranted (Harb et al., 2019; Howard et al., 2019; Seelman & Poteat, 2020).

Lastly, all health care facilities, including LGBTQ community health centers, should implement practices and initiatives at the patient, provider, staff, and organizational level that address interpersonal and institutional cissexism, racism, and heterosexism (DeMeester et al., 2016). These efforts may include revising the organizational structure so that it is more equitable, ensuring that clinical environments, practices, trainings, and materials are inclusive of the needs and lived experiences of transmasculine people of color, and providing a recourse for reporting (and accountability for addressing) experiences of multiple and interdependent forms of discrimination among marginalized patients, as well as providers and staff (DeMeester et al., 2016). Moreover, our findings suggest that health care facilities should provide patients with the option of having a person of their choice (e.g., friend and partner) present during their sexual and reproductive health care visits, which may help promote the delivery of person-centered care and mitigate violations of bodily autonomy (Seelman & Poteat, 2020). Health care organizations should also consider implementing patient navigator programs that hire and compensate people from diverse gender identity, sexual orientation, racial/ethnic, and age backgrounds to provide transmasculine young adults color and other marginalized populations with support during sexual and reproductive health clinical encounters (Ding et al., 2020).

In conclusion, our findings indicate that access to and utilization of sexual and reproductive health information and services among transmasculine young adults of color are simultaneously shaped by multiple interdependent and compounding forms of discrimination, including cissexism, heterosexism, and racism. Moreover, our study results suggest that, along with federal, state, and local laws, policies, rules, regulations, practices, and initiatives that mitigate cissexism, heterosexism, and racism in the health care system in particular and society in general, interventions at the provider and organizational level may help facilitate access to and use of person-centered and structurally competent sexual and reproductive health care among transmasculine young adults of color. Together, these multilevel efforts may facilitate sexual and reproductive health among transmasculine young adults of color and other social groups whose lived experiences are shaped by cissexism, heterosexism, and racism and, in turn, help promote sexual and reproductive health equity in the U.S. (National Academy of Medicine, 2020).

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

We are grateful to Jesse Najarro and Leanne Loo who served as notetakers during the focus groups. We also thank the Youth Community Advisory Board members for their thoughtful and insightful input throughout the research process. We are also grateful tothe focus group participants for their timeand expertise.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by a pilot grant (awarded to M Agénor) from grant R25MH087217, awarded by the National Institute of Mental Health to the Center for Interdisciplinary Research on AIDS at Yale University. The content of this article is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Biographies

Madina Agénor, ScD, MPH is an Assistant Professor in the Department of Behavioral and Social Sciences and the Center for Health Promotion and Health Equity at Brown

University School of Public Health. As a social epidemiologist, Dr. Agenoŕ investigates the structural and social determinants of sexual and reproductive health inequities in relation to intersecting social positions and systems of oppression–including race/ethnicity and racism, sexual orientation and heterosexism, and gender identity and cissexism–using a mixed-methods research approach. Dr. Agenoŕ ‘s current research focuses on understanding how state laws and policies, institutional and interpersonal discrimination in health care settings, and health care provider decision-making influence access to and utilization of preventive sexual and reproductive health services among marginalized U.S. populations.

Dougie Zubizarreta, BA is a Master of Science in Epidemiology candidate at the Harvard T.H. Chan School of Public Health. They are a social epidemiologist whose research focuses on structural and social determinants of health, quantitative and qualitative methods for intersectionality research, and sexual and reproductive health.

Sophia R. Geffen, MPH is a Master of Science in Nursing at Johns Hopkins University School of Nursing and Course Manager at the Center for Health Equity Education and Advocacy at Cambridge Health Alliance. She holds a Master of Public Health from Johns Hopkins University School of Public Health and a bachelor’s degree from Pomona College. Her research and practice interests pertain to health equity, mental and sexual health disparities, and LGBTQ adolescent health.

Natasha Ramanayake, PhD is a Psychology Postdoctoral Fellow at Cooper University Health Care. She holds a PhD in Clinical Psychology from Suffolk University and a B.A. in Psychology from Boston University. Her research interests pertain to mental health and sexual health among marginalized populations.

Shane Giraldo, BA is a graduate of the Sociology and Fine Arts programs at Simmons University and a former member of the Youth Community Advisory Board. They currently work at a technology company in Framingham, MA and consult on transgender health matters.

Allison McGuirk, BA is a Counseling Psychology doctoral student at the University of Wisconsin, Madison. Her research interests pertain to the intersection of sexual and reproductive health, queerness, and mental health.

