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**Sampling and recruiting LGBTQ+ populations in health research:
reflections on community consultations about antibiotic resistant
STIs**

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Research Note:**Title: “Sampling and Recruiting LGBTQ+ Populations in Health Research: Reflections on Community Consultations about Antibiotic Resistant STIs”****Abstract:**

In this paper, we explore negotiations around sexuality and gender diverse identities together with sexual practices, and the materialities of bodies, as they relate to the sampling and recruitment of LGBTQ+ participants in health social science research. The basis of our research note is a reflection on our experiences of undertaking a study on the social dimensions of antimicrobial resistance (AMR) in the context of sexually transmitted infections (STIs). We aimed to identify tensions and important considerations in the sampling and recruitment of LGBTQ+ populations in health and social science research. Recognising the fluidity and diversity of gender and sexuality, the multiple meanings attached to them, and the proliferation of gender and sexuality identifiers, we argue for the critical importance of reflexivity in curating a sampling frame, which is respectful of LGBTQ+ diversity. This contributes to the growing body of work that reflects on how to develop meaningful and informed approaches to do research with LGBTQ+ populations. We do this by complicating the often-linear presentation of sampling and recruitment processes within scholarly research.

Keywords: Qualitative Research, Interviews, Sociology, LGBTQ+, Sexual Health, Methodology

Introduction

Historical, sociological, and cross-cultural accounts of gender and sexuality demonstrate the ongoing constructions and situatedness of sexual and gender identities, and practices (Blackwood, 1986/2010; Khan et al., 2005; Weeks, 2012). Experiences of gender and sexuality, and the identities attached to them, are not only fluid over time and space, but also across an individual's life course (Brady, 2022; Sumerau, 2020). Moreover, contemporary sexuality and gender identifiers have proliferated in online spaces, providing 'opportunities for young people to articulate their gendered and sexual selves in terms of new ways of belonging and new forms of citizenship' like never before (Cover, 2019: 278). As people increasingly make meaning of their gendered and sexed selves through these identifiers, this raises important considerations about the sampling and recruitment of LGBTQ+ (i) people in health research. These include questions about how samples are conceived, the boundaries that we draw, and the epistemological consequences. In other words, when there is a gender and/or sex element in sampling and recruitment, researchers need to consider contemporary gender identities, bodily materialities, and sexual practices, so that sampling can be more inclusive and meaningful. For example, Mooney-Somer's et al. (2024) highlight that in the context of survey design for lesbian, bisexual and queer women, researchers must be reflexive and adapt to shifting expressions of gender, relations to bodies, new language, and different ways of conceptualising relationships. Such considerations are integral to ethical research and authentic knowledge production, with implications for whose voices and narratives are heard, and whose are not, and how we record and represent the (full) diversity that constitutes our societies.

In terms of gender, scholars have begun to advocate for more considered and innovative approaches to the collection of data, such as open fields for gender descriptors, asking participants to self-code the gender that best reflects their identification, or including specific questions about medical forms of gender affirmation (Callander et al., 2021; Vivienne et al. 2023). However, there is limited literature and guidance in health social science research on how to develop sampling frames for LGBTQ+ participants in general, and the considerations that go into this. In this research note, we draw on our experience of recruiting for a study, that aimed to examine community attitudes to antimicrobial resistance (AMR) in the context of sexually transmitted infections (STIs), to explore how health researchers can more meaningfully engage with LGBTQ+ communities at the nexus of bodily materialities, identities, and practices. In doing so, we explore the considerations made, and the boundaries subsequently drawn to create a sampling frame, and show how this is not the linear process it is often thought to be. These considerations speak to similar methodological concerns in other areas of study such as alcohol and drug use (see Fraser, 2020 on ontopolitically-oriented research), and the dialectic effects of survey participation (see Holt, 2013). As such, we invite people from different fields and disciplines to think with us, about how we do research that is responsive to social change and the complexities of lived realities.

