Seeking Reproductive Justice in LA County: Sexual and Reproductive Health Access in LGBTQ+ Communities

BY STINA ROSENQUIST
on behalf of Los Angeles
Coalition for Reproductive Justice

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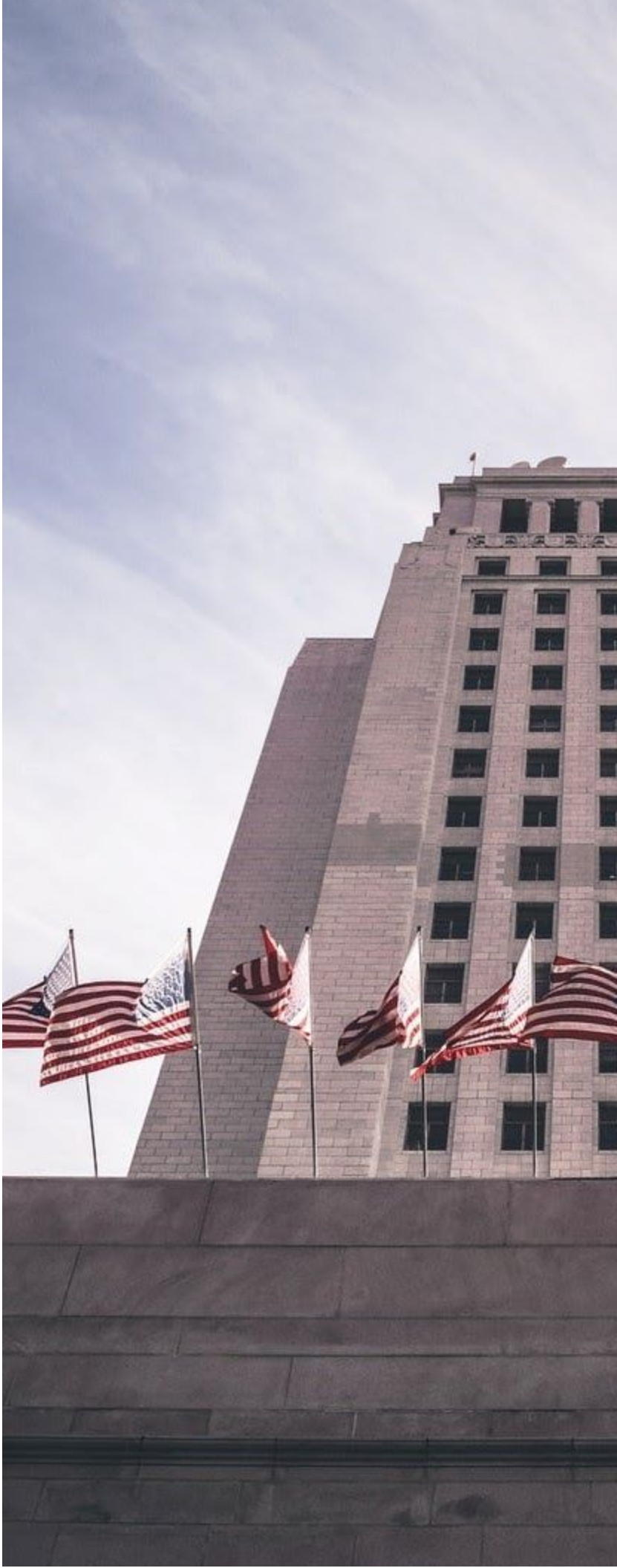

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Southern California, California Coalition for Reproductive Freedom, California NOW, California Religious Coalition for Reproductive Choice, California Women's Law Center, Essential Access Health, HEART Women & Girls, Hollywood NOW, Khmer Girls in Action, LOOM, National Center for Youth Law, National Council of Jewish Women|Los Angeles, National Health Law Program, Planned Parenthood Los Angeles, and Plan C.

About the Los Angeles Coalition for Reproductive Justice (LACRJ):

LACRJ is a coalition of over 20 social justice and health organizations collaborating to advance reproductive health, rights, and justice in Los Angeles. LACRJ leverages the expertise of our member base, both statewide and national, to enhance the leadership of reproductive justice organizations and promote reproductive justice strategies. By engaging advocates and decision makers, LACRJ is working to achieve reproductive justice[1] for all Los Angeles County residents.

[1] "Reproductive Justice [is] the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities." Sistersong, *The Herstory of Reproductive Justice*, available at https://www.sistersong.net/reproductive-justice.

Introduction

Initiated by the leadership of women of color, LACRJ understands that racism, classism, xenophobia, homophobia, transphobia, ableism, ageism, and other oppressive societal assumptions create disproportionate reproductive health disparities. During the summer of 2019, LACRJ conducted a community-driven research project in order to better understand these complex oppressions as experienced by LGBTQ+[2] individuals, with an emphasis on LGBTQ+ women and non-binary individuals. We spoke to key LGBTQ+ advocates about reproductive and sexual health access and reproductive freedom in Los Angeles (LA) County to inform our collective efforts to advance reproductive justice for all communities in Los Angeles.

Those conversations are summarized in this report. The report provides a snapshot of the landscape of sexual and reproductive health access in LGBTQ+ communities in LA County by lifting up the challenges, gaps in access/services, best practices, and priorities for investment as identified by the interviewees. LACRJ chose this focus because we wanted to center the experiences and needs of LGBTQ+ women and non-binary individuals within the reproductive health/rights/justice conversation and our work.

Defining Reproductive Justice

The term “reproductive justice” was officially coined by a group of Black women in Chicago in 1994. These women gathered right before the International Conference on Population and Development in Cairo which affirmed that the individual right to plan one’s own family must be central to global development. They named themselves Women of African Descent for Reproductive Justice, creating a term which acknowledged what had long been known- that the mainstream women’s rights movement, which was wealthy and white, could not address the realities of women of color, other marginalized women, and trans people. Shortly thereafter they founded an

[2] LGBTQ+ stands for lesbian, gay, bisexual, trans, and queer/questioning while the plus sign seeks to encompass many other sexualities, sexes, and genders not captured by these letters. We will use this acronym throughout this report unless citing a source which uses another language.

organization by the name of SisterSong to grow a national reproductive justice movement.[3]

LACRJ aligns itself with SisterSong's widely accepted definition of reproductive justice:

> *"Reproductive Justice [is] the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.[4]"*

By applying a reproductive justice framework to this project, LACRJ seeks to go beyond issues of sex education, STIs, and the like, to analyze how issues of health equity, economic equity, and other social determinants impact reproductive and sexual health.