Mateo Caballero, BA is a graduate of the College of Arts, Media, and Design at Northeastern University and a former member of the Youth Community Advisory Board. He currently works at Beth Israel Deaconess Medical Center.

Keosha T. Bond, EdD, MPH is an Assistant Medical Professor in the Department of Community Health and Social Medicine at the CUNY School of Medicine. Dr. Bond is a trained behavioral scientist and sexual health educator who has centered her work on the complex intersections of race, sexuality, social justice, and health equity among individuals of marginalized genders. Dr. Bond’s primary research interests have focused on understanding how socio-structural and cultural factors influence the transmission of HIV and the use of digital technology to develop culturally appropriate interventions to address these factors.

References

Agénor M, Cottrill AA, Kay E, Janiak E, Gordon AR, & Potter J. (2020). Contraceptive beliefs, decision making and care experiences among transmasculine young adults: A qualitative analysis. Perspectives on Sexual and Reproductive Health, 52(1), 7–14. 10.1363/psrh.12128 [PubMed: 31977155]

Agenor M, Murchison GR, Najarro J, Grimshaw A,´ Cottrill AA, Janiak E, Gordon AR, & Charlton BM (2021). Mapping the scientific literature on reproductive health among transgender and gender diverse people: Ascoping review. Sexual and Reproductive Health Matters, 29(1), 1886395. 10.1080/26410397.2021.1886395

Agénor M, Peitzmeier SM, Bernstein IM, McDowell M, Alizaga NM, Reisner SL, Pardee DJ, & Potter J. (2016). Perceptions of cervical cancer risk and screening among transmasculine individuals: Patient and provider perspectives. Culture, Health & Sexuality, 18(10), 1192–1206. 10.1080/13691058.2016.1177203

Bauer G, Travers R, Scanlon K, & Coleman T. (2012). High heterogeneity of HIV-related sexual risk among transgender people in Ontario, Canada: A province-wide respondent-driven sampling survey. BMC Public Health, 12. 10.1186/1471-2458-12-292

Birks M, Chapman Y, & Francis K. (2008). Memoing in qualitative research: Probing data and processes. Journal of Research in Nursing, 13(1), 68–75. 10.1177/1744987107081254

Bowleg L. (2012). The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. American Journal of Public Health, 102(7), 1267–1273. 10.2105/AJPH.2012.300750 [PubMed: 22594719]

Bradley EH, Curry LA, & Devers KJ (2018). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. Health Services Research, 42(4), 1758–1772. 10.1111/j.1475-6773.2006.00684.x

Braun V, & Clarke V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. 10.1191/1478088706qp063oa

Centers for Disease Control and Prevention. (2016). Sexual risk behaviors: HIV, STD, & teen pregnancy prevention. https://www.cdc.gov/healthyyouth/sexualbehaviors/

Cipres D, Seidman D, Cloniger C III, Nova C, O'Shea A, & Obedin-Maliver J. (2017). Contraceptive use and pregnancy intentions among transgender men presenting to a clinic for sex workers and their families in San Francisco. Contraception, 95(2), 186–189. 10.1016/j.contraception.2016.09.005 [PubMed: 27621044]

Clark H, Babu AS, Wiewel EW, Opoku J, & Crepaz N. (2016). Diagnosed HIV infection in transgender adults and adolescents: Results from the National HIV surveillance system, 2009–2014. AIDS and Behavior, 21(9), 2774–2783. 10.1007/s10461-016-1656-7

Coker AL, Hopenhayn C, DeSimone CP, Bush HM, & Crofford L. (2009). Violence against women raises risk of cervical cancer. Journal of Women's Health, 18(8), 1179–1185. 10.1089/jwh.2008.1048

Collins PH (2000). Black feminist thought: Knowledge, consciousness, and the politics of empowerment (Revised 10th anniversary (2nd ed.). Routledge.

Collins P, & Bilge S. (2016). Intersectionality. Polity.

Crabtree B, & Miller W. (1992). A template approach to text analysis: Developing and using codebooks. In Crabtree B. & Miller W. (Eds.), Doing qualitative research. Sage.

Crabtree B, & Miller W. (1999). Using codes and code manuals: A template organizing style of interpretation. In Crabtree B. & Miller W. (Eds.), Doing qualitative research (2nd ed., Vol. 1, pp. 163–177). Sage.