Case Study: Gay Men+ and Antibiotic Resistant STIs

Developing a Sampling Frame

According to the World Health Organization (WHO) (2023a) addressing AMR is a top global priority. Antimicrobials are foundational to the practice of contemporary medicine, and their growing ineffectiveness against pathogens will have a significant impact on healthcare

globally (WHO, 2023a). These concerns are particularly pertinent to STIs, where there are serious fears that *Neisseria gonorrhoeae* (gonorrhoea) will become resistant to last line antibiotics in the relative short term (WHO, 2023b), alongside significant challenges in treatment of *Mycoplasma genitalium* including escalating resistance to azithromycin (CDC, 2021). To understand community members' perceptions of resistant STIs, we are currently undertaking a study that involves consultations with gay and bi+(ii) men, other men (iii) who are part of these sexual networks, and trans and gender diverse people. This approach was taken so that communities mostly likely to be affected now or in the future by antibiotic resistant STIs could be consulted and meaningfully engaged in efforts to curb resistance going forward. We initially chose to work with men who have sex with men (MSM) due to higher rates of STIs in this group, and thus high use of antibiotics for treatment (Williams et al., 2023), noting that men who identify as straight may also be part of these networks. In an iterative process of ongoing discussion and deliberation in the research team we extended our sampling frame to include trans and gender diverse people, recognising that they too may be part of these MSM sexual networks, and therefore may also be affected by the rise of resistant STIs.

Deciding on the specific population to work with was not a straightforward process. It entailed thinking through the intersection of the materiality of bodies, the impacts of STIs on bodies, available categories of sex and gender, and how these may shape approaches to curb the rise of antibiotic resistance. For example, considerations were made about the impact of STIs on bodies with a uterus, fallopian tubes and ovaries, and those without, and how this may affect possible treatment of STIs in the context of AMR. One approach under consideration to combat resistance involves reducing the frequency of asymptomatic STI screening of cisgender MSM for gonorrhoea and chlamydia infections (see Wardley et al.,

2023). This approach is premised on the idea that frequent testing (of asymptomatic individuals) does not necessarily reduce prevalence of STIs, leads to greater consumption of antibiotics, and therefore places selective pressure on bacteria to develop resistance (Tsoumanis et al., 2018; Broom et al, 2023). As a result, a decrease in testing of MSM for gonorrhoea and chlamydia may be a consideration in guidelines in the future, given asymptomatic infections do not appear to cause major harm to cisgender men, and this may help to curb the rise of resistance (Wardley et al., 2023; Broom et al., 2023; Chandra et al., 2024).

In light of this, in our deliberations, we considered the logic that testing/treatment advice may be different for people with a uterus versus those without, as untreated bacterial STIs can cause pelvic inflammatory disease in people with a uterus, fallopian tubes, and ovaries, which can be painful and debilitating, as well as conferring a risk for future ectopic pregnancies and infertility, as well as chronic pain in the lower abdomen from inflammation (WHO, 2023b). Thus, while the differential impact of certain STIs is frequently presented as ‘women’s issues’, a gender-sensitive and inclusive approach recasts this in terms of people of all genders who are at risk of pelvic inflammatory disease and/or have uteruses. Importantly, the conceptualisation and medicalisation of ‘women’s’ bodies as sites of reproduction, and lack of research on men’s reproductive capacities due to STIs, appears to be tied to social ideas of gender, which primarily links ‘women’s’ bodies to reproduction (Chesney-Lind, 2017). Nonetheless, for reasons outlined above, we considered that people connected to LGBTQ+ community sexual networks with a uterus will have testing and treatment approaches deserving of specific research focus (i.e., they may have more regular testing for gonorrhoea and chlamydia). In a similar manner, we thought it reasonable to assume that testing and treatment will raise specific issues for cisgender men who have sex with people both with and

without a uterus, for example, bisexual cisgender men, due to the possibility of transmission of STIs that have particularly pathogenic impacts on the uterus as highlighted above. As a result, we considered the possibility of only recruiting cisgender gay men due to specific testing, treatment, and STI prevention procedures for this group in the context of antibiotic resistant STIs.

