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Structural barriers to sexual and reproductive health care among Black and Latina cisgender and transgender U.S. women who use drugs: a qualitative study

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Abstract

Background Black and Latina women and women who use drugs in the United States (U.S.) face multilevel barriers to receiving sexual and reproductive health (SRH) care that meets their needs. Although prior research has investigated barriers to SRH care among Black and Latina women in general, no study of which we are aware has examined how structural inequities shape the SRH care experiences of Black and Latina women who use drugs in particular in relation to multiple intersecting systems of oppression.

Methods Using a stratified purposive sampling strategy, we conducted in-depth interviews ($n = 18$) with Black and Latina cisgender and transgender women aged 18–45 years who use drugs and had received SRH care in Boston, MA, Providence, RI, or Washington, DC in the last 12 months. Interviews were coded and themes were developed using a template style thematic analysis approach. All study activities were guided by a Community Advisory Board composed of six Black and Latina cisgender and transgender women who use drugs.

Results Participants reported notable challenges accessing SRH services as a result of a lack of consistent health insurance, limited public transportation, high or unexpected costs, and criminalization by the legal system. Additionally, participants' health care experiences were undermined by sexism, racism, transphobia, classism, heterosexism, fatphobia, and substance use stigma, which resulted in poor quality sexual, reproductive, and other health care and in delaying or avoiding care. In contrast, participants expressed a strong preference for receiving care from health care providers who were respectful, compassionate, and attentive to their needs. Moreover, participants reported more positive experiences receiving SRH care from health care providers who used a person-centered approach, who tended to share their racialized and gender identities, in community-affirming institutions.

Conclusions Structural and collective efforts rooted in reproductive justice are urgently needed to address the precarious social and economic conditions, multiple intersecting systems of oppression, and criminal legal and health

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care practices that negatively impact the lives and SRH care of Black and Latina cisgender and transgender women who use drugs and, instead, foster health, healing, and well-being at the personal, community, and societal level.

Keywords Sexual and reproductive health, Black and Latina women, Women who use drugs, Transgender women, Discrimination

Background

Black and Latina cisgender and transgender women in the United States (U.S.) face unique and specific barriers to accessing and receiving person-centered [1–4] and structurally competent [5, 6] sexual and reproductive health care that meets their needs and preferences and respects their bodily autonomy [7–11]. These barriers, which are rooted in sexism, racism, xenophobia, transphobia, and the commodification of health care in the context of capitalism [10, 12–16], include a systemic lack of access to money, transportation, and health insurance [11, 12, 17, 18], mistrust of the health care system due to historical and ongoing medical abuses [10, 12, 19], and pervasive negative stereotypes and biased assumptions about minoritized groups among health care providers [13, 14, 19–22]. Moreover, women who use drugs experience notable barriers to obtaining voluntary, high-quality sexual and reproductive health care, including social and economic marginalization, substance use stigma in health care settings, intimate partner violence, and reproductive coercion [23–25]. From health care providers and institutions, women who use drugs may also experience mistreatment [23, 24], including poor quality, coercive, or harmful care and the removal of children by Child Protective Services when drug use is reported or suspected [23, 24, 26–28].

When addressing contemporary barriers to voluntary, high-quality sexual and reproductive health care among Black and Latina cisgender and transgender women who use drugs, it is imperative to consider the historical processes reinforcing the poor treatment of these multiply marginalized groups in today's sexual and reproductive health care settings [10, 19, 29, 30]. In the 18 th century, James Marion Sims—a white male physician called the "father of modern gynecology" by medical journals [31–33] and popular news media [34–36] alike—coercively developed contemporary gynecological procedures through experimentation using the bodies of enslaved Black women without their consent or the use of anesthetics [37]. Moreover, in the late 19 th and 20 th centuries, the rise of eugenics—a theory and practice of racialized population control claiming to "improve the race" by selectively breeding people with "desirable" traits and preventing the reproduction of those deemed "unfit"—precipitated scientific racism, in which white European and U.S. male scientists and physicians developed and perpetuated racist stereotypes of Black, Latina, and Native women as being "hyper fertile," resistant to pain, and a threat to "the race" through miscegenation and disease [38–42]. These racially and ethnically minoritized groups of women were deemed "undesirable" and in turn became the target of forced sterilization, which was sanctioned by sterilization laws passed (and largely maintained) in 31 U.S. states [19], in addition to other forms of population control and surveillance, such as racial residential segregation and policing [43–48].

Although Black, Latina, and Native women have collectively resisted reproductive injustices throughout history [46, 49–51], coerced or forced sterilization and contraception targeting women of color have persisted into the 20 th and 21 st centuries [49, 51, 52]. For example, in 2017, a Tennessee state judge ordered that the sentences of incarcerated women who "volunteered" to receive Nexplanon would be reduced by 30 days. The order was later rescinded due to backlash from national news coverage [52]. Additionally, the non-profit "Project Prevention"—originally established in 1997 in California as "Children Requiring a Caring Kommunity" or "C.R.A.C.K."—has disproportionately targeted and paid Black women and women of color who use or have used drugs to undergo coerced sterilization or use long-acting reversible contraception (LARC) [52, 53]. Among European nations recognizing people's "preferred gender identity," being infertile or sterilized was a requirement for change of legal gender identity until 2004, and sterilization is still required in nine countries among member states of the Council of Europe [54, 55]. In the U.S., 12 states currently require that individuals undergo "sex reassignment surgery" in order to change the gender marker on their birth certificate [56, 57]. Moreover, in the 1990 s and 2000 s, women who use drugs, poor women, and women of color—especially poor women of color who use drugs—were targeted for forced or coerced LARC insertion, which was often tied to the receipt of financial incentives, government benefits, or reduced criminal sentences in health care settings, prisons, and immigrant detention centers [37, 48, 52, 58–63].

