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Cultural Safety Framework for LGBTQIA+ Communities

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LEARNING OBJECTIVES

By the end of this chapter, the reader will be able to:

- List three ways that cultural safety differs from cultural competence.
- Identify the five tenets of cultural safety that will be used throughout this book to frame care for LGBTQIA+ people.
- Self-reflect on personal biases that prevent provision of culturally safe care.
- List clinical care modifications supporting the cultural safety for LGBTQIA+ patients.

INTRODUCTION

Although many readers may be most familiar with the term *cultural sensitivity* or *cultural competence*, this text instead uses *cultural safety* to frame best practice recommendations. The idea of cultural sensitivity focuses on the basic awareness and willingness to learn about cultural differences.[1] The term *cultural competence* is perhaps what most clinicians are familiar with, and it is often used to describe provider awareness about the beliefs, values, and norms for various diverse groups of people

From: Clinician's Guide to Lgbtqia+ Care
DOI: 10.1891/9780826169211.0001

and how we provide patient-centered care that respects differences in values, preferences, and needs.[2] These approaches, however, continually place the provider, not the patient, at the center. Culturally competent care was meant to be provided through a framework of patient empowerment.[3] Encouraging the examination of inherent power dynamics within the provider-patient relationship requires a strong theoretical foundation found to be lacking in cultural sensitivity and cultural competence frameworks.[4] Thus, these approaches are largely inadequate, especially for addressing the needs of marginalized groups, such as LGBTQIA+ communities.[4]

Cultural safety, however, reframes the cultural sensitivity and cultural competence approaches by building personal awareness and emphasizing patient-centered care. "Cultural safety involves understanding histories, safety needs, power imbalances and the influence of staff values and beliefs on service delivery."[5,6] Cultural safety is different from other frameworks because *safety* is defined by the patient rather than the healthcare provider. Cultural safety requires that healthcare providers prioritize the patient narrative, build community partnerships, and reflect upon the inherent existing power imbalances involved in patient care.[6] In order to achieve cultural safety, healthcare providers must seek out educational opportunities to guide personal, community and institutional growth while building strategic partnerships with LGBTQIA+ communities.[5,6] The authors of this text ask that you see beyond cultural sensitivity and competence and use the tools we provide to foster *cultural safety* for all patients (Figure 1.1).

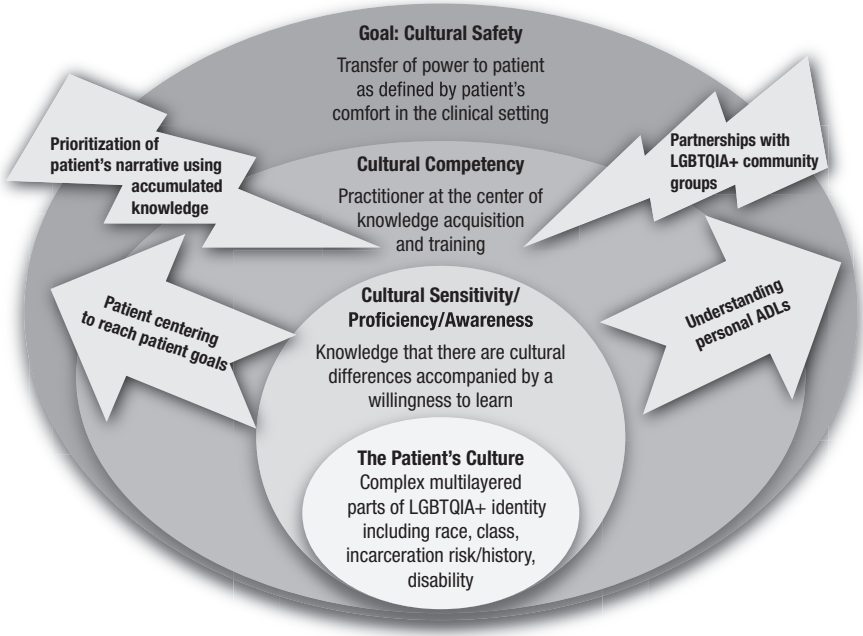

FIGURE 1.1 Connecting cultural competency to cultural safety. ADLs, activities of daily living.

