UNIVERZITA KARLOVA V PRAZE

FAKULTA HUMANITNÍCH STUDIÍ

Katedra Genderových studií

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Access to sexual healthcare is a feminist issue: Analysis of queer-friendliness and accessibility of STI testing clinics in Berlin, Germany

Diplomová práce

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Praha 2020

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V Berlíně dne 30. července 2020

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1. Introduction

Feminism has many definitions. Some agree that feminism cannot be explained with a singular description, but is defined differently by each individual that claims themselves a feminist. For me, feminism is mostly about intersectionality; that is about an understanding of how different kinds of oppression, such as gender, sexuality, race, class, ability, or religion, intersect and act together. Acknowledging such intersectional character of oppression means also identifying how deeply embedded this discrimination is in the structures and systems of our society, and how it is projected even into things, movements, or ideas that are created with the intention to be feminist or queer themselves, and that attempt to subsequently fight to dismantle these unjust arrangements. Thus, in my eyes, feminism is not a static idea or set of beliefs, but an action – a continuous, determined action to expose oppressive structures and to dismantle and revolutionize them. This is a mindset that I carry with me in all of my work, whether academic, artistic, or even personal, and it will likewise be reflected in this thesis, even in the way of how I conduct my research or how I present my findings. To manifest my own understanding of feminism as an action and an effort, I will engage in the so-called process of "queering" (definition and more theory of this practice can be found later in this paper), which I will apply to all aspects of my work, including topic decision, research methods, and thesis writing.

This thesis has two main goals: to evaluate queer femmes' access to sexual healthcare, and to conduct the research leading to such evaluation in a truly feminist way. I will be drawing my work on intersectional feminist theory, feminist methodology, queer theory, as well as sexuality and disability studies. I will aim to explore unusual ways of conducting feminist research in order to gain information and collect findings that not only serve academical purposes of this paper, but will later be useful for my own work as an artist tackling issues of gender, sexuality, and health, and as a sex educator, while still staying within the framework feminist academia follows and requires. I am writing this thesis with the wish for it to be unique, challenging (of the norms of gathering and valuing knowledge), and deeply personal – the issue of my own embedded position within the topic and research itself will be further discussed later in this paper.

The topic of access to sexual healthcare and STI testing has fascinated me for years now, ever since my very first visit to a sexual healthcare center. This rather unpleasant experience has become one of my crowd-pleasing anecdotes—

because of the long waiting times for appointment at the central sexual healthcare center in Copenhagen, where I lived back then, I tried to get STI tested using the clinic's walk-in time. I ended up waiting for seven whole hours in a small, unventilated waiting room, during which I met the person with whom I had the unprotected and unfortunate encounter that brought me to the get tested in the first place—, but also a catalyst to a dedicated work interest in the "downside" of sexual pleasure. Since then, I have explored the topic in various educational articles, Instagram posts, videos, art exhibitions, photo series, even interviews for magazines and workshops, as I have been engaging in the role of an online sex educator for several years now, and centering most of my work around sexual health and education. Choosing the issue of accessibility of sexual healthcare as the subject of my Diploma thesis therefore came very naturally, and without any hesitation.

As this an issue so close to me and my previous work, I have decided to also approach this thesis in a very personal way. For the research, I will be using my own lived experience as a way to a) "queer" feminist research and collect findings about the current situation of sexual healthcare in Berlin and its accessibility to queer femmes, overcoming the issue of the researcher's positionality and involvement by allowing myself to be fully positioned and involved in my research (this will be further elaborated on in the Methodology chapter), b) to battle with my own fear of blood work by intentionally exposing myself to repeated tests requiring blood drawing. This may sound like a silly or unprofessional reasoning behind a topic choice, but it was a big factor in my decision process, and also made the research I conducted more interesting and challenging to me. However, I will fully describe all the chosen methods I have implemented later in this paper.

The structure of this thesis will be the following: in the next few paragraphs, I will introduce my research questions with a brief explanation and description of them, present delimitation of my work, and provide explanation of crucial terms necessary for understanding of the thesis. This will be followed by a chapter dedicated to literature review, summarizing what has already been written about the researched topic by other academics and sex educators. Chosen methodology will be presented and explained after that; and, since I have decided to pursue somewhat of an untraditional choice of methods, a brief definition of them and reasoning as to why they are fitting for this work. Once that is established, I will move on to presenting the findings of my research, dividing into sub-categories for better understanding. The next chapter will be focus on discussion of the findings, and will address possible limitations of my methodological choices and my research altogether. A small part will also be dedicated to meditating on possible solutions and future steps to ensure more inclusive sexual healthcare not only in Berlin, but worldwide. This thesis will be brought to an end with a conclusion in which main findings will be presented.

1.1.Research questions

Since the topic of access to sexual healthcare is very broad, I will utilize the help of several research questions. These research questions will serve as guides throughout my research process, determining the scope and focus of my project. Furthermore, they will serve as a framework which I will attempt to look into with my research, and answer with my findings. The research questions are the following:

How many sexual healthcare centers are in Berlin, where are they located, and how do they function?

Firstly, I want to evaluate the current situation of sexual healthcare in Berlin to have an overview of the services available to both heterosexual and queer folks.

How many of Berlin's sexual healthcare centers specifically cater to queer femmes?

Out of these centers, are there any that claim their target group to be any of the following: women who have sex with women ("WSW"), bisexual or pansexual women, queer women, trans women who have sex with men or women, or anyone who identifies both as queer and anywhere on the femme spectrum but do not call themselves women per se (intersex, genderfluid, agender, non-binary, or genderqueer people who still identify with the term "femme")?

Is it necessary to have a German insurance in order to get tested for STIs in Berlin? What options do people without insurance have?

Is accessibility of Berlin's sexual healthcare centers, and specifically of STI testing, limited by the requirement of being insured in Germany? Are the same services provided to people with state insurance and to people with private insurance[1], or are there differences in the care provided based on the insurance type? Can people without insurance get tested for STIs, and receive subsequent treatment if testing positive?

Are Berlin's sexual healthcare centers accessible to queer femmes, especially in the sense of physical and financial accessibility?

This question is largely drawn upon disability studies, and assumption that class (and one's wealth) plays a big factor in access to healthcare. Are there any physical obstacles, such as the absence of lifts or ramps to ease access to wheelchair users or people with mobility aids, distracting sensory elements, poor signage or lack thereof, or insufficiency of specifically tailored services for visually or hearing impaired people, to name a few, at the sexual healthcare centers? Is information about such accessibility factors available online, on the clinics' websites? What is the proximity to public transport, and how accessible are the stops and the means of transport? Is it necessary to pay for the STI testing, treatment, or check-ups?

How can I use my own experience with STI testing at Berlin's sexual healthcare centers as a method of feminist research?

As I have decided to pursue autoethnography as my main research method, large part of my thesis will also deal with and tackle how to use such gathered information as a valuable source, presented in a form that deems it plausible and enriching to the topic and cause, but also sticks to the academic requirements? How can I, as a person that is fully immersed in the research project, turn myself into my own "lab rat", that is the subject of my own analysis, without comprising on the legitimacy of my work? How can I use past efforts by feminist (auto)ethnographers to guide me in my own process?

And lastly, perhaps more fitting to my personal quest rather than to my academic pursuits, but nevertheless important question I will try to solve with my thesis:

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[1] In Germany, one can have either a private or public/state insurance. Private insurance is accessibly to virtually anyone and ranges in the complexity of coverage based on the price paid for it. On the other hand, public insurance is usually deducted directly from one's salary, or paid by the unemployment office, and is more comprehensive and difficult to obtain for people without a job. However, it is possible to stay insured with a state insurance company even after quitting one's job or not receiving unemployment benefits – which is my case. Public insurance is often way more expensive, but covers way more procedures.

Will repeated STI testing through blood drawing help me get rid of my fear of blood tests?

By making myself the recipient of the sexual healthcare from centers I will aim to analyze, will it be beneficiary in tackling my own phobia of intravenous medical treatment?

1.2.Delimitation

In order to specify my research and avoid overwhelming of information impossible to make conclusions out of, I have decided to narrow down several aspects of my project. This, I believe, will help me in coming up with a more unified, concise, but also applicable results that will be easier to decode and present. Such choices will be guided by the scope and length limit of the Diploma thesis requirements, but also by my own personal beliefs and ideology.

Firstly, I have decided to explore and evaluate sexual healthcare centers located in Berlin, which has been my place of residence for the past four years, only. Comparing different STI clinics from all over Germany would for sure reveal interesting findings, as the nature and settings of each federal state are very distinct, but would prove very time-consuming and costly. Focusing on the German capital only will allow me easy access to fieldwork, compared to doing my research long-distance all over the country or, even, in the Czech Republic, where I am from. Furthermore, by choosing Berlin, I have the advantage of already being part of the local queer community (which I can later consult and interview for my research as well), understanding the healthcare system, benefitting from German insurance (which I obtained about six months ago), and awareness in terms of spatial orientation.

However, as my intention is to execute autoethnography as my main method, I will not evaluate all of Berlin's sexual healthcare centers, but will create a selection of less than ten spaces only. This will allow me for personal visits and potential treatment at all centers I choose to assess.

Berlin is a city known for its vivid and ample queer scene and community, which is often most associated with, and represented by, cis gay men.[2] Berlin's queer femmes are often left out of the picture and discussion, which is a trend not particular to the city only, but very common worldwide, appearing in media representation as well as academic research.[3] Therefore, I have decided to focus

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[2] https://www.thelocal.de/20161216/berlin-named-best-city-to-be-gay-and-single

[3] https://aha.confex.com/aha/2018/webprogram/Paper23485.html

on this underrepresented group instead of exploring experience of all queer people – rather, I will evaluate encounters of queer femmes, whether cis, trans, or identifying anywhere else on the femme spectrum. This will also allow me to enter my research as both an observer and a participant, as I myself identify as a queer, pansexual cis woman. My position is also of someone with a chronic mental illness (clinical depression and anxiety disorder) who engages in non-full-service sex work.

1.3.Terms

1.3.1.Sexual healthcare

As I pointed out earlier, I often cover the topic of sexual healthcare in my work, and usually, I define “sexual healthcare” as the combination of a) STI testing, treatment, and prevention; b) reproductive healthcare; c) gynaecology and urology. However, for the purpose of this thesis, the term “sexual healthcare” will only represent medical care that focuses on the management of sexually transmitted infections, that is offering tests to evaluate one’s sexual health status, and the option of subsequent treatment or prevention (such as pre-exposure prophylaxis, also known as PrEP).

1.3.1.1.Sexual healthcare center

Thus, when speaking of “sexual healthcare centers” in this thesis, it stands for an institution or a space that offers such services as described above, and is specifically designed for (mostly) just that purpose. Therefore, gynaecologists or urologists, or general practitioners, do not fit this description and will not be considered in my research nor my thesis. In Germany, such spaces meeting these requirements are often called “Venerologie”, “Infektiologie” or “Zentrum für sexuelle Gesundheit".

1.3.2. Sexually transmitted infections (STIs)

Sexually transmitted infections are infections mostly passed by physical sexual contact, but not only – they can also be transferred to an individual through intravenous drug use or from a mother to child upon birth (Díez and Díaz, 2011, p. 40). STIs can be bacterial, viral, and protozoal (Gorgos and Marrazzo, 2011, p.53); and the most common include gonorrhoea (Neisseria gonorrhoeae), chlamydia (Chlamydia trachomatis), syphilis (Treponema pallidum), herpes (Herpes simplex 1 or 2), HIV (Human immunodeficiency virus), HPV (human papillomavirus), as well as Hepatitis A, B, or C, or yeast infections, scabies, pubic lice, or mycoplasma (Díez and Díaz, 2011, p.42), all presenting themselves with different symptoms.

STIs are mostly, and wrongly, presumed to be a “side effect” of penetrative (vaginal or anal) sex that involves a penis, however, oral sex, use of sex toys, or even touching of genitals pose equal threat (Marrazzo, 2004, p.1974). While using safer sex protection, such as condoms, gloves, or dental dams, can greatly reduce the risk of STI transmission, but they are not one hundred percent reliable nevertheless (Planned Parenthood, n.d.).

Throughout this thesis, I will adopt the commonly used abbreviation “STIs” instead of writing out “sexually transmitted infections” in full. I would also like to point out that while STIs are also commonly referred to as “sexually transmitted diseases” or, simply, “STDs”, this expression has been deemed not correct by many experts, as the term disease suggests an appearance of symptoms, while many STIs stay asymptomatic (American Sexual Health, n. d.).

1.3.2.1. STI testing

The presence of an STI can be discovered through various types of tests. Blood samples are required for HIV, syphilis, or hepatitis tests; drawn from a finger prick or through intravenous collection. Swabbing the throat, vagina, and anus is used for unveiling chlamydia or gonorrhoea, often supported by a urine sample for more reliable results. Pap smears, during which a small sample of cells is collected from the cervix, are adopted for monitoring cell changes leading to cervical cancer, most often caused by HPV 16 and 18. Furthermore, some STIs can be revealed just by the appearance of symptoms, such as typical cauliflower-like genital warts of HPV, or cold sores of herpes simplex.

1.3.3.“Queer”

Just like “feminism”, the expression queer can have a different meaning for every single person using it, having both positive and negative connotations. In this thesis, I will use the term “queer” as an umbrella term for anyone deviating from heterosexuality, encompassing the LGB (lesbian, gay, bisexual) of LGBT, as well as pansexuality, asexuality, demisexuality, and such. “Queer” in this thesis does not describe someone’s gender identity, but merely sexuality.

Furthermore, as I believe "queer" is a label one has self-identify with, and it is only up to oneself to claim it, all participants and people described, addressed, and considered will be treated as such – proclaiming their queerness openly, instead of me assigning them this identity myself.

1.3.4.“Femme”

By using the term “femme” instead of simply “woman”, I attempt to revolt against gender essentialism that is very common in some branches of feminism (let alone the majority of non-feminist society), that associates one’s genitals as the main determinant of their gender. In my view, the expression “femme” encompasses not only cis and trans women, but also people of other gender identities—non-binary, agender, genderfluid, or intersex people, to name a few examples—that would still place themselves somewhere on the feminine spectrum.

Much of feminist ethnography bases its feminism on the fact that women are studied by women – I am following this habit to a certain extent by engaging in research specifically focusing on the experience of queer femmes, but subverting it by being more inclusive in terms of gender spectrum and sexuality.

1.3.5.“Queering”

As previously stated, with this thesis I aspire to employ the practice of so-called “queering”. Before I delve into a much thorough explanation of the term, I would like to use a quote by the feminist icon bell hooks, from 2014 “Are You Still a Slave? Liberating the Black Female Body” panel:

“Queer not as being about who you’re having sex with (that can be a dimension of it); but queer as being about the self that is at odds with everything around it and has to invent and create and find a place to speak and to thrive and to live.”

In this way, I see the process of queering not as a form of text analysis, as is common, but as carving one’s way in the structures embedded in the status quo, revolutionizing and recreating what is known but perhaps not fitting to everyone’s needs. Here I draw upon the theory presented in J. Halberstam’s work “The Queer Art of Failure”, built on the so-called “low theory”, which “might constitute the name for a counterhegemonic form of theorizing, the theorization of alternatives within an undisciplined zone of knowledge production” (2011, p.18). Halberstam explains counterhegemony, based on Stuart Hall’s interpretation of Antonio Gramsci, as “the production and circulation of another, competing set of ideas which could join in an active struggle to change society” (2011, p.18). Queering is thus an active effort of creating counterhegemony that challenges the hegemonic structures and ideas, participating in social change along the way.

2. Theory

In this chapter, I aim to present findings I acquired through extensive desk research. I consulted online databases like JSTOR, Academia.edu, SciELO, ResearchGate, Google Scholar, as well as public libraries, searching for keywords as “sexual healthcare LGBT,” “sexual healthcare lesbian,” “sexual healthcare queer women,” “sexual healthcare trans,” “STI lesbians,” “WSW STIs,” “access to sexual healthcare,” “access to STI treatment,” “sexuality queer disabled,” “LGBT discrimination healthcare,” “bias sexual healthcare,” “lesbian reproductive healthcare,” to name a few. Furthermore, I looked at books that deal with the topics of sexuality, queerness, and disability I had already owned, and also considered online articles, videos, and podcasts from feminist and queer magazines and platforms.

