Sexual Minority Women and Contraceptive Use: Complex Pathways Between Sexual Orientation and Health Outcomes

Compared with their heterosexual peers, sexual minority women (SMW; e.g., queer, bisexual, lesbian, pansexual) have an elevated risk for unintended pregnancy.

A team of social science and clinical researchers qualitatively documented the multilevel pathways leading to this disparity, particularly the contexts of contraceptive use. From August 2017 to April 2018, we conducted focus groups and interviews with young adult cisgender SMW in 3 cities: Chicago, Illinois; Madison, Wisconsin; and Salt Lake City, Utah.

Most participants reported experience with both penile–vaginal intercourse and contraception. However, they faced several queer-specific barriers to preventing unwanted pregnancy, including a comparative lack of self-concept as contraceptive users, fear of stigma from both queer and health care communities, use of less-effective methods because of infrequent penile–vaginal intercourse and a sense that longer-acting methods were "overkill," and previous experiences of discrimination such as homophobia and gender-based violence. However, participants also reported ways that contraception could align with queer identity, including both taking advantage of noncontraceptive benefits and framing contraception as sex- and queer-positive. These facilitators can inform future efforts to help SMW better meet their pregnancy prevention needs. (*Am J Public Health*. 2019;109:1680–1686. doi: 10.2105/AJPH.2019.305211)

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See also Agénor, p. 1626.

Given its foundational connection between health and social justice,[1] the public health field increasingly attends to the health of sexual minority individuals. In this article, the term "sexual minority" refers to people who either identify as something other than heterosexual or who have sexual relationships or attractions to others of the same sex or gender. (Of course, "sexual minority" does not equate "gender minority." The latter refers to people whose gender identity differs from their sex assigned at birth or whose gender expression differs from cultural norms or assumptions about one's sex assigned at birth. In this article, we focus on people who identify as queer women and who could also get pregnant [i.e., cisgender women], but we acknowledge the need for research and intervention efforts focused on transgender and gender-nonconforming people. Sometimes we use the term "queer" interchangeably with "sexual minority" to reflect the language most commonly used by our study participants.) *Healthy People 2020* foregrounds the importance of sexual minority individuals' health,[2] and the National Institutes of Health identifies sexual minorities as a priority health disparity population.[3]

After overlooking sexual minority individuals for decades, the reproductive health field has observed a nascent but striking surge of work in this area.[4] New evidence suggests that sexual minority women (SMW) constitute a considerable proportion of contraceptive-seeking clients—as many as 1 in 3.[5] However, SMW are less likely than are heterosexual women to receive clinical contraceptive counseling.[6] Given that upward of 20% of US youths claim a sexual minority identity,[7] contraception is indeed a part of queer health and health care—and, in turn, contraceptive care must attend to queer-specific needs.

Researchers have also documented sexual orientation disparities in unintended pregnancy rates. Perhaps surprisingly, both bisexual- and lesbian-identified adolescents report unintended pregnancy rates significantly higher than do their heterosexual peers.[8–12] More recent research among adult queer women suggests that this disparity persists into adulthood.[13]

Many adult SMW engage in sex that could lead to pregnancy,[14,15] but little research investigates SMW's contraceptive perceptions and experiences. Documenting the contexts in which queer women have penile–vaginal intercourse (PVI) and how contraception may or may not fit into those contexts is a critical next step. Specifically, research must document and address contraceptive barriers unique to queer women, particularly at the life stage—young adulthood—most strongly associated with experience of unintended pregnancies.[13,16]

We set out to address these gaps through a qualitative study with an interdisciplinary team of both social science and clinical researchers. Findings are intended to better meet queer women's contraceptive care and counseling needs.

METHODS

Data collection took place between August 2017 and April

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2018 in 3 cities: Chicago, Illinois; Salt Lake City, Utah; and Madison, Wisconsin. First, investigators conducted 5 focus groups with 22 women who identified as queer or nonheterosexual, were assigned female at birth, and were between the ages of 20 and 30 years. We selected focus groups given their utility in measuring social norms, expectations, and values.[17] Our focus groups were designed to explore (1) social norms pertaining to the contexts in which SMW engage in sex that could lead to pregnancy; (2) SMW's attitudes toward contraception, either dependent or independent of PVI; and (3) provider interactions with SMW regarding contraception.