OVERVIEW OF CULTURAL SAFETY

The goals of cultural safety go beyond recognizing disparities, and instead challenge systems that create inequality by focusing on provider-patient power dynamics as a source of this inequality.[7] To support the mission of this book, we have illustrated a model of cultural safety based on cultural safety literature. We describe cultural safety for LGBTQIA+ people using five main tenets that were adapted from the broader cultural safety literature.[4,7,8] These five tenets are: *partnerships*, *personal activities of daily living* (*ADLs*), *prevention of harm*, *patient centering*, and *purposeful self-reflection*.

More specifically, cultural safety seeks to form *partnerships* with patients in order to transfer power from the provider to the patient. It seeks to understand the patients' *personal ADLs* or everyday norms and experiences and incorporate them into clinical care. *Prevention of harm* is based on an understanding of what the patient needs to stay safe, with frequent check-ins from clinicians about whether the interactions or plan of care might inadvertently cause further harm. Also imperative for clinicians is to demonstrate *patient centering* by listening and providing meaningful care that fits into patients' lives. Finally, *purposeful self-reflection* is a process of uncovering one's own biases and beliefs that may lead to stigmatization or judgment, and transforming them so as to create a nonjudgmental environment.

Understanding clinical care through a cultural safety framework will provide a comprehensive approach to the management of the whole patient. This textbook will serve as a guide for clinicians in the management of LGBTQIA+ patients across primary care settings, sexual and reproductive health encounters, and urgent or emergency care. We will utilize a cultural safety framework to illustrate known barriers in accessing care for LGBTQIA+ patients. We will lean on this framework to demonstrate how the clinical needs of LGBTQIA+ patients are best met when care is approached through a cultural safety lens. What follows is a brief description of history of cultural safety, how it specifically applies to LGBTQIA+ patients, and an overview of the five major tenets of cultural safety used throughout this book.

ORIGINS OF CULTURAL SAFETY FRAMEWORK

Cultural safety was originally defined by Irihapeti Ramsden, a Maori Nursing Scholar working to ensure indigenous/aboriginal health equity.[8] Ramsden defined five major tenets of cultural safety as partnerships, protocols, process, positive purpose, and personal knowledge.[8] Overt, deliberate, and systemic change must be targeted and healthcare access and delivery must be improved for marginalized populations in order to create a space that is culturally safe for historically oppressed populations such as LGBTQIA+ individuals. Additionally, according to Ramsden, personal knowledge must include ongoing provider action shaped by self-reflection, and engagement or support of advocacy work that challenges and/or dismantles the provider's biases.[8] Finally, understanding historical and present day experiences of oppression is also a crucial component for enacting cultural safety.[8]

CULTURAL SAFETY AND LGBTQIA+ POPULATIONS

Based on these origins, it is important to examine closely the experiences of LGBTQIA+ people in healthcare today. According to the Healthcare Equality Index (the national benchmarking tool for LGBTQ healthcare equality), LGBTQIA+ patients are, by and large, unhappy with the care they are receiving by their healthcare providers due to stigma and bias.[9] LGBTQIA+ patients avoid seeking healthcare services, or avoid full disclosure about their sexual orientation or gender identity rather than face the possibility of misunderstanding, discrimination, or even maltreatment by a healthcare provider. Of those surveyed for the Health Equality Index in 2014, 70% of transgender and gender-nonconforming respondents and almost 56% of lesbian, gay, or bisexual respondents had at least one of the following negative experiences[9]:

- Healthcare providers using harsh or abusive language
- Healthcare providers refusing to touch them or using excessive precautions
- Being blamed for their health status
- Healthcare providers being physically rough or abusive
- Patients being refused needed care

The clinical care that LGBTQIA+ patients want and deserve must not be prohibited by provider or institutional bias, cost of care, or lack of provider knowledge.[10–12] LGBTQIA+ patients deserve to receive healthcare that supports and decreases harm. End of story. Each tenet of culturally safe care, as described in the text that follows and illustrated in Figure 1.2, is essential.

Research suggests that many clinicians have little experience caring for LGBTQIA+ populations.[13–15] This lack of experience impacts provider confidence to adequately care for patients identifying as LGBTQIA+, which leads to increased health disparities.[15] This book has been created as a guide to caring for LGBTQIA+ populations. To guide clinical practice, we use a cultural safety framework encouraging self-reflection and critical examination of interpersonal and societal power dynamics.[4] Care must reach beyond the low expectation of competency in order to best serve the needs of LGBTQIA+ patients.[4] "Cultural knowledge is important, but knowledge about how populations are marginalized is vital" (p. 97).[16] With that statement, Meleis and Im acknowledge that clinicians must be able to provide care informed by the narratives and history of oppression experienced by their patients.[16] Historical processes of oppression are fueled by ideologies that shape what is considered normal, and these processes subsequently create categories of individuals seen as "other," contributing to marginalization and inequalities.