Unfortunately, as became obvious after a quick search, queer femmes’ access to sexual healthcare specifically is not such a well-researched, frequently-written-about topic just yet, and therefore the amount of materials I could peruse was not as high as if I was focusing on a broader, more commonly discussed issue. Nevertheless, I believe I have managed to gather enough information that was helpful and very important for my research (and my work as a sex educator too), which I now intend to introduce. I have divided my findings into sub-chapters for better orientation and easier understanding.

2.1. Theoretical grounding

Before I present the findings I acquired through desk research and literature review, I would like to anchor my thesis within feminist and queer theory to make sure the main theoretical concepts are understood prior to delving into topic-specific information. First of all, I want to discuss the paradigm within which this thesis is written. Guba and Lincoln describe paradigm as "the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways." (1994, p.105). They identify four main paradigms in qualitative research: 1) positivism, 2) postpositivism, 3) critical theory, 4) constructivism (1994, p.109). With my project, I am implementing constructivism – which is, in Adom et al’s words, “an approach that asserts that people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences,” (2016, p. 1).

As I already mentioned, feminism can have many meanings and definitions, and here I would like to present the type of it I identify with, and which will thus frame this thesis. Opposing the often essentialist beliefs of liberal and radical feminisms, I base my feminist understanding of the society and its structures mainly on the work of scholars of color, especially what is known as Black feminism, represented by, for example, The Combahee River Collective, bell hooks, Audrey Lorde, or Angela Davis, who all aim to call out not only sexist oppression, but highlight discrimination based on race, class, religion, dis/ability, and other elements as well. My feminist position is also guided by works of post-colonial feminists, often addressing the issue of orientalism (concept which dissects the issue of putting the "developed" Western culture in opposition to "simpler" Eastern world within a binary system built on fetishization of the "Orient," and deep misunderstanding of it, presented in Said's eponymous book from 1978), double colonization (as discussed by Parente-Čapková, 2005, who thus defines the reality of women in colonized countries suffering under both imperial and patriarchal ruling), and standpoint theory (which puts the experience the marginalized groups in focal point and embraces their own retelling of it, without the lens of othering and fetishization, as pioneered by Hartsock or Harding). Furthermore, I am inspired by works of Mohanty and Spivak, who also specifically focus on the issue of the privileged Western view of cultures and minorities and its tendency of homogenization of experiences, fetishization, and inability of surpassing the imperialist Western lens. Spivak goes as far as to reject any kind of essentialism and homogenization, with the exception of what she coins as strategic essentialism, which a strategic form of using essentialism, which, however, has to always be defined by specific context, place, time, and such, as a tool fit for attempts at political change (1988, 1996). All in all, the feminism I am guided by, and strive for, is intersectional, following the work of Kimberlé Crenshaw, who coined the term in 1989. Intersectionality is built open the recognition of simultaneous, thus intersecting, factors of oppression.

For this thesis, it is also important to address the subject of gender versus sex, and how it is understood within the context of this work. Gender, as seen by Butler, is performative and produced by continuous repetition of characteristics and behaviors associated with given gender identity, and is thus not innate to any human being, but rather constructed and maintained by our society (1993, 1999, 2004). Bartky (1997) goes as far as explaining how such gender role conditioning is in its essence working on the same mechanism as what Foucault presents as the concept of docile bodies in Discipline and Punish, which sees prisoners as being disciplined by the domineering penal system. Using the example of the panopticon prison, Foucault describes how a prisoner is constantly surveyed thanks to the specifically voyeuristic design of the prison, and thus never knows whether they are watched or not, and becomes their own discipliner in order to avoid repercussions (1975). Bartky sees the same pattern in how women are enforced into performing traditionally feminine roles, guarding themselves and other women around them, reinforcing the sexist gender binary system by participating in it. Similarly, the concept of sex, tied to interpreting the type of one's genitals as a determinant of one's gender or sex, is sustained by societal beliefs and assumptions and thus is not hereditary to people, but rather human-made. Šmausová sees such mechanisms as participating in what she views as these roles becoming the "second nature," maintained by the gender binary social propaganda.

With gender binary comes the issue of compulsory heterosexuality, present in the majority of our society. Such practice is called heteronormativity, which Warner describes as the general presumption that heterosexuality is the "natural," dominant form of sexuality, with all other sexualities being immoral and abnormal (1999). Such embedded presence of compulsory heteronormativity (Rich, 2003) then fuels stigmatization of all other sexualities; such process is what Katz calls erotic apartheid (2013). Shame and stigma attached to identifying as non-heterosexual does not only come from the outside, but can also be internalized. Goffman speaks of internalized homophobia (1963), while Warner mentions the feeling of sexual shame, demanded by the mainstream heterosexual society (1999). The subject of sexual stigma is also addressed by Foucault in his History of Sexuality: Volume 1, where he also theorizes sexuality to be a social construct (1976).

Lastly, this thesis is grounded in disability theory, especially in such that focuses on the issue of access and disability justice. As Mia Mingus, disabled activist and blogger, puts it: "accessibility is concrete resistance to the isolation of disabled people," (2011), and the matter of (not only) physical accessibility is given special attention in this paper. Berlant theorizes such structural inequalities as a contributor to what she calls slow death, a continuous process in which inaccessibility of medical services, capital, as well as social life fuels suffering that steadily diminishes the living conditions of especially people with disabilities (2007). I also implement the practice of worldmaking as defined by McRuer, who sees it as queer re-making of the normative world (2018), by giving importance to the needs of otherwise marginalized groups that can be seen as precarious or redundant.

Now that this has been settled, I will move onto presenting the findings from my literature review and similar research.

2.2.Minority stress and sexual healthcare

The concept of minority stress theory is often linked to mental health issues more common in people from sexual minority groups, being built on the belief that "sexual minorities experience the chronic stress resulting from the suffered social stigmatization, with negative impacts on health," (Alencar et al., 2016, p.5), it can be used as a tool to look at and evaluate any kind of experience (such as sexual healthcare, in this case) and identify how different it is from the experience of the norm of the society (e.g. heterosexual, cis, able-bodied, white people), and what effects this has on the minorities (Gessner et al, 2019, p.1). Through that, it is possible to examine how "sexual minority people must negotiate and navigate their sexual minority identity with health care professionals," (Gessner et al, 2019, p.1).

Alencar et al. point out that this ongoing stress may be the reason why there is a lower demand for healthcare services than in mainstream (non-queer) population (2016, p.5). When there is fear of discrimination, disbelief, or even potential violence—physical or mental—in place in real life, it is not unreasonable that queer folks might expect to be met with the same when seeking healthcare (2016, p.6). Moreover, minority stress theory indicates that this recurrent stress not only prevents LGBTQIA+ people from receiving healthcare, but that also has direct negative impact on their health and can aggravate already existing symptoms much more than in settings where minority stress is not experienced (Frost et al., 2019).

It is also important to acknowledge that minority stress increases when there are more minority identities at play (Gessner et al, 2016, p.1)– such as being trans, non-binary or intersex, being a person of color, lower/working class, or being disabled on top of being queer. Thus, it is imperative to apply intersectionality here as well, and recognize that stigma, trauma, and violence can accumulate and is therefore uniquely different for each person (2016, p.2).

As discussing one’s sexual history is often necessary when receiving sexual healthcare, minority stress based on previous negative personal or collective experience can place a great communication barrier for many queer people (Gessner et al, 2016, p.2). When speaking specifically of femmes, an added tension might also stem from a very common pain bias in medicine, which assumes women feel “less pain” than men as well as underestimates or dismisses the seriousness of health factors when treating femmes (Kiesel, 2017).

2.3.Queer femmes and STIs

While one can find a lot of data on the rates and specifics of STIs among gay men (MSM, or men who have sex with men), there is unfortunately very few sources that specifically focus on sexual health amongst lesbian women and femmes (WSW, or women who have sex with women) (Gorgos and Marrazzo, 2011, p.S84). This is due to the fact that such research is simply not conducted as often as it is for MSM (Marrazzo, 2004, p.1974), as well as because people with uteruses (no matter which gender they identify with; as one’s genitals are not an indicator of one’s gender) often seek treatment for STIs at their gynecologists, where one’s sexual orientation/history is not necessarily always disclosed, whilst MSM are more likely to visit specialized testing places.

Even though studies show that MSM are on the receiving end of STI treatment the most (Llewellyn et al, 2009, p.36), this a) can mean that they merely prefer to stay more informed about their sexual health, b) does not imply that lesbian sex is “less risky.” Yet, this is a misconception held amongst many health professionals, even those specifically focusing on sexual healthcare. It is important to recognize that the term “lesbian sex” does not necessarily mean vulva-on-vulva sex only, that each individual’s sexual lifestyle is entirely different, and that bi- or pansexual femmes also belong into the WSW group. As Gorgos and Marrazzo put it: “Women who have sex with women (WSW) are a diverse group with variations in sexual identity, sexual behaviors, sexual practices, and risk behaviors. WSW are at risk of acquiring bacterial, viral, and protozoal sexually transmitted infections (STIs) from current and prior partners, both male and female,” (2011, p.S84).

By acknowledging that one’s genitals are not a prerequisite of their gender and trans women, intersex or non-binary people with penises are lesbians as well, we should also accept that lesbian sex can thus also mean penetration of a vagina or anus with a penis. Furthermore, lesbian sex also encompasses digital (by hand)-vaginal/anal/oral contact, use of sex toys (which, when shared, are a transmission ground for virtually all STIs), and, of course, oral sex (Marrazzo, 2004, p.1974; De Oliveira et al., 2014, p.299). All of these practices involve the exchange of bodily fluids, which can then lead to a transmission of STIs.

Again, one's genitals do not determine their likeliness of becoming infected with an STI, but they can be a deciding factor in how the infection develops and what form it takes. In general, people with vaginas (I prefer to use this term instead of "women," as womanhood is not equated with having a vagina) tend to be asymptomatic for longer times, and thus only seek medical care later, which results in further complications of STIs (Brady, 2003, p.135), which can culminate into complete infertility when untreated (2003, p.136). Furthermore, the longer STIs are left without any treatment, the more weakened one's immunity is, the more susceptible the body is to transmitting even more STIs (Moscicki et al., 2013, p.409). Studies show that even though all people face the same risk of contracting HIV/AIDS, people with vaginas get infected at much younger age (Brady, 2003, p. 134). While exchange of infected blood (e.g. through skin tears during anal sex) needs to happen for HIV infection, many STIs are transmitted only through skin-to-skin contact, or through exchange of mucus (vaginal discharge, semen, or even saliva), and thus can be very easily exchanged during lesbian sex too (Marrazzo, 2004: 1975). In WSW, infection with chlamydia, trichomoniasis, syphilis, herpes simplex virus (HSV), or hepatitis A is very common (Marrazzo, 2004, p.1975; Gorgos and Marrazzo, 2011, p.S85). Additionally, Marrazzo states that bacterial vaginosis is much more prevalent in WSW than in heterosexual women, the difference being 24%-51% in WSW in comparison to only 21% in heterosexual women (Marrazzo, 2004, p.1975).

Assuming that a big part of queer femmes are people with vaginas, it is important to discuss the increased threat of human papillomavirus (HPV) as compared to people with penises. HPV is one of the most common STIs, often said to be contracted at least once over the sexual life of every single sexually active person (NHS, 2019). There are several types of HPV, some causing skin warts (mostly, but not only, in genital areas), some leading to cervical cancer. While there are vaccines against HPV (such as Cervarix or Gardasil), they are not effective against all types of HPV (Cervarix only protects against HPV 16 and 18, while Gardasil does against 16, 18, 6, and 11), and does not target HPV types that cause skin warts at all (Storgaard, Søgaard, and Bonde, 2014). According to Gorgos and Marrazzo, "WSW are at risk from acquiring HPV both from their female partners and from current or prior male partners, and thus are at risk for cervical cancer," (2011, p.S86). Cancerous growth caused by HPV is discovered through Pap smear tests. This test is often part of the routine gynecological checkup, yet many studies suggest that WSW are less likely to receive it (Alencar et al, 2016, p.7; Marrazzo, 2004 p.1974, 1976), often due to the misbelief that lesbian sex/sex that does not involve intercourse with a penis does not pose the risk of HPV, held by the medical professionals themselves (Marrazzo, 2004, p. 1976). This poses a very high threat of developing cervical cancer to queer femmes – as Marrazzo puts it: "Recommendations for Pap smear screening among lesbians should not differ from those for heterosexual women, a point that should be clearly communicated in national guidelines and relevant training programs," (2004, p.1976).

2.3.1.Risk factors leading to STIs in queer femmes

While all sexual activity, regardless of the sexual orientation of those who participate in it, poses an unavoidable possibility of contracting an STI, there are certain factors that increase the risks of queer femmes becoming infected. In this sub-chapter, I aim to list them out. Before I delve into that, I would like to point out that this part discusses issues of sexual violence against sexual minorities as well as people with disabilities, as this can be triggering for many readers.

As was pointed out many times before in this thesis, being a queer femme, or even a cis lesbian, does not necessarily mean vulva-on-vulva sex only (Gorgos and Marrazzo, 2011, p.S87) – studies show that most lesbians with vaginas have had sex with someone with a penis, and some even "report previous pregnancy, induced abortion, and hormonal contraceptive use," (Marrazzo, 2004, p.1974). To sum up, one's self-identified sexual orientation does not automatically represent their past or present sexual activity (Gorgos and Marrazzo, 2011, p.S87).

Another risk factor is danger of sexual assault that sexual minorities face more than heterosexual population (Everett, 2012, p.3). Studies show this is directly linked to "increased STI risk in young adulthood [of queer people]" (Everett, 2012, p.3). Such sexual violence can often take form of so-called corrective rape, through which queer people are "punished" (by being raped) for their "otherness" (their non-heterosexual orientation), assuming this will "cure" them (turn them heterosexual) (Lock Swarr, 2012, p.962). Sexual assault rarely involves protection (such as condoms), therefore the likeliness of transmitting an STI is very high.

When discussing the risk of sexual violence, it is important to acknowledge that carrying other minority identities on top of being a sexual minority increases such risk. I would like to specifically focus on the intersection of being a queer femme and having disabilities – Kaufman, Silverberg, and Odette point out that women with disabilities face two to ten times higher risk of being sexually assaulted than able-bodied people (2007, p.275), while also dealing with the possibility of physical abuse, financial exploitation, neglect, denial of opportunities, and exploitation for medical and treatment purposes (2007, p.276). The issue of disabled people facing sexual assault is very particular, because, as Kaufman, Silverberg, and Odette state, "commonly, unwanted sexual comments or touch may be made while someone is carrying out caregiving duties," (2007, p.274), while it can also be difficult to simply differentiate what is necessary help with personal/intimate care (such as catheterization, or assisting with the use of menstrual hygiene products), and what is inappropriate, sexually abusive action (Kaufman, Silverberg, and Odette, 2007, p.277; Odette, 2012). Issues of discrediting disabled people's recounting of assault (Kaufman, Silverberg, and Odette, 2007, p.288), as well as possible communication barriers – e.g. how is a person using augmentative and alternative communication (AAC), such as a word board or a communication and writing tablet, supposed to voice their concerns or recount their experience, when they are lacking the language to describe it (Odette, 2012)?

Of course, people with disabilities' connections to sex is not only as victims of sexual abuse, but they sexually active human beings too – which is something often forgotten in our society, as disabled folks are seen as asexual (Odette, 2012, p.174). However, those who experience limited mobility might have issues with using protective barriers, and might have to rely on their partners, or even assistants (who might not be comfortable with helping their clients with such intimate part of their lives) in fulfilling this need, and cannot make sure enough precaution is taken themselves (Kaufman, Silverberg, and Odette, 2007, p.105). Similarly, people with mobility issues have to rely on others for cleaning their sex toys (which can transmit STIs as well), or monitoring if there are any unusual changes in one's genitals (such as warts, discharge, and such), things that are done by the sexually active person themselves in able-bodied scenarios. As Kaufman, Silverberg, and Odette ask: "How do you self-monitor [your own genitals, or your sex life in general] when you have no feeling in the area?" (2007, p.257). This lack of privacy can also be problematic during doctor meetings or counseling sessions, as often assistants or interpreters are needed by many folks with disabilities (Kaufman, Silverberg, and Odette, 2007).

