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► **To cite this version:**

Gabriel Girard, Elise Marsicano, Emmanuel Beaubatie, Yael Eched, Mona Le Bris, et al.. Investigating health services for sexual and gender minorities in France: a qualitative study protocol. *BMJ Open*, 2023, 13 (4), pp.e068716. 10.1136/bmjopen-2022-068716 . hal-04200642

HAL Id: hal-04200642


<https://hal.science/hal-04200642v1>

Submitted on 8 Sep 2023

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BMJ Open Investigating health services for sexual and gender minorities in France: a qualitative study protocol

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To cite: Girard G, Marsicano E, Beaubatie E, *et al.* Investigating health services for sexual and gender minorities in France: a qualitative study protocol. *BMJ Open* 2023;**13**:e068716. doi:10.1136/bmjopen-2022-068716

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2022-068716>).

Received 29 September 2022
Accepted 27 March 2023



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ABSTRACT

Introduction Discrimination and structural violence experienced by sexual and gender minorities are the source of social inequalities in health. The last decade has been marked by major developments in the provision of sexual health services for these minorities in France. This paper presents the research protocol of the Services for Minorities-Lesbian Gays Bisexuals Transgender Intersex+ (SeSAM-LGBTI+) study, which aims to document the health, social and professional challenges in the organisation of current health services for sexual and gender minorities in France.

Methods and analysis The SeSAM-LGBTI+ study relies on a multidisciplinary qualitative study. It has two objectives: (1) to analyse the history of the development of LGBTI+ health services in France, through interviews with key informants and rights activists and through a study of archives and (2) to study the functioning and challenges of a sample of health services currently offered to LGBTI+ people in France, through a multiple case study, using a multilevel and multisited ethnography. The study will rely on approximately 100 interviews. The analysis will be based on an inductive and iterative approach, combining sociohistorical data and the cross-sectional analysis of the case studies.

Ethics and dissemination The study protocol has undergone a peer review by the Institut de Recherche En santé Publique's scientific committee and has been approved by the research ethical committee of Aix-Marseille University (registration number: 2022-05-12-010). The project has received funding from December 2021 to November 2024. The results of the research will be disseminated from 2023 onwards to researchers, health professionals and community health organisations.

INTRODUCTION

Sexual and gender minority health issues in France

Discrimination and structural violence experienced by sexual and gender minorities (SGM) are the source of social inequalities in health.¹ These inequalities are related to the relatively high prevalence and incidence of sexually-transmitted infections (STIs),² suicide attempts and mental health problems,³ psychoactive substance use⁴⁻⁶ and cancers⁷ observed in this population.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The study conducts a multilevel and multisited ethnography of lesbian, gay, bisexual, transgender and intersex (LGBTI+) health services.
- ⇒ The study diversifies the ethnographic sites in order to avoid the bias of over-representation of territories where sexual and gender minority services are concentrated.
- ⇒ The study employs the term 'sexual and gender minorities' to overcome the difficulties in including the full range of experiences within the LGBTI+ population.

The lack of training for health professionals on the realities and specific needs of SGM contributes to these challenges.⁸ Presuming that patients are heterosexual can impact how diagnoses are made.⁹ Moreover, the difficulties encountered by lesbian, gay, bisexual, transgender and intersex (LGBTI+) people can be related to mechanisms of internalised LGBTI+ phobia¹⁰ and to minority stress.¹¹ These various inequality elements create a syndemic context¹² in which the aggregation of health problems and situations of discrimination and violence affect the living conditions of LGBTI+ people. In several countries, university curricula have begun to include training on the health realities of LGBTI persons.¹³ In France, such training remains sporadic and is an active process on the part of service providers and essentially by community-based organisations.

Inequalities and discrimination have prompted SGM to develop community-based health interventions. In France, health interventions for SGM have historically been structured around responses to HIV/AIDS. The specific sociobehavioural and epidemiological characteristics of this population have led to increased prevention and screening activities, particularly for gay and bisexual men—often categorised by public health organisations as 'men who have sex with men' (MSM)—and

for transgender people, especially sex workers. However, two populations have remained on the margins of these health interventions. The first are women who have sex with women (WSW), a group that has never been a target for public health; the second are bisexuals and their sexual partners; these persons are often lumped together under the MSM category, with the resulting risk that their different identity and sexual behaviours is invisibilised.¹⁴ Appropriate care for transgender men remains less developed, but has improved over the past decade thanks to the mobilisation of transgender activists.