Crenshaw K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 1989(1), 139–167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crenshaw KW (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. The Public Nature of Private Violence, 43(6), 1241–1299. 10.2307/1229039

Davis AY (1981). Women, race & class. Random House.

DeMeester RH, Lopez FY, Moore JE, Cook SC, & Chin MH (2016). A model of organizational context and shared decision making: Application to LGBT racial and ethnic minority patients. Journal of General Internal Medicine, 31(6), 651–662. 10.1007/s11606016-3608-3 [PubMed: 26988980]

Deterding NM, & Waters MC (2018). Flexible coding of in-depth interviews: A twenty-first-century approach. Sociological Methods & Research, 50(2), 708–739. 10.1177/0049124118799377

Ding JM, Ehrenfeld JM, Edmiston EK, Eckstrand K, & Beach LB (2020). A model for improving health care quality for transgender and gender nonconforming patients. The Joint Commission Journal on Quality and Patient Safety, 46(1), 37–43. 10.1016/j.jcjq.2019.09.005 [PubMed: 31708472]

Downey MM, & Gómez AM (2018). Structural competency and reproductive health. AMA Journal of Ethics, 20(3), 211–223. 10.1001/journalofethics.2018.20.3.peer1-1803 [PubMed: 29542432]

Ellard-Gray A, Jeffrey NK, Choubak M, & Crann SE (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. International Journal of Qualitative Methods, 14(5), 1–10. 10.1177/1609406915621420

Epstein RM, Fiscella K, Lesser CS, & Stange KC (2010). Why the nation needs a policy push on patient-centered health care. Health Affairs, 29(8), 1489–1495. 10.1377/hlthaff.2009.0888 [PubMed: 20679652]

Fenway Health. (2021). LGBTQIA+ glossary of terms for health care teams. LGBTQIA+ Health Education Center. https://www.lgbtqiahealtheducation.org/publication/lgbtqia-glossaryof-terms-for-health-care-teams/

Fereday J, & Muir-Cochrane E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International Journal of Qualitative Methods, 5(1), 80–92. 10.1177/160940690600500107

Gómez AM, Đỗ L, Ratliff GA, Crego PI, & Hastings J. (2020). Contraceptive beliefs, needs, and care experiences among transgender and nonbinary young adults. Journal of Adolescent Health, 67(4), 597–602. 10.1016/j.jadohealth.2020.03.003

Gómez AM, & Wapman M. (2017). Under (implicit) pressure: Young Black and Latina women's perceptions of contraceptive care. Contraception, 96(4), 221–226. 10.1016/j.contraception.2017.07.007 [PubMed: 28756187]

Gonzales G, & Henning-Smith C. (2017). Barriers to care among transgender and gender nonconforming adults. The Milbank Quarterly, 95(4), 726–748. 10.1111/1468-0009.12297 [PubMed: 29226450]

Harb CYW, Pass LE, De Soriano IC, Zwick A, & Gilbert PA (2019). Motivators and barriers to accessing sexual health care services for transgender/genderqueer individuals assigned female sex at birth. Transgender Health, 4(1), 58–67. 10.1089/trgh.2018.0022 [PubMed: 31032422]

Hoffkling A, Obedin-Maliver J, & Sevelius J. (2017). From erasure to opportunity: A qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. BMC Pregnancy and Childbirth, 17(Suppl 2), 332. 10.1186/s12884-017-1491-5 [PubMed: 29143629]

hooks b. (1981). Ain't I a woman: Black women and feminism. South End Press.

Howard SD, Lee KL, Nathan AG, Wenger HC, Chin MH, & Cook SC (2019). Healthcare experiences of transgender people of color. Journal of General Internal Medicine, 34(10), 2068–2074. 10.1007/s11606-019-05179-0 [PubMed: 31385209]

Israel B, Eng E, Schulz A, & Parker E. (2013). Introduction to methods for CBPR for health. In Israel B, Eng E, Schulz A, & Parker E. (Eds.), Methods for community-based participatory research for health (2nd ed., Vol. 1, pp. 4–37). John Wily & Sons, Inc.

James SE, Herman JL, Rankin S, Keisling M, Mottet L, & Anafi M. (2016). The report of the 2015 U.S. transgender survey. National Center for Transgender Equality. http://www.transequality.org/sites/default/files/docs/USTS-FullReport-FINAL.PDF

Kcomt L, Gorey KM, Barrett BJ, & McCabe SE (2020). Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. SSM–Population Health, 11(2), 100608. 10.1016/j.ssmph.2020.100608

Keller LH, & Sonfield A. (2019). More to be done: Individuals' needs for sexual and reproductive health coverage and care. Guttmacher Policy Review. https://www.guttmacher.org/sites/default/files/article_files/gpr2200819.pdf

King N. (2018). Using templates in the thematic analysis of text. In Ciesielska M. & Jemielniak D. (Eds.), Qualitative methods in organization studies-volume II: Methods and possibilities. Palgrave Macmillan.