Engaging in sex work is another factor that can put queer femmes in higher danger of acquiring an STI (Steen and Dallabetta, 2003, p.74). Many queer people engage in various kinds of sex work (such as selling nude photos of themselves, performing in porn, stripping, BDSM work, “sugarbabying,” or full service sex work), with some using it for additional income, some for bare survival (Shah, 2012). This line of work bares more exposure to STIs, which can be multiple at once – Steen and Dallabetta indicate that “half to two-thirds of women working as sex workers typically have a curable STI at any one time, [and] many women have multiple infections,” (2003, p.74).

Access to protective methods, and use of it, can also be a risk factor for queer femmes. Due to insufficient sex education and general stigmatization of sex, condoms are largely thought of as prevention against pregnancy, with not as much attention being given to their effectiveness in protecting from STIs (O’Reilly, Dehne, and Snow, 1999, p.57), which can lead to queer femmes’ lesser likeliness of using condoms, as well as other protective methods, when sexually active. Another issue is that safer sex barriers specifically intended for non-penetrative sex, such as dental dams, gloves, or finger condoms, are not as readily available as condoms, which are sold in most supermarkets and drugstores and even offered for free at sexual healthcare clinics, while dental dams, for example, are usually only sold in sex shops (FUSION, 2015).

2.4.Obstacles to testing

After debunking the myth that queer femmes are less susceptible to STIs than heterosexual people or gay men, and presenting risk factors that put queer femmes in vulnerable positions of contracting an STI, I intend to focus on determinants that complicate their access to STI testing and treatment, or prevent them from doing so altogether.

2.4.1. Lack of insurance

Something as simple and necessary as health insurance is, even nowadays, a luxury for many people of minority identities. Racism, classism, queerphobia, and other forms of discrimination come at play here; Alencar et al. assume that “the reality is that many countries are crossed by frames of exclusion and violation of fundamental human rights, especially for minority social groups such as Lesbians, Gays, Bisexuals, and Transgender [people],” (2016, p.1). In general, queer people tend to show lower rates of health insurance (Gessner et al, 2019, p.1; Macapagal, Bhatia, and Greene, 2016, p.435), often due to lower income, parental rejection, or higher likeliness of unemployment and/or homelessness (Macapagal, Bhatia, and Greene, 2016, p.439). Again, the more minority identities person has, the more difficult their access to sufficient health insurance is (Renzetti and Curran, 1992).

2.4.2.Bias in sexual and reproductive healthcare

While queer people are said to be more prone to health issues, including STIs (Alencar et al, 2016, p.2), they are also more likely to have unmet needs when it comes to healthcare (Macapagal, Bhatia, and Greene, 2016, p.435). De Oliviera, Almeida, and Nogueira report that “non-heterosexual people delay or avoid using health care services because of heterosexism or previous negative experiences with practitioners,” (2014, p.298), which can lead to much worse development of symptoms than in those who receive regular healthcare. According to Barry and Sherrod, treating an STI in an early stage proves to be much less costly than care for complications caused by an untreated STI (as addressed earlier, one of such complications can be infertility) – lack of access thus does not only pose risks to individual people, but can exhaust the medical industry of resources, both in terms of finances and necessary medications (2014).

Research shows that anti-queer biases are very present amongst medical practitioners themselves (Alencar et al, 2016, p.6), mostly due to “vocational training in health [being] grounded on a heteronormative and prejudiced culture, which implies an institutional violence in health services,” (2016, p.5). Even when there is no overt homophobia, transphobia, or general queerphobia present, such heterocentric approach to teaching and practicing medicine results in oversights of specific issues and needs particular for the queer community (Alencar et al, 2016; Macapagal, Bhatia, and Greene, 2016).

This often leads to a shared fear of being stigmatized by many queer folks, who thus refrain from disclosing their sexual orientation in healthcare settings (Alencar et al, 2016, p.6). Such lack of disclosure only further enhances the discrepancy in the care they are receiving and the care they ought to be receiving, putting them at increased risk yet again (Alencar et al, 2016, p.6). Indeed, Marrazzo lists “healthcare providers’ lack of knowledge about disease risk and indications for screening” and “providers’ failure to obtain a complete sexual history from lesbians when relevant, or to do so in a sensitive, nonjudgmental manner" as two of the four main potential barriers lesbians face when trying to access preventive care (2004, p.1976). Macapagal, Bhatia, and Greene talk about how the issue of non-disclosure affects bisexuals: "Providers may not address health concerns relevant to bisexual people, such as safer sex with same-sex partners, or mental health and substance use issues that disproportionately affect them (e.g., depression, alcohol use)," (2016, p.435), while De Oliviera, Almeida, and Nogueira identify how this creates obstacles in regulating the spread of HIV/AIDS: "Since [LGBT women] do not disclose their sexual orientation, they receive less information on prevention and safer sex behaviors in accordance with their specific sexual practices," (2014. p.300). Gorgos and Marrazzo conclude that omitting the use of self-identified sexual orientation and instead asking about one's sexual history (which partners they have currently/in the past) proves more helpful in identifying health risks of individuals, removing a part of the stigma associated with having to voice one's identification with a certain sexual orientation (2011, p.S86).

It is important to note that queerphobia is not the only bias that creates a barrier for queer people to access not only sexual healthcare, but all healthcare in general. Yet again, intersectionality comes at play, and when speaking of biases in medicine, one must not gloss over the racist history (and present) of modern day healthcare, and all the racially charged prejudice it operates on/with. Amidst the plethora of racist medical experiments, there are some that are directly connected to sexual and reproductive healthcare – for example, modern gynecology was developed by American white doctor J. Marion Sims, who practiced all of his experiments (he mostly focused on treating vesicovaginal fistulas, but not only) on three enslaved Black women Lucy, Anarcha, and Betsey he had purchased, solely without anesthesia, making them stay on all fours during all procedures, while inviting other white male doctors to observe or even practice their skills themselves without the consent of his enslaved patients (Washington, 2007, p. 61-68). The Tuskegee Syphilis Experiment is another instance of a racist medical practice; during which Black men were unknowingly infected with syphilis and monitored over forty years, thinking they were receiving regular free healthcare – while incredibly shocking on its own, it is just a continuation of similar experimentation with enslaved Black bodies and their exposure to serious illnesses (Washington, 2007). There is also the violation of Saartjie Baartman's

(“Hottentot Venus”) body, during and after her life (Washington, 2007), forced sterilizations of women of color—for example, Black, Latina, and Native American women in the US, Roma women in the Czechoslovakia (Washington, 2007; Renzetti and Curan, 1992; Sokolová, 2005)—, or certain birth control methods being specifically targeted towards women of color, such as Norplant (Malat, 2000). While this might sound as an issue of the past, studies show that racist bias is still very clearly present in modern healthcare, such as that Black people “feel pain less” (Samarrai, 2016, Sabin, 2020). Thus, many people of color tend to avoid receiving a medical treatment (another issue at play is also more difficult access to health insurance), which is even heightened in sexual minorities that are also people of color (Wilson and Yoshikawa, 2007).

Alencar et al. see all these factors as leading to queer people’s higher likeliness of searching self-medication methods first, and only getting “proper” medical health later, when the solutions that are more accessible to them prove to be unsuccessful (2016, p.7). They see this a driving cause of some diseases worsening or reappearing, making those suffering from such complications end up at emergency wards with serious developments of otherwise easily treatable illnesses (2016, p.7). Macapagal, Bhatia, and Greene state that LGBTQIA+ people more commonly “skip needed medical care, [in comparison] with cisgender heterosexual people, (2016, p.434).”

Many agree that a way to address and prevent this is to ensure more queer-inclusive training for medical experts. “Effective delivery of sexual health services to WSW requires a comprehensive and open discussion of sexual and behavioral risks, beyond sexual identity, between care providers and their female clients,” say Gorgos and Marrazzo (2011: p.S84), while Alencar et al. suggest: “There is the need to provide, in the training of health professionals, evidence-based clinical information relating to the health care process facing the LGBT population. These requirements are: communication patterns; understanding the relationship between health, illness, and gender issues; sensitive approach to the homosexual patient; and addressing the most common health problems,” (2016, p. 6). This is also voiced by medical practitioners themselves, who agree their training on the specificity of the queer experience has been insufficient, according to De Oliviera, Almeida, and Noguiera (2014, p.306).

2.4.3.Access to genital-specific STI testing methods

Another obstacle faced by queer femmes is difficulty in accessing STI testing methods that fit their specific needs. As was pointed out in the previous chapter, people with vaginas, both queer and heterosexual, are at more risk of certain STIs, or their complications. However, much evidence points to the issue of sexual healthcare services segregated by either sexual orientation or genitals, with much smaller portion being specifically targeted at queer people with vaginas (O'Reilly, Dehne, and Snow, 1999, p.49). Some STI testing places offer service for people regardless of their genitals or their gender identity, yet do not execute checkups needed for people with vaginas, such as Pap smears (Barry and Sherrod, 2014).

O'Reilly, Dehne, and Snow point out that there is a tradition of STI testing clinics targeting people with penises (mostly MSM), while people with vaginas are supposed to visit family planning centers, where STI testing is, however, not the main priority (1999, p.49). When there are sexual healthcare centers including specific needs of people with vaginas, often they serve sex workers only (1999, p. 49).

Thus, there is a need for more integrated services that encompass care for all, regardless of their genitalia or sexuality. Brady calls for the promotion of "triple protection," which is medical care that focuses on preventing STIs, unwanted pregnancy, and infertility all at once (2003, p.137). The question is, however, whether such connection of STI testing to reproduction might not further enhance queer people's limited access due to stigmatization of their sexual orientation.

One way to improve and innovate this situation could be the emergence of at-home testing techniques. Shoveller et al. express that "online STI/HIV testing services (i.e. online risk self-assessment with access to self-collection kits or downloadable laboratory requisition forms) are a promising new approach for improving access to testing, and have proven to be a feasible method for reaching youth and identifying positive STI cases," (2012, p.14). Such self-testing is essentially a form of testing during which "the individual collects their own sample, [and] performs a simple, rapid laboratory test," (Napierala Mavedzenge, Baggaley, and Corbett, 2013, p.125), and is currently only offered for detection for HIV, while an HPV test in form of a tampon has not been approved yet (McCartney, 2010). However, it is also possible to simply order supplies for swabbing and blood collection for various STI tests from certain sexual healthcare centers, and send the collected samples to them for analysis. Participants of Shoveller et al's research found that experience positive as it allowed them to skip visiting an STI testing place, and to obtain the results in a faster, more private way (2012, p.15).

2.4.4.Issue of disclosure and stigma

In our stigma-ridden society, being diagnosed with an STI, especially HIV/AIDS, involves being subjected to a lot of potential shaming as well as one's medical status being put onto national medical records that might later influence other parts of one's life. Dixon-Mueller talks about many AIDS activists focusing on people's right not to be subjected to routine HIV testing if they do not specifically want to, especially since it is not usually followed up by free treatment (2008, p. 285).

It is not only medical stigmatization that might prevent queer people from getting tested and/or seeking treatment for possible STI symptoms, but also potential prejudice amongst their partners and peers. Napierala Mavedzenge, Baggaley, and Corbett state that "knowledge of partner HIV status is low, and a significant pro portion of transmission occurs within stable serodiscordant couples," (2013, p.136). However, non-disclosure of one's sexual health status, especially if known to the person themself, can be seen as a breech of consent, and is certainly a form of sexual coercion and violence. As Dixon-Mueller puts it: "The right to the highest achievable standard of sexual and reproductive health involves not only an entitlement to receive comprehensive information about sexuality, education, and sexual and reproductive health care, but also a personal responsibility to protect (insofar as possible) one's own and one's partner's health and well-being," (2008, p.286).

3. Methodology

As was pointed out in the Methodology class, the choice of methodology for one's research is ideological, and presents the way we understand the world and its systems and structures. Ramazanoglu and Holland say that "taking any methodological decision makes you vulnerable to criticisms from those taking other decisions," (2004, p.146), and therefore, I intend to explain my choice of methods in this section to ensure better understanding of my decisions and why they, in my view, fit my project and research topic; to "be clear about how [my] claims can be challenged and defended (not only in academic debate, but also at the level of everyday knowledge and personal practices)" (Ramazanoglu and Holland; 2014, p.146).

3.1.Positionality

Prior to presenting my methodological choices, I would like to quickly address my personal position, as it greatly influences the way I navigate my research and how I later analyze the findings. As I have already mentioned, I am a white, queer, pansexual, cis woman, which means I enter the research space with significant privilege. While I have no physical disabilities, I do experience mental health issues that can be very limiting, especially in new situations with a lot institutional pressure.

While I have no professional medical experience, my work as a sex educator allows me to enter my research with a plethora of knowledge about problems related to sexual health, sex education, and sexuality in general. With that also comes more openness and less shame about sharing and writing up these very intimate situations and experiences as a given, as I am used to freely communicating about it and creating content that thoroughly explains such topics.

3.2.Feminist methodology

Before I delve into the actual methodology "action plan" of my project, I would like to take some time to discuss the topic of feminist methodology, what it consists of, and why it is important for feminist and queer scholars to implement and benefit of, as opposed to mainstream methodology. When figuring out how to draft and design my thesis project, I was sure about one thing – I wanted to pursue feminist methodology, and explore it to find ways to produce knowledge that challenge the status quo of how research should look like, who produces it, and how it is written up and presented. Therefore I find it necessary to first introduce the readers to the practice of feminist methodology for them to make sense of my work process.

Ramazanoglu and Holland describe feminist methodology as "distinctive to the extent that it is shaped by feminist theory, politics and ethics and grounded in women's experience," (2004, p.16), and say that "research projects can be thought of as feminist if they are framed by feminist theory, and aim to produce knowledge that will be useful for effective transformation of gendered injustice and subordination," (2004, p.147). It stems from the rejection of the hegemonic methods based on patriarchal understanding of the world, and interpreting it through an androcentric lens (Reinharz, 1992). Feminist methodology thus aims to employ methods that do not feed into the narrative of the knowledge, which is produced by positivist research, being seen as “truer”, more meaningful and less biased; and instead highlight others – as Reinharz puts it: “"alternative" or nonpositivist methods—particularly open-ended interviewing and ethnography—must have a prominent place in feminist social science,” (1992, p.46). She also concludes that in this way, some feminists see their feminist approach to fieldwork and research as “a struggle against positivism and androcentric concepts,” (1992, p.46).

By being more aware of not only the gender divide in our society, but also of what Butler calls the heterosexual matrix, the hierarchy of race, class, and dis/ability, as well as other biases present in everyday life, feminist methodology is able to generate findings that allow for more representation of both the researched subject and the researcher’s positionality itself. There is an emphasis put on retelling of personal stories and experience instead of presenting pure numbers and statistics, with extra focus on and inclusion of how there researcher’s own background influence the analysis, as opposed to claiming complete objectivity and presenting findings as facts standing outside of the social system as well as power dynamics of the research itself. Reinharz suggests that “[feminist] social research should be guided by a constructivist framework in which researchers acknowledge that they interpret and define reality,” (1992, p.46).

Often, feminist methodology is centered around women researchers exploring women’s experience, gathering the information they need directly from women informants (Reinharz, 1992, p.52, 55). This can be done by either working with a specific group of women, or by writing about the woman researcher’s own reality. Through that, women, after a long history of being silenced and dismissed, can earn a much needed voice and platform to express themselves, whether directly or with the help of a researcher – “understanding the experience of women from their own point of view corrects a major bias of non-feminist participant observation that trivializes females' activities and thoughts, or interprets them from the standpoint of the men in the society or of the male researcher,” (Reinharz, 1992, p.52).

3.2.1.Why choose feminist methodology?