Purpose of this Report

Through this report the coalition strives to:

- Identify gaps in resources, policy, and enforcement in the provision of reproductive and sexual health services and programs in LA County, along with priorities for investment
- Build partnerships and deepen relationships with diverse, community-based organizations to improve the health and well-being of LGBTQ+ individuals, their families, and their communities
- Collectively engage policymakers to advance more LGBTQ+ inclusive policies

Our intention is to elevate the experiences of LGBTQ+ individuals in accessing reproductive health and achieving reproductive freedom in LA County. Through this project we have sought to build relationships with diverse, community-based organizations and other stakeholders working towards reproductive justice within LGBTQ+ communities in the County. This report gathers the priorities of these local stakeholders, noting both overlapping needs and community-specific responses.

[3] Sistersong, *supra* note 1.
[4] *Id.*

Ultimately, this report seeks to bolster advocacy efforts to grow funding and programming, promote leadership, and create progressive policy change to improve LGBTQ+ sexual and reproductive health in LA County.

Methodology

To begin this project LACRJ Coalition members developed an initial list of organizations working at the intersection of reproductive and LGBTQ+ justice. Through coalition member introductions we requested interviews with individuals at these organizations. This list continued to develop as interviewees provided input on who should be included. We paid special attention to reaching a broad pool of organizations who work with different racial, geographic, and LGBTQ+ communities and utilize varied methods of change (advocacy, organizing, direct service, research etc.).

Thirty-five interview requests were made via email by coalition members, interviewees, or LACRJ's Research Consultant. Dr. Paula Tavrow of UCLA supported us in the development of an interview script (see Appendix A for the final script). Twenty-three interviews were conducted by the research consultant over the phone or in person. Interviews were about 45 minutes in length and were recorded with the interviewees' consent. A process of iterative coding of interview notes and transcripts led to the discovery of the themes discussed in this report. See Appendix B for a timeline of the full research process.

The interviewees we spoke to are experts in their particular field. They are advocates, organizers, and service providers working to improve the lives of LGBTQ+ individuals in LA County. They represent the organizations listed below:

- Asians and Pacific Islanders for LGBTQ Equality
- City of West Hollywood, Strategic Initiatives Dept
- National Center for Youth Law: LA Reproductive Health Equity Project for Foster Youth (RHEP) Youth Advisory Board
- JQ International
- Connect 2 Protect (C2PLA)
- West Hollywood Transgender Advisory Board

- LA County Women & Girls Initiative
- Friends Community Center
- Bet Tzedek: Transgender Medical-Legal Partnership
- ACLU of Southern California, LGBTQ, Gender, & Reproductive Justice Team
- Black AIDS Institute
- Los Angeles LGBT Center
- SAHARA
- Colors LGBTQ Youth Counseling
- Trans Service Provider Network
- Translatin@ Coalition
- Children's Hospital Los Angeles
- The Center for Transyouth Health and Development
- Project NATEEN
- San Gabriel Valley LGBTQ Center
- LA County Lesbian, Bisexual, and Queer Women's Health Collaborative

Limitations

This report is not intended to be a comprehensive survey of LGBTQ+ reproductive and sexual health in LA County but rather a discussion with expert interviewees and a launching pad for further research. This report represents a small sample, largely made up of employees of LGBTQ+ serving and/or reproductive justice organizations, and not necessarily those being served by these organizations.

It also does not cover every intersection within the movement. As previously mentioned, our conversations were largely centered around LGBTQ+ women and non-binary individuals and therefore did not speak specifically to the experiences of trans men. Furthermore, it is of note that we sought to, but were unable to connect with an organization focused specifically on aging LGBTQ+ populations in Los Angeles, though the Los Angeles and San Gabriel Valley LGBT(Q) Centers mentioned that reaching this community is a current priority for their organizations.

Though not all voices were captured through this project, an effort was made to talk to those working at many intersections, with the hope that this report will provide a valuable advocacy tool and a springboard for future LGBTQ+ reproductive justice work in LA County.

Literature Review

To provide context for this project, and an understanding of our research interests, we have included a literature review of existing data on disparities between LGBTQ+ and heterosexual/cisgender individuals, broadly, and when possible, within Los Angeles County specifically.

Poverty

Collectively, LGBT people have a poverty[5] rate of 21.6% compared to 15.7% for cisgender heterosexual people in the United States.[6] However, this rate varies greatly within LGBT communities and is highest among transgender individuals. In 2015, 29% of respondents to the U.S. Transgender Survey were living in poverty, compared to 12% of the general U.S. population. This economic disparity is compounded for people of color: 38% of Black respondents were living in poverty (compared to 24% of Black people in the U.S. population), 43% of Latino/a respondents (compared to 18%), 41% of American Indian and Alaska Native respondents (compared to 20%), and 32% of Asian and Native Hawaiian/Pacific Islander respondents (compared to 11%).[7] Disparity in unemployment was also compounded for respondents of color.[8]

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[5] The cited research (citation below) uses a standard definition of poverty in the United States- "an individual is considered to be experiencing poverty if their family income falls below the official federal poverty threshold."

[6] M. V. Lee Badgett, Soon Kyu Choi, and Bianca D.M. Wilson, *LGBT Poverty in the United States: A Study of Differences between Sexual Orientation and Gender Identity Groups*, UCLA Williams Institute, (October 2019), *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf.

[7] National Center for Transgender Equality, *2015 U.S. Transgender Survey: Report on the Experiences of People of Color* (2016), available at http://www.ustranssurvey.org/reports#POC

[8] *Id.*

In California, LGBT women are doing worse than their male counterparts on socioeconomic indicators such as income and whether they have enough money for healthcare. Thirty percent of LGBT women reported an income less than $24,000 (versus 23% of LGBT men) and 30% of LGBT women reported lacking money for healthcare (versus 21% of LGBT men).[9]

Health Care Coverage and Access

Collectively the LGBTQ community has a similar rate of health insurance coverage to the general population, but access to care can vary. For example, bisexual individuals have more limited access to care, while lesbian and gay adults have rates comparable to their heterosexual peers.[10] Transgender individuals face a particularly wide array of barriers to accessing health care through insurance. Though it is illegal in California for Medi-Cal and most types of insurance plans to exclude gender affirming care, many transgender individuals continue to face obstacles, including discrimination, refusal of care, and disputes over whether some treatments are medically necessary.[11]

Health Outcomes

Though the research on the health status and healthcare needs of members of the LGBTQ+ community is limited (especially for women and non-binary individuals),

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[9] The Williams Institute, *The LGBT Divide in California*, 5 (2015) [hereinafter "The LGBT Divide in CA"], *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/California-LGBT-Divide-Jan-2016.pdf.