THE DETRIMENT OF NORMALCY

Ideas of normalcy about sex, gender, and sexuality pervade healthcare and institutional spaces. Diagnoses produce categories of "health" versus "illness" that

incorporate norms about gender and create systems of disciplinary power and reinforcement of racialized gender norms within our society.[17] In "Queer History, Mad History, and the Politics of Health" (2017), Kunzel[18] points out that medical systems have historically decreased autonomy and agency of LGBTQIA+ people by labeling common nonheterosexual, noncisgender identities as diagnoses or pathologies. Efforts to construct gayness as healthiness worked to align the definitions of modern lesbians and gays with gender normativity, supposed whiteness, and mainstream economic/relationship acceptability while showing all other types of queer/gay individuals as being the exception and representative of sickness and lack of health.[18] These ideas of normalcy and its associations with health continue to persist within healthcare. For example, LGBTQIA+ patients seen as "good" are contrasted with those who experience state violence, incarceration, institutional exclusion, racism, and other forms of prejudice. Kunzel clearly showcases how whiteness and economic stability in LGBTQIA+ populations is associated with "good" LGBTQIA+ identity while BIPOC (Black, Indigenous, people of color) populations are less likely to achieve that same status.[18]

Categories and ideas of normalcy create exclusion and lack of comfort for LGBTQIA+ patients including those with intersectional identities, such as African American trans women or same gender loving men of color or LGBTQIA+ people with disabilities as well as people who fall along the asexuality spectrum. Patients engaged in illegal activities such as sex work, despite the common cultural bias against such activities, will also face pathologization in healthcare settings due to ideas of normalcy.[18,19] As Spade and Willse state, "[b]y reconceptualizing how power works and attending to different forms of power, we can account for the seeming contradictions of systems where control occurs in multiple intersecting ways, including through processes of norm creation and enforcement that help us all see, experience and reproduce ourselves and the world according to racialized gender hierarchies" (p. 5).[17]

FIVE TENETS OF CULTURAL SAFETY FOR LGBTQIA+ POPULATIONS

With this understanding of the cultural safety framework and historical processes that contribute to lack of safety for LGBTQIA+ populations, what follows is an introduction to the main tenets of cultural safety we will use throughout this book. We will also discuss how culturally safe healthcare for the LGBTQIA+ patient will support health equity. Throughout the textbook, we will weave together details about how reproductive, racial, disability, and economic justice are impacted within these populations. We begin with outlining the five tenets of cultural safety, illustrated in Figure 1.2.

Tenet 1: Partnerships

Partnering with the patient and community provides collaborative care, and respects and incorporates patient knowledge and experiences as vital. When partnering with

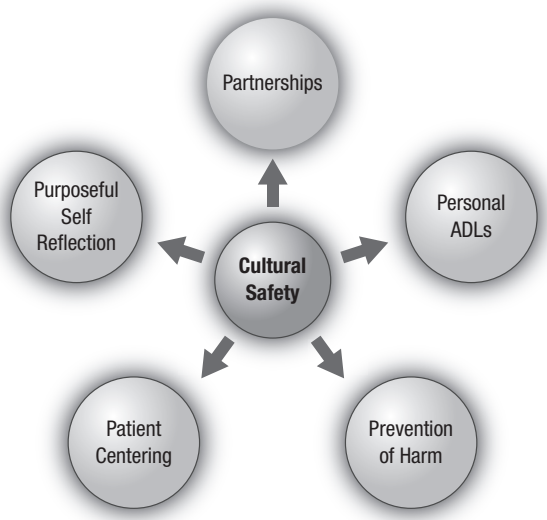

FIGURE 1.2 Cultural safety model for working with LGBTQIA+ populations.
ADLs, activities of daily living.
Source: Data from Ball J. Cultural safety in practice with children, families and communities. *Early Childhood Development Intercultural Partnerships*. Accessed November 19, 2019. http://www.ecdip.org/culturalsafety; Brascoupé S, Waters, C. Cultural safety exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *Int J Indig Health*. 2009;5(2). doi:10.3138/ijih.v5i2.28981; Ramsden I. Cultural safety. *N Z Nurs J Kai Tiaki*. 1990;83(11):18–19.

patients to achieve cultural safety, providers should work to unite with patients and the community in order to provide collaborative care and transfer of power to patients, while respecting and incorporating patient knowledge and experiences. With LGBTQIA+ communities, this means providing care for patients as partners in their care. How does "Partnering" look?