As was already pointed out, feminist methodology positions itself against the mainstream science and ways of knowledge-making, which are seen as sexist due to the fact that experience of white privileged men is seen as representative of the reality of all, without any consideration for differences across gender, race, class, religion, ability, and such. Since this tendency has been common and used for centuries, it has lead to biased understanding of what “reliable knowledge” is. Ottenberg traces “the need to objectify data and record the facts” to “positivistic age when personal impressions were not seen as important,” and suggests that “the privilege given to observations and “factual” descriptions is based on realist ideology,” (1990, in Wall, 2008). However, it has been deliberated that some of these “legitimate” sources of world-making are built on literal stacks of biases, as well as unethical or questionable practices – for example, Reinharz talks about laboratory experiments, which are predominantly seen as the ultimately accurate method and the most preferred in psychology research, as showing serious oversights in regards of sex/gender (to which I would add race, class, and other factors as well) (1990, p.95). She states: “[...] Psychologist Rhoda Unger suggests that laboratory experimentation may have led to a particular blindness in psychology with regard to sex. This suggestion is striking given that laboratory experiments are the normative research method in much of psychology, as well as in the physical sciences and clinical medicine (1990, p.95). Davis and Craven thus see feminist ethnography as a direct opposition to “neoliberalism’s apolitical stance and its tendency toward reductive individualism and faulty dependence on objectivity,” (2011, p.191). They assume that “although critical debates within the social scientific community over reflexivity and objectivity in research predate neoliberalism, feminist ethnography and the burgeoning [...] field of activist scholarship offer new frameworks to respond to the intensification of these concerns,” (2011, p.191).

Thus, feminist methodology can be seen as a way of creating “new forms of data,” as suggested by Reinharz (1990, p.216). Simply put, feminist methodology is a ground for innovation; an innovation in a plethora of ways and directions. Reinharz points out that “one of the many ways the women's movement has benefitted women is in freeing up our creativity in the realm of research, [...] and one of the ways feminist researchers, in turn, have benefitted the societies in which we live is by the spirit of innovation,” (1990, p.239). Such novelty can come as simply the choice of who or what is studied, particularly groups or experience on the margins, formerly ignored, or including female/non-white/trans/queer/etc. historic figures who do not reach the prominence their mainstream counterparts do, or creating new forms of methodology, or coming up with new ways of writing up their research, or even inventing new vocabulary to supplement the male-experience-centric language of our society – for example, as Reinharz compiles, Robin Morgan's "herstory," Frye's "phallism" and "phallist", Demetrakopoulos' "to sacralize", "gynagogoy", or Reinharz's own "gynopia," (1990, p.216).

Innovation to such degree is of course not fundamental for a methodology to be (considered) feminist. It can also rely on the already established systems, using methods praised by the mainstream, and infiltrating them with feminist findings – "even when feminist researchers rely on traditional methods of data collection, the very asking of feminist questions and the attempt to create new knowledge in which women's experience is central can create subtle shifts," (Reinharz, 1990, p.219). This is due to the belief, shared by some feminists, that "only studies conducted according to "rigorous" scientific procedures will convince the skeptics," (Reinharz, 1990, p.239).

3.2.2.What does feminist methodology consist of?

Even though Letherby points out that it is not particular methods that are feminist per se, but rather "the way in which [they] are used," (2003, p.81), there are certain methods that are more commonly used for feminist research than others. Most often, qualitative methods are preferred, despite their lesser "validity" in the eyes of mainstream scientists and researchers (Guba and Lincoln, 1994). Adopting qualitative research is, of course, very common in all social science, and thus this fight for increased credibility of these methods has been around for quite a while – Guba and Lincoln mention that John Stuart Mill "is said to have been the first to urge social scientists to emulate their older, "harder" cousins, promising that if his advice were followed, rapid maturation of these fields, as well as their emancipation from the philosophical and theological structures that limited them, would follow." (1994, p.106).

This choice of preference stems from the criticism of the superior status of quantitative research, and often from an opposition to the binary division into quantitative and qualitative methods as two mutually exclusive ways of knowledge-making (Letherby, 2003). For example, Morrow criticizes this, believing both types of methods engage in activities typically associated with one of them only (1994), whilst Letherby points out how connecting quantitative methods with masculinity and qualitative ones with femininity just plays into sexist gendered stereotypes, allowing certain information to be devalued based on that (2003). As Oakley points out, in feminist methodology, it is important not to merge "critique of quantitative" with the “critique of mainstream/malestream” (1998, p.708), and acknowledge that the way a certain method is executed is what makes it feminist, and not whether it is quantitative or qualitative.

Nevertheless, feminist methodology prefers to apply qualitative methods, endorsing them for the closeness to the researched topic and subject, allowing for more access as well as own participation. Feminists often use interviews, questionnaires, or ethnography, often fully engaging in their own observation. Interestingly, feminists can also draft their own experiments—which tend to be much more ethical than those carried out by mainstream researcher—, or use consciousness-raising as a away to share and evaluate own experience (with a group of women/feminists) and come up with strategical steps of change (Reinharz, 1992).

3.2.3.Challenges

Due to its novelty and opposition to the status quo of mainstream methodology, feminist methodology faces several challenges in presenting its findings and having them accepted in the same way as other, “androcentric” methods would. Ramazanoglu points out that “there are taken-for-granted distinctions in western thought, for example, between the authority of knowledge produced through scientific procedures, and that of knowledge produced in literature, horoscopes or dreams. It is easy to class feminist knowledge as unscientific, biased and lacking in authority,” (2004, p.2).

Apart from this fight against mainstream science and its doubting of the rationality and accuracy of its discoveries, Ramazanoglu and Holland also recognize that feminist methodology can face two more obstacles (2004, p.3, 4). One of them is the struggle to recognize that women’s experience (if given feminist methodology/method only focuses on exploring living reality of women – which is, as was pointed out earlier, not a prerequisite for all of feminist methodology) is vastly varied, and differs because of diverse cultural and social structures and hierarchies (Ramazanoglu and Holland, 2004, p.3). That is why it is very important for feminist methodology to be mindful of intersectionality, and implement it along every step. Even though Reinharz assumes that “feminist consciousness typically makes researchers sensitive to gendered behavior, racism, cultural misogyny, and coping behaviors,” (1992, p.64), however, the history has proven that even within feminist methodology, or simply in methodology lead by women, there are cases of harmful biases and unethical practices – such as Margaret Mead, known for her anthropologist work studying “more sexually open” cultures in Samoa, Papua New Guinea, or Melanesia, who is often criticized for her observations of communities of people of color, written up and viewed through the lens of a white anthropologist. Newman believes this was a common practice among many researchers as well as artists in the early decades of the 20th century (1996, p. 234).

However, Visweswaran assumes this practice was not prevalent in the past only, and states that “despite a variety of textual forms and strategies advanced by feminist ethnography, life histories, or life stories, continue to be popular modes for first world feminist ethnographers to write about (largely) third world subjects, who somehow reflect the entire culture,” (1997, p.615). Of course, nowadays, there has been more awareness surrounding this issue, created by feminists of color – Davis and Craven specifically mention Anzaldùa, Mohanty, Mullings, and Zavella (2011, p.197). Still, it is important to be wary of the power dynamics that race, class, and even country of origin create, and understand that as a white researcher, whether feminist or not, one enters any kind of research with plenty of privilege, that, if analyzing cultures or folks of different color, class, or religion, can lead to either fetishization or barbarization of the observed people, or the white savior complex[x]. It is thus important to strive for intersectional understanding and approach when engaging in feminist methodology, as well as grasp how one’s own position (whether privileged or unprivileged) may prevent them from getting access to the researched group or topic (Reinharz, 1992, p.64).

Furthermore, Ramazanoglu and Holland see the third challenge as the tension between feminist knowledge and postmodern and postsructuralist thinking that questions the essence of feminist thought (Hekman, 1992, Nicholson 1990, in Ramazanoglu and Holland, 2004). They state: “Feminist knowledge claims are tangled in tensions between knowledge of gender relations that take the existence of women for granted, and theories that take apart the grounds of feminist claims to knowledge, and treat 'women' and 'gender' as products of ideas rather than of embodiment, patriarchy or social construction,” (2004, p.4).

On top of that, it is important for feminist researchers to be aware of the prejudices, ideas, and beliefs they bring into the research with them. Ramazanoglu and Holland say “all researchers, however inexperienced, carry intellectual, emotional and political baggage with them,” (2004, p.148) – it is indeed impossible to enter a research project without any social, intellectual, or political influence

(2004). It is thus important to “check” one’s own values, theory, ontology, and epistemology (Ramazanoglu and Holland, 2004, p.149). It is also crucial to keep in mind the question of ethics when initiating research – keeping in mind not to unethically treat one’s subjects, to acclaim information in a non-deceitful way, or to not plagiarize someone’s previous work.

3.3.My methodology plan

After introducing the reader to the reasons behind my choice for feminist methodology, in this chapter, I am planning to present the “methodology action plan” of my project. As was pointed out earlier, sadly, there is not much of literature or research already addressing the topic I have decided to explore, and therefore the option of executing a content analysis, comparing the existing sources touching upon sexual healthcare and access to it. Conducting an experiment also comes out of question given the medical context of this work; and thus, I narrowed my options to observation (of other people), interviews, or (auto)ethnography. As someone who is very interested and critical of how knowledge is produced (and who gets to do so), and likes to challenge and question the power dynamics of academia, especially feminist and queer academia, I have decided to embark on a very unusual, and potentially risky journey – I have chosen autoethnography as the main form of gathering information for my thesis. In this decision, I channel Ramazanoglu and Holland’s quote from “Feminist methodology: challenges and choices,” where they say: “your decisions about your research can be framed both by the realities of institutional demands and, where appropriate and possible, by resistance to them, (2004, p.149). Thus, I see my choice of methodology as both a revolt against what I view as classist, sexist, and racist hierarchies in the world of academia, as well as staying within the academical framework that is needed for fulfilling the requirements of this Diploma thesis. This resolution is no doubt courageous in both the positive and negative sense, yet it is a choice that aligns with my personal views and my stance as an intersectional queer feminist, and I can but hope I will manage to convince the readers of its suitability and importance for my own research project, and that it will be received well.

Autoethnography as a method is intriguing in the way that there is no prescribed way to write it up or present it. Feminist researchers engaging in autoethnography have put together projects that differ immensely, but their main focus stays on their own experience and reasoning with the topic explored. For example, Jennifer Hunt first focused on her own fieldwork dreams, later following up by gathering similar information from other fieldwork researchers (Reinharz, 1992, p.52). Kristen Yount joined the mining communities for five months, later to leave her work position as a miner, distanced herself, and interviewed the people she met along the process (Reinharz, 1992, p.52). Sarah Wall simply wrote about her experience as a mother of an adopted child (2008). Even Shulamit Reinharz herself document her own experience of miscarriage, before moving onto learning of the reality of other women who had gone through miscarriage as well (1992, p. 52).

In a similar fashion, I have decided not to present my own findings and observation (despite it still being the central point of my methodology), but also consult others to better understand and interpret my own discovery. Thus, I designed my methodological plan in the following way: First, I have carried out a questionnaire, aimed at queer femmes with experience of STI testing and/or obtaining sexual healthcare, to analyze their needs and wishes, and get familiar with what I myself should later focus on when executing my own autoethnographic research. Apart from that, I also prepared and executed a similar questionnaire specifically asking about demands of queer femmes with disabilities. I used that as a guide for own evaluation of the STI testing I endured, and the sexual healthcare spaces I visited. Before that, however, I have compiled an overview of sexual healthcare clinics in Berlin, and classified them in terms of the care offered, insurance dependency, information about accessibility, ways to make an appointment, and such. Then, I made a selection of places I was to visit, got STI tested there (and in one case, even treated for an STI), and chronicled my experience through ethnography diary as well as checklists I have created prior to my research. Once my own investigation was done, I followed it up with interviews with several queer femmes who have been tested in Berlin within the past year, to be able to gain more insight and comparison to my own experience. In the upcoming sections, I aim to disclose more details about how my research was executed.

3.3.1.Pre: Questionnaire

In order to get prepared for my autoethnographic research, I decided to first evaluate the needs of queer femmes through an online questionnaire, executed via the platform SurveyMonkey. Questionnaires are characterized by all participants receiving and answering the same questions. It is crucial to pretest those questions to make sure they are easy to understand, the structure of the questionnaire functions well, and, overall, the recipients do not face any problems when trying to answer them – omitting the pretesting is a common mistake when carrying out questionnaires (Pavlík, 2018). Participants can be chosen randomly or on purpose; and again, this choice can be a downfall for much of questionnaire research (2018).

For my project, I created two separate questionnaires: one called "Queer femmes' STI testing experience," and the other "Disabled queer femmes' STI testing experience." I used SurveyMonkey for both of them, compiling questions that evaluate the participants' history of receiving sexual healthcare/getting STI tested, whether they have health insurance in the country of their residence (to see how important it is to find sexual healthcare centers independent of public health insurance), if they ever received treatment for an STI, what STI tests were done to them, how did they receive results, and such. On top of that, I asked the participants to assess how important factors like physical accessibility, queer-friendliness, anonymity, price, or possibility of walk-ins were to them. The second questionnaire that focused specifically on disabled queer femmes had added questions about accessibility and experience with doctors' reception of their disability. The full list of questions can be found in the appendix (Appendix nr. 1 and 2).

The participants were found by sharing the links to the questionnaires online; specifically via my own Instagram platform (that has over five thousand followers) and several queer community groups on Facebook, as well as being circulated around Gender Studies students at Humboldt University and with the community of Berlin's queer parties (Room4Resistance); using snowballing method. The data was collected over the period of one month. Overall, I managed to gather seventy responses to the "Queer femmes' STI testing experience" questionnaire, and five to the one entitled "Disabled queer femmes' STI testing experience."

3.3.2.During: Autoethnography

After collecting some inspiration through the answers of the questionnaires, my next step was embarking onto the autoethnographic research, guided by the information gathered from the previous analysis. But, before I fully delve into explaining how exactly I went about that, I would like to take some time to better present autoethnography as a method and why I myself chose it, despite its obvious limitations and challenges. I see that as necessary for the readers to understand my decision, and how it connects to intersectional feminist beliefs in general, as well as why I view it as fitting specifically for the topic I write my thesis about.

3.3.2.1.What and why of autoethnography

Autoethnography, simply put, is a qualitative method that focuses solely on the researcher's own experience, combining the roles of the complete observer and the complete participant at once (Reinharz, 1992, p.69), and connects it to larger structural and societal topics. Méndez characterizes it as a method that "allows researchers to draw on their own experiences to understand a particular phenomenon or culture" (2010:280). Holt assumes autoethnography "emerged during the 'crisis of representation' period (the mid-1980s)," (2003, p.18). Maréchal reckons autoethnography works with three different understandings of the self: "self as representative subject (as a member of a community or group) self as autonomous subject (as itself the object of inquiry, depicted in 'tales of the self') and other as autonomous self (the other as both object and subject of inquiry, speaking with their own voice)," (2009, p.2). By placing the focus on the self, it directly puts itself in opposition to the positivist and postpositivist paradigm – it explicitly rejects the belief of mainstream science that any information produced by research can be truly objective and applicable to all possible situations and narratives (Ellis, 2008).

Despite sharing most of its name with ethnography, autoethnography differs in that it highlights and praises the subjectivity of the researcher themself (Wall, 2008, p.39). The researcher is there to both experience and to document, blurring and challenging the hierarchical division of the observer and the observed. As Wall puts it, "autoethnography begins with a personal story," (2008, p.39) yet it is "the intersection of the personal and the societal that offers a new vantage point from which to make a unique contribution to social science" (Laslett, 1999, in Wall, 2008, p.39).

It is this acclamation of the subjectivity of autoethnography that I myself find so appealing. Rather than striving for an unattainable level of objectivity (since societal rules, norms, and biases are so deeply ingrained in all of us, it is really impossible for anyone to be truly neutral and impartial, and view any given situation without any baggage of previous experience and social conditioning), it outright assumes the most subjective position. Through that, I believe, it works towards the recognition and acceptance of emotions and feelings as important, and useful for otherwise reserved, almost sterilely detached research and knowledge making. I see this refusal of emotions and personal experience as stemming from patriarchal, sexist beliefs that dismiss any information encompassing or built on feelings or as “too” sentimental, or even hysterical or weak; words often negatively associated with femininity and the female thought itself – just like methods are divided into the “masculine” quantitative ones and “feminine” qualitative ones (Letherby, 2003; Morrow, 1994), but brought to an extended degree.

Thus, it validates the feminist/female voice, by praising and implementing a method that is commonly ridiculed for its emotionality and focus on the self. As was pointed out in previous chapter, in feminist methodology, the emphasis is put on the retelling of the reality of women’s lives and experience (Reinharz, 1992), which feminist autoethnography can fulfill greatly. Furthermore, Reinharz sees that one of the goals of feminist researchers engaging in feminist ethnography—which I also apply to autoethnography—is “to understand the experience of women from their own point of view” (1992, p.51) – autoethnography chronicling feminist researcher’s own experience is thus perfect for that. By doing autoethnography, one omits the need for “breaking in,” a process that is usually required for pursuing ethnography, which allows the researcher to enter and immerse themselves in the studied environment or community (Eriksson, 2010).