[10] Jane Kates, Usha Ranki, et. al, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, Henry J Kaiser Family Foundation, 12 (May 2018), available at https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/

[11] Andrew Cray and Kellan Baker, *FAQ: Health Insurance Needs for Transgender Americans*, Center for American Progress, (2012), available at http://www.americanprogress.org/issues/lgbt/report/2012/10/03/40334/faq-health-insurance-needs-for-transgender-americans/; Abigail Coursolle, *California Pride: Medi-Cal Coverage of Gender-Affirming Care Has Come a Long Way*, National Health Law Program (June 22, 2018), available at healthlaw.org/california-pride-medi-cal-coverage-of-gender-affirming-care-has-come-a-long-way

available data still demonstrate clear disparities.[12] Lesbian women are more likely than heterosexual women to report moderate psychological distress, poor or fair health, multiple chronic conditions, heavy drinking and heavy smoking. In addition, bisexual women are more likely than heterosexual women to report multiple chronic conditions, severe psychological distress, heavy drinking, and moderate smoking.[13] STI rates are higher among some LGB groups than heterosexuals, and rates have been increasing for certain infections. Furthermore, lesbian women have historically faced barriers to STI testing and treatment due to the perception that they are inherently a low risk group.[14]

HIV rates are particularly high for transgender individuals. Three-tenth of a percent of the U.S. population is living with HIV, compared to 1.4% of respondents to the U.S Transgender Survey. This number is even higher for some trans people of color, particularly Black transgender women- of those who responded to the survey, 19.0% were living with HIV.[15]

Health disparities are due in part to individual prejudice, social stigma, and discrimination.[16] Thirty-four percent of Black respondents to the 2015 U.S. Transgender Survey who saw a health care provider in the last year reported having at

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[12] Kesha Baptiste-Roberts, Ebele Oranuba, et al., *Addressing Healthcare Disparities among Sexual Minorities*, Obstet Gynecol Clin North Am, 2 (March 2017) (discussing the dearth of research on the health needs of sexual minority women and transgender populations).
[13] *Id.* at 2 (citing Gilbert Gonzales, Julia Przedworski, and Carrie Henning-Smith, *Comparison of Health and Health Risk Factors Between Lesbian, Gay, and Bisexual Adults and Heterosexual Adults in the United States: Results From the National Health Interview Survey*, JAMA Intern Med., (Jun 27, 2016))
[14] Kesha Baptiste-Roberts, *supra* note 12, at 4 (citing Greta R Bauer and Sethe L Welles, *Beyond Assumptions of Negligible Risk: Sexually Transmitted Diseases and Women Who Have Sex with Women*, Am J Public Health, 1282-1286 (August 2001); JM Marrazzo, *Barriers to Infectious Disease Care Among Lesbians*, Emerg Infect Dis, 1974–1978 (November 2004); Jennifer Power, Ruth McNair, and Susan Carr, *Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action Regarding Safer Sex and Sexual Health Information*, Cult Health Sex, 67-81 (Jan 2009).
[15] Sandy E. James, Carter Brown, and Isaiah Wilson, *2015 U.S. Transgender Survey: Report on the Experiences of Black Respondents*, National Center for Transgender Equality, (2017), *available at* https://www.transequality.org/sites/default/files/docs/usts/USTSBlackRespondentsReport-Nov17.pdf.
[16] Kesha Baptiste-Roberts, *supra* note 12, at 1.

least one negative experience related to being transgender, such as being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.[17] And LGBT youth in particular may find it difficult to share their sexual identities with their clinicians. Often, clinicians are not well trained in addressing the concerns of members of this community. This lack of communication can be responsible for a poor therapeutic alliance, failure to give appropriate education, inadequate screening for communicable diseases, and inadequate intervention to prevent STDs.[18]

Findings on negative healthcare experiences were echoed locally by a focus group study conducted by the LA County Lesbian, Bisexual, and Queer Women's Health Collaborative in 2012. The focus groups were composed of women identifying as lesbian or bisexual, who were also women of color, veterans, and/or 65 years of age and older. Participants cited concerns that providers were often holding to heterosexual cultural norms and that provider assumptions about sexual orientation/sexual practices frequently compromised their care. Participants supported the idea of certification for providers skilled in LGBTQ+ health but expressed skepticism that such programs would necessarily result in better care.[19]

Violence

According to the FBI's crime reporting statistics, one in five single-bias incident hate crimes nationwide is due to sexual orientation bias.[20] Overall, 47% of respondents to the 2015 U.S. Transgender Survey reported having been sexually assaulted at some point in their lifetimes.[21] This number was even higher for many transgender people of

[17] National Center for Transgender Equality, *supra* note 15, at 3.
[18] Hafeez H, Zeshan M, Tahir M A, et al., *Healthcare Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, 4-5 (April 20, 2017) (citing Jeffrey A. East and Fadya El Rayees, *Pediatricians' Approach to the Health Care of Lesbian, Gay, and Bisexual Youth*, J Adolsec. Health, (1998)).
[19] Sue LaVaccare , Allison Diamant, et al. *Healthcare Experiences of Underrepresented Lesbian and Bisexual Women: A Focus Group Qualitative Study*. Health Equity Volume 2.1, 113-138 (2018), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6071790/
[20] Jane Kates, *supra* note 10, at 10 (citing U.S. Department of Justice Federal Bureau of Investigation, Hate Crime Statistics, (2016), *available at* http://www.fbi.gov/about-us/cjis/ucr/hate-crime/2011).
[21] Sandy E. James, Carter Brown, and Isaiah Wilson, *supra* note 15, at 3.

color: 65% of American Indian and Alaska Native, 53% of Black respondents, and 48% of Latino/a respondents reported having been sexually assaulted at some point in their lifetimes.[22] It is estimated that almost half (46%) of bisexual women have been raped, compared to 17% of heterosexual and 13% of lesbian women. Sixty-one percent of bisexual women have encountered intimate partner violence, along with 44% of lesbian women, compared to 35% of heterosexual women.[23]

Many LGBTQ youth face violence or threats of violence at school. Nearly 16% of LGB youth reported not feeling safe at school, versus 4.9% of their non-LGB peers. And transgender youth are five times more likely than their cisgender peers to report not feeling safe at school (27.3% versus 5.1%).[24] LGB youth are more likely to report being pushed, shoved, slapped, hit, or kicked by someone one or more times on school campus than their non-LGB peers (30% versus 20.9%). The difference is even more stark for transgender youth, at 32.7%.[25]

Incarceration

Transgender people are disproportionately represented in the criminal justice system. Twenty-one percent of transgender women and 10% of transgender men report having served time in jail or prison, compared to 2.7% of the general population.[26] And transgender individuals face a high risk of sexual assault and harassment while incarcerated.