To more deeply explore individual experiences and contexts of PVI, in the second part of data collection, we conducted 11 one-on-one interviews in the same 3 cities with queer women aged 20 to 30 years who had engaged in PVI at least once in the past year. The goal was to assess SMW's actual experiences, or lack thereof, with contraception within the context of recent PVI.

Recruitment and Sampling

Using network-based sampling and recruitment strategies used in other public health research on sexual minority health,[18,19] we recruited participants primarily via social media by using targeted posts on lesbian, gay, bisexual, and queer advocacy and social groups. Some participants referred friends and acquaintances. E. C. contacted interested participants to establish eligibility and conduct enrollment.

Data Collection Procedures

Focus groups took place in university conference rooms in each of the 3 study locations. E. C. and 1 study team member local to each city served as facilitators. Groups contained between 2 and 7 participants (total n = 22) and lasted 2 to 2.5 hours. E. C. conducted all the interviews, which lasted 60 to 90 minutes. Four interviewees were from Madison, 4 from Chicago, and 3 from Salt Lake City (n = 11). Madison interviews took place face to face in private rooms in local libraries; Chicago and Salt Lake City interviews took place on Zoom, an online videoconferencing program with recording capabilities.

The study team developed semistructured focus group and interview guides. Pertinent questions from the focus group guide included the following:

> Most queer or non-straight women at least sometimes have sex that could lead to pregnancy. When, why, or how does this kind of sex happen among you and your friends?

> When queer women do have sex that could lead to pregnancy, they're less likely to use contraception than heterosexual women. Why do you think this happens?

Pertinent questions from the interview guide included the following:

> Please tell me about whether or not you've ever used contraception, and how that may have changed over time—particularly in thinking about your sexual identity.

> Please think about a time recently that you had sex that could potentially lead to pregnancy—maybe the most recent time. Can you tell me what happened?

At the conclusion of the focus group or interview, participants received $40 cash or gift card credit and, if applicable, $5 to cover transportation costs. All focus groups and interviews were audio-recorded, then transcribed verbatim by a study team member or independent transcription service.

Data Analysis

We employed a qualitative descriptive approach, meaning that we used data to describe participants' attitudes and experiences versus using data to build theory or imbue descriptions with theoretical meaning.[20,21] We also used a combined inductive and deductive approach: we analyzed data according to both pre-existing codes and themes as well as codes and themes that arose from the data themselves.

Halfway through collection of both focus groups and interviews, J. A. H. and E. C. generated a first-draft codebook of possible codes based on both the research questions of interest and in vivo themes that arose during data collection. Input from 2 additional authors (M. Z. G. and C. E. H.) led to codebook revisions. Six trained team members then applied codes to the first focus group transcript, both to refine the codebook and to gain consistency in application codes. The final codebook contained 24 parent codes. Two of the 6 coders independently coded each subsequent transcript, then met to discuss each code until reaching 100% agreement. We entered final codes in ATLAS.ti (version 8; ATLAS.ti Scientific Software Development GmbH, Berlin, Germany), a qualitative software package. All team members read reports generated by the code called "determinants of contraceptive use and nonuse," took individual notes, then met to compare and confirm a list of subthemes.

RESULTS

As Table 1 indicates, study participants represented a broad range of sexual identities. Most reported a racial/ethnic identity of White only, but approximately 1 in 4 claimed another racial/ethnic identity. Most participants had a bachelor's degree or higher, but approximately 2 in 5 did not have a college degree.

Study participants (all names are pseudonyms) described a range of contraceptive experiences. Many barriers they faced in obtaining and using contraceptives were consistent with those described by straight women in other studies: challenging negotiation with partners, contraceptive side effects and dissatisfaction, pregnancy ambivalence, and—less frequently cited—health care access and insurance obstacles. However, our study participants also described a variety of contraceptive-related themes that affected queer women in unique ways compared with straight women. We focus below on 5 salient contraceptive barriers that help explain queer women's elevated risk for unwanted pregnancy. We end with 2 themes that suggested ways in which contraception could work in tandem with queerness. A summary of those 7 themes appears in the box on page 1684.