Yet another appeal I find in autoethnography is its innovative format. Since it is both relatively new and unusual method as well as a practice highly emphasizing one’s own way of “doing and feeling”, it is unconstrained in the sense of form and content. As Méndez puts it, “it seems that there are no formal regulations regarding the writing of an autoethnographic account since it is the meaning that is important, not the production of a highly academic text, (2013, p. 281) – however, that does not mean it has no academic merit. I see this as a highly creative form, which allows feminists to create their own knowledge contrasting the traditionally patriarchal canon of the written word. According to Wall, “autobiographical writing is part of a new writing imagination that is based on movement, complexity, knowing and not knowing, and being and not being exposed,” (2008, p.41). I would go as far as to say that the method of autoethnography thus enables a woman researcher to “write herself,” as Hélène

Cixous once implied[4], – in a similar way, any member of a marginalized group usually studied by researchers who are of other culture or privilege (such as white Western researchers observing original tribes of people of color) can reclaim their own story and be able to share their experience without a fetishizing view of the West, or, to cite Edward Said, without the orientalist lens – Visweswaran lists a plethora of examples of “feminist ethnography”, which is feminist in the sense of focusing on women’s lives and experiences, that is still racist and classist, but does not acknowledge so. By implementing autoethnography, I aim to avoid the issue of viewing the participants of my research as the “exotic other” (Bell, 1993, p. 41, in Letherby, 2003, p.94).

To conclude, in many ways, I see autoethnography as the only ethical method a feminist can employ for their research. In doing so myself, I want to fully embrace my biases, my own positionality and proximity to the topic, and create a work that is fully true to what was experienced without any chance of misinterpretation or communication noise that could occur if the information was obtained from a source different from myself.

3.3.2.2.Advantages

As already pointed out, autoethnography bears the benefit of unusual freedom and space for creativity not often shared by other methods (Reinharz, 1992, p.73). Furthermore, there is more emphasis on the content than the form per se, allowing the researchers to truly delve into the researched topic. Davis and Craven state: “For feminist ethnographers [and autoethnographers, I would add], it becomes important to figure out how to produce materials that speak to both academic and nonacademic audiences alike,” (2011, p.199).

Again, autoethnography is a great way of reclaiming the field of research and fighting against its tendencies of exotification. In her work, Méndez cites Richards who calls autoethnography an “emancipatory discourse” as “…those being emancipated are representing themselves, instead of being colonized by others and subjected to their agendas or relegated to the role of second-class citizens,” (2008, p.1724, in Méndez 2010, p.282). This allows many to “transition from being an outsider to an insider in the research,” (Méndez 2010, p.282).

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[4] Cixous, H., 1976. The Laugh of the Medusa. Translated by Keith Cohen, and Paula Cohen. *Signs: Journal of Women in Culture and Society.* 1(4), 875-893.

On top of that, autoethnography also brings the advantage of much easier way of gathering data. It allows for flexibility in how information is obtained, over what amount of time, and how it is processed.

3.3.2.3.Disadvantages

It comes as no surprise that choosing autoethnography also brings a lot of challenges and potential negative reactions. According to Sparkes, since the introduction of autoethnography, it has steadily remained somewhat of a troublesome method, mostly because of its outright focus on the personal narrative (2000, p.22).

Many view autoethnography as too “self-obsessed,” and thus are unwilling to accept it as of value (Méndez, 2013, p.238). This criticism often includes doubts about the experience of a singular person being applicable to a larger extent, or simply being representative of more than the lived reality of this specific researcher. Yet, Bochner and Ellis refute this claim by asking “If culture circulates through all of us, how can autoethnography be free of connection to a world beyond the self? (1996, p.24, in Méndez, 2013, p.238). Furthermore, as feminist/ female researchers often face issues of lack of access or simply silencing of their own voices in mainstream science, autoethnography is a great, and sometimes only way to reclaim that space (Reinharz, 1992, p.61).

Another critique of autoethnography is that it is unscientific and not objective enough (Reed-Danahay, 2001, p.411, in Eriksson, 2010), going as far as claiming that the purpose of autoethnography is “therapeutic rather than analytic” (Eriksson, 2010, p.284, Atkinson 1997). Duncan advises against including too much emotion in one’s research (as opposed to other, more detached methods) and instead recommends to be fully honest about one’s involvement and motivation (2004, in Wall, 2008, p.40) – however, Wall challenges this by stating “no subject can be a fully self-identified, fully aware, or fully intentional author because unconscious desire makes fully intentional subjectivity impossible” (Clough, 1998, in Wall, 2008, p.41).

For many traditional methodologists, there is also the issue of “insufficient” objectivity in autoethnography, but, as was pointed out earlier, autoethnography does not really strive for or presents itself at an objective method, and rather embraces its own subjectivity and works with and benefits off it (Wall, 2008, p.42). To further challenge this need for the ultimate objectivity, I would like to include a rather long quote from Wall’s paper “Easier Said than Done: Writing an

Autoethnography": "Sparkes (2000) related a story about the use of his published autoethnography in an undergraduate class, explaining that his students do not consider his autoethnography to be research. However, when asked whether it would be research if someone else had interviewed a man named Andrew Sparkes; collected his medical records, diary excerpts, and newspaper stories; analyzed the collection, and written it up, the class says yes. Likewise, if a researcher had interviewed me about my experiences as an adoptive mother and had recorded and transcribed it, it would have legitimacy as data despite the fact that both the interview transcript and my autoethnographic text would be based on the same set of memories," (2008, p.45).

Yet another negative side of autoethnography could be its lack, or rather flexibility, of form and specific requirements. Wall documents her own struggle with finding the right way of writing up her own autoethnographic research (2008), and Méndez (2013, p.284) cites Bochner and Ellis: "due to the particular characteristics of autoethnography, the reactions to a personal narrative cannot be foreseen and the interpretation may be varied, (1996).

3.3.2.4.Execution

Now that I have, hopefully successfully, presented some theory and reasoning behind my choice of autoethnography, I will move onto describing the actual process of my autoethnographic research. I slowly began working on it by gathering information about the sexual healthcare situation already in summer 2019, and finished the actual STI testing visits in May 2020.

First, I started by researching where one could get STI tested in Berlin. I used Google to search for keywords such as "STI test Berlin," "Where to get STI tested in Berlin," "Sexuell Übertragbare Krankheiten Berlin," "Sexuelle Gesundheit Berlin," or "Venerologie Berlin." After collecting the names, addresses, and websites of the local sexual healthcare centers, I created a Google Map into which I registered all of my findings.

After that, I created an Excel sheet document, and filled it out with information about each space I recorded in the map. I focused on the topics that I found to be of importance to the queer femmes who had responded to my questionnaire. That way, I had a great overview of where each center is, how to get there, what is required (insurance/money), which tests they offer, accessibility, and so on.

Based on this table, I selected five different centers I intended on visiting over the course of the next few months, leaving at least a month between each visit in order not to strain the medical system, face questions or even additional payments from my insurance company (not all medical services are covered by insurance in Germany), and to give myself enough time to process and chronicle my experience. Apart from that, I decided to also try using a subscription based delivery system providing STI tests, and to visit a regular gynecologist and attempt to get tested there, assuming that queer femmes might tend to seek help of their gynecologist first and foremost. I engaged in these testing visits from September 2019 till May 2020. Throughout the process, I kept an ethnography diary in which I recorded my each visit right at the spot, often filling it out when waiting to be called to the doctor’s office or to the lab. This way, I gathered eleven different entries, chronicling both the testing process as well as obtaining the results, and in one case even treatment of an STI. Apart from the ethnography diary, I also reviewed/ journaled each visit through a checklist evaluating how the conditions found important through the questionnaires were met.

In the end, I transferred this information into yet another table, allowing for easy comparison of the conditions, requirements, testing process, and such. This helped me in fast and straightforward extraction of results of my research.

3.3.3.Post: Interviews

As was already pointed out, I decided to follow the steps of several other feminist researchers, and supplement my autoethnography with information to see how other people’s experience differs—or not—from mine. Since this was not my main research method, I only executed the interviewing on a smaller scale, again, just as an add-on to the material already gathered.

Due to the coronavirus situation, I was unfortunately unable to conduct the interviews in person, and instead did them through online calls (Skype, Whatsapp) due to safety reasons. This unfortunately meant more communication noise, such as problems with technology, poor sound and video conditions, or inability to fully observe one’s body language.

I published a call out through social media accounts of another Berlin-based sex educator to ensure different reach than for my the previously done questionnaires, searching for queer femmes residing in Berlin who had been STI tested in the past year. I made sure these people had not participated in the questionnaire. In the end, I interviewed seven people, differing in gender identity, origin, race, and dis/ability. I opted for semi-structured interviews, for which I prepared several topic areas and pointing questions to guide the discussion but also leave enough space for the interviewees to be able to tell their own story without me influencing it.

3.3.4.Aftermath: Coding

Once all this information was collected, I organized it by applying coding to it. I was guided by Coffey and Attkinson's Making sense of qualitative data, which I found very helpful in instructing me how to do so. Coding allows the researcher to identify key topics and phenomenons appearing in the gathered information; simplifying it and breaking down into categories that are later easier to work with (1996).

I coded findings from each method (questionnaire, autoethnography, interviews) separately. Then, I compared the codes from all methods to gain an overview of what has come out of my research as a whole.

4. Analysis

Now that I have presented the theoretical and methodological parts of my thesis, I will introduce the main findings of my research. As was pointed out, I engaged in various types of methodology, and will present them separately at first, only to conclude with an overview of how they overlap or contradict themselves.

Before I delve into the presentation of the analysis, I would like to remind the reader of which research I partake in, and thus what the structure of this chapter will be. I started by finding out about the needs of queer femmes by conducting online questionnaires via SurveyMonkey, which I then took along as guiding points of my autoethnographic research. That I commenced by gathering information about sexual healthcare centers in Berlin, which I put into a map as well as a sheet where I collected important data about each space, such as its address, website, insurance coverage, and much more. Then, I embarked onto in-person visits of selected sexual healthcare centers, where I got STI tested myself and recorded my experience in an ethnographic diary. Later, I reflected upon this experience and compared my findings to see what was similar or different throughout my visits. To get an outside view on the same experience, I subsequently interviewed several Berlin-based queer femmes about their STI testing encounters.

4.1.Questionnaire

As was pointed out earlier, I decided to conduct two separate questionnaires: one assessing queer femmes' experience and needs regarding sexual healthcare, and one exploring specific demands of disabled femmes’ in more depth. I see the second, more particular one as an addition to the more general first one, and will thus structure my analysis in this order.

4.1.1. Queer femmes' STI testing experience

The questionnaire began with a few general questions to get to know some basic information about the participants. All of the seventy respondents of this questionnaire were aged under forty-five years, with most being between twenty-five and thirty-four (36). Twenty-nine participants were aged eighteen to twenty-four, three under eighteen, and two were aged thirty-five to forty-four. 85.28%, that is fifty-nine participants, stated they identified as white (I allowed all respondents to use their own words to describe their race instead of choosing from a pre-made answer selection), two chose not to reply, and the rest as diverse femmes of color: Arab (2), Latinx (2), Asian (1), North African (1), Aboriginal Australian (1), Black Asian (1), mixed Asian and white (1), and Filipino (1). Furthermore, I inquired about whether they were insured in the place were they resided/regularly received medical treatment or not – great majority (58) responded they were.

Next, I asked about the participants’ previous testing experience. Majority (61) had been tested or received treatment for STIs (the other nine thus skipped all of the questions relating to their testing experience, as they had not undergone it yet), with about half of them (31) stating it was a routine check requested by them. Ten respondents claimed it was a routine exam decided by a doctor, for seven it was part of an acute treatment, ten said it was a combination of two or all these reasons, and for some it was a part of another medical procedure: such as sperm freezing (1), donating white blood cells (1), or when getting an IUD (1). In regards to where they received the sexual healthcare (multiple choice was possible), twenty-four replied it was through their gynecologist (or similar), twenty-four through an STI clinic, nineteen through a general practitioner, three through other facility – hospital (2), dermatologist (1). 53.85% disclosed their sexuality when receiving STI-related medical care (35), six did not remember whether they did, and the rest claimed they did not disclose it. The 35 femmes whose queerness was made aware to the medical practitioners expressed that they were neither comfortable nor uncomfortable disclosing it (the average answer was exactly 50, therefore “neutral” – with “very comfortable” being ranked 100, and “not comfortable at all” 0). Out of the sixty-one participants answering this set of questions, most did not experience any doubting or shaming comments about their sexuality (28), while sixteen did, eleven weren’t sure, and six did not remember. Following, the respondents were asked to select different types of STI tests they had done, with a multiple choice allowed: fifty respondents (79.37%) underwent genital smears (for gonorrhea, chlamydia, and mycoplasma), forty-one (65.08%) got their blood drawn for blood tests, thirty-nine (61.9%) underwent a genital exam, nineteen (30.16%) oral smears, and only thirteen (20.63%) anal smears. Most (27) received their results in one week, twenty within a few days, seven in two weeks, four immediately (this is common only for rapid HIV or syphilis tests), and three in longer than two weeks.

The third and last part of the questionnaire was set to evaluate what is important for the participants when receiving sexual healthcare. I asked them to choose the importance of the several factors on the scale of one to ten, with ten being the most important. The following is a list of these factors, ordered by their rating: queer-friendliness (95/100), acceptance of one’s insurance (90/100), price (83/100), possibility of walk-ins (81/100), if there is information about the tests, treatment, accessibility etc. available online (80/100), how fast are the results ready (75/100), physical accessibility of the space (wheelchair accessible, close to public transport, easy to access) (75/100), anonymity (71/100), whether treatment is also done at the center (64/100), integration to general healthcare system (independent center or a facility that is, for example, part of a hospital or medical practice) (62/100).

My conclusion of these findings thus is that queer femmes aged under forty-five, most of which were white, report quite positive experience with receiving sexual healthcare, which they often requested themselves. There is not one specific place they would tend to favor for getting STI tested or treated; they reported visiting sexual healthcare centers, their gynecologists, as well as general practitioners. Only half of them reported disclosing their queerness, with generally feeling neutral about the experience, with less than one third communicating shaming or doubtful comments from the medical practitioners’ side. Vaginal smears, blood work, and genital exam are leading STI testing methods in queer femmes, with oral and anal smears not being done as much. Average waiting time for receiving results was one week. The three most important factors to the queer femmes responding to this questionnaire were queer-friendliness, acceptance of one’s insurance, and price.

4.1.2. Disabled queer femmes' STI testing experience

Now, I will present the replies of disabled queer femmes to, in most aspects, a similar questionnaire. However, I chose to go more in depth with questions touching upon issues of physical accessibility, as compared to the previous questionnaire.

I only gathered replies from five respondents, out of which three were aged between eighteen and twenty-four, and two between twenty-five and thirty-four. All of them identified as white, and only one reported not being insured.

Again, this basic information section was followed by questions about their previous testing experience. Four participants had been previously tested or treated for STIs, and thus continued with this question portion. Most reported it was a routine check of their choice (3), and only one underwent as part of a routine exam decided by a doctor. 75% reported disclosing their sexuality (3), ranking neutral on the scale of how comfortable they were with disclosing it (average 48 out of 100). One respondent claimed they had experienced doubting or shaming of their queerness. When asked how would they rate their experience with the medical practitioners reacting and understanding to their visible disability, or disclosed invisible disability, majority (3) stated such experience was negative, and the reaction to what their experience was with getting their specific needs met was also rather mixed to negative – one responded their experience was neutral, two claimed it was negative, and one chose not to reply. None of the participants was accompanied by a caretaker to the STI testing/treatment; three went on their own, and one with someone close to them. All four respondents that had underwent previous STI care were subjected to genital smears and blood work, two to oral smears, and one to a genital exam, with none getting anal smears done. Results of those tests were received immediately in one case, in one week in two cases, and longer than two weeks in one case.