In 2012, the adoption of regulatory standards for implementation of the Prison Rape Elimination Act (PREA) introduced important protections for LGBTQ individuals against

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[22] National Center for Transgender Equality, *supra* note 7.
[23] Jane Kates, *supra* note 10, at 9-10.
[24] Chapman University, *Health and Safety of LGBT Youth in California*, 1 (2015), *available at* https://www.chapman.edu/education/_files/research/ca-lgbt-narrative.pdf.
[25] *Id.*
[26] Jaime M. Grant et al, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey, National Center for Transgender Equality & National Gay and Lesbian Task Force* 163 (2011), available at http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

sexual assault.[27] But PREA still needs to be better implemented and further work needs to be done. In 2015, an estimated 34% of transgender people held in local jails reported experiencing one or more incidents of sexual victimization; 23% of these incidents were perpetrated by jail staff.[28] In 2016, the ACLU of California reported that the vast majority of transgender women are still automatically placed in "male" housing locations despite the serious safety risks, violence, and increased isolation they encounter there.[29]

Local Poverty and the Housing Crisis

On the whole, LGBTQ+ people in California are doing better than estimated national averages on indicators such as educational attainment, income, and money for health care.[30] However, health outcomes vary dramatically by intersecting factors such as race, income, and geography. Nearly one in every five Los Angeles residents (18.4%) lives below the poverty line, which is about $24,600 a year for a family of four.[31] But this alarming statistic does not tell the whole story as there are large geographic disparities in poverty within LA County .[32] For example, in the Southeast Cities, the communities of Watts and Willowbrook, as well as in the Cities of Compton and Paramount and the community of Westmont, there are many census tracts showing unemployment rates above 15% and poverty rates of 29% or more.[33]

Los Angeles' housing crisis places another burden on the LGBTQ community. Los Angeles ranks seventh out of the largest 150 metro regions in renter housing burden,

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[27] American Civil Liberties Union, PREA Toolkit, *available at* https://www.aclu.org/other/prison-rape-elimination-act-prea-toolkit-end-abuse-protecting-lgbti-prisoners-sexual-assault

[28] U.S. Department of Justice, PREA Data Collection Activities, Office of Justice Programs, Bureau of Justice Statistics, (2015), *available at* http://www.bjs.gov/content/pub/pdf/pdca15.pdf.

[29] ACLU of California, *Reproductive Health Behind Bars*, (January 2016), *available at* https://www.aclusocal.org/sites/default/files/wp-content/uploads/2016/01/Reproductive-Health-Behind-Bars-in-California.pdf.

[30] The LGBT Divide in CA, *supra* note 9, at 1.

[31] PolicyLink and PERE, *An Equity Profile of the Los Angeles Region*, 6 (2017), *available at* https://dornsife.usc.edu/assets/sites/242/docs/EquityProfile_LA_Region_2017_Summary_Final.pdf

[32] The LGBT Divide in CA, *supra* note 9, at 7 (graph displaying percentage of residents below the Federal Poverty Level across L.A. County).

[33] An Equity Profile of the Los Angeles Region, *supra* note 31, at 4.

with nearly 6 in 10 (59%) renters spending more than 30% of their household income on housing costs.[34] And many Angelenos are experiencing homelessness. Forty percent of Los Angeles' homeless youth are LGBT. Parental rejection, lack of employment opportunities, and physical assault and bullying all contribute to a disproportionate amount of LGBT youth being forced to live on the streets.[35]

Recent Successes

Despite these vast disparities, some progress is being made across the state and within LA County. In California, the Fair Employment and Housing Act (FEHA) and Unruh Civil Rights Act have been updated to explicitly protect people against discrimination based on gender expression, gender identity, and sexual orientation by business establishments, housing providers, and virtually all employers.[36]

In addition, in 2019, Governor Gavin Newsom approved $17.5 million for the creation of the unprecedented Lesbian, Bisexual, and Queer (LBQ) Women's Health Equity Fund under the California Department of Public Health. The landmark funding was included in the 2019 State Budget signed by the Governor and marks the first time a state has specifically designated funds for LBQ women's health.[37]

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[34] *Id*. at 6.

[35] Equality California Institute, *Fair Share for Equality*, 47 (2015), *available at* https://www.eqca.org/equality-california-releases-report-detailing-lgbt-health-and-wellbeing-disparities

[36] Cal. Gov. Code § 12940 et seq; Cal. Civ. Code § 51 et seq.; see also Department of Fair Employment and Housing, Unruh Civil Rights Act Fact Sheet (April 2019), *available at* https://www.dfeh.ca.gov/wp-content/uploads/sites/32/2017/12/DFEH_UnruhFactSheet.pdf.

[37] Los Angeles LGBT Center, *Los Angeles LGBT Center Applauds California Legislature, Gov. Newsom for Nation's First-Ever Funding for LBQ Women*, (June 28, 2019), *available at* https://lalgbtcenter.org/about-the-center/press-releases/los-angeles-lgbt-center-applauds-california-legislature-gov-newsom-for-nation-s-first-ever-funding-for-lbq-women.

Findings and Analysis: Reproductive Justice Gaps

The interviews conducted for this report provided a wide variety of perspectives on the state of reproductive justice for LGBTQ+ individuals in LA County. Some common themes emerged from these conversations, pointing to both current gaps and future priorities. These are outlined below.