Contraceptive Barriers

1. Queer women "excluded from" contraception. Participants said that, in keeping with other exclusionary practices, the larger heteronormative world fails to perceive queer women as contraceptive users. Some women had internalized this idea, not thinking of themselves as contraceptive users even when in sexual situations that could result in pregnancy.

TABLE 1—Demographic Characteristics of Study Participants: Qualitative Study of Sexual Minority Women and Contraception: Chicago, IL; Madison, WI; and Salt Lake City, UT, 2017–2018

Characteristic	Mean (SD) or No.
Age, y	23.8 (2.77)
Sexual orientation	
Queer	9
Queer + something else (e.g., pansexual, lesbian, bisexual, femme)	8
Bisexual	5
Pansexual	3
Lesbian	3
Gay	1
Demisexual	1
Lesbian/bisexual	1
"Not straight"	1
Race/ethnicity	
Non-Hispanic White	26
Hispanic/Latina	2
Filipina and White	1
Indian	1
Japanese American	1
Arab American and White	1
"Mixed"	1
Education	
High school/GED	1
Some college	12
Completed college	20
Recruitment location	
Madison, Wisconsin	16
Chicago, Illinois	8
Salt Lake City, Utah	9

Note. GED = general education development degree. The sample size was n = 33.

Buffy (21 years old, pansexual, focus-group participant) suggested that contraception is culturally controversial, and queer people's contraceptive needs can be even more marginalized:

> People make it pretty clear that they don't really care about women's rights to birth control. When we talk about queer women in particular, it's even less so. No one even talks about us, really. . . . All the media and conversations that happen around contraception have to do with heterosexual sex, so you don't think about yourself as a part it.

As Buffy's quote suggests, queer women could internalize these exclusionary cultural messages and fail to think of themselves as people who would need or use contraception. Daisy (20 years old, pansexual polyamorous, interviewee) discussed how this internalization could potentially undermine contraceptive use, particularly when combined with partners unwilling to take responsibility for pregnancy prevention:

> When you're a queer woman and you're adjusted to a lesbian or queer lifestyle, in your mind, contraception is for straight people so it doesn't apply to you. So, in the off-chance that you do begin an intermittent relationship with a straight man who may think, "Can I get away from an active, adult discussion [about contraception]? Can I kind of just sneakily let this happen?". . . and combine that with a woman who, because heterosexual sex is so unfamiliar, they don't even remember to consider contraception. That's kind of a recipe for disaster.

2. Navigating contraception on top of navigating queer identity. Women said that it is hard enough to be queer or to use contraception; doing both could be insurmountable. Buffy reported,

> Even straight women have a hard time taking the steps to protect themselves. Then add the extra layer of somebody who already has to struggle with their identity because they're persecuted for it. That's a lot of fog to climb through to protect your health.

Shame and stigma featured in participants' experiences of navigating queer identity and contraception—not just fear of homophobia but also fear of judgment from queer communities for engaging in sex with cisgender men. Logan (25 years old, lesbian, interviewee) illustrated,

> Queer people are often stigmatized in society. But it would be equally taboo if I were to come out to my friends and tell them I were hooking up with a guy. . . . One of my good friends is very outwardly gay. She was recently interested in a guy, but she didn't let anyone know. We fear this judgment for even considering, you know, going back to the "other side."

In a related dimension of this theme, some participants reported how additional stigma could result from "screwing up"—that is, by having unprotected PVI. Jules (23 years old, queer, focus-group participant) said,

> You can't tell your friends you had unprotected sex because they'll ask, "Why weren't you smart?" The stigma of having unprotected sex is especially high in a situation where it could cause pregnancy. So when that happens, I've dealt with that solo.

Like Jules, several participants said they would be ashamed to tell friends if they became pregnant or had a pregnancy scare. Jo (21 years old, queer/bisexual, focus-group participant) said "I could definitely picture a scenario in which someone who's always been identified as lesbian [would] need Plan B and not want to tell their friends, then having to go it alone or not do it at all." This queer-specific stigma could render queer women more isolated in their efforts to prevent unwanted pregnancy and to make decisions about unintended pregnancies that occurred.