When asked about what was important to them when accessing and receiving sexual healthcare, the responding disabled queer femmes’ ranked the factors in the following order: anonymity (96/100), location being close to public transport (88/100), possibility of walk-ins (87/100), clearly marked areas (which room is which, where to go, etc.) (85/100), if there is info about the tests, treatment, accessibility etc. available online (85/100), queer-friendliness (84/100), price (81/100), acceptance of one’s insurance (74/100), if there is a lift if on higher floor (74/100), whether treatment is also done at the center (73/100), if the location has enough space to move around (e.g. with a wheelchair, walking stick etc.) (67/100), information about physical accessibility can be found online (65/100), integration to general healthcare system (independent center or a facility that is, for example, part of a hospital or medical practice) (60/100), how fast are the results ready (56/100), access to reading devices (53/100), if the location is wheelchair-accessible (44/100), access to information in Braille (42/100). When asked about other specific needs, three of the participants answered the following: (1) “Friendly, helpful, and informed front desk who do not discriminate,” (2) “Trans-inclusive language, signage, forms. Sensory sensitive space (i.e. preferably no florescent lighting). Ability to bring carer/support into the testing room if requested,” (3) “Information in various languages, especially in locations with high concentrations of immigrants or expats.”

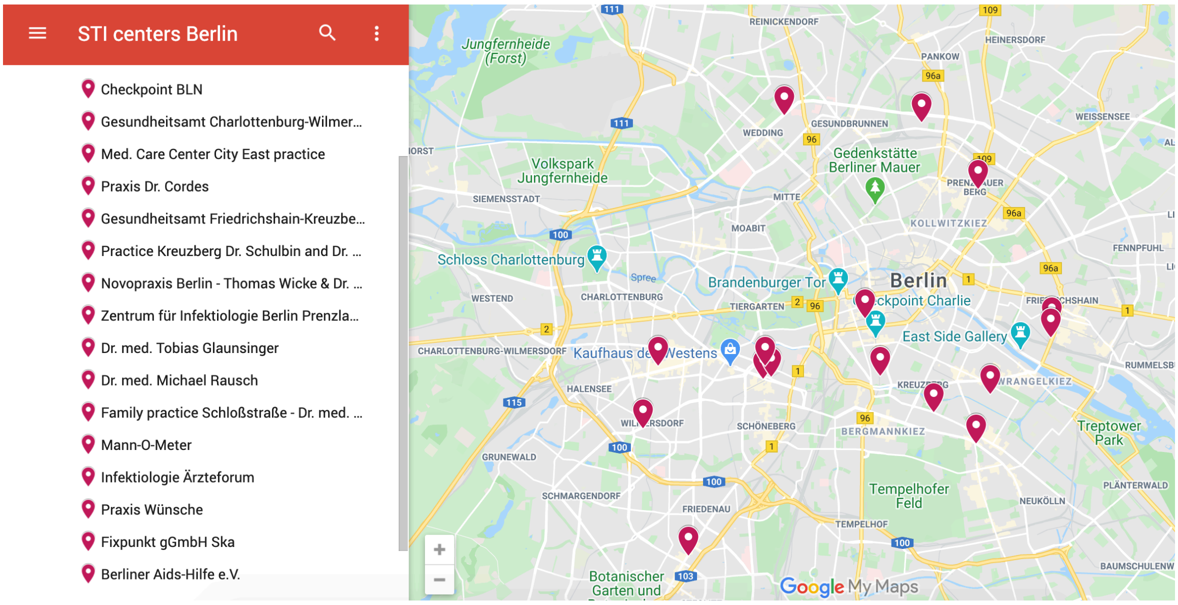
To sum up, despite it was a very small sample that completed the questionnaire, it provided me with interesting points to focus on when later conducting my autoethnographic research. All five disabled queer femmes were aged under thirty-five years and white. With one exception, they all had a health insurance. Their experience with previous STI testing and treatment was more mixed than that of the queer femmes responding to the previously described questionnaire – many reported having negative experience with getting their needs met, somewhat negative to neutral feeling about disclosing their sexuality and reactions to it. Furthermore, they reported much less complexity in the STI testing methods they underwent, with none getting anal smears done, and only one oral smears. The factors they found the most important to them were different than those queer femmes participating in the other version of the questionnaire chose; their top three was anonymity location being close to public transport, and possibility of walk-ins, with queer-friendliness, which ranked the most important for queer femmes, only at the sixth position. In general, this questionnaire has helped me in picking out which aspects of physical accessibility I should focus on scrutinizing when entering the STI testing research myself.

4.2. STI center overview

In order to be able to execute the autoethnographic research, I had to first develop an overview of the current structure of of sexual healthcare centers in Berlin. For that, I gathered data about where STI tests and treatment could be done in Berlin, and chronicled them into a themed Google Map and a spreadsheet with various information that I found important or useful. This I did not only for the purpose of this Diploma thesis research, as a way to be able to quickly access and compare each place's policies and terms, but also for future application in my personal sex education work (which I will further touch upon in the next chapter).

4.2.1.Map

Throughout my search, I discovered sixteen different sexual healthcare centers located in Berlin, spread out all over the city. Some of these centers were clinics only specializing in treating STIs (such as Checkpoint BLN, Gesundheitsamt Charlottenburg-Wilmersdorf, Novopraxis Berlin, Mann-o-Meter, or Berliner AIDS-Hilfe), while other places offered a more diverse selection of treatments, sometimes in combination with general practitioner services (Praxis Wünsche), or focusing on infectious diseases in general (Infektiologie Ärzteforum or Zentrum für Infektiologie Berlin Prenzlauer Berg).

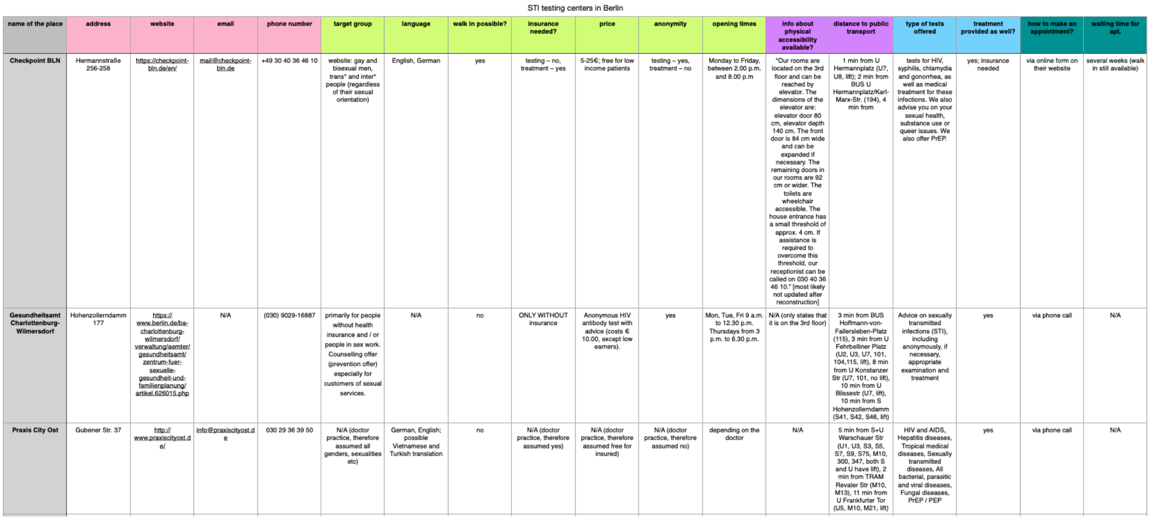


- Checkpoint BLN
- Gesundheitsamt Charlottenburg-Wilmer...
- Med. Care Center City East practice
- Praxis Dr. Cordes
- Gesundheitsamt Friedrichshain-Kreuzbe...
- Practice Kreuzberg Dr. Schulbin and Dr. ...
- Novopraxis Berlin - Thomas Wicke & Dr. ...
- Zentrum für Infektiologie Berlin Prenzla...
- Dr. med. Tobias Glaunsinger
- Dr. med. Michael Rausch
- Family practice Schloßstraße - Dr. med. ...
- Mann-O-Meter
- Infektiologie Ärzteforum
- Praxis Wünsche
- Fixpunkt gGmbH Ska
- Berliner Aids-Hilfe e.V.

Image nr. 1 – Screenshot of a Google Map with all of Berlin's sexual healthcare centers

4.2.2.Information spreadsheet

In this spreadsheet, I collected information handy for anyone planning a visit to one of sexual healthcare centers, whether it is an acute visit or a simple checkup. I looked for seventeen different points on each centers' website, such as what they stated as the facility's target group, how an appointment could be made and whether walk-ins were possible, or information about physical accessibility, as well as basic information as their address, phone number, or e-mail. All of this research was done between January and March 2019. At first I only intended this table as a resource helping to ease my own navigation within the Berlin's sexual healthcare complex, but after filling it out, I realized it was a useful source for analysis of the state and accessibility of STI-related care in the German capital, and therefore decided to present my findings from it here as well (the spreadsheet can be viewed in full in Appendix nr. 3).



STI testing centers in Berlin

name of the place	address	website	email	phone number	target group	language	walk in possible?	insurance needed?	price	anonymity	opening times	info about physical accessibility available?	distance to public transport	type of tests offered	treatment provided as well?	how to make an appointment?	waiting time for apt.
Checkpoint BLN	Hermannstraße 256-258	https://checkpoint-bln.de/en/	mail@checkpoint-bln.de	+49 30 40 36 46 10	website: gay and bisexual men, trans* and inter* people (regardless of their sexual orientation)	English, German	yes	testing – no, treatment – yes	5-25€; free for low income patients	testing – yes, treatment – no	Monday to Friday, between 2.00 p.m. and 8.00 p.m	"Our rooms are located on the 3rd floor and can be reached by elevator. The dimensions of the elevator are: elevator door 80 cm, elevator depth 140 cm. The front door is 84 cm wide and can be expanded if necessary. The remaining doors in our rooms are 92 cm or wider. The toilets are wheelchair accessible. The house entrance has a small threshold of approx. 4 cm. If assistance is required to overcome this threshold, our receptionist can be called on 030 40 36 46 10." [most likely not updated after reconstruction]	1 min from U Hermannplatz (U7, U8, lift); 2 min from BUS U Hermannplatz/Karl-Marx-Str. (194), 4 min from	tests for HIV, syphilis, chlamydia and gonorrhea, as well as medical treatment for these infections. We also advise you on your sexual health, substance use or queer issues. We also offer PrEP.	yes; insurance needed	via online form on their website	several weeks (walk in still available)
Gesundheitsamt Charlottenburg-Wilmersdorf	Hohenzollerndamm 177	https://www.berlin.de/ba-charlottenburg-wilmersdorf/verwaltung/aemter/gesundheitsamt/zentrum-fuer-sexuelle-gesundheit-und-familienplanung/artikel.626015.php	N/A	(030) 9029-16887	primarily for people without health insurance and / or people in sex work. Counselling offer (prevention offer) especially for customers of sexual services.	N/A	no	ONLY WITHOUT insurance	Anonymous HIV antibody test with advice (costs € 10.00, except low earners).	yes	Mon, Tue, Fri 9 a.m. to 12.30 p.m. Thursdays from 3 p.m. to 6.30 p.m.	N/A (only states that it is on the 3rd floor)	3 min from BUS Hoffmann-von-Fallersleben-Platz (115), 3 min from U Fehrbelliner Platz (U2, U3, U7, 101, 104,115, lift), 8 min from U Konstanzer Str (U7, 101, no lift), 10 min from U Blissestr (U7, lift), 10 min from S Hohenzollerndamm (S41, S42, S46, lift)	Advice on sexually transmitted infections (STI), including anonymously, if necessary, appropriate examination and treatment	yes	via phone call	N/A
Praxis City Ost	Gubener Str. 37	http://www.praxiscityost.de/	info@praxiscityost.de	030 29 36 39 50	N/A (doctor practice, therefore assumed all genders, sexualities etc)	German, English; possible Vietnamese and Turkish translation	no	N/A (doctor practice, therefore assumed yes)	N/A (doctor practice, therefore assumed free for insured)	N/A (doctor practice, therefore assumed no)	depending on the doctor	N/A	5 min from S+U Warschauer Str (U1, U3, S3, S5, S7, S9, S75, M10, 300, 347, both S and U have lift), 2 min from TRAM Revaler Str (M10, M13), 11 min from U Frankfurter Tor (U5, M10, M21, lift)	HIV and AIDS, Hepatitis diseases, Tropical medical diseases, Sexually transmitted diseases, All bacterial, parasitic and viral diseases, Fungal diseases, PrEP / PEP	yes	via phone call	N/A

Image nr. 2 – Example of the information collected in the information spreadsheet

The first thing I looked into was what was the centers claimed to be their target group. As the list was a mix of both specifically sexual healthcare centered spaces and more general healthcare providers, there were great disparities in whether this information was even provided at all. Most of the doctor practices omitted this info (8 – Praxis City Ost, Praxis Dr. Cordes, Praxis Kreuzberg, Praxis Prenzlauer Berg, Dr. med. Michael Rausch, Infektiologisches Zentrum Steglitz, Infektiologie Ärzteforum, and Praxis Wünsche), therefore I assumed that the centers do not specialize in treating either gender and welcome all sexualities. Novopraxis Berlin was the only "praxis" that specifically stated that they welcome people of all sexual orientations and with any kind of sexual experience or history. Zentrum für Infektiologie Berlin Prenzlauer Berg voices the same target group specifics on their website, as well as Gesundheitsamt Friedrichshain-Kreuzberg, which, however, communicates a specialization in support of pregnant people ("women," according to the website) and sex workers. Gesundheitsamt Charlottenburg-Wilmersdorf is "primarily for people without health insurance and/or people in sex work," while Fixpunkt prioritizes people using drugs, sex workers, men who have sex with men, and people at high risk of getting infected with hepatitis C. Mann-O-Meter and Berliner AIDS-Hilfe are exclusively targeting men who have sex with men (including bisexual and trans men), and Checkpoint BLN states that they are for "gay and bisexual men, trans* and inter* people (regardless of their sexual orientation)," but is known to treat femmes as well.

The information about languages spoken at the sexual healthcare centers was also seldom specifically provided, thus the language offer of the websites was in many cases assumed as the language of the provided services as well. Most of the centers offered information solely in German – this was the case for Gesundheitsamt Charlottenburg-Wilmersdorf, Praxis Kreuzberg, Zentrum für Infektiologie Berlin Prenzlauer Berg, Infektiologisches Zentrum Steglitz, Infektiologie Ärzteforum, and Praxis Wünsche (that means 7 centers out of 16). Berliner AIDS-Hilfe advertised Russian on top of German, while the rest—Checkpoint BLN, Praxis City Ost, Praxis Dr. Cordes, Gesundheitsamt Friedrichshain-Kreuzberg, Novopraxis Berlin, Praxis Prenzlauer Berg, Dr. med. Michael Rausch, Mann-O-Meter, and Fixpunkt—promoted services in both German and English. Some centers stated they also offered support for those speaking Arabic, Bulgarian, Hungarian, Romanian, Turkish (all at Gesundheitsamt Friedrichshain-Kreuzberg), Spanish (Praxis Dr. Cordes), or translation to Vietnamese and Turkish (Praxis City Ost).

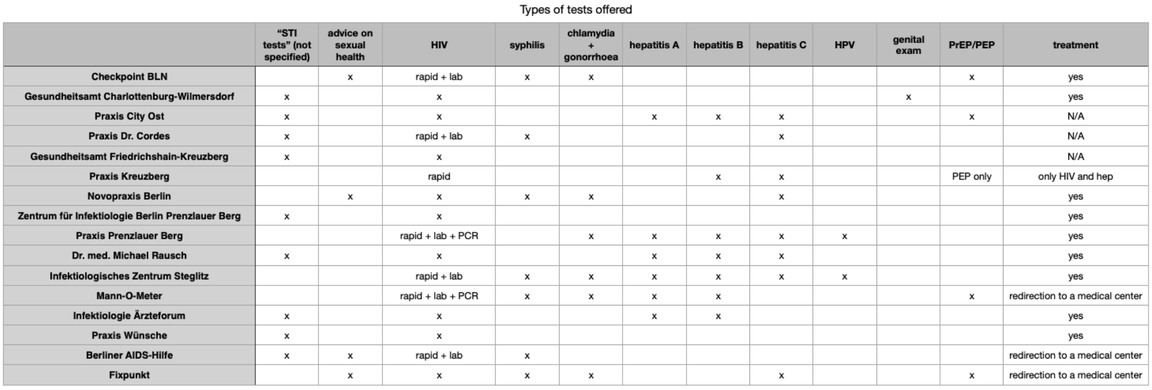
When it comes to making an appointment, majority of the centers requires a phone call (11), and many offer an option of booking through an online form (8). Some of the facilities offer both. Only two places (Praxis Kreuzberg and Infektiologie Ärzteforum) allow for making an appointment over email. Mann-o-Meter is the only place that offers walk-ins only, which means a person can show up and receive treatment without any prior scheduling. This allows for more time-related freedom, but sadly comes with a risk of the patient limit of the day being exceeded before one arrives. Walk-ins are also offered by six other facilities – Checkpoint BLN, Praxis Dr. Cordes, Zentrum für Infektiologie Berlin Prenzlauer Berg, Dr. med. Michael Rausch, Mann-O-Meter, Infektiologie Ärzteforum, Fixpunkt (however, some of the facilities temporarily suspended walk-ins due to COVID-19). In general, the average waiting time for an appointment, regardless of a facility, was around three to four weeks, with a few exceptions – for example, when I reached out to Infektiologie Ärzteforum, they offered me an appointment in the same week.