Invisibility and a Lack of Representation

Many of those we interviewed spoke about the invisibility and lack of representation felt by LGBTQ+ women and non-binary individuals seeking reproductive and sexual health care. They spoke about pervasive hetero and cis normative images, forms, and front desk staff, as well as the dearth of sexual and reproductive health providers and decisionmakers with LGBTQ+ identities. They connected this feeling to a historical emphasis in LGBTQ+ sexual health on HIV services for gay cisgender men, an issue that, while important, long overshadowed the needs of LGBTQ+ women and non-binary individuals in many spaces, creating a gap which can still be seen in Los Angeles. The recent funding win mentioned above was applauded by a number of the advocates we spoke to, who hope that these resources will begin to fill part of this gap.

> *"One of the biggest challenges facing LBQ women is that they are simply invisible...most LBQ women's identities are erased in the medical process."*
>
> **— Terra Russell Slavin**
> Director of Policy and Community Building at the Los Angeles LGBT Center
> (A similar sentiment was expressed by advocates focused on trans and non-binary individuals.)

Many of the interviewees we spoke to noted that there has been little research on LGBQ+ women and non-binary individuals, as well as on trans indidivuals. They argued that when these identities are unacknowledged (or less acknowledged) in research realms, it means that communities have less access to concrete information on the effects of different treatments or procedures. Even when research has been done, information is less readily available to LGBTQ+ individuals in mainstream sexual health

spaces. The combination of a lack of research and accessible, quality information means misinformation spreads more easily, as documented by the providers we spoke to who described having to counter pervasive myths (e.g. about how gender affirming hormones do or do not affect one's body).

This invisibility was also identified by interviewees in the images and language used in many medical informational materials, websites, and administrative forms which did not acknowledge the fluidity of sexuality and gender. As many of the interviewees pointed out, this happens even in health care and other service centers that consider themselves "welcoming" to LGBTQ+ individuals. Though often unintentional, this emphasis on heterosexual and cisgender identities can make individuals feel invisible, excluded, and devalued.

Beyond visibility in the waiting room or at the front desk, interviewees identified a need for more LGBTQ+ representation in the healthcare workforce. Interviewees did not necessarily see themselves in the providers that render health care services to their community or the decision makers who represent their community. This was brought up by interviewees in regards to both organizational leaders and elected representatives. A lack of representation, of individuals with lived experiences similar to the interviewees (or the communities they serve), means a lack of power in ensuring equitable and effective decisions. It is important to note that these gaps were identified in regards to racial representation as well as in gender and sexuality identification.

LGBTQ+ Competency and Gatekeeping

A majority of the experts interviewed identified a gap in LGBTQ+ competency among medical providers, social workers, and other healthcare professionals. This is related to the issues of visibility discussed above, but also encompasses a broader emphasis on competency for individuals working in this space. Interviewees reflecting on this theme talked about overt discrimination but also misinformation and a frequent need to explain oneself or educate a medical provider, the person at the front desk, or any other number of individuals that one may come into contact with when seeking sexual and reproductive health care, even in "progressive" spaces. Terra Russell Slavin from the Los Angeles LGBT Center shared that in her discussions with LBQT individuals, everyone had experienced some sort of discrimination, "from veiled microagressions, to

hostility and violence." As she said, a lack of visibility and competency, "affects access to what sexual health education [LBQT individuals] may be receiving, how they may be treated for domestic and sexual violence, etc."

Interviewees described gaps in competency, painfully demonstrated by medical professionals:

- Jaci Cortez from the NCYL Youth Advisory Board described how doctors often question a lesbian woman asking for birth control.
- Phimy Truong from Project Nateen put it bluntly, "I don't think...staff [is] used to viewing a queer or trans young person as someone who would have a family or be a parent."
- Corri Planck, Strategic Initiatives Manager for the City of West Hollywood noted that some women with LGBQ+ orientations face an assumption of heterosexuality, which makes striking up a conversation about starting a family that much more difficult.

> *"Medical staff don't think that there is a need for a conversation around family planning for trans people..[there is an] assumption that we have no intention to have families or bear children."*
>
> — **Gia Olaes**
> Trans Service Provider Network

This lack of competency can lead to adverse health outcomes because individuals begin to avoid medical professionals all together. This tendency was specifically mentioned a number of times for trans individuals. Dakota Belle Witt, the LGBTQ Rights Policy Advocate and Organizer at the ACLU of Southern California pointed out that some communities and organizations have created, with varying levels of formality, lists of providers who are not only LGBTQ+ friendly but also competent, providing a Band-Aid solution for a system that can often be hostile or unwelcoming to LGBTQ+ individuals. Still, Tracy Zhao, the Executive Director of Asians and Pacific Islanders for LGBTQ

Equality, pointed out that LGBTQ+ competent providers don't always accept a patient's insurance plan, especially when it comes to mental health care.

Interviewees expressed feeling that medical providers act as "gatekeepers" by making assumptions based on gender identity and/or sexual orientation about what a person needs and what procedures or supports are applicable. HIV came up multiple times in this context. Kristen Flickinger and Terra Russell Slavin from the Los Angeles LGBT Center pointed to instances of medical providers assuming lesbian women had a positive HIV status, with others refusing to administer an HIV test based on the fact that a patient identified as a lesbian woman. And Maria L. Roman-Taylorson, Vice President & Chief Operations Officer at Translatin@ Coalition, spoke of individuals being tested for STIs without expressing desire or giving consent to the medical provider.

The experience of provider "gatekeeping" also came up very frequently in regards to the process of seeking gender-affirming care. As Maria from Translatin@ Coalition described, trans individuals are asked to get the sign off of a mental health provider- to "prove" their need for hormones and be given a diagnosis- and are often asked to repeat this process across providers. Many advocates we spoke to discussed the harm caused by this gatekeeping. As Gia from TSPN said, "having to display as sick to access hormones, and [having to receive] a diagnosis to get services puts an individual in an even more marginalized space." Many advocates, including Tracy from API Equality, explained that this link between mental health care and hormone therapy means that trans individuals cannot always feel safe in therapeutic spaces, and are therefore not necessarily meeting their mental health needs. As Dr. Johanna Olson-Kennedy, Medical Director at The Center for Transyouth Health and Development (Children's Hospital Los Angeles), said:

> *"The community has a script that the community and members of the community need to follow in order to get what they need...people are required to engage in therapy before they start medical interventions...that therapist is going to act as an assessor, an evaluator, but then they are also supposed to have this role of this*

person that you establish a therapeutic relationship with. But you can't do that if you know that this person is either going to give you a checkmark or not…

There is such a mistrust created, such harm perpetuated on the community because of this model, that overarching thing of 'we don't trust you to know your own gender' and even more than that, 'we don't believe in your autonomy to take on that risk.'"