Tenet 2: Personal Activities of Daily Living (ADLs)

Personal ADLs include an understanding about the daily activities of life and survival that LGBTQIA+ individuals engage in as they face marginalization, stigma, and discrimination within society. Providers must explore and understand these experiences and the daily tasks that help people to resist and survive these challenges. In order to provide culturally safe care, clinicians must avoid asking patients to explain themselves, their practices, and identities in a way that resonates as invasive, ignorantly curious, or unnecessary. Researching about the various daily struggles that LGBTQIA+ people face and respecting ADLs is crucial. Avoiding asking unneeded, not-overly-curious questions about these practices helps to create trust between providers and patients. When working with patients whose gender identities or sexual practices may be unfamiliar to clinicians, be aware that various personal ADLs may

be important to understand and discuss in a nonjudgmental way. For example, a norm for many trans men is chest-binding either before or instead of double mastectomy. Chest-binding can cause chest pain, muscle atrophy, or other musculo-skeletal complications.[20] Clinicians who are working toward cultural safety would support patients to achieve their desired gender presentation through this personal ADL of chest-binding, despite the risk of clinical complications.

Tenet 3: Prevention of Harm

Prevention of harm is patient-driven engagement that works to support a patient's journeys toward health. Providers should engage in mutual learning with frequent check-ins to make sure the plan of care is safe and appropriate for the patient's lifestyle. This means, for example, supporting LGBTQIA+ patients who may be engaged in underground economy jobs such as sex work and helping to decrease harm in patients' lives by offering more routine STI testing, prophylaxis medication such as PrEP, or expedited treatment. Or, with regards to the previous example of trans men doing daily chest-binding, clinicians can recommend activities such as stretching or massage to decrease muscular atrophy and pain from this practice. In each case the focus should and must be the patient's priorities, even though clinicians recognize that there may be complications as a result of these goals.[21]

Tenet 4: Patient Centering

Patient centering is when the practitioner provides the means to achieve healthcare goals as decided by the patient, and then helps the patient move toward their goals. When providers have aligned purposes with patients, to provide the means to achieve the goals that patients want and/or need, this solidifies clinicians as part of patients' positive moves toward their goals. Completing prior authorizations with insurance companies is a simple way of helping trans and gender expansive patients access gender affirming care. Supporting patients without judgment when they are in difficult relationships also supports patient centering.

Tenet 5: Purposeful Self-Reflection

Purposeful self-reflection is when the provider becomes aware of their own cultural beliefs, including reflecting on their own blind spots and internal biases. This requires self-reflection and processes of accountability to deal responsibly with these internal processes, so they do not interfere with the provider-patient relationship. Providers should develop a practice of self-reflexivity to develop awareness of innate, tacit, and biased cultural beliefs in order to address them. In the context of the powered provider-patient relationships, the onus of understanding cultural biases falls on the provider rather than the patient. With LGBTQIA+ patients (as with most patients), it may not be appropriate to speak these biases out loud but instead to eradicate their impact within the patient experiences.

ONLINE TOOLS FOR SELF-REFLECTION

- **Break the Prejudice Habit:** https://breaktheprejudicehabit.com/
- **LGBT Health Education Implicit Bias Guide:** www.lgbthealtheducation.org/wp-content/uploads/2018/10/Implicit-Bias-Guide-2018_Final.pdf
- **Hidden Bias Test:** www.tolerance.org/professional-development/test-yourself-for-hidden-bias

ENACTING CULTURAL SAFETY WITHIN SPECIFIC LGBTQIA+ PATIENT POPULATIONS

What follows is a description of barriers to culturally safe care experiences by various LGBTQIA+ population groups, followed by brief examples of how the five tenets of culturally safe practices can be applied to benefit the health and well-being of LGBTQIA+ patients. Although groups are labeled according to commonly used identity terminology, we caution against assuming all people who describe themselves using a certain label will have identical or even similar experiences. Experiences of healthcare are influenced by the many identities that patients hold as well as the entrenched biases that systems, institutions, and providers have. This includes the resources available based on insurance and clinical/hospital access. Cultural safety approaches and considerations will be summarized at the end of each chapter throughout this book, providing greater detail about specific aspects of care and patient scenarios.