Intersectionality, an analytical framework rooted in Black feminist thought and praxis, postulates that multiple forms of oppression, including racism, sexism, and classism, are mutually constituted and simultaneously affect the lived experiences of Black women and other multiply marginalized groups in unique and compounding ways [64–66]. Although limited prior research has addressed how discrimination undermines sexual and reproductive health care among Black and

Latina cisgender [7, 9, 13, 14, 17, 67–70] and transgender [71–74] women in general, no study of which we are aware has examined the specific sexual and reproductive health care experiences of Black and Latina cisgender and transgender women who use drugs in particular in relation to racism, sexism, transphobia, and substance use stigma, which disproportionately affects racialized and transgender women [13, 19, 20, 72]. Thus, to further our understanding of how multiple intersecting systems of oppression impact the sexual and reproductive health care experiences of Black and Latina cisgender and transgender women who use drugs and inform programs, policies, and practices that promote reproductive justice [75, 76], we designed a qualitative research study to explore structural barriers to accessing voluntary, person-centered sexual and reproductive health care in these multiply marginalized populations.

Methods

Study population and participant recruitment

Using a stratified purposive sampling strategy, we recruited study participants who met the following eligibility criteria: identified as a Black or Latina cisgender or transgender woman; were aged 18–45 years; received sexual and reproductive health care in Boston, Massachusetts (MA), Providence, Rhode Island (RI), or Washington, DC in the last 12 months; reported injecting, ingesting, smoking, or inhaling drugs to get high in the past year; and had the ability to respond to interview questions in English, Spanish, or American Sign Language. We used quota sampling [77–79] based on race/ethnicity, gender identity, and geographic location to recruit approximately equal numbers of Black and Latina women, cisgender and transgender women, and participants in all three geographic locations. Moreover, we also used maximum variation sampling [78, 79] based on age to ensure the inclusion of both young adult and middle-aged participants, who may have different experiences accessing and utilizing sexual and reproductive health services. Participants were recruited between January and June 2023 by sharing study flyers with community health centers, community-based organizations, and online forums in MA, RI, and Washington, DC. Additionally, we used a snowball sampling approach, wherein study participants were asked to disseminate the study flier to individuals in their social networks who may be interested in participating in the study. We sought to achieve data saturation in relation to the study's research question pertaining to structural barriers to voluntary, person-centered sexual and reproductive health care among Black and Latina cisgender and transgender women who use drugs [80].

Data collection

We conducted in-depth interviews with Black and Latina cisgender and transgender women who use drugs (n = 18) to better understand their experiences accessing and utilizing sexual and reproductive health care in relation to multiple intersecting systems of oppression. Interviews were conducted by four trained interviewers, all cisgender women of color (i.e., Black, Latina, Asian) with training and research experience in qualitative methods, sexual and reproductive health, substance use, and health inequities, using a semi-structured interview guide (see Supplement). The interview guide was developed using an intersectional approach to elicit information on how multiple interlocking systems of oppression (e.g., sexism, racism, transphobia, substance use stigma) simultaneously and uniquely shape the sexual and reproductive health care experiences of Black and Latina cisgender and transgender women [10, 14, 81–83] in social context.

The guide consisted of a series of open-ended questions and probes on the following topics: interpersonal, institutional, and structural discrimination linked to gender, race/ethnicity, socioeconomic position, and drug use; barriers to, facilitators of, and experiences with sexual and reproductive health care; and recommendations for facilitating access to needed sexual and reproductive health services among Black and Latina cisgender and transgender women who use drugs. Interviews took place in person, by telephone, or via video conference and were conducted in English, Spanish, or American Sign Language, based on participants' preferences. Interviews were audio-recorded and lasted approximately 40 min. At the end of each interview, participants were asked to complete a brief demographic questionnaire. Participants received a $75 debit card for their time. All research activities were reviewed and approved by the Brown University Institutional Review Board.

Data analysis

Members of the research team transcribed interview audio recordings verbatim and entered transcripts into Dedoose (version 9.0.107, Manhattan Beach, CA) for analysis. Two independent coders (M.N. and T.D.) analyzed the transcripts using a template style thematic analysis approach involving inductive and deductive codes organized using a hierarchical codebook [84–88]. After testing and refining the codebook using four transcripts, the coders applied the codebook to all transcripts, iteratively revising it as needed; a subset (20%) of transcripts were double coded to ensure consistent application of the codebook. Discrepancies were resolved through discussion and consensus among the coders and other members of the research team (M.A.). Final themes and sub-themes were developed iteratively by M.A. through discussions with M.N., T.D., and members of the

Community Advisory Board (CAB), memo writing, and additional clustering of codes in the template. Finally, all transcripts were reviewed to ensure that all relevant coded excerpts had been included in the present analysis [87, 89].

Community advisory board (CAB)

All study activities were guided by a Community Advisory Board (CAB) composed of six Black and Latina cisgender and transgender women who use drugs living in Boston, Providence, or Washington, DC. CAB members had both lived and professional experience in drug use and sexual and reproductive health care in the context of structural inequities linked to gender, race/ethnicity, and socioeconomic position. Over a series of three, one-hour online meetings, CAB members provided guidance and input on study aims, recruitment strategies and materials, data collection instruments, deductive and inductive codes, preliminary themes and sub-themes, and dissemination of study results to study participants and relevant community-based organizations. All results are reported according to the Standards for Reporting Qualitative Research (Appendix) [90].