However, we next considered that focusing on cisgender gay men would potentially exclude others who are part of sexual networks where resistant STIs are a particular concern. These include trans women, MSM who do not identify as gay, and non-binary individuals, all of whom may have the same testing, treatment, and STI prevention regimes, if they are exclusively having sex with people without a uterus. This was an important consideration especially given the increasing number of people identifying with diverse genders and sexualities (Cover, 2018). As the project team considered which groups to include in the study, and the complexities this entailed, they settled upon the notion of ‘meaningful inclusion’. Said another way, we wanted to include participants in a way that was not perfunctory and spoke to the key aims of the project: to understand community knowledges, perspectives, and experiences as they relate to STIs, for people most likely to be affected by increasing antibiotic resistance.

Our deliberations highlighted that ‘meaningful inclusion’ was not always self-evident. Rather, it is contextually situated, and inclusion is made meaningful in situ. Our thinking was shaped by things like contexts, research questions, available resources, and investigator knowledge and lived experiences. There are various considerations here, including the often less visible material realities of a project, generally not spoken about as ‘methodology’ but integral to it, including budget, staffing, and deadlines, and the opportunities and limitations

they open-up. These have flow-on effects on funds available (e.g. for travel, recruitment, transcription, and analysis), and shape the scope and feasibility of a project, including how many people can be included in a project. The various aims of the project also play an important role in drawing boundaries around the sampling frame, in defining what constitutes meaningful engagement, and in establishing what is appropriate. Alongside this, considerations about meaningful inclusion entail thinking about what is already known in the literature, the gaps, and who has been included and excluded from certain research topics thus far. These reflections, and the considerations made above, meant that our team developed meaningful inclusion iteratively, involving back and forth negotiation around multiple considerations, like knowledge about bodies vis-à-vis medical interventions, project demands, resources, aims of the study, and the existent literature, both through discussion within the research team, and by drawing on colleagues for advice, including ACON (a key Sydney based LGBTQ+ community organisation). Importantly, seeking ethics approval from a community organisation like ACON (alongside university ethics approval) allowed us to better reflect on and engage with inclusivity grounded in community perspectives and to ensure greater accountability to LGBTQ+ community members (see also Mooney-Somers et al., 2024).

When reflecting on this project, key considerations we made about meaningful inclusion related to impacting AMR and STIs in the real world, groups who had been included/excluded thus far in studies on antibiotic resistant STIs, and individuals most likely to be affected going forward. We decided that meaningful engagement with our participants was about developing a detailed and inclusive account of the sexual practices of those at risk, their medical experiences, and their thoughts about AMR in the context of STIs. We also realised that while studies on community perceptions of antibiotic resistant STIs are nascent,

those that do exist, have focused on cisgender gay men (Wardley et al., 2023; Williams et al., 2022). In other words, there have been limited opportunities for people identifying with other genders and sexualities to participate, who are also likely to be affected as they are part of ‘gay’ community sexual networks. Initially, we decided to exclude people with a uterus, or others who have sex with someone with a uterus, due to the potential for different testing, treatment and STI prevention regimens (see above). However, ultimately, we decided against this approach. The team came to the conclusion that while STIs have different impacts on different organ systems, it was important to understand the experiences of people who otherwise might be excluded from this kind of research, such as transgender men, as resistance would still have an impact on their lives due to the sexual networks they may be a part of. In other words, it was more important to engage with diversity in the context of resistant STIs, even if there may be different medical approaches to different types of bodies (i.e., with a uterus versus those without). Given these considerations, we decided to sample gay and bi+ men, other men connected to these sexual networks, and trans and gender diverse individuals, which included people with a uterus.