Several examples of the root causes of various barriers to culturally safe care for LGBTQIA+ populations include:

- Lack of understanding about gender diversity and the resulting assumptions about gender identity in relation to assigned-at-birth sex impacts trans people's ability to receive culturally safe care in all healthcare settings.[22,23]
- Assumptions about heteronormative sexual orientation and identity prevent lesbian, bisexual, and gay patients from receiving care that acknowledges their relationship experiences.[14]
- Lack of knowledge regarding innate diversity of human physiological and endocrinological differences, beyond the incorrect assumption that sex is binary, impacts the care of intersex patients.[24]
- Misunderstanding of healthy sexuality as driven by dominant ideologies about physical desire, romance, and marriage impacts proper healthcare of asexual patients.[25]

The following are some specific barriers for various groups of people in the LGBTQIA+ umbrella.

For People Who Are Trans, Nonbinary, or Gender Diverse: The barriers that trans and nonbinary people face in clinical settings have still not been fully addressed,

despite the abundance of available guidelines.[11,26] Within the healthcare setting, trans patients report denial of care and verbal harassment, as well as lack of provider knowledge regarding appropriate gender-affirming interventions as barriers to revealing trans-status.[27] These barriers to care demonstrate the lack of cultural safety, especially a lack of patient centering and purposeful self-reflection that has led to a devaluation of trans people's narratives, needs, and experiences.[28–30] In this textbook, cultural safety will guide all aspects of the care of trans patients, including preventive care, hormonal care, surgical care, nonbinary and gender nonconforming identities, and fertility options, as well as some aspects of psychosocial well-being.

For Lesbians, Same Gender Loving/Attracted Women, Women Who Have Sex With Women, and More: For lesbian-identified people and women who have sex with women, care is often complicated by a lack of provider knowledge about the health needs for people who have experiences outside of the dominant heterosexual culture's understanding about sexual identity and behavior.[31] Dominant ideologies assume penile-vaginal or insertive-receptive sex is the norm, and anything outside of that is often misunderstood. Health needs for women, including trans feminine people, who have sex with women or lesbian-identified people must also include racial, cultural, and economic differences that impact their patient process.[31] Care that incorporates personal ADLs for same gender loving/attracted women might include asking questions about what types of sex a person is having, if and how toys are used, and what body parts go where during sex. Understanding what kind of sex people are having is crucial to understand what types of sexual health screening is appropriate or unnecessary. For example, a lesbian-identified patient may be of trans experience themselves, or have, for example, trans feminine or trans masculine partners; this changes some aspects of these lesbian-identified patients' care because patients may have unique fertility or contraceptive needs. Additionally, trans masculine patients may have similar health needs to same gender loving/attracted women.

For Bisexual/Pansexual Patients: Bisexual- and pansexual-identified people experience increased disparities in LGBTQIA+ communities due to the stigmatization of being attracted to people of various genders. Often bisexual and pansexual people are labeled as "promiscuous" or incorrectly as nonmonogamous, simply because they acknowledge attractions to multiple different types of people. People who identify as bisexual may find themselves hiding their identities or having their identities erased within the LGBTQIA+ community, and therefore less likely to access resources than gay- or lesbian-identified patients. Lifetime intimate partner violence (IPV) is greatest for bisexual women (56.9%) versus lesbian women (40.4%), and still higher than in heterosexual women (32.3%).[32] Provider knowledge of their bisexual patients can incorporate purposeful self-reflection when we address our own personal bias around assumptions about sexuality, as well as research or ask about struggles bisexual or pansexual patients may have around their identities and relationship experiences, including asking questions in a way that is both trauma-informed and validating.

For Gay Men, Same Gender Loving/Attracted Men, Men Who Have Sex With Men, and More: Gay men and men who have sex with men (MSM) patient populations experience health disparities in healthcare settings due to a stigmatization of their identities and sexual behavior, which is historically rooted in centuries of

governmental control and legislation that criminalized specific sexual practices. Providers today still have a significant lack of understanding related to personal ADLs of the various types of sex, such as penile-anal and penile-oral sex. Lack of purposeful self-reflection leads to discomfort during the visit when these practices are discussed, inadequate screening and prevention, as well as a lack of culturally appropriate resources to support their lives and protocols.[14,31] African American MSM or same gender loving/attracted men receive a significant amount of public health focus because they are currently at greater risk for HIV acquisition due to ongoing processes of systemic racism that perpetuate barriers to HIV prevention, testing, and access to HIV care.[33] As a result, some communities of African American MSM have an increased viral load, making HIV transmission more likely, perpetuating significant health inequities in this population.[34] Partnerships with same gender loving/attracted men of color could include partnering with community-based organizations to understand specific needs and knowledges about barriers to care. Personal knowledge must include self-reflexivity about implicit biases around racial and sexual orientation stereotypes.[32] Trans masculine patients may also be men who are same gender loving/attracted men. Therefore, trans masculine people may require specific reproductive and sexual healthcare that often goes unaddressed. Understanding personal ADLs of all patients will ensure that screenings and other preventive measures are not missed due to provider assumptions.