Results

Participant sociodemographic characteristics

Study participants' sociodemographic characteristics are presented in Table 1 (N = 18). Participants' age ranged from 23 to 45 years, with a mean of 33 years. Most participants identified as Black or African American (72%, n = 13), approximately one fifth (22%, n = 4) identified as Latina/e/x, and about one tenth identified as Native (11%, n = 2) or multiracial (17%, n = 3). In terms of gender identity, most participants were cisgender women (56%, n = 10), and about one fifth identified as transgender women (22%, n = 4) or nonbinary, gender non-conforming, or genderqueer (22%, n = 4). With regard to sexual orientation, approximately one quarter of participants identified as heterosexual (28%, n = 5), while the majority selected a minoritized sexual orientation identity—specifically, bisexual (17%, n = 3), pansexual (17%, n = 3), lesbian or gay (17%, n = 3), queer (6%, n = 1), and asexual (6%, n = 1).

Half of the study sample had received sexual and reproductive health care in Rhode Island in the past year (50%, n = 9); others had obtained care in the District of Columbia (39%, n = 7) and Massachusetts (11%, n = 2). The majority of participants were enrolled in a public health insurance plan (78%, n = 14), with approximately one fifth enrolled in a private health plan (17%, n = 3). Most participants received care from a private doctor's office (72%, n = 13), with substantial minorities accessing community health centers (22%, n = 4), hospital clinics (17%, n = 3), and family planning clinics (22%, n = 4) as their usual source of care. Moreover, the majority of participants

Table 1 Sociodemographic, health care, and substance use characteristics of Black and Latina cisgender and transgender women who use drugs (N = 18)

Characteristic	*n*	%
Age (years; mean, standard deviation): 33.1, 6.8		
Sex assigned at birth		
Female	12	67
Male	5	28
Prefer not to answer	1	6
Gender identity*		
Cisgender Woman	10	56
Transgender Woman	4	22
Nonbinary, gender non-conforming, genderqueer	4	22
Prefer not to answer	1	6
Sexual orientation identity*		
Heterosexual	5	28
Bisexual	3	17
Pansexual	3	17
Lesbian or gay	3	17
Queer	1	6
Asexual	1	6
Prefer not to answer	4	22
Race/ethnicity*		
Black or African American	13	72
Latina/e/x/	4	22
Native	2	11
Multiracial	3	17
Another race/ethnicity	1	6
Language		
American Sign Language	1	6
English	16	89
Spanish	1	6
Geographic location		
Rhode Island	9	50
Massachusetts	2	11
District of Columbia	7	39
Health insurance status		
Public	14	78
Private	3	17
None	1	6
Usual source of sexual and reproductive health care*		
Private doctor's office	13	72
Community health center	4	22
Hospital clinic	3	17
Hospital emergency room	2	11
Family planning clinic	4	22
Community-based organization	1	6
None	1	6
Type of usual health care provider*		
Physician (MD, DO)	16	89
Nurse (RN, NP)	6	33
Physician Assistant (PA)	2	11
Another type of provider	1	6
None	1	6
Substances used in last 12 months*		

Table 1 (continued)

Characteristic	*n*	%
Marijuana	15	83
Cocaine	6	33
Ecstasy	2	11
Methamphetamine	2	11
Alkyl nitrites/poppers	2	11
Psilocybin	3	17
LSD	1	6
Benzodiazepine	1	6

Percentages may not add to 100% due to rounding

* Categories are not mutually exclusive

reported receiving care from a physician (89%, $n = 16$). Approximately one third received care from a registered nurse or nurse practitioner (33%, $n = 6$).

Marijuana was the most commonly used substance in the past year (83%, $n = 15$). Other substances used by participants in the past year included cocaine (33%, $n = 6$), MDMA (ecstasy; 11%, $n = 2$), methamphetamine (11%, $n = 2$), alkyl nitrites/poppers (11%, $n = 2$), psilocybin (17%, $n = 3$), LSD (6%, $n = 1$), and benzodiazepine (6%, $n = 1$).

Theme 1. Black and Latina women who use drugs face pronounced structural barriers to accessing sexual and reproductive health care

Overall, participants experienced notable challenges accessing sexual and reproductive health services, which many linked to structural barriers, including limited access to care due to a lack of consistent health insurance and limited public transportation, high or unexpected costs, and criminalization by the legal system.

Access

Several participants faced barriers to sexual and reproductive health care as a result of a lack of access to health insurance and transportation. For example, a Black cisgender woman explained how lacking health insurance undermined her ability to renew her contraceptive method prescription prior to its expiration: "I no longer have health insurance so I'm worried […]. For example, I have Nexplanon, but it actually technically 'expired' back in February. […] So I'm worried about, how am I going to get new birth control if I decide to continue with birth control?" Moreover, referring to the lack of accessibility of sexual and reproductive health services using public transportation, she noted: "The whole problem is that they're so hard to get to. I feel like it's pointless for them to be offering it." Instead, she recommended "making sure that it's public transit accessible, and then for those who don't use public transit, there's parking that's affordable." Similarly, a Black, Native, and multiracial nonbinary individual mentioned: "Transportation at my regular doctor's office isn't always easily accessible for me because [the] bus line is right off the highway and you have to get off just before the highway and then cross over. And then the other place is like, good luck finding a bus to get over there, period. And […] my dad is the only one who drives, and he can't really drive me to appointments."