Next, I examined at which centers was a German (or European) insurance required, and what the pricing for various treatment was. Again, I was not able to recover this information from many sexual healthcare centers' websites or promo materials, and a significant portion of guessing was done in this instance – as many of the centers are doctors practices, I assumed they required insurance from their patients by default. That was the case of Praxis City Ost, Zentrum für Infektiologie Berlin Prenzlauer Berg, Dr. med. Michael Rausch, Infektiologisches Zentrum Steglitz, and Infektiologie Ärzteforum (5 out of 16). Many places offer testing without insurance, but require it for subsequent treatment (Checkpoint BLN, Praxis Dr. Cordes, Praxis Prenzlauer Berg, Novopraxis, Praxis Wünsche, and Fixpunkt – 6 out of 16). Only four centers offer all service for those uninsured —Gesundheitsamt Friedrichshain-Kreuzberg, Mann-O-Meter, Berliner AIDS-Hilfe, Gesundheitsamt Charlottenburg-Wilmersdorf—with the latter solely treating people without insurance. This information could not be retrieved for Praxis Kreuzberg at all. When it comes to prices for testing and treatment, again, my assumption is that the services of those centers that require an insurance are covered by it, and therefore the patients are not asked to pay anything. At other places where one could get tested regardless (Checkpoint BLN, Gesundheitsamt Charlottenburg-Wilmersdorf, Gesundheitsamt Friedrichshain-Kreuzberg, Mann-O-Meter, Berliner AIDS-Hilfe, Fixpunkt), the prices range between five and twenty-five euros, with Checkpoint BLN and Fixpunkt allowing those with low income to get tested for free. Praxis Prenzlauer Berg is the only center that encloses a price list for those insured privately or not insured at all; with prices starting at fourteen euros and amounting up to a hundred and thirty-five euros.

Something I also found very important to look for, given the intimate nature of dealing with one's sexual health, was whether Berlin's sexual healthcare centers allow for anonymous visits. However, only a small number does so – Gesundheitsamt Charlottenburg-Wilmersdorf, Gesundheitsamt Friedrichshain-Kreuzberg, Mann-O-Meter, Fixpunkt (which nevertheless requires obligatory reporting of testing positive for Hepatitis C), and Berliner AIDS-Hilfe (5 out of 16). Checkpoint BLN's testing is anonymous, but the treatment is not; while at Infektiologisches Zentrum Steglitz only receiving a rapid HIV test can stay nameless. Six of the examined centers required one's personal details already at the booking of an appointment (Novopraxis, Zentrum für Infektiologie Berlin Prenzlauer Berg, Praxis Prenzlauer Berg, Infektiologie Ärzteforum, and Praxis Wünsche), for three, I assumed anonymity was not an option as they are doctor practices (Praxis City Ost, Praxis Dr. Cordes, Dr. med. Michael Rausch), and one center did not provide this information at all (Praxis Kreuzberg).

Scrutinizing the opening times, I discovered that there were great disparities in how long each center was operating a day, and on which days they were open. Nine out of sixteen are open from Monday to Friday, allowing for certain flexibility when it comes to scheduling an appointment. Many places (8) are also open after 6 PM. However, I observed that those centers that do not require an insurance are often operating for only few hours a day, with Fixpunkt only offering their services for less than four hours once a week, and both Berliner AIDS-Hilfe and Mann-O-Meter being open two days a week only. Checkpoint BLN is the only exception with its opening times from 2 to 8 PM every day of the week.

I also looked into what types of tests were offered at each center. As this would be a very long and exhausting list, I have decided to compile this data into a table, that I am enclosing below, instead of writing out the options advertised by all of the sixteen centers.



Types of tests offered

	"STI tests" (not specified)	advice on sexual health	HIV	syphilis	chlamydia + gonorrhoea	hepatitis A	hepatitis B	hepatitis C	HPV	genital exam	PrEP/PEP	treatment
Checkpoint BLN		x	rapid + lab	x	x						x	yes
Gesundheitsamt Charlottenburg-Wilmersdorf	x		x							x		yes
Praxis City Ost	x		x			x	x	x			x	N/A
Praxis Dr. Cordes	x		rapid + lab	x				x				N/A
Gesundheitsamt Friedrichshain-Kreuzberg	x		x									N/A
Praxis Kreuzberg			rapid				x	x			PEP only	only HIV and hep
Novopraxis Berlin		x	x	x	x			x				yes
Zentrum für Infektiologie Berlin Prenzlauer Berg	x		x									yes
Praxis Prenzlauer Berg			rapid + lab + PCR		x	x	x	x	x			yes
Dr. med. Michael Rausch	x		x			x	x	x				yes
Infektiologisches Zentrum Steglitz			rapid + lab	x	x	x	x	x	x			yes
Mann-O-Meter			rapid + lab + PCR	x	x	x	x				x	redirection to a medical center
Infektiologie Ärzteforum	x		x			x	x					yes
Praxis Wünsche	x		x									yes
Berliner AIDS-Hilfe	x	x	rapid + lab	x								redirection to a medical center
Fixpunkt		x	x	x	x			x			x	redirection to a medical center

Image nr. 3 – Table of types of tests offered at each sexual healthcare center

However, I would still like to draw some more conclusions I have gathered upon this analysis of provided services. All of the Berlin's sexual healthcare facilities offer tests for HIV, often both in the form of rapid and laboratory tests (these differ in the way the blood sample is drawn, and often in the waiting time after possible exposure to the infection too). Many centers do not enclose which tests they offer specifically, while some (such as Checkpoint BLN, Novopraxis, or

Fixpunkt) make the distinctions between blood tests used to identify HIV, syphilis, and hepatitis, and smears (oral/anal/vaginal) and urine tests used for gonorrhea and chlamydia. Tests for hepatitis are offered by most centers, but, interestingly, often differ in which type of hepatitis (A, B or C) they test for. Only one center, Gesundheitsamt Charlottenburg-Wilmersdorf offers genital exams too, and just two facilities (Praxis Prenzlauer Berg and Infektiologisches Zentrum Steglitz) also test for HPV. PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis), which is a medication used for prevention of HIV, is offered by five centers only – Checkpoint BLN, Praxis City Ost, Praxis Kreuzberg (PEP), Mann-O-Meter, Fixpunkt. Subsequent treatment can be accessed at most centers, with only Fixpunkt, Berliner AIDS-Hilfe, and Mann-O-Meter redirecting their patients to a different medical center.

Lastly, I analyzed information about physical access to each of the sexual healthcare center. Unfortunately, I found that most websites (13 out of 16) did not feature this message at all. This means that a person with limited mobility would have to call and inquire about such information prior to even deciding if they want to get treated at the given clinic, which can be very discouraging and alienating. Both Gesundheitsamt Charlottenburg-Wilmersdorf and Berliner AIDS-Hilfe state their offices are located on a higher floor, but do not disclose if there is a lift available or not. Only three facilities include clear information on their accessibility – Checkpoint BLN (details the dimensions of the elevator and the front door), Gesundheitsamt Friedrichshain-Kreuzberg (mentions special side access with a ramp and a lift), and Infektiologie Ärzteforum (states only “adequate access for the disabled, free parking in the courtyard”). Only Gesundheitsamt Friedrichshain-Kreuzberg advertises a wheelchair-accessible toilet. When it comes to distance to public transport, while it is rarely stated on the STI centers’ websites, all of the sixteen centers are within five minute walking distance to a public transport stop (bus or tram), often under ten minutes from U/Sbahn (based on a Google Maps journey planning I concluded myself).

4.3.Autoethnography

Gathering all the information about each of the sixteen sexual healthcare centers in the Berlin area made me realize how different each place was, in terms of the services offered, the general atmosphere and mode of operation it had, or simply the way information was provided. This lead me to an understanding that each facility I intended to visit would supply me with a unique experience, and that it would most likely be very hard to make generalized assumptions or comparisons between the spaces. Such finding further deepened my determination that autoethnography is a fitting method to examine the status of queer femmes' access to sexual healthcare in Berlin, as personal visits would really allow me to see how each center navigates the issue of providing sexual healthcare services to queer femmes.

In this chapter, I will analyze my experience with conducting autoethnographic research. Firstly, I decided to write a personal reflection on how the whole process of engaging in such unusual method was for me. As was pointed out earlier in this paper, one of the interesting characteristics of autoethnography is that it is very free in how it is written up, and that is why I chose to include a section of text that would perhaps not generally be considered academic or "professional" enough under regular conditions, which, however, is very fitting for this method. It will allow me to evaluate the full period of almost a year of research as a whole, and reflect upon my overall feelings and discoveries, before moving on to dissecting the experience in a more analytic, specific way.

After presenting this personal recounting of my autoethnography, I will move onto introducing an overview of my findings stemming straight from my personal visits of sexual healthcare centers. During the whole time, I kept an autoethnographic diary in which I journaled my experience right as it was happening. Instead of rewriting this very informal source, I decided to only include scans of it in the appendix (Appendix nr. 4), and present a more concise and formatted evaluation of the my notes and findings.

4.3.1.Reflection

Engaging in autoethnographic research was undoubtedly a very intriguing and new experience for me. I had never been one who would willingly seek medical treatment that is not utterly necessary, and living in Berlin and navigating a foreign country's healthcare system without speaking the language only increased this reluctancy. But lately, I have been trying to challenge myself in various parts of my life, which is why I decided to "dive into this head first" nevertheless. While it certainly felt very uncomfortable in the beginning, over the time I grew at ease with it and it no longer seemed as a dreadful chore to me.

However, my research was certainly maimed by the surge of the corona virus and the precautions put in place to prevent it. At the end of February, I quit my day job to focus solely on working on my thesis, and was planning to get tested at as many sexual healthcare centers as possible, wanting to have an appointment scheduled every other week. By the first week of March, the situation had drastically worsened, and I realized I would have to adjust my initial plans to the unexpected reality of living through a worldwide pandemic. Thus, I decided to reduce the number of centers to visit to lower the exposure to the virus, and instead opted for exploring German order-at-home options of STI testing as well. The amount of sexual healthcare facilities ended being even lower than I expected, as I myself had to undergo a COVID-19 related quarantine twice during this time, because of which I had to cancel/postpone two testing appointments. The pandemic also meant that local providers of sexual healthcare were less willing to provide care for cases that were not urgent, and that their capacities were much lower than usually. More safety measures were taken, and in general, the whole process and experience was very different to what I had experienced pre corona virus.

As I had expected, the visits of each center were all completely unique. In the end, I managed to “try out” seven different sexual healthcare providers, some in person, some only by attempting to access their services and failing (which I will address further later in this chapter). It turned out that having a German public health insurance was incredibly helpful, as the offer for those without it is very limited and was even more so during the pandemic. My experience with centers that required an insurance and those where one had to pay for the treatment were strikingly different – at the insurance-covered clinics, it was enough to say I wanted a routine check for STIs, and I would be immediately sent to get all possible STI tests done without any lengthy discussions or invasive questions. On the other hand, when I visited centers that operated independently of the main healthcare structure and thus asked for payment for their services, I felt like I had to prove I was “eligible” to use their offer (which was the case of my visit of Fixpunkt), or had to disclose a lot of information about my personal life to be able to get tested for STIs. This made me more aware of the privilege I have as someone being able to have access to public insurance even when currently unemployed, and also simply saddened me to see how stressful or even unattainable receiving sexual healthcare can be for many. However, by using my insurance card as somewhat of an “entrance ticket” to STI testing, that also brought the issue of not being able to stay anonymous – which, while possible for testing at both Checkpoint BLN and Fixpunkt, was taken away from me once I had to receive a treatment.

In my autoethnography diary, I journaled my thoughts and impressions about each visit as I was experiencing them, most often during the short waiting periods between the different parts of appointments (consultation, testing, blood drawing, and so on). This was definitely an interesting and fun thing to do, and helped me in becoming more observant about my surroundings and my own position in medical settings. It also greatly helped in distracting me from the intense anxiety and fear I would have before the blood tests, as it provided me with something else to focus on. Writing about what I was experiencing in almost another person's view was truly a compelling practice and I really enjoyed the stance of being both the observer and the observed. In general, I did disclose that I was participating in writing a thesis reviewing Berlin's sexual healthcare centers to most of the medical providers, but I did not share my notes with them. Of course, this raises some ethical issues, but at the same time, I see my practice, in its essence, to be the same as publishing a review of a medical facility on Google Maps or on one of the many websites that serve patients to disclose their experience with the doctors they visit. Moreover, throughout the whole process of my visits and journaling, I did not include any personal details of the staff or any other sensitive information, apart from my own.

Another very strange yet riveting experience was my diagnosis and subsequent treatment of oral gonorrhea, which happened in January 2019. Initially, I was not sure if I should even include such intimate information in a formal paper like this. Despite being a sex educator who likes to think of herself as very open-minded and "chill" about STIs, I too was experiencing shame and internal stigma upon finding out about my infection. However, I quickly realized this was a teachable moment for me as well, and decided to go completely against my ashamed gut feeling – I went fully vocal with my gonorrhea story, and even created an educational series of content about it. Therefore, I chose to include this part of my sexual health story in my thesis as well, as it not only provided me with a lot of insight into how STIs are treated in Germany (prior to that, I had only been treated for HPV in the Czech Republic, and therefore had no previous experience with STI treatment in Germany), and also influenced a lot of my later interactions with the sexual healthcare centers I visited after. In the end, what at first felt really strange and scary ended up being a great learning moment and allowed me to approach my research with more vulnerability and be empowered by it.

Over the time, it felt like I had become an expert of which tests were done for which STIs, and I had learnt to perform self-swabbing tests (used for collecting samples from the anus and vagina that are later tested for gonorrhea, chlamydia, and mycoplasma) in an instant. My fear of blood tests was truly tremendous at the beginning of my research, and even prevented me from getting the intended treatment for my gonorrhea, but ended up subsiding almost completely towards the end of this autoethnographic research. While it is still something that gives me a lot of stress and anxiety, I no longer completely panic before the tests, or faint after.

Even though my research was generally a very positive and truly rewarding ordeal, I experienced some uncomfortable moments as well. Interestingly enough, none of them were related to the medical practitioners questioning my identity as a queer woman, as I would have assumed. Instead, the situations I encountered were unrelated to that, and each of a different kind, yet they all left somewhat of a "sour taste in my mouth." As an expat living in Germany, I am quite used to (not only) medical providers being invasively interested in where I come from, yet during my autoethnography research I came across two instances of the staff that was treating me making strange comments about the level of my English, being surprised it was "so good for someone from the Czech Republic" – this is an actual quote I heard at two different sexual healthcare centers, in the span of two months. My experience of getting tested at Novopraxis was hugely maimed by my interaction with their receptionist who was very rude to me when I tried to obtain my results, which lead me to feeling very angry and disappointed with a center I otherwise enjoyed visiting. When getting my gonorrhea treatment at Checkpoint BLN, which was in general already very traumatizing due to the medical staff not being able to administer the infusion into my vein and endlessly poking me with needles and causing me a lot of pain, a doctor that was called in to help crossed my boundaries by touching me (e.g. caressing my cheek) and making comments in a way I did not like as a way to "calm me down," which only increased how uncomfortable I was feeling in the situation. I also experienced a lot of medical professionals doubting or criticizing Checkpoint BLN's choice of treatment when I disclosed my experience at the centers I got tested at afterwards, as if it was something I could have influenced myself, which, again, felt out of place.