The prolonged focus on interventions concentrating on HIV/AIDS and individual prevention and screening behaviours started to show its limitations during the 2000s. More specifically, the continued high incidence of STIs¹⁵ and HIV¹⁶ despite these interventions demonstrated the need for a more comprehensive approach to sexual health issues that took into account structural barriers to access to health services.¹⁷ Furthermore, it would appear that a lack of epidemiological data led to the invisibilisation of sexual health issues other than HIV, and to lesbians and bisexual women being overlooked in SGM public health programmes.¹⁸ This particular issue led to a number of more comprehensive and inclusive community-based initiatives, despite the low level of funding dedicated.

In the last decade, France has seen major developments in the provision of sexual health services for SGM, including the creation of several sexual health centres in Paris, the development of community-based rapid HIV testing, the spread of pre-exposure prophylaxis and follow-up services (particularly online), the structuring of self-support initiatives for transgender people, and the development of sexual health programmes for lesbian and bisexual women.¹⁹ Often driven by collaborations between associations, health professionals and researchers, these services—inspired by initiatives in other countries (eg, Switzerland, the UK, the USA and Canada)—mostly combine traditional healthcare with community resources, complemented by digital tools. However, given the absence of any specific public policy and no official research agenda, the field of SGM health is poorly structured, with services often being provided by local instead of national mobilisation. This situation weakens the potential for these services to expand. This results in a lack of awareness of LGBTI+ issues among health providers, which has consequences in terms of early detection of STIs, certain cancers and mental health issues.

To our knowledge, no study to date has analysed current interventions for SGM in a comprehensive and comparative manner in the French context. Moreover, unlike in English-speaking countries, the health of SGM is an underexplored subject in the field of social sciences in France,^{20 21} and most of the published work is gay-centric. Some of the few French studies that have explored SGM health focused on the subjective experience of this population in the medical care context.²² Dimensions related

to access to health services remain understudied. In light of these shortcomings, Services for Minorities-Lesbian Gays Bisexuals Transgender Intersex+ (SeSAM-LGBTI+) will focus on the organisation of current services for SGM and the related activities of healthcare actors.

STUDY AIMS AND HYPOTHESIS

This paper presents the research protocol of the SeSAM-LGBTI+ study, which will explore the social and professional challenges in the organisation of existing health services for SGM in France. SeSAM-LGBTI+ has two main objectives:

Objective 1

The first objective is to investigate the social and political conditions influencing the development of health services for SGM in France over the last two decades, the inclusion of these conditions in public health policy and the tensions related to their concrete implementation.

Objective 2

The second objective is to analyse the functioning of existing health services and interventions targeting SGM in order to better understand how they are organised, how well they meet the needs of the populations concerned, problems related to training healthcare professionals, collaborations and coordination between different actors, the participation of users (eg, in a board of directors), and the development of a burgeoning new field of health promotion which lies at the frontier between public health intervention and community-based intervention.

The research is based on three hypotheses:

Hypothesis 1

The notion of ‘community health’, which is omnipresent in the field of SGM health, is polysemous and subject of controversy in France. It covers divergent interests within the LGBTI+ populations, but also among the associations and health professionals involved. The project will focus on the differing definitions of ‘community’ and ‘community health’ by all SGM health actors and in related public debates. It will show how these variations reflect differences in local contexts, intellectual influences, training of healthcare providers and socioprofessional trajectories.

Hypothesis 2

The current provision of health services for SGM highlights tensions between intervention paradigms (universal/community based), professional skills (generalist/specialist), the types of knowledge used to study the population concerned (medical/lay knowledge) and categorisations of gender and sexuality. These tensions help shape the field of SGM healthcare in France.

Hypothesis 3

As is the case for most healthcare services, services for SGM are structured by social power relations (gender, race and social class dynamics). The consequence is the

differential treatment of patients by health professionals and community workers. We aim to analyse whether or not these dimensions of intersectionality are taken into account in the development and provision of services for SGM.