— Dr. Johanna Olson-Kennedy
Medical Director at The Center for Transyouth Health and Development
Children's Hospital Los Angeles

As Dr. Olson also pointed out, this mistrust means that trans individuals are often less likely to want to participate in research, which makes it harder to answer important questions and grow trans provider competency.

Funding Inequality

The lack of visibility and competency discussed above have contributed to a lopsided distribution of funding for LGBTQ+ sexual and reproductive health. Again, many interviewees brought up the fact that historically, funding for research and services within these communities has been focused on gay cisgender men and HIV, or STIs more broadly. Oliva Campbell from the Los Angeles LGBT Center spoke about how LGBT spaces in the past often grew out of a desperate need for HIV services, which left other gaps open. Today, the invisibility of certain populations continues to mask needs. Terra Russell Slavin, also from the Los Angeles LGBT Center, who helped advocate for the recent budget win for LBQ funding, reflected on the fact that in the process of seeking funding she often heard, "Is it really that big of an issue?" This misconception provides an indication of the struggle that still lies ahead in the fight for visibility and equitable funding.

Part of this lack of awareness may stem from the fact that Californians think of themselves as progressive and as Tracy Zhao from API Equality said, may see the state as "all set" after progress on marriage equality, discrimination protections, and other LGBTQ+ issues. We know this is not true, even after the more recent budget win; this

one pot of money does not answer all the needs of the diverse communities we are discussing here. Disparate funding is not just seen between different gender identities and sexual orientations but also across different geographies and races/ethnicities within LGBTQ+ identified groups.

There is a particular lack of funding when it comes to organizations focused on communities of color and/or on geographic regions beyond typical LGBTQ+ strongholds. Marie-Fatima Hyacinthe, the Training and Capacity Building Manager at The Black AIDS Institute pointed out the alignment of these geographic disparities with racial gaps- specifically the fact that despite high *prevalence* rates of people living with HIV in West Hollywood, the "higher *incidence* rates are in poorer, blacker

neighborhoods." She also pointed to the fact that "It is very hard to get sustainable funding for projects around Black women and HIV- part of that is because the rates for Black women have gone down but they are still so much higher than women of other races." She noted: "We have all the biomedical tools to end the epidemic...we have all the science...it's the disparities that are getting in the way."

Jessica Amaya, the Board President of the San Gabriel Valley LGBTQ Center, described what she sees as a focus on the Westside of Los Angeles, which was echoed by other interviewees, who saw a need for more investment, particularly beyond West Hollywood and Santa Monica.

It is important to note that trans individuals were not highlighted in the recent state budget, though Translatin@ Coalition made an advocacy push. Maria from Translatin@ Coalition explained that this push was part of their larger effort to get funding for community needs beyond HIV.

Across LGBTQ+ communities, it is clear that more funding is needed to support services, research, and advocacy for a more equitable Los Angeles.

Unaddressed Social Determinants of Health

Perhaps the most consistent theme across the advocates we spoke to was the emphasis on social determinants of health. The Federal Office of Disease Prevention and Health Promotion defines social determinants of health as "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." They reference examples such as "Availability of resources to meet daily needs (e.g., safe housing and local food markets); Access to educational, economic, and job opportunities; Access to health care services; Quality of education and job training;

Transportation options; Public safety; Social norms and attitudes (e.g., discrimination, racism, and distrust of government)."[38]

When we asked "What are some of the unique challenges _____ [insert community of focus] face in accessing SRH in LA County?" we had expected to hear an emphasis on issues of racism, sexism, transphobia, homophobia, ableism, xenophobia, etc. While those issues were apparent in many conversations, it was the challenge of housing that came up most frequently, in almost every single interview. Those that we spoke to expressed the fact that individuals can't focus on their sexual and reproductive health when they are too worried about this more "basic" need.

Advocates also mentioned barriers related to transportation, substance use, health insurance, and access to broader health care, along with instability in employment and schooling:

- Asher Gellis, Executive Director of JQ International shared: "We are seeing an increased number of people not taking care of themselves because it is too expensive and their housing is too expensive…life is too expensive…and they are making sacrifices to their health as a consequence."
- Olivia Campbell, Nurse Practitioner at the Los Angeles LGBT Center emphasized: "Housing and access to health insurance and mental health care- I can't do much if those things aren't in place- it's just not possible."

[38] Office of Disease Prevention and Health Promotion, Social Determinants of Health, available at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

- Phimy Truong, Project Coordinator for Project NATEEN, pointed out that those who move from school to school often miss sex education and that those with limited access to transportation have a hard time keeping up their health, as it is hard to make it to any medical appointments.

Joaquin Gutierrez, Coordinator for C2PLA, explained that the young people he works with are less focused on issues of sexual and reproductive health and more concerned with:

"How am I going to eat today? How am I going to help my mom pay the rent? How am I going to stay safe?"

Unaddressed social determinants of health were even more apparent for advocates working with the trans community in Los Angeles. Housing insecurity is heightened and the options for inclusive housing support are limited. Advocates also emphasized the threat of physical violence, especially for trans women of color.

- Gia R. Olaes from the Trans Service Provider Network noted "...relying on local shelters is not really an option for a lot of trans women unless they are willing to experience some discrimination and a whole lot of discomfort."
- Dakota Belle Witt, Policy Advocate and Organizer at the ACLU, blatantly put it: "How are you going to get to the doctor when the trip there could put your life in jeopardy?"
- Maria L Roman-Taylorson explained that reproductive and sexual health has not been a big focus for Translatin@ Coalition "...because the truth is that the majority of folks we are providing services to sometimes that is sort of on the backburner. The main issue at hand... is the fact that the key essential things to be able to survive- shelter and food- are kind of missing...so to think of developing a family, having a healthy relationship, those things are sort of secondary to the fact that people are in survival mode. I have always felt that as a trans woman, many of us are in fight or flight mode, from the minute we leave our home- our guards are up because we are always under attack."

To work on reproductive justice is to work on social determinants of health, ensuring housing, safety, and stability. These directly impact an individual's ability to maintain bodily autonomy and make decisions about their sexual and reproductive health.

Advocate Recommendations and Best Practices

We asked each interviewee the following:

1. What types of investments need to be made most immediately to improve the quality and/or increase access to sexual and reproductive health services in LA County?
2. How do you feel the current dynamics of power need to change in order for these changes/recommendations to be successful?