Cost

Some participants also described how high costs and unexpected bills were a notable challenge to obtaining sexual and reproductive health care. For example, a Latina cisgender woman explained: "I went to emergency care and that was even more frustrating because they had me do testing and gave me yeast infection medication. And my insurance was supposed to cover it, but I guess because I kept on having problems, they wanted to charge me $300 for getting a test. And I was like, 'I'm having health issues. [You] can't just be charging me out here because I don't have money for that. That's too expensive.'" Additionally, describing an unexpected expense while receiving sexual and reproductive health care, a Black cisgender woman noted: "…the PCP [primary care provider] I had before this one, I got charged for a behavioral health screening, and I was like, 'I don't remember being screened for behavioral health.' And they listed the name of the screening. And I was like, 'I literally use that screening at my job. I would have noticed if somebody did it on me.' But they're like, 'no, technically, we pulled the short version of it as a questionnaire in the intake forms, and now you have to pay for it.'"

Criminalization

Further, a few participants discussed how prior experiences of criminalization by the legal system undermined their access to and utilization of sexual and reproductive health services. For example, a Black transgender woman explained how her criminal legal history negatively impacted her employment opportunities and, in turn, her ability to access health insurance, gender-affirming care, and HIV prevention services, saying: "Oh, it's been bad because […] when you are previously incarcerated and you have to go through certain loopholes to get back into networking and get back into society […] it's more of a stigma […] I was a CNA [Certified Nursing Assistant] and so now I can't even do my CNA because I have a record."

Teme 2. Compounding experiences of multiple discrimination undermine receipt of sexual and reproductive health care among Black and Latina women who use drugsh

Several participants described how their receipt of sexual and reproductive health care was undermined by experiences and fears of multiple intersecting forms of discrimination, including sexism, racism, transphobia,

classism, heterosexism, and fatphobia. While many participant accounts focused on the negative impact of discrimination related to sex and gender, several Black cisgender women and transgender women discussed the compounding effects of sexism, transphobia, racism, and other systems of oppression and linked their poor treatment in sexual and reproductive health care settings to their multiply minoritized social position. Some participants also discussed how substance use stigma shaped their health care experiences in general.

Sex- and gender-based discrimination

Many cisgender and transgender participants reported experiences and fears of poor treatment in the context of sexual and reproductive health care in relation to their sex assigned at birth, gender identity, and gender expression. For example, discussing barriers to obtaining needed sexual and reproductive health information from health care providers as a person assigned female at birth, a Black, Native, and multiracial nonbinary individual explained: "What if they think that I'm just paranoid? And it's just because I feel like a lot of times women are not taken seriously. […] As a woman, I feel like we're just brushed off, with what goes on, because it's not that serious. 'Oh, get over yourself. It's just because you're getting your period or it's this' and nobody wants to take anything seriously sometimes." Moreover, a Black and multiracial cisgender woman explained how discrimination based on gender expression undermined her access to contraceptive care, which tends to be gendered as "female":

> *[…] At a point I used to present as much more masculine. I feel like if you don't look a certain way initially, you get treated differently. If they feel like they're not sure what's going [on with] your gender identity, […] I feel like you get kind of the looks. […] There is another piece of how you look when you walk in as well and […] how you're dressed and how you speak and how you present yourself. I don't think [that] has anything to do with—or should have anything to do with—your quality of care.*

Several participants described how sex- and gender-based discrimination led them to delay or avoid seeking sexual and reproductive health care, particularly from providers who they thought were more likely to treat them poorly as a result of their sex assigned at birth and/or gender identity or expression. For example, a Black cisgender woman noted: "I have been more disbelieved by male medical professionals. So I try to avoid male medical professionals."

Further, Black and Latina transgender women in our study discussed how their sexual and reproductive health care experiences were negatively impacted by transphobia. For example, a Latina transgender woman noted: "Before I got my name legally changed, if I went somewhere and had to use my identification, it wouldn't match me. And then sometimes people will want to refer to me as to what is said there. When I specifically told them not [to]. Not caring to understand." A Black, Native, and multiracial nonbinary individual expressed concerns about seeking sexual and reproductive health because of transphobic laws:

> *[…] I'm not very open about my identity with everyone because not everybody is accepting, and I'm afraid of how I'll get treated, especially given what happened when Trump was president. They tried to overturn something and make medical providers… they actually were allowed to not treat you, even if you came into the hospital dying. Like if it said you were nonbinary, transgender, they could let you die.*

Highlighting the toll that these laws took on them internally and in the context of interpersonal interactions, including in health care settings, they continued: "I'm kind of scared. I'm not completely open [about my gender identity], which does affect me as a person because I feel like I can't be my authentic self around most people. It's like I have to be two different people. I have to pass [as] straight to people even though I'm not because of fear for my safety or for [how] I'm going to get treated." Although some transgender participants reported that LGBTQ + health centers and organizations provided them with gender-affirming sexual and reproductive health care, a few participants reported experiencing transphobia in health care settings geared towards LGBTQ + patients in general. For example, when asked whether she received better care at LGBTQ + health care facilities, a Black transgender woman responded: "No, it's the same because you can even go into places where it's trans friendly or trans this and that, and there's still stigma behind a trans name regardless."