METHODS

Theoretical approaches

This study is rooted in the field of sociology of health, and uses a multilevel and multisited ethnography. The theoretical approach mobilised is inspired by the critical sociology of power relations, and more particularly by feminist and intersectional theorisations of social relations.²³ In this perspective, we consider that gender and sexuality identities are socially and historically constructed.²⁴ They are the result of socially determined power relations—in society as well as within the communities concerned—that can be transformed. Feminist and intersectional analyses of health^{25 26} help us to better understand the way in which current LGBTI+ health services are structured in France, and aspects that have not been considered in this structuring.

Study population

Data collection will involve three distinct populations.

1. Key informants/experts in the field of SGM health. A total of 20 researchers, policy-makers, national-level healthcare providers and LGBTI+ rights activists will be interviewed. They will be preidentified during the literature review will be the first persons interviewed. Using a snowball technique (by asking at the end of these interviews: ‘Who do you think are the key people in this field?’), we will then interview others. Interviews with 15 lesbian and bisexual women in the field of HIV activism will also be conducted.
2. Service providers/local health service staff. We plan to interview up to 60 people working in a professional or volunteer capacity in diverse LGBTI+ health service settings (type of structure (community based/medical), geographical location (urban/rural/Paris region/other regions), types of services offered and target public). Our aim to ensure a diversity of sociological profiles (age, career path, gender identity, race and sexual orientation). Recruitment will happen during the ethnography of health services, in order to identify the most relevant people to interview within a given service.
3. Users of health services. We will conduct focus groups with LGBTI+ people who use dedicated health services. These persons are not the priority target of this study but their experience of these services is a key element in understanding the quality of care currently provided. We plan to hold 10 focus groups, with a total of 50 people, and to ensure their profiles are diverse in terms of age, gender identity, race and sexual orientation. Recruitment will be based on the ethnography.

The study will be conducted from December 2021 to November 2024. Data will be collected from October 2022 to December 2023. Data analysis will take place during 2024.

Study design

SeSAM-LGBTI+ is a qualitative research study, conducted by a multidisciplinary team of social science researchers: sociologists, sociodemographers and archivists. Our complementary skills (ethnography, history and archival studies) will allow us to meet the study’s two objectives.

The study will use a multilevel and multisited ethnography. We will analyse the history of the development of LGBTI+ health services in France, through interviews with key informants, a study of archives and retrospective interviews with lesbian and bisexual rights activists from the 1980s to the 2000s. This part of the ethnography will be multilevel, as the study of activist archives, the interviews with activists, decision-makers and researchers, and the analysis of public policies will be all performed at different geographical scales (local, regional, national). We will also study the functioning and challenges of a sample of health services currently offered to SGM in France, through a multiple case study.^{27 28} This second part of the ethnography will be multisited, as the case studies will be selected to reflect the diversity of profiles of SGM health services in France in terms of geography, the target population, the type of structure, etc.

We chose to perform an ethnography arises as we aim to create an original database on the health of SGM in France, which includes the documenting of several dimensions that have been understudied in these populations until now. More generally, outside of sexual health, LGBTI+ health is not very well known and often invisibilised. Given the fact, as mentioned above in the Background section, that WSW have been marginalised in terms of interventions over the years, we decided to focus one section of our study on the history of lesbian mobilisations in HIV activism since the 1980s.

Data collection

A variety of data collection methods will be used; they are presented below in relation to the two main study objectives (figure 1).

To meet the first objective of the study, the ethnographic data collection will include:

Scoping interviews with key informants

Twenty semistructured interviews with actors in the development of SGM health in France: association activists, health professionals, policy-makers. Interviews will take place online or in person, lasting approximately 1 hour. Participants will be asked about their experiences and thoughts around LGBTI+ health. At the end of the interview, they will be asked to draw a personal map of the field of LGBTI+ health actors in France.