3. "It's a 1-time thing." Although some participants consistently had relationships with cisgender men, many only sporadically engaged in sex that could lead to pregnancy. Less frequent PVI meant that some women used condoms or withdrawal instead of longer-acting methods that could seem like "overkill." In fact, women portrayed getting on a longer-term contraceptive method as a burden. Benny (22 years old, queer/bisexual, focus-group participant) said,

> For me personally, if I wasn't planning on having sex with a man, it would be too much of a hassle to go out and get an IUD [intrauterine device]. You'd have to go to a doctor and make a doctor's appointment and that's a lot of work.

Women, thus, could be comparatively less protected

against unwanted pregnancy when PVI did occur, either because they were using less-effective methods or because they were less motivated to use methods "perfectly." When Renee (23 years old, bisexual, focus-group participant) reflected on why queer women may be more likely than straight women to experience unintended pregnancies, she suspected 1 reason could be "remembering to take a pill every day if it's not on the forefront of your mind, like, 'oh I'm having sex with someone who could get me pregnant.' Especially if [PVI] is more sporadic."

Vanessa (30 years old, queer, interviewee) described how she was on the pill when she first started engaging in PVI, then discontinued when she entered her first long-term relationship with a woman. "I thought, 'I don't want or need [the pill] anymore,'" she said. Later, when engaged again in a relationship with a cisgender man, they used condoms or withdrawal. She experienced an unintended pregnancy and sought an abortion.

In addition to highlighting condoms and withdrawal, respondents indicated that emergency contraception is a common contraceptive tool for queer women. For example, Juliana (22 years old, queer, interviewee) reported using Plan B twice, in part because her partner refused to use condoms and she was not using another method. Bone (25 years old, bi/queer, focus-group participant) reported experiencing "horrifying" pregnancy scares and had taken emergency contraception at least twice. She said, "A lot of my queer friends take emergency contraception post sex with a male body. It's not ideal, but it happens a lot."

4. Patriarchy, violence, and trauma. Qualitative data collection on sexual and reproductive health with all women can be closely linked to narratives of gender-based power and sexual violence. However, we were still struck by the airtime given to power, violence, and trauma in our focus groups and interviews. This preponderance is not surprising given well-established connections between sexual minority identities and increased risk of violence.[22,23] Unique to the current analysis is how participants connected this phenomenon to contraceptive use.

Vanessa reported sexual trauma, including a sexual assault that resulted in a pregnancy and a difficult later-term abortion that she had delayed because of emotional fallout from the assault. Vanessa related these previous experiences to her current preference for inebriated PVI. "I don't generally enjoy sober sex with men," she said, "from past trauma and things like that." When reflecting on why queer women may have higher rates of unintended pregnancies, Vanessa answered,

> I've had two unintended pregnancies. I've been on and off birth control mostly with my partners who were women but also when I was with men, for different reasons. We also know that queer women are at higher rates for violence and higher rates for experiencing mental illness, and they have different access to resources. And those experiences all resonate with me too. . . . How do I negotiate contraception in each of those very different experiences?

In a related aspect of this theme, respondents expressed how gender-based oppression affected sex and contraceptive use with cisgender men. Daisy reported,

> Our society sees sex as a man's world sort of thing. As a woman, you're secondary. That's reinforced in all sorts of pornography, society, movies, etc. Because of that, when I was first becoming sexually active, I never thought that I had a lot of power as far as choosing contraception or having those kinds of conversations or starting those conversations. I just assumed that was the responsibility of somebody else.

Though gender-based power differences can also undermine heterosexual women's contraceptive use, our participants' abilities to perceive and articulate such differentials were likely heightened by their queer identities as well as, in many cases, their comparative experiences with same-sex partners.

5. Health care system barriers. Our analysis revealed that complex, identity-based interactions with providers could affect queer women's relationship with contraception and lead them to eschew reproductive health care visits altogether. (For a more thorough analysis of SMW's interactions with health care providers in this study, please see Greene et al.[24])

Participants described a paradox: on one hand, providers would assume they were straight; on the other hand, if women acknowledged their queer identity, providers would assume their patients had no need for contraception. Beatrice (21 years old, bisexual, focus-group participant) said,

> In our society, everyone is assumed straight until proven otherwise. . . . Either medical professionals are like "Why aren't you on contraception?" because they don't know or assume that you're straight, or they go the opposite direction, where they're like "Oh, you're queer or whatever," then they completely ignore contraception.