Recruitment in Practice

In our recruitment of participants, we aimed to ensure that recruitment material was open to the diverse sexualities and gender identities which formed our sampling frame, so that we could purposively capture multiple experiences in the study. We did this by providing clear explanations of our sampling strategy to the community and collecting demographic data during the recruitment process. Our public-facing study advertisements (digital and physical) stated our selection criteria: participants had to be 18 years old or over; identify as a gay or bi+ man, trans or gender diverse person, or a man who is part of these networks; and be

living in Australia. We added an asterix in the advertisement, which told potential participants to *'please see the Participant Information Sheet in the linked survey for more information on participation and sampling'*.

To express interest in the study, potential participants were asked to complete an online Qualtrics expression of interest (EOI) survey, which they were directed to by the advertisement through a link or QR code. We attached a copy of the Participant Information Sheet (PIS) to the Qualtrics survey. At the start of the survey, potential interviewees were invited to read the PIS, which provided further information on the sampling strategy of the study. Under the section on 'participation and sampling' the PIS read:

A key aim of this study is to examine possible approaches to reduce antibiotic resistant STIs. We have chosen to focus on gay and bi+ men, trans and gender diverse people, and other men in these networks, as individuals in these sexual networks are most likely to be affected by antibiotic resistant STIs.

We acknowledge the diversity and fluidity of gender and sexuality identifiers in undertaking this study. Individuals in the sexual networks mentioned above may identify with a variety of labels such as straight, questioning, pansexual, non-binary and so on. We welcome this diversity in our study.

Participants need to be 18 years old, or over.

Please contact the research team, using the details below, if you would like more information or have any questions about participation

We did this to ensure there was accountability to LGBTQ+ communities about our method, to provide greater clarity on who was included and why, and to explicitly acknowledge our recognition and inclusion of diversity, within the parameters of our sampling frame. As stated, we also made sure to encourage potential participants to contact us if they had any questions about sampling and participation, recognising people may want to check if they qualify for participation in the study.

The EOI survey asked participants about their age, sexual orientation, gender identification, sex assigned at birth, if they were born with a variation of sex characteristics, if they were born in Australia, ethnic background, which Australian state or territory they live in, and if they live in urban, regional, or rural Australia. While we provided options, which potential participants could select from about gender and sexuality, we also included open boxes, where participants could write down the identifications they were most comfortable with. Following Hanckel and Chandra (2021), this demographic data was collected to purposively recruit participants, specifically to ensure a diversity of sexual and social identifiers, and experiences, in the final sample of the study. For example, we have received many responses to our EOI survey from potential participants. The project does not have capacity to interview everyone, so we have been sending invitations to potential interviewees via email for participation, which were provided in the EOI survey. Invitations are being sent to potential participants using demographics from the survey to ensure people with a range of lived experience are invited to participate.

This process is underpinned by the theoretical understanding that sexuality, gender and social lives are enacted, constructed, made, and felt, by and in the contexts people occupy, including temporally (Chandra, 2022; Waling, 2021), and according to place, such as country, region

and so on (Janoff, 2022; Lyons, 2015; Mishra, 2020). In other words, the use of online technology, and the affordances it provides to purposively recruit and interview diverse people across multiple Australian contexts (including advertising to a wider range of people than in-person interviewing allows), collection of demographic data, and video conferencing, have been crucial to exploring diversity in the context of antibiotic resistant STIs (see also Prescott et al., 2016; Warren et al., 2015). Significantly, these reflections demonstrate that whilst use of digital spaces are not without issues (Drysdale, 2023; Littler & Phillip, 2021), they can enable and provide a rich opportunity for understandings of diversity and multiplicity, which are key to how we address antibiotic resistant STIs.