Compounding negative impact of gender-based discrimination and racism

Several Black cisgender women in particular discussed how the negative impact of gender-related discrimination was compounded by racism, resulting in experiences of being dismissed, judged, and stigmatized during sexual and reproductive health care visits based on their multiply minoritized social position at the intersection of gender and race. For example, a Black cisgender woman explained how she encountered negative stereotypes and experienced poor treatment during a sexual and reproductive health care encounter as a result of health care provider bias related to both her gendered and racialized

social position. She explained: "I just kind of felt that as a Black woman in that space, I was treated like I was just overreacting, like [I was] really emotional. Like I'm probably not in that much pain. And that's kind of just how I was treated. And, it made me feel really crazy. It made me feel like I was making it up. [But] I knew I wasn't. I didn't feel like I was taken seriously." Similarly, referring to the negative assumptions that white health care providers made about her based on both her gender and race and the ensuing poor clinical treatment she experienced, another Black cisgender woman explained: "I think being Black and being a woman makes doctors minimize your pain, not believe you, not take you seriously, not give you the same amount of support for the same issue." Additionally, underscoring the entanglement between sex/gender-based discrimination and racism in the context of sexual and reproductive health care, a Black, Native, and multiracial nonbinary individual explained: "You hear about it a lot where people just assume that people of color are just having kids to stay on welfare when that's not always the case. […] Sometimes, something's happened to them, and then they end up pregnant, or they can't afford birth control. […] They don't go get an abortion because now there's a stigma attached to, oh, people of color getting pregnant, because they just like saying stuff about us […], stuff that I've heard my entire life."

Compounding negative impact of gender-based discrimination, racism, classism and fatphobia

A few of the aforementioned participants linked the poor treatment they experienced in sexual and reproductive health care settings to the ways in which sexism and racism intersect with other forms of discrimination, including classism and fatphobia, and foster negative stereotypes about Black women's education and intelligence. For example, a Black cisgender woman described how white health care providers in particular inferred her social class based on her race, gender, and weight and her ability to understand sexual and reproductive health information based on her presumed social class, which negatively impacted her care: "It definitely feels like a different experience unless the person is also not white. […] It definitely feels like [I'm] perceived as like an overweight Black girl from the South. Like the assumption is […], I'm not educated enough to understand my own body, that sort of thing." Similarly, a Black cisgender woman described:

> *I remember a time when I was going to get shots and this doctor was being pretty rude. […] But then I […] made a comment about something that I had learned in my neuropsych(ology) class. […] And once they heard me say that, they switched how they were treating me. […] So, I think that people see me and don't take my pain seriously or don't think that [I'm smart].*

Substance use stigma

Some participants also reported experiencing substance use stigma from health care providers in the context of receiving health services more broadly, which negatively impacted their access to and use of care in general. For example, a Black and multiracial cisgender woman described being stigmatized for her drug use while waiting for an appointment as follows: "Lots of ignored, lots of 'you're just here to get drugs.' 'Alright, it's not that serious.' Or waiting for a long time when you get there first. A whole bunch of people for some reason get to be seen before you, even though you've been waiting there." Similarly, a Black, Native, and multiracial nonbinary individual noted: "I've had or remember going to check to see if I had arthritis because it runs in my family. And I had a lot of pain that I put off for years before I struggled with substance use. […] Well, I went to my doctor and I got accused of drug seeking." Describing the implications of this stigmatizing treatment, they explained: "Well, now I don't want to go to the doctor anymore. So whenever things come up, I'm scared they're going to assume I'm trying to get drugs from them when I never have done that." None of the participants in our study, the majority of whom reported using marijuana and none of whom reported using injection drugs, discussed how substance use stigma shaped their sexual and reproductive health care experiences in particular.

Theme 3. Person-centered care in community-affirming institutions facilitates receipt of sexual and reproductive health care among Black and Latina women who use drugs

Person-centered care

Many participants discussed how respectful, compassionate, and attentive care from health care providers heightened their willingness to use sexual and reproductive health services. For example, when asked what she liked about her place of care, a Latina cisgender woman responded by describing her providers' positive behavior as follows: "Cause everybody there is awesome. They show they care. They show their support, and they show, 'We're here for you.' They don't treat you like you have something or they might catch something. You know? […] You're being seen." Similarly, a Black, Native, and multiracial nonbinary individual described their satisfaction with their sexual and reproductive health care because of their providers' caring demeanor and concern for their health and well-being: "I feel like they're more than just an ob/gyn. They also care about my mental health and how I am as a mom and making sure things are good with my relationship with my son. I feel like they're very personable, the ob/gyn, which is good." When asked

to describe her ideal provider, a Latina cisgender woman similarly echoed a desire to receive care from a provider who is attentive to her holistic well-being: "…in an ideal world, someone nice. Someone like… a woman of color. Like is very sweet, so personable, like, you know, just asking questions about my day and, like, you know, making sure I have all the resources that I need and don't have any questions…" Participants also expressed a preference for health care providers who were attentive and responsive to their sexual and reproductive health concerns. For example, a Black and multiracial cisgender woman noted: "I had mentioned that [ovarian cysts] [have] been in my family history in my chart [patient health care portal] since I was 16, and nobody's ever asked me about it before. But she asked me about it [and was like], 'This is what this would feel like. And if you ever feel this pain here, let me know because of your family history, that is something to look into.'".