Some participants felt negatively judged by providers for their sexuality in addition to their contraceptive practices. Rachel (24 years old, queer, interviewee) described getting her first Pap test: "My doctors freaked out that I wasn't on birth control." I said to them, "Listen, I've primarily only been with women. . . . I'm not worried about it and if I am with a guy, we use a condom.' And they were still really upset." These sorts of experiences could disincline queer women from regularly seeking reproductive health care, including contraceptive care.

Contraceptive Facilitators

Next, we describe 2 facilitators—examples of how queer identity could enable contraceptive use, particularly for those well-established in their queerness.

6. Contraception could be queer-positive, sex-positive. Several participants explained how the process of coming out had facilitated their ability to use contraception and assert their wishes in sexual encounters. Bone stated, "It wasn't until I came out as non-straight that I had enough of a hold on my identity and a grasp on feminism and health. And I think that's when my negotiation [in sexual relationships] shifted for the better." She also tied her own IUD use with her queer pride:

> Once I found some sort of feminism or pride in my queer identity, I decided, "I'm going to take my body and my contraception into my own hands and no one can mess with a condom to mess with me." I wanted something that was long acting and in my body and couldn't be taken from me.

FIVE CONTRACEPTIVE BARRIERS AND 2 CONTRACEPTIVE FACILITATORS DESCRIBED BY SEXUAL MINORITY WOMEN: CHICAGO, IL; MADISON, WI; AND SALT LAKE CITY, UT, 2017–2018

Contraceptive Barriers[a]
1. Exclusion from contraceptive messaging means that queer women can be unlikely to think of themselves as contraceptive users.
2. Queer women face difficulties navigating contraceptive use on top of managing queer identity. Concerns about negative judgment from within the queer community could undermine contraceptive use.
3. Less frequent PVI can make more effective contraceptive methods feel like "overkill"; use of condoms, withdrawal, and emergency contraception more common.
4. Queer women's experiences with gender-based violence and power differences can make contraceptive use more difficult.
5. Experienced or anticipated stigma within the health care system can render queer women more reluctant to seek contraceptive care.
Contraceptive Facilitators[b]
6. The process of coming out can contribute to sexual empowerment and improve some queer women's ability to meet their contraceptive needs.
7. Noncontraceptive benefits of contraception are a major and perhaps underemphasized boon for a number of queer women.

Note. PVI = penile–vaginal intercourse.
[a]Conflicts between contraceptive use and queer identity; potential contributors to unintended pregnancy among queer women.
[b]Areas of alignment between queer identity and contraception; potential ways to amplify positive aspects of contraception among queer women.

Helen (29 years old, queer femme, interviewee) described a similar connection between the strength of her queer identity with her ability to take control of her sexual and reproductive health:

I think a big part of queer identity is, like, owning and feeling control over your experience of having sex with another person. . . . And I actually think that contraception is a tool that enables that. Historically, birth control has been a really important tool for women to own their sexuality. Not just queer women, but including queer women.

7. Noncontraceptive benefits of contraceptive use. Women highlighted the noncontraceptive benefits of a variety of methods, and these benefits had served as an entryway into contraception for some. In part because PVI could be comparatively less frequent, participants clearly perceived the benefits of contraception as going beyond "only" pregnancy prevention. Jules said,

I have an IUD because I wanted my periods to stop, not because I'm worried about pregnancy. I think it's 80% "I don't want periods anymore" and 20% "Wow, now I can have PVI, I guess." [laughter from group]

Ashely (25 years old, nonstraight, focus-group participant) said,

> The majority of my friends who take hormonal contraception don't actually take them for reasons related to pregnancy prevention. It's more about periods or not getting cysts and those reasons.

Using contraception to improve health versus prevent pregnancy could incur fewer threats to queer identity. As Sara (23 years old, pansexual, interviewee) reported,

> [Contraception] isn't at odds with my sexuality. I'm currently having sex with a male-identifying person, but I don't feel like contraception hinders my identity because I take birth control for other health reasons.

Sara's quotation illustrates how noncontraceptive benefits (i.e., using contraception for "other health reasons") could protect queer women from some of the aforementioned stigma surrounding contraception for the purposes of sex with cis men.