At the present moment, we assume the data will be presented through forums such as journal articles, presentations, and symposiums, and to diverse audiences such as researchers, community organisations, health services and clinicians. As such, we believe the communication of findings should be purposeful, and directed at what is most useful to an audience, in ways that are accessible to them. In other words, reporting is an extension of other aspects of the study as described above; it is also socially produced. This means that reporting data is not a singular event; rather, there are multiple forms of reporting with back-and-forth learning between stakeholders and researchers. Key considerations for this study include how to report data to maintain participant confidentiality, which has implications for how demographics are presented, whilst also ensuring the needs/experiences of particular participant groups are conveyed with fidelity. Consulting community organisations and other stakeholders such as clinicians in these ways, after data collection, can be instructive for understanding how to report findings that address the needs of different audiences ethically.

Future Directions

Drawing on our experiences, we provide some practical ways forward to develop best practice for how we sample and recruit LGBTQ+ people in health research, and invite others to further develop and contribute here.

Meaningful inclusion: Engage in discussion with stakeholders and the research community about what meaningful inclusion means for your research project, in reference to aims, anticipated impacts, project opportunities and constraints, existent literature, timelines, funding and so on. Moreover, publishing openly about the logic underpinning meaningful inclusion in your project, as a way to help others reflect as well (see also Lau et al., 2020).

Creative use of technology: As digital spaces become increasingly central to our lives, they can be used in creative and innovative ways to recruit LGBTQ+ people in health research. This means thinking about how digital affordances/tools such as advertisements, QR codes, surveys, and information sheets can be assembled in ways that complement each other, and respond to the complex realities of people, identities and practices, and allow for their inclusion.

Clear explanations: Take advantage of different elements in the recruitment process, such as the PIS, to provide clear explanations about the sampling strategy to potential participants, and the community broadly. This will help the community understand why research is being done in the way that it is. In the future, such approaches also need to increasingly consider how to include people with limited English language skills in more accessible ways too. It is also important to work with, and take into

consideration that not all members of the LGBTQ+ community (and more broadly) understand terminology such as ‘cisgender’ (see also Mooney-Somers et al., 2024). They may find such language, and the ontologies they refer to as unfamiliar. We are not saying that such language should not be used. Rather, we should not assume that people will understand it, and we need to find ways to address this. A potential way to do this may be to include simple and clear explanations throughout recruitment where possible.

Research on recruitment processes: We need research with LGBTQ+ people and the population more broadly, to understand how individuals relate to and receive recruitment information. For example, how does a straight identifying cisgender man relate to recruitment material for a study predominantly directed at LGBTQ+ people, but may also include them if they have sex with other cisgender men or trans women? Or how many ‘queer’ experiences do people feel they need to qualify them to be in a study? Such insight will be instructive for how researchers can improve their recruitment methods.

Ask others for support: Draw on your colleagues and community organisations who most likely have a wealth of knowledge on how you can think about meaningful inclusion, the framing of your study, identities, wording, practicalities of recruitment and so on.

For Consideration: Towards Practice-Based Sampling?

As we have critically reflected on our deliberations and thought processes in creating a sampling frame for this study, we have become increasingly aware of potential limitations in using gender and sexuality identifiers as selection criteria, even in our own project. For example, our study has not sought to recruit cisgender women. However, on reflection, one could reasonably argue that, for example, cisgender heterosexual women who have sex with cisgender bisexual men, could technically be a part of our study, as they are in our relevant sexual networks. In fact, cisgender heterosexual women often seem to be missing in queer health framings; however, if they are having sex with cisgender bisexual men, for example, who are also having sex with cisgender gay men, then one may reasonably argue that they do belong. They belong by virtue of relation or practice, if not necessarily identification (i.e., they might not identify as sexuality or gender diverse). Conversely, in the context of this study, a cisgender gay man might be in a monogamous sexual partnership, and therefore their risk of contracting an antibiotic resistant STI might be less than the hypothetical cisgender heterosexual women described earlier; however, this gay man meets our selection criteria.