Krueger RA (2015). Focus groups: A practical guide for applied research (5th ed.). Sage.

Light AD, Obedin-Maliver J, Sevelius JM, & Kerns JL (2014). Transgender men who experienced pregnancy after female-to-male gender transitioning. Obstetrics and Gynecology, 124(6), 1120–1127. 10.1097/AOG.0000000000000540 [PubMed: 25415163]

Light A, Wang L-F, Zeymo A, & Gomez-Lobo V. (2018). Family planning and contraception use in transgender men. Contraception, 98(4), 266–269. 10.1016/j.contraception.2018.06.006 [PubMed: 29944875]

Lombardi E. (2001). Enhancing transgender health care. American Journal of Public Health, 91(6), 869. 10.2105/AJPH.91.6.869 [PubMed: 11392924]

Lombardi E. (2009). Varieties of transgender/transsexual lives and their relationship with transphobia. Journal of Homosexuality, 56(8), 977–992. 10.1080/00918360903275393 [PubMed: 19882422]

MacQueen KM, McLellan E, Kay K, & Milstein B. (1998). Codebook development for team-based qualitative analysis. CAM Journal, 10(2), 31–36. 10.1177/1525822X980100020301

Marshall M. (1996). Sampling for qualitative research. Family Practice, 13(6), 522–525. 10.1093/fampra/13.6.522 [PubMed: 9023528]

Maxwell JA (2005). Qualitative research design: An iterative approach. Sage.

Metzl JM, & Hansen H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. Social Science & Medicine, 103, 126–133. 10.1016/j.socscimed.2013.06.032 [PubMed: 24507917]

Miles M, Huberman A, & Saldana J. (2014). Qualitative data analysis: A methods sourcebook (3rd ed.). Sage.

National Academy of Medicine (2020). Understanding the status and well being of sexual and gender diverse populations. https://www.nationalacademies.org/our-work/understandingthe-status-and-well-being-of-sexual-and-gender-diversepopulations

Newman SD, Andrews JO, Magwood GS, Jenkins C, Cox MJ, & Williamson DC (2011). Community advisory boards in community-based participatory research: A synthesis of best processes. Preventing Chronic Disease, 8(3), A70. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103575/ [PubMed: 21477510]

Obedin-Maliver J, & Makadon HJ (2016). Transgender men and pregnancy. Obstetric Medicine, 9(1), 4–8. 10.1177/1753495X15612658 [PubMed: 27030799]

Patton M. (2002). Qualitative evaluation and research methods (3rd ed.). Sage.

Peitzmeier SM, Agenor M, Bernstein IM, McDowell M,´ Alizaga NM, Reisner SL, Pardee DJ, & Potter J. (2017). "It can promote an existential crisis": Factors influencing pap test acceptability and utilization among transmasculine individuals. Qualitative Health Research, 27(14), 2138–2149. 10.1177/1049732317725513 [PubMed: 28836483]

Peitzmeier SM, Khullar K, Reisner SL, & Potter J. (2014). Pap test use is lower among female-to-male patients than non-transgender women. American Journal of Preventive Medicine, 47(6), 808–812. 10.1016/j.amepre.2014.07.031 [PubMed: 25455121]

Prather C, Fuller TR, Jeffries WL, Marshall KJ, Howell AV, Belyue-Umole A, & King W. (2018). Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. Health Equity, 2(1), 249–259. 10.1089/heq.2017.0045 [PubMed: 30283874]

Prather C, Fuller TR, Marshall KJ, & Jeffries WL (2016). The impact of racism on the sexual and reproductive health of African American women. Journal of Women's Health (Larchmont, N.Y. 2002), 25(7), 664–671. 10.1089/jwh.2015.5637

Reisner SL, & Murchison GR (2016). A global research synthesis of HIVand STI biobehavioural risks in female-to-male transgender adults. Global Public Health, 11(7–8), 866–887. 10.1080/17441692.2015.1134613 [PubMed: 26785800]

Reisner SL, Perkovich B, & Mimiaga MJ (2010). A mixed methods study of the sexual health needs of New England transmen who have sex with nontransgender men. AIDS Patient Care and STDs, 24(8), 501–513. 10.1089/apc.2010.0059 [PubMed: 20666586]

Reisner SL, White JM, Mayer KH, & Mimiaga MJ (2014). Sexual risk behaviors and psychosocial health concerns of female-to-male transgender men screening for STDs at an urban community health center. AIDS Care, 26(7), 857–864. 10.1080/09540121.2013.855701 [PubMed: 24206043]

Roberts D. (1998). Killing the Black body: Race, reproduction, and the meaning of liberty. Doubleday.