Additionally, participants appreciated receiving sexual and reproductive health care from providers who took the time to listen and respond to their questions and concerns and understand facets of their personal background. For example, a Black and multiracial cisgender woman explained: "I went to the gynecologist last year to refill my birth control prescription. So while I was there, that was the first time I met the Black gynecologist woman that I see now. And it was just so different than any visit I've had before. […] She really took the time to pause and talk to me [about any concerns I had] about the long-term effects of taking birth control and not having a period this many years […] just easing all of those concerns for the first time." Caring and compassionate treatment from health care providers in turn led to open patient-provider communication about sexual and reproductive health issues. For example, the aforementioned participant further elaborated: "I'm always a little hesitant with doctors, with sharing certain things. I don't want to be judged or treated differently. But I know it's better to share more information, like don't lie to your doctor. But yeah, she made it to where I felt comfortable being very honest with her."

Care from providers with shared racialized and gender identities

Several Black participants who reported experiences of person-centered sexual and reproductive health care described receiving this care from Black, especially Black women, providers. For example, a Black cisgender woman explained: "I definitely think he treated me a lot better because he was also Black. I think he understood my anxieties. I didn't have to over explain. I just feel like whenever I'm seeing someone, a provider who's not my ethnicity, it's very difficult to explain where I'm coming from. Like what my anxiety might be rooted in. It's like, how do you explain to somebody what your life is like, what your perception of the world is? Yeah, it's like a lot of effort. Very emotionally exhausting versus him just being like, 'Oh, I know how you feel. Mm hmm. I have a Black wife and a Black daughter. Black cousins, a Black mom. I get it.'" Similarly, a Black and multiracial cisgender woman also noted: "I like seeing a Black doctor, especially a Black woman doctor because I […] feel like I get asked more questions about things and it's more details, like a more detailed visit when I'm with a Black doctor."

Notably, a Black and multiracial cisgender woman described a preference for providers who were Black women because they were attentive to her pain and sought to promote her comfort: "I went to a PWI [predominantly white institution], and I had known that I wanted a Black doctor for vaginal health. I just read that it would be easier if I could find a Black woman doctor or at least a woman if I couldn't find a Black woman." She continued: "She [Black female gynecologist] told me that when the time came for me to get my Pap smear, it's going to be this year that they have the tools now where it's not as painful. They try to make it as painless as they possibly can because I feel really uncomfortable and she really prioritized my comfortability." However, one participant warned that although patients may expect better treatment from providers who share their social identities, patient-provider gender and racial concordance was not a guarantee of positive health care experiences. Referring to the disappointment she felt when her pain was dismissed by a Black woman health care provider, a Black cisgender woman noted:

> *She just put it in one ear and out the other. […] And it was just more frustrating, the fact that she was a Black woman. And I'm coming at this incredibly vulnerable moment. I'm in pain. I just don't know what to do. I'm depressed about this. I'm not sleeping. Socially, I can't do anything. […] And that's the first thing she says after I share all that with her. 'Why didn't you call me?'*

Care from community-affirming institutions

Additionally, participants in our study reported greater positive sexual and reproductive health care experiences in institutions that were respectful and affirming of their racialized and gendered social identities and communities. For example, referring to her experience obtaining an intrauterine device (IUD) at a reproductive health care facility, a Black cisgender woman explained: "I had heard good things about [a family planning clinic] […] So that's when I first started going there and I had a pretty positive experience, comparatively speaking. The least racist doctors and medical professionals I've interacted with or I had interacted with up until that point were from [a

family planning clinic], so I just keep going there." Additionally, a Black, Native, and multiracial nonbinary individual said:

> *Some places…[family planning clinic], some of them were personable and they would give you advice or even [LGBTQ+-affirming clinic] is pretty nice. Like given the fact that they're kind of there, they cater to people who are trans and nonbinary. So that's a plus in regards to how I identify. But then anywhere else I usually just put that I'm female […].*

Similarly, a Black transgender woman reported receiving comprehensive, gender-affirming care at a LGBTQ + community health center: "They are LGBTQ-friendly, and they specialize in HIV/AIDS patients… I've been going before I even had HIV… They help me with my name change or they help me with, you know, my surgery…" A Latina transgender woman similarly highlighted the importance of feeling cared for as a transgender woman when seeking sexual and reproductive health care, which she described experiencing at a harm reduction center than provides support to transgender people: "…[center name] has the trans groups so often. I don't come every meeting because I got things to do in my life. But any time I could come here, and spending time with the other girls like me, it makes me happy and comfortable to know that there's a place that cares."

Discussion

Guided by intersectionality [64–66], we examined barriers to and facilitators of sexual and reproductive health care among Black and Latina cisgender and transgender U.S. women who use drugs in relation to multiple intersecting systems of oppression. Although prior research has examined the sexual and reproductive health care experiences of Black and Latina cisgender women [7, 11, 13, 17, 91, 92] and predominantly white cisgender women who use drugs or are in treatment for substance use disorder [23, 24, 93, 94], this is the first study of which we are aware to center the specific and unique experiences of Black and Latina women, both cisgender and transgender, who use drugs. Specifically, we found that Black and Latina cisgender and transgender women who use drugs faced notable structural barriers to accessing sexual and reproductive health care, including a lack of health insurance, limited transportation, and criminalization, which is aligned with the findings of prior studies conducted among Black and Latina cisgender [11, 13, 17, 91, 92] and transgender [95–97] women in general as well as among predominantly white cisgender women who use drugs or are in treatment for substance use disorder [23, 94].