The interviewees' responses and recommendations largely aligned with the gaps described earlier in this report. For each recommendation, we have outlined suggestions for providers, guidance for policymakers, and best practices which are largely relevant to both groups.

1. Create Visibility and Representation

Provider Recommendations

To ensure individuals feel seen, valued, and empowered, providers should:

- Prioritize creating materials, offices, and spaces in which individuals can see themselves represented
    - Emphasize diverse images and references on websites and in informational materials
    - Create forms that recognize the gender spectrum
- Grow relationships with non-traditional partners to more widely share information
    - Ensure that community centers, foster homes etc. have resources on reproductive health for LGBTQ+ individuals

    - “Put non traditional things in traditional places so that it becomes the norm”- Jessica Amaya, San Gabriel Valley LGBT Center
- Build leadership pathways to link frontline staff to positions of power
- Establish and empower advisory bodies to provide their own affected communities with a voice

> *“Put non traditional things in traditional places so that it becomes the norm.”*
>
> **— Jessica Amaya**
> San Gabriel Valley LGBT Center

Best Practices

- Marie-Fatima Hyacinthe at The Black AIDS Institute described the many ways in which the organization intentionally ensures that their materials and services are inclusive and representative. She framed it as “an essential mobilizing concept- the people closest to the problem need to lead” and added, “this has been an ongoing theme since our founding.” She described:
    - The Black Women and PrEP Toolkit-built by Black women on the staff and in focus groups.
    - Their Peer Mentorship program- mentors help connect their peers to HIV services in LA County
    - When forms are not inclusive: “We teach people how to ask open ended questions around gender, race, and sexual orientation - how to go back separately and fill in the forms but not put people into a box they don’t subscribe to.”
- San Gabriel Valley LGBTQ Center volunteers received and are now providing “Safe Zone” trainings — “a LGBTQ+ 101 course” which provides basic information on different gender identities, sexualities etc., and how to create a safe space.
    - These trainings are held in partnership with medical providers as well as many non-medical organizations, including foster homes and schools (from teachers to bus drivers)

- The LA RHEP Youth Advisory Board provided feedback to LA RHEP members on how to improve the inclusivity of their websites:
    - “We said ‘you should use more youth friendly language, you should have more LGBT+ resources’...they took our feedback...they fixed [their websites] so that all youth would feel comfortable. Before it was more heteronormative.”- Jaci Cortez, Youth Advisory Board

Policymaker Recommendations

To ensure communities feel seen, valued, and empowered policymakers should:

- Support a pipeline for medical providers and clinic staff that represents the intersectional identities found in their community
    - “This could come in the form of outreach and scholarship”- Jordan Aiken, Bet Tzedek
- Get a more diverse group to decision-making tables
    - Ensure that people with lived experience are at the table, To support this, provide more transparency about how LA County governance functions.- Marie-Fatima Hyacinthe, Black AIDS Institute
    - Build advisory bodies ***and*** integrate community members into standing leadership bodies
- Address gaps in data by funding more research on LGBTQ+ communities in LA County, with particular attention to LGBTQ+ women and non-binary individuals
- Monitor implementation and enforcement of California’s prohibition on sexual orientation/gender identity discrimination (including by health providers and insurance plans)
- Ensure implementation of California’s requirements for sex education inclusivity

2. Promote LGBTQ+ Competency

Provider Recommendations

To ensure individuals feel understood, respected, and supported, providers should:

- Prioritize LGBTQ+ competency training for all medical staff and administrative workers who work in spaces that are intended to support mental and physical health

Best Practices

Many advocates described their organization's efforts to train up their staff.

- The LA County Lesbian, Bisexual, and Queer Women's Health Collaborative conducts free professional development trainings. The trainings focus on exhibiting cultural humility and sensitivity, examining health disparities, fostering disclosure, promoting inclusive care and environments, and clarifying terminology.
- The Black AIDS Institute ensures the organization's competency in its internal and external work through many efforts, including staff training on:
    - "Social determinants of health and health equity- to frame HIV as a social and racial justice issue"
    - "Gender, sex, and sexuality…to make sure we are all on the same page on pronouns, gender identity vs sex, etc."- Marie-Fatima Hyacinthe
- Many other organizations like the San Gabriel Valley LGBTQ Center and the Children's Hospital Adolescent Medicine Division described similar trainings for their staff. However, all discussed the need to further strengthen and scale up these efforts through additional resources and organizational emphasis.

Policymaker Recommendations

Organizations like those listed above, and others mentioned throughout this paper, provide valuable examples of efforts that the County can seek to scale up and institutionalize. We urge policymakers to:

- Create mandatory LGBTQ+ competency training for county medical staff (including administrative and other frontline staff) which includes learning on sexual orientation as well as gender identity and expression

3. Alleviate Funding Inequality

Provider Recommendations

To ensure that funding accounts for the specific needs of communities that haven't been previously prioritized, providers should:

- Seek more funding to tailor services to LGBTQ+ women and non-binary individuals to ensure their reproductive and sexual health needs are met
- Apply for more funding across diverse geographies, to serve communities that have been previously geographically isolated from LGBTQ+ resources

Best Practices

- The LBQ Women's Health Equity Fund win presents an example of coalition work amongst groups seeking to serve these communities.
- The Los Angeles LGBT Center is working to better target LGBTQ+ women through their Audre Lorde Center.
    - Those we spoke with at the Center expressed that historically this effort was reliant on individual efforts.
    - To increase the Center's success, these efforts need to become further institutionalized, which requires both the LGBTQ+ communities' commitment and the continuance of public funding and government support.
- A number of organizations we spoke to had conducted their own research in the form of needs assessments, despite limited funds. Such efforts provide data which reduce invisibility and can be used for funding advocacy.