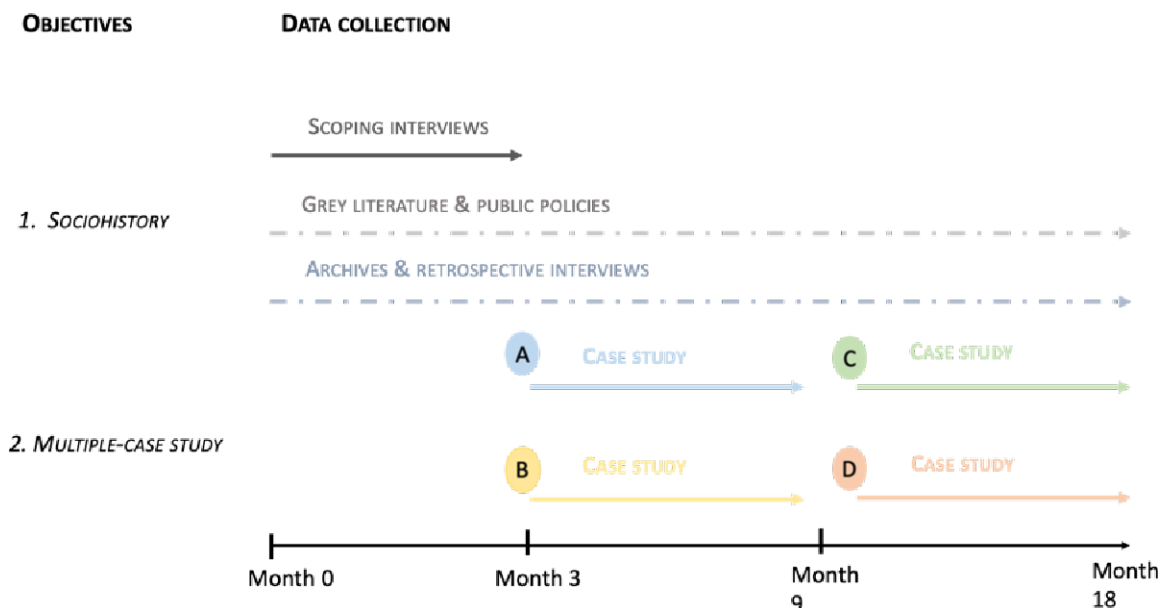


Figure 1 'Data collection'. Data collection stages of the SeSAM-LGBTI+ project. SeSAM-LGBTI+, Services for Minorities-Lesbian Gays Bisexuals Transgender Intersex+.

Grey literature and public policy documents in the field of LGBTI+ health

Collection of grey literature and public policy documents: public health plans, national sexual health strategy between 2000 and 2022.

Archives and retrospective interviews on the involvement of lesbian and bisexual women in the fight against HIV/AIDS sexual health

Collection of archives on the involvement of lesbian and bisexual women in the fight against HIV/AIDS in France (Lesbian Archives, Research and Culture) between the 1980s and 2000s and 15 semistructured interviews with activists of lesbian associations, focusing on their involvement in the fight against HIV/AIDS since the 1980s.

With regard to the second objective of the study, one of the first elements of the study is to decide which case studies to include. In this context, we already performed an exploratory mapping of the main LGBTI+ health services in France, by combining our knowledge with an internet search. This revealed a large concentration of

services in Paris. Accordingly, we opted to use a definition criterion, specifically, that each case refers to a structure offering health services to LGBTI+ persons (ie, as opposed to a territory).

Given that we to analyse a diversity of configurations in terms of geography, services offered and target audiences, and that each case includes an analysis of the network of actors with whom collaborative links exist (patient referrals, training of service providers, partnerships, etc), we finally chose four case studies, reflecting a diversity of geography (Paris, Grenoble, Toulouse and Saint-Brieuc), city size and target audiences. This selection is not representative, but illustrates the plurality of GSM health service profiles currently available in France.