For Asexual Patients: Asexual patients' identities and behaviors are not often understood or discussed thoroughly enough with asexual individuals by clinicians, once again, due to a lack of provider personal knowledge and personal ADLs, including sexual activity and relationship formations. For example, the self-identification, attraction, and behavior characteristics of asexual people may overlap but are distinct. The highest numbers of asexual individuals are noted when patients are asked about self-identification (71.3%) and lack of sexual attraction (69.2%) versus behavior.[25,35] Similarly in the push for "healthy sexuality," clinicians may lose sight of the pathologization inherent in seeing people with no need for sexual contact as disordered if patients themselves are not experiencing it that way.[35,36] Proper partnering will respect and incorporate patient knowledge, and for people who have asexual identities this can occur when providers respect asexuality as a valid identity and maintain nonjudgmental communication when discussing patient experiences.

For Queer Patients: When an individual presents for care and describes their identity as "queer," negative connotations or a lack of knowledge regarding this terminology may result in shock or surprise from providers unfamiliar with this term. The word *queer* is considered by many as an all-encompassing term to describe an aspect of themselves that is non-normative in one or more ways, usually describing sexual orientation or relationship structure. Queer might also describe gender identity, although it may often be referred to specifically as "genderqueer." Patient centered care means that there is an explicit lack of assumption about what a person might need in the way of healthcare simply because of how they identify themselves. It is important to understand that self-descriptive labels about identity are primarily a tool for understanding how a patient describes themselves, not a diagnosis that mandates a certain protocol of care. Rather, the culturally safe approach presented in this book

encourages the provider to make space for asking about how a person identifies, but more importantly asking nonjudgmentally about patient practices (personal ADLs) and creating a plan of care that is appropriate and individualized (patient centered). Queer can be an umbrella term used by people who hold nonheterosexual or noncisgender identities.

Intersex Patients: Too often intersex patients are burdened with cancer scares related to their genitalia or gonads, even though we know the risks are low; thus, intersex people are subjected to unnecessary medical examinations. These practices are devoid of partnership with patients.[37] The pathologization and misunderstanding (lack of clinician personal knowledge) of intersex individuals' lives is central to the oppression that intersex patients have experienced in clinical settings. This is partially a result of a lack of understanding of the clinical implications associated with intersex status.[24,37,38] Likely, some of the clinical oppression that intersex patients experience is linked with overly curious invasive provision of care paired with conscious or unconscious othering by clinical providers. Intersex individuals may or may not identify with the LGBTQA patients depending on life experiences, identity, and/or personal preference. However, the possible medical history of nonconsensual genital surgeries and hormones, as well as the lack of understanding of the physiology and psychosocial needs of these patients, means that intersex patients may be lacking in culturally safe and conscientious care.[24,37]

LEGISLATIVE BARRIERS TO LGBTQIA+ HEALTH

Gender and identity have often been the subject of legislation, much of it since 2016, aimed at decreasing the rights that LGBTQIA+ people have. These laws are constantly shifting but are often shaped by federal and state legislation. We include several legislative examples in the text that follows that have impacted trans patients, individuals in the sex trade and street economies, undocumented LGBTQIA+ people, and those seeking access to abortion.

Protections of Trans Patients

State-by-state legislation regarding trans exclusion and discrimination vary wildly. Approximately 46% of LGBTQIA+ people live in states with high gender identity tallies, which indicate protections and freedoms related to "Non-Discrimination, LGBT Youth, Health and Safety, Ability to Correct the Name and Gender Marker on Identity Documents, and Adoption and Parenting."[39] The states with the most trans-inclusive legislation and policies are largely in the northeast and west coast of the United States, along with such states/territories as Puerto Rico, Minnesota, Colorado, New Mexico, and Illinois. More than half of LGBTQIA+ people (55%) live in the states with more restrictive and hostile policies; in fact, 28% of all LGBTQIA+ people are living in states with the most restrictive gender policies, with over two-thirds of trans people living without identification that matches their gender

identity, often out of necessity related to their ongoing healthcare. Additionally, as of July 2019, 26 states in the United States have state Medicaid policies that negatively impact the care of trans patients.[39] These policies increase the lack of access to health and well-being that patients face while the inclusive policies within states with more trans-inclusive policies do not guarantee access to trans-inclusive providers, clinics, and other healthcare environments.