DISCUSSION

This study uncovered a number of contraceptive barriers that help explain, at least in part, SMW's elevated risk for unwanted pregnancy. Some barriers were more conceptual. For example, queer women's lack of self-concept as contraceptive users could impede their ability to prevent unwanted pregnancies. Some barriers were more logistical or instrumental. For example, comparatively less frequent PVI in queer women's lives led to contraceptive nonuse or use of less effective methods when such sex did occur. Finally, some barriers illustrated larger structural discrimination, including both homophobia and gender-based violence, that could render queer women comparatively less able to protect themselves against unwanted pregnancy. In keeping with the broader literature on queer identity and health, our analyses highlight the tremendous complexity of the relationship between sexual minority status and health outcomes. In the absence of simple pathways or straightforward solutions, the public health field will need to continue pursuing change on multiple levels: individual-level messaging and health care and community-level interventions, as well as larger cultural reductions in homophobia, sexism, and gender-based violence.

Despite these complex challenges, our findings also uncovered some potential pathways to help queer women better meet their contraceptive and reproductive health needs. Women in our study highlighted the major appeal of noncontraceptive benefits and suggested that these benefits may be underemphasized to queer women, who could take better advantage of many methods' multiple uses. Given the potential stigma of contraception in queer communities, as well as our culture's marked discomfort with sexuality, the public health field may wish to better underscore

these noncontraceptive benefits in their outreach to queer clients and communities. Providers can also work to make contraceptive services, including health histories and contraceptive counseling, more inclusive to queer patients.[25,26] Increasing easy, affordable, queer-friendly access to all Food and Drug Administration–approved contraception may make a wider variety of methods more available and attractive to queer women.

Findings should be considered in light of study limitations. Most centrally, despite strategic recruitment efforts, our sample consisted of queer women who were relatively socially advantaged. Most participants were White and had a college degree. We applaud studies of sexual minority health such as the Chicago Health and Life Experiences of Women study that include more diverse populations.[27]

Our study did not gather information specifically regarding sexually transmitted infection prevention as a factor in contraceptive decision-making. Many study participants did discuss their sexually transmitted infection prevention concerns in relationship to condom use in particular; however, we did not systematically collect such narratives, and readers should recognize that SMW have dual prevention needs as well.

We also remind readers that interviewees in this study had all engaged in PVI in the last year. Not all SMW engage in sex that could lead to pregnancy, and a study with a broader group of queer women might have garnered different results. Along those lines, a constellation of factors—and not just contraceptive use—may help explain SMW's elevated risk for unwanted pregnancy, and we have not examined all such factors here. Factors such as discriminatory health care experiences,[24] the poor quality of sex education for sexual-minority youths,[28] and other structural, cultural, and psychosocial influences may also play a role and are worthy of further research.

Despite its limitations, this study adds a valuable social science perspective to a recent public health disparity. Our team found that our world is a difficult place for queer women to use contraception effectively. However, queer-friendly contraceptive care and narratives of contraception as queer-positive could potentially help increase capacity to meet SMW's reproductive health care needs. However, such advances cannot occur independently of efforts to dismantle both homophobia and sexism. AJPH

CONTRIBUTORS

J. A. Higgins, B. G. Everett, and S. Haider conceptualized the original study design and secured funding support; they also served as site principal investigators for each of the three cities involved in the study (Madison, Wisconsin; Salt Lake City, Utah; and Chicago, Illinois, respectively). J. A. Higgins led qualitative analysis for the larger project and took the lead on writing this article. E. Carpenter was involved in study design and served as the project manager; she also conducted all interviews, co-facilitated all focus groups, and played a lead role in qualitative analysis. M. Z. Greene and C. E. Hendrick participated in all stages of the analysis for the broader project and this article. All authors read and edited earlier versions of this article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to report.

HUMAN PARTICIPANT PROTECTION

Before study proceedings, institutional review board (IRB) applications were approved at the University of Wisconsin and University of Utah and waived at the University of Chicago. The latter IRB deemed the study exempt under federal Common Rule category 45 CFR 46.101(b)(2) but insisted that investigators conduct the research in accordance with the highest ethical standards. All participants provided informed consent before taking part in the study.

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