For each case study, there will be five phases of data collection (table 1):

Phase 1: online ethnography

This will consist in consulting public documents (reports, articles, websites) and grey literature (meeting minutes, internal reports, evaluation tools used by the structure)

Table 1 Multiple case study data collection

Phase	Method	Timing	Targets (population/media/actions)	Data collection
1	Online ethnography	Continuous	Websites of LGBTI+ community health facilities	Public Information, public image
2	Interviews	Months 4–16	Professionals in LGBTI+ health facilities	Experience, perceptions
3	Observations	Months 4–16	Actions within the LGBTI+ health facilities (working meetings, public events)	Internal functioning, work environment
4	Focus groups	Months 6–18	Users of LGBTI+ community health services	Evaluation, needs, expectations, feedback
5	Interviews	Months 8–18	Professionals within the facility's network	Network functioning

LGBTI, lesbian, gay, bisexual, transgender and intersex.

in order to understand the context in which the service in question emerged and developed. It will be necessary to understand and locate all the actors involved, the initial objectives and the evaluation procedures envisaged at the outset. This phase will provide detailed knowledge of the structure studied and its activity statistics. In this first phase, we shall pay particular attention to online-based interventions, through a detailed investigation of their modalities and scope.

Phase 2: interviews with professionals in LGBTI+ health facilities

We will conduct interviews with the actors of the service studied, aiming to include diverse points of view (employees/volunteers, years working in the structure). These will focus exclusively on the professional and/or activist background and practices of the interviewees. The number of interviews will vary according to the size of the structure (between 5 and 10 interviews) (interview guide: online supplemental file 1).

Phase 3: observations

We will perform observations of work meetings in the service studied, with prior agreement from the structure. The objective is to study the organisation of the related work, the challenges encountered and how they are overcome, as well as the role of each actor. Between 5 and 10 observation sessions (each approximately 2 hours long) are planned for each case study. The aim is not to focus on individual logics, but rather on more general social logics (professional relations, gender, race and class relations, etc).

Phase 4: focus groups

We will organise two focus groups per case study with LGBTI+ service users. An analysis of users' perceptions of the service offered (evaluation of the quality of reception in the structure, the service offered, user expectations, etc) will be conducted. The organisation of these focus groups will be based on information disseminated on social networks and to the users of the services concerned. The information notice and the study consent form will be sent to people who contact the research team indicating their interest in participation. The focus groups will comprise between 5 and 10 people, and will be facilitated by the study's research team. The focus groups will take place in person, in a venue independent of the health services studied. We will aim for a diversity of profiles and experience of the services (focus group guide: online supplemental file 2).

Phase 5: interviews with professionals working in structures' partner networks

Finally, we will conduct interviews with actors working in the particular structure's (ie, that is providing the health service studied) partner network. The objective is to analyse collaboration between the structures studied. Interviewees will include health professionals, association-based rights activists and LGBTI+ community members. The number of interviews will vary depending on the case

(between 5 and 10 interviews), and will focus exclusively on the professional and/or activist background and practices of the interviewees.

These different data collection operations will constitute the case study for each service included. In total, the local reports will include between 15 and 25 interviews, and between 10 and 20 focus group participants. The overall number of interviews will, therefore, be between 90 and 150, while the overall number of participants in the focus groups will be between 60 and 80.

Data analysis

The archives collected in phase 1 will be classified and grouped in a database created specifically for SESAM-LGBTI+. This database will be accessible to all the team's researchers. Audiorecorded data from interviews, focus groups and field notes will be transcribed verbatim for analysis. Data will then be interpreted based on the theoretical approaches employed by the study (see above the theoretical approaches section). For the key informant interviews, we will conduct an inductive analysis. The aim is to identify the main themes which emerge from their discourses by condensing the results into a summary format. For this summarisation stage, we will use a categorical thematic analysis. We will iteratively read all the transcripts to identify emerging themes, and will use NVivo software to systematise our observations. Data will then be interpreted based on the theoretical approaches employed. At the end of the data collection, we will be able to propose an analysis of the challenges involved in developing health services for SGM in the French context. This summary will be based on both the socio-historical analysis and the cross-sectional analysis of the case studies, and will lead to a final activity report. Data triangulation techniques (combination of interviews, observations and archives) will help to limit memory bias, especially regarding sociohistorical dimensions of our study.