Of note, the present study contributes in-depth information on the influence of multiple forms of discrimination, including sexism, racism, transphobia, classism, heterosexism, fatphobia, and substance use stigma, on access to and utilization of sexual and reproductive health care, which few studies have examined together [7, 11, 13, 17, 91, 92, 95–97]. Indeed, prior studies have largely investigated how access to and utilization of sexual and reproductive health services is shaped by sexism and racism among Black and Latina cisgender women [7, 11, 13, 17, 91, 92], and sexism among predominantly white cisgender women who use drugs or are in treatment for substance use disorder [24, 93] separately, with little attention to the compounding and co-constituted nature of these intersecting systems of oppression [66, 98–100]. Moreover, although some prior studies have addressed the combined negative effects of racism, sexism, and substance use stigma on the health care experiences of Black and Latina women who use drugs (e.g., in the context of barriers to mental health and substance use treatment), they did not investigate their impact on women's experiences in the context of sexual and reproductive health care [101–103]. Addressing how multiple intersecting forms of discrimination shape sexual and reproductive health care in particular is critical given the long history of reproductive exploitation, control, and coercion by health care providers and institutions targeting Black and Latina women [19, 43, 44, 48, 104–106]. In our study, participants discussed how experiences of multiple dimensions of discrimination reduced the quality of care they received from providers, leading them to feel dismissed, judged, and shamed during sexual and reproductive health care visits. As a result, some participants reported delaying or avoiding seeking care altogether and not obtaining the sexual and reproductive health services and information they needed.

Our findings on the negative implications of health care providers' poor treatment of Black and Latina cisgender and transgender women who use drugs—such as treating women as if they are overreacting and dismissing their concerns and experiences, for which there is long historical precedent in U.S. society [19, 43, 44, 48, 104–106]—align with previous literature on Black and Latina women's sexual and reproductive health care experiences [7, 13, 17, 96, 107–110]. Prior studies among Black cisgender women have extensively documented instances of providers being dismissive, judgmental, and unconcerned with providing health information and resources most relevant to patients' lives [7, 17], as well as being neglectful, coercive, or abusive [107–110]. Research shows that this poor treatment by health care providers in turn led to Black cisgender women to stop asking questions during appointments, avoiding care altogether, or investing additional time and energy in self-advocacy at their appointments [7, 17, 109]. Similarly, previous literature indicates that Latina cisgender women are subjected

to judgment, stereotyping, and discrimination [13] as well as medical neglect [110] when accessing sexual and reproductive health care, also leading them to avoid needed care [13]. Additionally, previous studies indicate that Black transgender women are often unheard and disrespected during patient-provider interactions and are subjected to misgendering, erasure, and abuse in health care settings [96].

Participants in our study provided several recommendations related to how health care providers and institutions can improve the sexual and reproductive health care experiences of Black and Latina women who use drugs. Notably, participants expressed a strong preference for receiving sexual and reproductive health services from providers who were respectful, compassionate, and attentive to their needs, which in turn facilitated more open patient-provider communication about sexual and reproductive health topics. Moreover, participants reported more positive experiences receiving sexual and reproductive health care from health care providers who used a person-centered approach, who tended to share their racialized and gender identities, in community-affirming institutions. These findings are aligned with prior research examining Black and Latina cisgender women's sexual and reproductive health care experiences [7, 11, 17, 91, 92], Black and Latina transgender women's health care experiences in general [95–97], and the sexual and reproductive health care experiences of women who use drugs [23, 111]. In particular, in prior studies, Black cisgender women recommended the provision of person-centered care in sexual and reproductive health care settings [91] as well as improvements in provider structural competence [5, 6, 112] and greater access to care from providers who shared their racialized and gender identities [17, 91]. In addition, reports from Black women-led organizations have highlighted the need for providers to practice transparent communication, extend respect and compassion, and provide unbiased, culturally respectful care to Black women [75, 113]. Further, in previous research and organizational reports, Latina cisgender women have also recommended increasing the availability of and access to health care providers who speak Spanish in sexual and reproductive health care settings [11, 92, 114].

In the context of the present study, Black and Latina transgender women in particular recommended that sexual and reproductive health services offer comprehensive, gender-affirming care tailored to the unique and specific needs of transgender and nonbinary people. This recommendation is aligned with both the prior literature on the health care experiences of Black and Latina transgender women [95–97] and the recommendations of transgender-led organizations [115, 116]. Black and Latina transgender women have expressed a need for health care providers who are competent in transgender health, engage in gender-affirming practices, and respect their multiple marginalized social identities and lived experiences [95–97, 115, 116]. Black and Latina transgender women have also highlighted the need for all staff in health care settings to be gender-affirming, not just providers [95–97]. Additionally, Latina transgender women specifically have expressed the need for Spanish-speaking providers or interpreters trained in working with transgender patients [97, 115], as well as providers who are aware of how immigration status can impact access to care [95]. These considerations are crucial given that, although some transgender participants in our study reported that LGBTQ + health centers and organizations provided them with gender-affirming sexual and reproductive health care, a few participants reported experiencing transphobia in health care settings specifically geared towards LGBTQ + patients [96, 117]. Sexual and reproductive health services must be inclusive of all LGBTQ + communities, including transgender people whose needs are often not met, even in spaces supposed to be inclusive [96, 117]. Finally, research on the sexual and reproductive health care preferences of women who use drugs is limited, but two prior studies have shown that women in treatment for substance use disorder are supportive of integrating sexual and reproductive health services into substance use treatment [23, 111].