Intersecting Identities—LGBTQIA+ and Consensual Sex Working

Sex work is often a viable albeit stigmatized employment option for LGBTQIA+ people who have been excluded from institutional environments and other workplaces, are transiently housed, have experienced incarceration, or are otherwise left with few viable options for sustainable work. Research shows that stigma and discrimination experienced by transgender individuals contributes to a lack of economic opportunities. Transgender adolescents and young adults, for example, who have been ostracized by friends and family may end up running away from home and are more likely to exchange sex to generate income for rent, drugs, medicine, hormones, and gender-related surgeries.[40] Those who exchange sex may regularly experience the social repercussions of such stigmatized work.[40]

In the United States, the structural environment has recently become more detrimental to sex worker health and safety. Current political currents run counter to internationally accepted evidence-based human rights-informed best practice public health recommendations for the full decriminalization of sex work.[41,42] In April 2018, the Allow States and Victims to Fight Online Sex Trafficking Act of 2017 (FOSTA) (H.R. 1865—115th Congress: Allow States and Victims to Fight Online Sex Trafficking Act of 2017, 2018) was signed into law, creating an exception to section 230 of the 1996 Communications Decency Act, holding websites criminally responsible for third parties who advertise for prostitution on their platforms. Also in April 2018, the Department of Justice seized and shut down Backpage, an affordable online advertising platform that allowed sex workers to advertise their businesses, screen clients, and work independently indoors.[43]

These events have limited sex workers' ability to advertise for themselves on the internet, thereby exacerbating their financial insecurity and pushing increasing numbers of sex workers into higher-risk work environments on the streets and under the control of exploitative third parties.[43] As websites respond to FOSTA without knowledge of how it will be enforced, health promotion and safety information resources for sex workers are also being affected, limiting access to essential information when sex workers need it most.[44] Social, economic, and policy changes like these, which shift the dynamics of existing sex marketplaces, affect sex worker HIV/STI risk.[45]

The FOSTA/SESTA 2017 legislation ostensibly made it illegal to advertise sex trafficking, knowingly benefit financially from participation in a venture that advertises sex trafficking, and to engage in activities related to sex trafficking besides advertising, knowingly or in reckless disregard that sex trafficking is involved.[46] The

legislation targets consensual sex workers more than it does traffickers. For example, in 2018 alone, trafficking increased in San Francisco by 170% while nontrafficked sex workers have been forced to work in more unsafe environments without the safety of internet traceability of customers.[47]

Immigration Policy

According to a 2013 Williams Institute report,[48] there are approximately 270,000 undocumented LGBTQIA+ people and about 640,000 immigrants with legal documentation in the United States; however, LGBTQIA+ people are often excluded in news coverage about immigration. The vast majority of undocumented migrants are Latinx, and among documented immigrants approximately one-third each of immigrants are Latinx and Asian or Pacific Islander. Additionally, approximately 10% of all DACA recipients identify as LGBTQIA+.[48] Beyond these estimates, very little is known about LGBTQIA+ people and immigration due to lack of safe and proper census data collection. When designating people as asylum seeking refugees versus immigrants who may or may not achieve legal citizenship in the United States, immigration decisions are minimal considering how lack of LGBTQIA+ safety in countries of origin may impact LGBTQIA+ people. Although immigration policy has often been exclusive at best, exclusion of LGBTQIA+ immigrants has been increasing in the last decade.[49]

Access to Safe Abortion

Many LGBTQIA+ people need access to safe abortion.[50] Often the same legislators fighting for LGBTQIA+ exclusions are the same legislators fighting against access to safe abortion. In this way, the battle for LGBTQIA+ rights echoes that of people choosing to access reproductive termination resources.

TACKLING BARRIERS

In order to tackle these barriers for LGBTQIA+ patients, clinicians must increase their own clinical personal knowledge, seeing LGBTQIA+ patients as partners in their own healthcare, and actively creating and engaging in policies that prevent access to conscientious care.[51] Addressing barriers to care for LGBTQIA+ patients may occur in clinical settings, with patients, with insurers, with institutional settings where patients may be working or receive services, as well as local governmental agencies. Additionally, providers' involvement in changing healthcare policy is crucial to increasing healthcare access for trans patients.