The analysis process will not be limited to the final phase of the study. Intermediate analyses will be produced during the course of the study, particularly around the local reports of the different cases studied. The data analysis process will be based on research team workshops, repeated at several stages of the study. These workshops will allow us to cross-read the raw data and produce a collective interpretation by sharing perspectives. Following the quality assessment principles, we will proceed by parallel coding of interviews, as well as by triangulation of the collected data. These analyses will be shared with the members of the steering committee, the scientific committee and actors involved in the case studies. This phase will consist in presenting our preliminary analyses to the health service actors and beneficiaries. This exchange will allow us to verify the soundness of the analyses, to improve them, to clarify any grey areas and to plan knowledge transfer actions. This process will require the organisation of collective feedback meetings.

In addition to the preparation of articles and scientific communications, the data analysis phases will be devoted to the preparation of activities and tools for knowledge transfer (good practice guide, training, summer schools, etc).

Patient and public involvement

None.

ETHICS AND DISSEMINATION

Ethics approval and consent to participate

The study protocol has undergone a peer review by the Institut de Recherche En santé Publique's scientific committee and has been approved by the research ethical committee of Aix-Marseille University (registration number: 2022-05-12-010). The study has received funding from 1 December 2021 to 30 November 2024.

Details on the protection of the data collected will be specified in an information letter given to each person invited to participate. All key informants and respondents will be over 18 years old and will participate voluntarily with no monetary compensation. However, considering ethical recommendations, participation will be at no cost for participants; for instance, transportation fees will be reimbursed. All participants will provide written informed consent.

The interviews will be recorded with the oral consent of the participants, and will be fully transcribed and anonymised. A number will be assigned to each interviewee (Health L 01, etc); all identifying information (names of people, places) will be erased. Only the following sociodemographic information will be reported in the analysis and publications: age range, gender and level of education. Observations will be recorded in situ and will be systematically anonymised (Structure X 01, etc). The anonymised transcripts will be made available to all the members of the research team.

Data deposition and curation

Data will be stored in encrypted form on a secure server in Aix-Marseille University cloud, will be accessible only to authorised researchers. The data processing implemented for the needs of this study will be performed in compliance with MR 004 and declared to the Data Protection Officer (DPO) registry of Aix-Marseille University.

Dissemination plan

Study findings will be disseminated from 2023 onwards to various audiences. We will communicate our findings to researchers at scientific gatherings and publications in peer-reviewed journals. Dissemination events will be organised for health professionals and community-based services. In addition, results will be used as pedagogical material for training courses and summer schools aimed at health professionals.

DISCUSSION

Since the early stages of this planned study, specific challenges have necessitated discussions within the research

team. The first challenge concerns the spatial dimension of SGM health. The over-representation of LGBTI+ populations in urban areas translates into an uneven distribution of health services for SGM throughout France: dense and concentrated in the Paris region and in some metropolises with over 400 000 inhabitants, more disparate in cities with less than 300 000 inhabitants, and rare in working-class neighbourhoods of large cities and in rural areas. To ensure diversity in our investigations, we decided to implement the study by using the type of facility (community/medical-community/medical), geographical area (Paris region/non-Paris region) and intervention area (urban/rural) as three variables.

The second challenge concerns the heterogeneity of experiences covered by the LGBTI+ and the different realities and experiences of LGBTI people. One of the objectives of SeSAM-LGBTI+ is to analyse how existing health services for LGBTI+ in France meet the diversity of health needs these populations have, and what the barriers and limitations are to their accessing healthcare. For scientific reasons, we, therefore, chose to use the term 'SGM', which in our opinion is more inclusive of the diversity of identifications and their evolution, and better reflects our critical approach to analysing the processes of essentialisation of minority identities.

To conclude, SESAM- LGBTI+ will provide the first in-depth analysis of health services for LGBTI+ people in France. We hope that the results of this work will help inform the development of professional training and health promotion approaches in this area.

Contributors GG, EM, EB, YE, MLB and LP designed the research protocol. LV and GG wrote this paper and GG, EM, EB, YE, MLB, LP and MR participated in reviewing and approving the final text.

Funding The project has received funding from the Institut de Recherche En santé Publique (IRES) from December 2021 to November 2024. The project was evaluated twice, through an independent scientific committee commissioned by IRES: once on the basis of a letter of intent (September 2020), and a second time on the basis of a full project (January 2021). The results were formalised in June 2021, and the funds were disbursed in December 2021. Award/grant number: NA.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

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