Rollston R. (2019). Promoting cervical cancer screening among female-to-male transmasculine patients (p. 27). Fenway Health. https://fenwayhealth.org/wp-content/uploads/TFIP-28_TransMenCervicalCancerScreeningBrief_web.pdf

Sadler GR, Lee H-C, Seung-Hwan Lim R, & Fullerton J. (2010). Recruiting hard-to-reach United States population sub-groups via adaptations of snowball sampling strategy. Nursing & Health Sciences, 12(3), 369–374. 10.1111/j.1442-2018.2010.00541.x [PubMed: 20727089]

Scheim AI, Bauer GR, & Travers R. (2017). HIV-related sexual risk among transgender men who are gay, bisexual, or have sex with men. JAIDS Journal of Acquired Immune Deficiency Syndromes, 74(4), e89. 10.1097/QAI.0000000000001222 [PubMed: 27798432]

Scheim AI, Santos G-M, Arreola S, Makofane K, Do TD, Hebert P, Thomann M, & Ayala G. (2016). Inequities in access to HIV prevention services for transgender men: Results of a global survey of men who have sex with men. Journal of the International AIDS Society, 19(3S2), 20779. 10.7448/IAS.19.3.20779

Scheim AI, & Travers R. (2017). Barriers and facilitators to HIV and sexually transmitted infections testing for gay, bisexual, and other transgender men who have sex with men. AIDS Care, 29(8), 990–995. 10.1080/09540121.2016.1271937 [PubMed: 28027664]

Seelman KL, & Poteat T. (2020). Strategies used by transmasculine and non-binary adults assigned female at birth to resist transgender stigma in healthcare. International Journal of Transgender Health, 21(3), 350–365. 10.1080/26895269.2020.1781017 [PubMed: 34993514]

Spade D. (2015). Normal life: Administrative violence, critical trans politics, and the limits of law (revised (expanded ed.). Duke University Press.

Stark B, Hughto JMW, Charlton BM, Deutsch MB, Potter J, & Reisner SL (2019).The contraceptive and reproductive history and planning goals of trans masculine adults: A mixed methods study. Contraception, 100(6), 468–473. 10.1016/j.contraception.2019.07.146 [PubMed: 31400297]

Stephenson R, Riley E, Rogers E, Suarez N, Metheny N, Senda J, Saylor KM, & Bauermeister JA (2017). The sexual health of transgender men: A scoping review. Journal of Sex Research, 54(4–5), 424–445. 10.1080/00224499.2016.1271863 [PubMed: 28140660]

The Combahee River Collective. (1977). The Combahee River collective statement. https://www.blackpast.org/africanamerican-history/combahee-river-collective-statement-1977/

TM Health Justice: LA. (2021). Transmasculine health justice: Los Angeles—a participatory research report. TM Health Justice: LA. https://www.tmhealthstudyla.org/2021-report/

University of California San Francisco. (2020). Terminology and definitions: Transgender care. https://transcare.ucsf.edu/guidelines/terminology

Vaismoradi M, & Snelgrove S. (2019). Theme in qualitative content analysis and thematic analysis. Forum : Qualitative Social Research; Berlin, 20(3). 10.17169/fqs-20.3.3376

Washington HA (2008). Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present (Reprint ed.). Doubleday.

White Hughto JM, Reisner SL, & Pachankis JE (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. Social Science & Medicine, 147(C), 222–231. 10.1016/j.socscimed.2015.11.010 [PubMed: 26599625]

Williams DR, Lawrence JA, & Davis BA (2019). Racism and health: Evidence and needed research. Annual Review of Public Health, 40(1), 105–125. 10.1146/annurev-publhealth-040218-043750

Xavier J, Bobbin M, Singer B, & Budd E. (2005). A needs assessment of transgender people of color living in Washington, DC. International Journal of Transgenderism, 8(2–3), 31–47. 10.1300/J485v08n02_04