Our study findings should be interpreted in the context of several limitations. First, this study recruited participants from Boston, MA, Providence, RI, and Washington, D.C., all of which are large metropolitan areas in the Northeastern U.S. with liberal policies related to gender identity, sexual orientation, and access to sexual and reproductive health. Thus, study results may not be applicable to Black and Latina cisgender and transgender women residing in other geographic regions (e.g., Southeast) or in rural or suburban areas with more conservative political (e.g., more punitive drug use laws) and social (e.g., less acceptance of transgender individuals) contexts. Our sample had a small number of Latina participants (22%), and all but one was English-speaking. As such, the issue of language access could not be explored in our interviews, even though the lack of health care providers who speak Spanish is a known barrier to sexual and reproductive and other health care among immigrant Latina cisgender and transgender women [11, 92, 97]. Additionally, the majority of participants in our study reported using marijuana; in particular, only a few participants reported using cocaine, MDMA, methamphetamine, alkyl nitrites/poppers, psilocybin (17%, $n = 3$), LSD (6%, $n = 1$), or benzodiazepine, and no participant reported using injection drugs. The primary use of marijuana, which has gained wider social acceptance in recent years, among participants may have resulted in limited discussion of substance use stigma during our

interviews and thus hindered our ability to ascertain its impact on participants' sexual and reproductive health care experiences. Notably, people who use injection drugs are frequently discriminated against in sexual, reproductive, and other health care settings, creating barriers to timely, compassionate care that is responsive to their needs [118–120]. Thus, future research studies on the sexual and reproductive health care experiences of Black and Latina cisgender and transgender women who use drugs should also investigate structural barriers based on immigration status, nativity, language, geography, and stigma related to the use of injection drugs.

Conclusions

Our findings have important implications for programs, policies, and practices that can be implemented now to promote reproductive justice—that is, the right to not have children, the right to have children, and the right to raise children in safe and supportive environments—for Black and Latina cisgender and transgender women who use drugs [51, 63]. First, increased funding for and availability of voluntary, person-centered, and structurally-competent sexual and reproductive health services, including contraceptive and abortion care, cervical cancer screening and follow-up care, HIV and STI testing, prevention, and treatment, and gender-affirming care, at no cost and in health care and community-based settings are needed to facilitate access to these preventive services among these multiple marginalized groups [75, 114, 121, 122]. Second, with regard to Black and Latina cisgender women who are pregnant in particular, advocates recommend the expansion of informed consent laws for drug testing as well as the elimination of non-consensual drug testing, mandated reporting of the co-occurrence of substance use and pregnancy, and criminal and civil penalties for pregnant people who use drugs [121–124]. Additionally, in line with reproductive justice principles of bodily autonomy, Black and Latina cisgender and transgender women who use drugs must also have access to fertility services that allow them to have children based on their uncoerced fertility desires, including but not limited to in vitro fertilization and fertility preservation services [125, 126].

Lastly, to truly ensure reproductive justice, the precarious social and economic conditions of Black and Latina cisgender and transgender women who use drugs must be addressed through structural and collective efforts. Federal and state policies that facilitate access to social and economic resources for (multiply) marginalized people, including but not limited to health care, transportation, affordable housing, gainful employment, and childcare, are urgently needed. Moreover, broader structural changes that combat discrimination towards and the criminalization of Black and Latina cisgender and transgender women who use drugs are also necessary [127–130]. For example, community-based organizations and advocates have advocated for the decriminalization of sex trades and of drugs [128, 131–133] and the abolition of policing practices that target Black and Latine people, people who use drugs, LGBTQ + people, and their families and communities [122, 123, 128, 134]. Moreover, reproductive justice and Black, Latine, disabled, and LGBTQ + advocates havecalled for the creation of new structures, institutions, and practices that are outside of those that perpetuate the devaluation, dehumanization, and mistreatment of (multiply) marginalized people in the first place and instead promote individual and community health, healing, and well-being through ethics of care and collective action [135–138]. In the face of multiple intersecting systems of oppression, holistic community care outside of formalized health care systems offers opportunities for not only individual healing but also community well-being and social transformation that support sexual, reproductive, and health justice for all [135]. Ultimately, Black and Latina cisgender and transgender women who use drugs are the best authority on their own lives; thus, it is critical for researchers, providers, and policymakers to follow their lead and support the implementation of solutions that are most relevant to their lives as part of a community-led reproductive justice approach [139].

Abbreviations

U.S.	United States
LARC	Long-acting reversible contraception
MA	Massachusetts
RI	Rhode Island
DC	District of Columbia
CAB	Community Advisory Board
PCP	Primary care provider
CAN	Certified Nursing Assistant
PWI	Predominantly white institution
IUD	Intrauterine device

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions

M.A., K.B., and A.B. conceptualized and designed the study. A.T., T.D., R.D, and K.R. conducted the interviews that served as the basis of this manuscript. T.D. and M.N. coded and analyzed the interviews, and M.A., R.D., and Q.B. contributed to data analysis and interpretation. M.A., A.T., and M.B. drafted the

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Data availability
The data used in this manuscript are not available for dissemination as participants did not consent to the analysis of their interviews for purposes other than the ones of the present study. The interview guide is provided as a supplement.

Declarations

Ethics approval and consent to participate
This study was approved by the Brown University Institutional Review Board (Protocol #3383) in adherence with the Declaration of Helsinki [140]. All participants provided oral informed consent before participating.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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