Policymaker Recommendations

To narrow the gap policymakers should:

- Trust communities in need- fund services for groups/geographies that have not previously been prioritized

- Fund further research to demonstrate the needs of these groups more broadly and methodically
    - Research must prioritize the disaggregation of data to better understand the unique intersections in each community

4. Emphasize Social Determinants of Health

Provider Recommendations

To truly employ a reproductive justice framework to their work, providers should:

- Partner with those working on affordable housing, education, violence prevention, transportation, and economic justice

Best Practices

- Bet Tzedek Transgender Medical-Legal Partnership provides training for medical professionals working with trans individuals so that the medical workers can more effectively direct patients to legal services.
    - The Partnership has worked with:
        - Medical social workers
        - Shelters, community centers, hospitals, and mental health services
        - The LGBT Bar Association of Los Angeles
        - Project Q, LA Law Library, and Planned Parenthood
    - “We [providers and legal experts] work together using the skills that each is best at”- Jordan Aiken
- Translatin@ Coalition was being approached by folks who were experiencing homelessness or housing insecurity. As a reaction to this need the organization started what it calls the “HOPE house”:
    - A transitional living program with wraparound services for transgender, gender non-conforming, and intersex individuals in which:
        - Employees are trans, gender non-conforming, and intersex individuals

        - Housing is $500 a month, but participants receive $3,000 when they graduate and find their own permanent housing
        - Case managers provide individualized plans- “no cookie cutter approach”
- Alexis Sanchez from the from the West Hollywood Transgender Advisory Board lifted up APAIT, an organization that was not interviewed but is working in reproductive health (on HIV and other health disparities).
    - Alexis pointed to their efforts to address certain social determinants of health through bus tokens, a ride- sharing partnership, and assistance on connecting individuals to benefits.

Policymaker Recommendations

There are opportunities for policymakers to both directly advocate for improvements on social determinants of health and to better connect organizations that can work together at these intersections. Policymakers should:

- Create more County opportunities for community and alliance building
    - Connect service providers and funders through events that bring together organizations/agencies to raise awareness and open up funding paths-Enrique Lopez, Colors LGBTQ Youth Counseling Services
- Stop arrests for prostitution, loitering, and crimes of survival
    - “Stop punishing people for surviving”- Dakota Belle Witt, ACLU of Southern California
- Advocate for healthcare for all
    - “Even if people pay for insurance, they can’t get healthcare they need”- Asher Gellis, JQ International
- Protect current affordable housing and grow affordable housing stock across the County

Final Thoughts

We hope that this report proves to be a valuable resource for future advocacy efforts to grow funding and programming, promote leadership, and create progressive policy change to improve LGBTQ+ sexual and reproductive health, and pursue reproductive justice, in LA County.

APPENDIX

Appendix A: Interview Script

Hi, my name is _____and I am a member of the Los Angeles Coalition for Reproductive Justice. Los Angeles Coalition for Reproductive Justice (LACRJ) is a coalition of over 20 social justice and health organizations collaborating to enhance reproductive health, rights, and justice in Los Angeles. If you agree, I will be creating an

audio recording only to ensure that I accurately represent our conversation. Please let me know if you would like your identity to remain confidential beyond this meeting.

Thank you for agreeing to be interviewed for our research on sexual and reproductive healthcare in the LGBTQ+ communities. We expect this interview to take approximately one hour. The purpose of this study is to better understand the current landscape of SRH work in this community, gaps in access/services, and priorities for investment.

We will be interviewing other advocates like you and will use the information collected from the interviews to draft a report. Your insights will help elevate the SRH needs of LGBTQ+ individuals to local policymakers. Please know that there are no right answers and I hope that you will feel comfortable sharing your true thoughts. Let's get started:

1. What does your organization/project do?
2. Do you work with a specific community within this population?
    a. If so, which one?
    b. [For Service Providers]: Have you received training to serve this community? If so, what did that training entail?
    c. [For those working in advocacy]: How do you engage or outreach members of the community? Did you receive any education particular to engaging with this community? If so, what did the education entail?
3. What types of issues does your organization currently focus on?
    a. [If not answered by the above]: Please describe the core issues/topics of your work on a daily basis.
    b. What methods does your organization use to achieve its goals? (litigation, policy advocacy, etc)
4. Why did you/your organization choose these areas of focus?
    a. Is this different than the issue or community that receives the most attention and resources?
        i. Why do you think this other issue or community receives this focus?
5. What are some of the unique challenges _____ [insert community of focus] face in accessing SRH in LA County?
    a. [Probe]: Issues of racism? Sexism? Transphobia? Homophobia? Ableism? Xenophobia?

6. What are some SRH projects/initiatives your organization has taken on in the past that worked?
    a. What did you do? How did you do it? Who did you serve? What made it successful? How did you measure success?
    b. Why do you think this project/initiative was successful?
    c. What did you learn from this experience?
        i. Did this change the work of your organization?
            - If so, how?
7. What are some SRH projects/initiatives your organization has taken on in the past that didn't work?
    a. Why do you think this project/initiative failed?
        i. [Probe]: Lack of funding? Lack of time? Lack of coalition? Something else?
    b. What did you learn from this failure?
        i. Did this change the work of your organization?
            - If so, how?
8. Does your organization have any SRH priorities moving forward?
    a. Are there new directions you are envisioning?
9. What districts are you active in?
    a. Does your approach to work in one district vary from your work in another?
    b. If not mentioned, probe further: do you do any work in District 3? If so, could you please describe this work.
10. What types of investments need to be made most immediately to improve the quality and/or increase access to SRH services in LA County?
    a. Where do these investments need to go?
    b. [Probing]: What do you think the priorities should be for the county and/or health agencies?
11. How do you feel the current dynamics of power need to change in order for these changes/recommendations to be successful?
12. Do you have anything to add? Anything else you would like me (or others) to know?

Thank you again! We will share our report with you and ask for your feedback before it is released.

Appendix B: Timeline (June - December 2019)

- June
    - Designed methodology with input from Dr. Paula Tavrow, UCLA Associate Adjunct Professor
    - Coalition built list of potential organizations to interview
    - Wrote and gathered feedback on interview script
    - Workshopped the organization target list and interview script with the Research Implementation Committee
    - Finalized one page summary document to be distributed via intros
    - Connected with initial organizations of interest through Coalition member networks
    - Set up preliminary calls
- July
    - Worked with the Supervisor's office to broaden list of SD3 organizations
    - Reached new organizations through Supervisor and coalition introductions
    - Scheduled interviews
- August
    - Completed eight interviews and scheduled more
- September
    - Completed seven interviews
    - Outlined initial themes
- October
    - Continued building report outline
    - Conducted research workshop at the coalition's monthly meeting, collected and incorporated coalition feedback
    - Completed final interviews
- November
    - Completed analysis and writing

    - Conducted research workshop at the coalition's monthly meeting, collected and incorporated coalition feedback
- December
    - Conducted research workshop at the coalition's monthly meeting, collected and incorporated coalition feedback
    - Collected and incorporated interviewee feedback
    - Finalized report