These examples highlight that research epistemologies that centre identity have limitations. Identities become proxies for risk and behaviour, and ultimately carry assumptions about what people do and do not do. In saying this, we are not discounting the fact that identities are part of social worlds, bringing people into relations and sexual cultures, opening opportunities for exploration and so on, and that these processes can reciprocally inform identities. However, a practice-based sampling frame – recruiting participants based on what people do – opens the possibility of overcoming some of the limitations of identity-based categories. We believe this does not necessitate an either/or approach, rather, it is important to consider how identity and practice-based approaches can be used in conversation with each other to recruit participants depending on the aims of a study. For example, a more practice-

based approach may consider explicitly asking about sexual practices as part of the recruitment process, so we can talk to people who are most likely to be affected by a particular health concern at a given time. As such, together with others, we would like to reflect on what a more practice-based sampling process would look like? Should we ask about sexual history? How would we frame it? How would we communicate it, so the community understands it?

We also believe that thinking with practices has ethical implications. For example, if a research project is particularly budget constrained, then talking to people who will most benefit from the study may be useful, which a practice-based approach to recruitment may help with. Of course, we are not advocating for exclusion based purely on utilitarian modes of knowledge production – sometimes we find important insights when we least expect them, and we do not want to close this possibility. However, at the same time, inclusion for the sake of it should not signify ethical conduct *sui generis*, as inclusion is made ethical in context. Ultimately, it is about balancing different needs to achieve the social good that we are aiming for, including people's health.

Conclusion

In this research note we have explored how decisions about the sampling and recruitment of LGBTQ+ populations in health research is not a linear process, rather it encompasses reflectively considering who to include and why, within contexts of opportunities and limitations. Using different modalities of communication (i.e. advertisements, information sheets), and the affordances of online technologies, we were able to create a method of sampling and recruitment which targeted a particular group of people, while recognising

diversity, and the multiplicity of sexuality and gender-based experiences, including contextual dimensions. Our reflections are intended to open lines of enquiry on how to sample and recruit LGBTQ+ people (and others) in health research ethically and is an invitation to others to join the conversation, so we can collectively reflect on our research practices, and navigate the tensions we come across together.

Notes

- (i) We are using LGBTQ+ to refer to sexuality and gender diverse people as a collective, however, in doing so, we acknowledge that people relate to terms in different and unique ways, that people have diverse experiences within the community, and that not all people may feel a part of the ‘community’ in the first place (see Chandra et al., 2024).
- (ii) The term bi+ is used to capture the diversity under the ‘bisexual umbrella’ for people who are attracted to multiple genders, including gender identifications such as nonbinary, agender and gender queer.
- (iii) We used the phrase ‘other men’ in our recruitment material to indicate that straight identifying men were welcome to take part in the study. We were wary about using the term straight in case heterosexual men who exclusively have sex with cisgender women thought the study was directed at them as well. We were particularly concerned about doing this, as our public facing recruitment flyers/material did not have the word ‘sexual’ in it, and simply referred to ‘networks’. In this recruitment material we said we wanted to talk to ‘gay and bi+ men, trans and gender diverse people, and other men in these networks’. We removed the word ‘sexual’ as we were worried about being censored by online

platforms. However, we referred to ‘sexual’ networks more specifically in the information sheet when discussing sampling, which was not public facing.

In hindsight, we may have been overcautious with our assumption that heterosexual men who exclusively have sex with cisgender women might think the study was directed at them. It was also not our intention to indicate that all trans and gender diverse people identify as men, but we can see how some people may have read ‘other men’ in this way. For the purposes of this research note, we are using the phrase ‘gay and bi+ men, other men who are part of these sexual networks, and trans and gender diverse people’, or the like, where appropriate.

Ethics Declaration

Ethics approval for this project was obtained through The University of Sydney Human Research Ethics Committee (Reference Number: 2024/060), and the ACON Ethics Committee (Reference Number: 202336).

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The authors report there are no competing interests to declare.

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