Intersectional identities should be seen as crucial to the health of the patient alongside evolving identities that may change or shift with patients' desires or needs.[4] For example, there are multiple scholars within LGBTQIA+ studies frameworks who explore sexual and gender variance experiences through a disability framework.[18,52]

Even beyond this, the intersectional identities within disability frameworks are not often well-understood or explored within clinical contexts. Conversely, much of the disability sexual orientation discourse is rooted in heterosexual identity.[52] As with the experiences of LGBTQIA+ people and those with disabilities, the experiences of LGBTQIA+ people with disabilities are poorly understood by healthcare providers and, therefore, so is sexuality and relationship-building. Additionally, the type of disability matters greatly when assisting patients with disabilities with their identity-validation and health goals. A patient with a central spinal cord injury or a neurodivergent patient or a patient with an amputation will have very different needs and will experience their involvements in dating, sexuality, and relationships differently. Some people may have intersectional disabilities or adjacent identities, such as deaf people, who often do not identify as having a disability.[52,53] In order to support patients with disabilities, providers must fulfill a narrative exploration with patients in order to make sure that our healthcare interventions meet patients' goals and that their access to services is bettered by receiving clinical care. Although this textbook will not focus on LGBTQIA+ people with disabilities, please note the highlighted areas that focus on special considerations for being in solidarity with disability justice movements within clinical settings.

HOW DO WE KNOW IF WE ARE PROVIDING CULTURALLY SAFE CLINICAL CARE?

Initially, it may be easier to recognize lack of cultural safety rather than the presence of cultural safety. A lack of cultural safety exists when practices demean, devalue, or disempower LGBTQIA+ patients' identities. A common example is the leveraging of hormone prescriptions as a way to reward HIV+ trans patients for taking their HIV treatment medications, thereby devaluing the trans identity of the patient. Additionally, many clinicians working with asexual patients may create a goal of "having healthy sex" for their patients, even though this might not be the patient's goal. This can disempower the patient from choosing their own progress and goals.[7]

As a clinician, you can take specific action steps toward creating culturally safe healthcare encounters by focusing on the tenets of cultural safety and the examples provided throughout this book. Reducing health disparities for LGBTQIA+ patients will require a concerted effort on the part of clinicians; cultural safety is one proposed framework that may help clinicians better advocate for and support their LGBTQIA+ patients. The cultural safety framework recognizes that knowledge regarding the disadvantaged social status of oppressed populations is missing from most available clinical care guidelines or healthcare practice.[8] Cultural safety is defined as an outcome, wherein LGBTQIA+ individuals' historical and personal narratives are recognized and valued by clinicians. Cultural safety is an outcome for patients produced largely through the application of cultural competence in the clinical setting and the active work of providers to decrease barriers when outside of the patient-provider setting.[53]

Cultural safety does not end with the patient visit. Providers and staff must engage in creating avenues for increased access to safe and legal employment options for

LGBTQIA+ patients. To promote culturally safe care, clinicians must be leaders. We must educate current and future care providers, as well as public and private insurers, about the medical and economic needs of LGBTQIA+ patients. We have a responsibility to challenge biased insurance coverage that impacts patients' abilities to achieve appropriate testing, hormonal, or surgical needs while challenging queer- and transphobia within the healthcare systems.[50]

CONCLUSION

The cultural safety framework recognizes that the current health disparities of LGBTQIA+ people is a result of their systemic oppression and denial of equality within the healthcare system. The clinician is an active tool in decreasing the harm of ongoing stigma when working with LGBTQIA+ patients, via equalizing the power dynamic within the provider-patient relationship.[7] Clinicians working with the cultural safety framework can look to the five tenets outlined in this chapter: partnerships, personal ADLs, prevention of harm, patient centering, and purposeful self-reflection. Clinicians are tasked with understanding LGBTQIA+ patients' goals, cultural practices of achieving these goals, and patient choices related to said goals.

Because the authors of this text are using a framework of cultural safety to support best clinical practices for LGBTQIA+ patient care, each chapter ends with cultural safety summary points. These points intend to weave the chapter content together through the five cultural safety tenets. Keeping cultural safety at the forefront of clinical practice guides clinicians in culturally informed, conscious, and mindful care that acknowledges a patient's narrative and history of oppression. Maintaining a mindful clinical practice brings LGBTQIA+ patients one step closer to health equity and justice.

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