Despite of these incidents, looking back, I am incredibly glad I chose to conduct autoethnography, as it did not only provide me with research for my thesis, but helped me grow both professionally, in terms of narrowing my expertise of sex education and providing me with many new opportunities thanks to that, and personally, by overcoming my fear of blood tests as well as general anxiety about visiting doctors, especially in a country whose language I do not speak. It allowed me to learn so much about the German healthcare system and testing and treatment of STIs. By being vocal about what my research for my thesis was about, I managed to create a lot of interesting content about the issue of sexual healthcare and STI testing, and was even invited for interviews and held a lecture backed by the local Freie University about my work.

4.3.2.Findings

During my autoethnographic research, these are the places I analyzed, and how I did it:

Checkpoint BLN

– 16 September 2019, STI testing
– 20 September 2019, obtaining results via call

Fixpunkt

– 18 November 2019, STI testing
– 27 November 2019, obtaining results via call

Checkpoint BLN (gonorrhea treatment)

– 14 January 2020, STI testing (to confirm my gynecologist's suspicion of gonorrhea)
– 17 January 2020, obtaining results via call
– 21 January 2020, doctor visit
– 22 January 2020, treatment
– 19 February 2020, STI re-testing

Novopraxis

– 16 April 2020, cancelled STI testing
– 21 April 2020, cancelled STI testing
– 23 April 2020, STI testing
– 3 May 2020, cancelled results appointment
– 18 May 2020, obtaining results in person

s.a.m health

– 20 April 2020–15 May 2020, attempts at obtaining at-home STI tests

Infektiologie Ärzteforum

– 25 May 2020, STI testing

– 2 June 2020, obtaining results via call

Gynecologist Hatice Alkaya

– 26 May 2020, attempt at getting STI tested

Gesundheitsamt Charlottenburg-Wilmersdorf

– 10 June 2020, attempt at making an appointment

Praxis Prenzlauer Berg

– February–June 2020, attempts at making an appointment

Now, I am to present some of my main findings that I discovered after reviewing my autoethnography diary notes. As my thesis focuses on queer femmes’ access to STI testing, I was particularly interested in not only the specific care femmes might require offered, but also at how many other femmes I would meet during my research period, whether as patients too or in the position of medical staff. Unfortunately, in most cases, I was surrounded by masc people. Out of, perhaps, forty other patients I met during my research, less than five were femmes, even at places that advertised being for everyone regardless of their gender or sexual identity. When it comes to the practitioners themselves, again, the percentage of femme employees was significantly lower, with them usually taking the position of nurses but not doctors (4 cases), or receptionists (1 case). Furthermore, focusing on the make up of the medical staff, I only encountered one person of color, and that was in the position of a receptionist (at Fixpunkt) – except for gynecologist Hatice Alkaya, who prioritizes in treating the local Turkish community, whose staff was all women of color, including herself. Throughout my research, I did not meet a single person with any visible disabilities or limitations, neither as patients nor staff.

As I pointed out earlier, information about the accessibility of the majority of Berlin’s sexual healthcare centers was difficult to obtain. In most cases, I came across narrow entrances or staircases with limited access to lifts, possbile to see amongst my visit documentation on camera (Appendix nr. 5). Even Checkpoint BLN, which was the only place I visited that included accessibility information on their website, ended up reconstructing its premises during the time I was receiving my gonorrhea treatment, and information about the changes, which included temporary loss of access to a lift and smaller entrance space, were not updated on the websites. In fact, as the rebuilding was happening without the suspense of Checkpoint BLN’s services, the layout and thus general accessibility of the space kept on changing on literal daily basis, making it difficult to find one’s way around the center even after a few previous visits.

In general, I discovered that was fairly hard to find a sexual healthcare center that one would be able to visit without having to wait for several weeks. The waiting time for an appointment was usually around three to four weeks, both prior and during the COVID-19 pandemic. Because of it, some of the spaces I wanted to visit reduced their operating capacity or priorities, which resulted in me not being able to book an appointment at Praxis Prenzlauer Berg at all, even though I tried to do so over the span of four months. I also decided to forgo my visit to Gesundheitsamt Charlottenburg-Wilmersdorf after learning that they were prioritizing mainly full service sex workers and people in acute need during the pandemic; since I am neither of the two, I chose not to take up space for those who might really need the testing or treatment. Walk-ins without a prior appointment were completely suspended from March 2020 on, but before that, I used such option both Checkpoint BLN and Fixpunkt.

When it comes to navigating sexual healthcare as a queer femme, I did not experience any stigma regarding my identity. In fact, not once I had to “out myself” as a pansexual woman, and I only had to disclose who my sexual partners were in two cases, both not directly to the practitioners, but as part of a questionnaire about my sexual history required by the centers (Checkpoint BLN and Fixpunkt). While this was for sure a positive finding, at the same time, I also did not receive any femme-specific care, such as getting a genital exam for growth on the vulva and inside the vagina, or a pap smear (apart from when visiting the gynecologist). As I summarized in my theoretic part of this thesis, screening for HPV and other STIs that people with vaginas are more prone to (bacterial vaginosis or even urinary tract infections) is very important in ensuring good sexual health of many queer femmes, and it discouraging to experience this not being done, or even discussed, at all throughout my research. Furthermore, apart from Checkpoint BLN, none of the spaces I visited advertises itself as specifically queer-oriented.

I also looked at the ambience of the centers I visited, and I have to conclude that it was rarely different from “regular” medical centers, except for Novopraxis and Checkpoint BLN once it was reconstructed, which reminded me more of Berlin’s hipster cafés than of actual doctors’ practices (Appendix nr. 5). None of the facilities had a particularly queer vibe; it was often only provided by including the free queer magazine Siegessäule in the waiting area(Checkpoint

BLN, Fixpunkt, Novopraxis), and, in case of Novopraxis, placing a small bejeweled penis-shaped sculpture at the reception desk. Believing that sexual healthcare centers should also encourage the practice of safe(r) sex, I was interested in analyzing whether the facilities also provided free condoms and other barriers to their clients – yet only Checkpoint BLN and Fixpunkt did so.

An important thing I learned throughout my research process was that each sexual healthcare center differs not only in the services they provide and how the whole space is set up, but also in how they treat STIs. This occurred to me after getting treated for gonorrhea at Checkpoint BLN, and later discussing my experience at Novopraxis and Infektiologie Ärzteforum (as well as sharing my story with other people who had been treated for the same STI in Berlin). As I already addressed, I came upon certain comments about Checkpoint BLN's choice of treatment from practitioners from other clinics, who were often quick to tell me how they go around treating gonorrhea and other STIs at their facility. For example, while my oral gonorrhea was attempted to be cured by an intravenous infusion at Checkpoint BLN, and replaced by a three-day set of antibiotics upon failing to administer it, it would be treated by an injection into the behind at both Novopraxis and Infektiologie Ärzteforum. What was also very surprising to me was to learn that despite the treatment being covered by insurance, one has to still pay for the medication separately, and has to pick it up from the pharmacy in person, as it is not provided by the sexual healthcare centers. In my case, that meant that I had to postpone my gonorrhea treatment to the next day, as the antibiotic infusion was not in stock in either of the seven pharmacies in the Neukölln area, where Checkpoint BLN is located, and had to wait till the next day for it to be delivered. Furthermore, when the infusion proved to be impossible to administer, I was given another prescription for a set on antibiotics, which I had to pay from my own pocket as well, rounding the price of the medication to around twenty euros.

Such difference was similar in how the results of the STI tests were obtained. In most cases, I was able to call during a specific time period and request my results, whether by telling my name and date of birth (Infektiologie Ärzteforum) or by saying my code number and a password (Checkpoint BLN, Fixpunkt), at many places. When it came to getting my results from Novopraxis, however, I went through what cannot be described in other words than "a whole ordeal." Firstly, I was surprised by neither the doctor nor the nurse telling me about the specifics of the process, and almost left the premise after my tests was it not for the receptionist calling after me, telling me I had to schedule an in-person appointment for my results, which was only available in two weeks, a period that was a week longer than at other sexual healthcare centers. I had to cancel this appointment upon learning I had been exposed to COVID-19 and thus had to stay in quarantine, and found it extremely difficult to get ahold of my results after that. I went through a long e-mail exchange with Novopraxis' receptionist, whose responses came off as very rude to me (using sentences like "Listen, I told you..." when I asked a simple question and such) both on e-mail and on the call, to which I had to later resort as my e-mails were no longer replied to. Novopraxis insisted on picking the results up in person, yet telling me "if there was something serious, we would call you," which, to me, seemed like a very confusing statement – do they see some STIs as "more serious" than others? Or, if all STIs are equally serious, does not receiving a call mean my results were clear, and therefore I do not need to pick them up in person? I inquired about this but to no luck, and had nothing left but to schedule another appointment at the center, which was, however, only available a whole month after my initial test. The Novopraxis receptionist cited German privacy laws as the reason why I could not receive my results over the phone (which seems like a better and safer option during a global pandemic anyway), yet when I later got tested at Infektiologie Ärzteforum, they had no issues with informing me of my sexual health status via call. This encounter was extremely draining and discouraging to me, and completely changed my view of the center which I had otherwise liked after the testing itself.

To gain even broader overview of queer femmes' options of checking their sexual health, I also wanted to analyze order-and-do-at-home STI testing kits available in Germany. I came across two services—testalize.me and s.a.m health—and chose whose offer was cheaper. Unfortunately, I came upon another set of major difficulties when trying to order my tests, as the system itself was not working properly. This was all due to the fact that one had to undergo an online video consultation with a medical practitioner who would then confirm if one was eligible for the tests, which never happened because of, in s.a.m health's customer support words, "issues with transferring to a new system." After being "stood up" by the practitioner with whom I finally managed to schedule the video call after days of trying, I decided to request my money back (69 euros) and not proceed with analyzing s.a.m health at all. While the other service, testalize.me, might be working better, its pricing is very inaccessible, as a set of basic smear tests can amount to around 120 euros.

I also went to a general gynecologist to see if it was possible to access sexual healthcare there. I made an appointment with Hatice Alkaya, a gynecologist in Tempelhof, which I had to make around two weeks in advance. My experience was very positive with the doctor, but after asking about a possibility of a routine STI checkup, I was told I would have to pay for the tests myself in the case of not having any symptoms. Despite having a public insurance that usually covers most treatments and tests in Germany, the costs would still be around 60 to 80 euros, and thus I decided not to go forward with them.

4.4.Interviews

As I made known earlier in this paper, I followed up on my autoethnographic research with a few interviews of queer femmes that had been STI tested, or received sexual healthcare, in Berlin in the past year. I decided to do this in order to supplement my own experience with getting STI tested, to be able to compare it with other people’s stories. I saw this method merely as an addition to the research I had done prior to that, a way to be able to understand the sexual healthcare system in Berlin outside of my own observations, and thus do not give them significance as important as I do with my autoethnography. It is also vital to mention that I conducted these interviews only after I finished my own sexual healthcare visits, and therefore I was bringing all of my findings and biases caused by the research with me to those interviews, despite trying to stay as neutral and uninfluenced by them as possible. All of the interviews were semi-structured, with me preparing general topic areas and questions beforehand, but allowing the participants to recount their own stories without any rigid question structure or interrupting.

I ended up interviewing seven different queer femmes. I made sure these people, which were all given nicknames of their choice to ensure their anonymity, were from different backgrounds and of different identities: Alex, a twenty-six years old, French, white, bisexual, able-bodied, cis woman with public insurance; Angel, a twenty-seven years old, Russian, white, queer, able-bodied, cis woman with private insurance; Zahra, a thirty-two years old, Iranian, Arab, uninsured, qenderqueer sex worker; Mario, a thirty-seven years old, German, white, lesbian, disabled, cis woman with public insurance; Venus, forty-one years old, American, Black, able-bodied, non-binary femme with public insurance; Sage, a twenty-nine years old, Colombian, Latinx, agender sex worker without insurance; and Nic, a thirty years old, Norwegian, white, non-binary person with private insurance.

The experience of the interviewees was in many ways similar to mine, and was a mixture of both positive and negative remarks. Alex had a very pleasant experience with being treated for chlamydia at Checkpoint BLN, where I received my gonorrhea treatment as well, and reported it being a very fast process – after realizing she was showing symptoms of chlamydia, she called to Checkpoint about a possible appointment and was able to come there the next day, and managed to consult the doctor and receive the treatment (which was an intravenous infusion similar to the one I was to undergo) in around two hours. Just like me, she paid less than ten euros for the medication, and was asked to come for retesting in about four weeks, which was also very speedy and free of problems for her. Mario, who has an invisible disability, also sought sexual healthcare at Checkpoint BLN, but was not as satisfied. She found the space's accessibility insufficient, especially in terms of it being small, on a higher floor, and lacking clear signage, and also find the waiting time for an appointment (five weeks in her case) to be too lengthy. However, she appreciated the consultation that takes place prior to getting tested, and was able to request extra tests that are not on Checkpoint BLN's regular offer (trichomoniasis and mycoplasma).

Both of the interviewed sex workers, Zahra and Sage, also shared their testing experience was positive. Zahra, who went to Gesundheitsamt Charlottenburg-Wilmersdorf after learning about a possible HIV exposure, described their encounter as "satisfying was it not for the language barrier," and appreciated that they were able to come to the clinic in three days after their initial call and that they did not have to pay for the test as someone with a low income. Sage's visit to Fixpunkt, which only took about thirty minutes and cost them twenty-five euros, was also pleasant, except for the space being "a bit too difficult to find" and the ambience "too old school and random."

Nic had to wait for three week to get their appointment at Praxis City Ost, where they went for a regular checkup. They said the experience was "just ok," but complained about the lack of queer people in the staff, which made them feel alienated and not so well understood. Venus, who identifies as femme but was assigned male at birth (AMAB), also shared their distress about being treated as a cis gay man when getting routinely STI tested at their general practitioner (hausarzt). Apart from these two cases, none of the participants expressed other encounters of queerphobia or misgendering.

Perhaps the most dissatisfied was Angel, who got tested at her gynecologist's. Since she has a private insurance, which often does not cover all treatments and tests but is generally cheaper, she ended up being charged around 150 euros for the tests her doctor performed, which did not even include blood work. Angel had not been warned about this possibility beforehand, and was "very upset and felt betrayed" afterwards. "I only wanted to know if I was healthy, but if I had known it would be this expensive, I would not ask for the tests at all," she told me.

All of the interviewees got their test results within a week, with the exception of Venus, who had to wait for two weeks. They were all able to receive them via call, and did not have to pick them up in person.

4.5.Overview

In this very last sub-chapter of my research analysis, I aim to ponder over the findings of the three methods combined and present common themes and topics that arose during my study of queer femmes' access to sexual healthcare in Berlin. The discoveries I will present here will be the outcome of thoroughly analyzing the data stemming from the questionnaires, autoethnography, and interviews I engaged in and later coded, and will serve as somewhat of a synopsis and a summary of the findings presented earlier in this chapter.

One of the main conclusions I discovered was that while all being focused on providing sexual healthcare, each of the Berlin-based centers differs drastically. They alter in the prices for the service offered, STI tests they provide, how they subsequently treat STIs, languages spoken, ways of obtaining results, opening times and possibilities of walk-ins, or requiring insurance. This made me realize that it is very difficult to make general assumptions about Berlin's sexual healthcare structure as a whole, and even though I reflected upon both my own experience and that of others, it strikingly differs.

However, there were certain common themes I unearthed throughout my analysis for sure. One of them is the fact that many of sexual healthcare centers in Berlin primarily target men who have sex with men, or simply people with penises, with some places being exclusively for them. At the same time, there is not a single provider that only focuses on treating femmes or people with vaginas.

This “male domination” also seeped into other aspects of the clinics, mostly in the composition of their staff, which was often very masc-lead. Masc people were often those in higher position of doctors, while femmes only maintained jobs as nurses or receptionists. I also noticed that most of the fellow clients were masc, meeting less than five femme patients throughout my whole autoethnographic research, which is a sentiment also resonated by the queer femmes I interviewed.

In general, femme queerness was rarely presenting a significant obstacle, instead, it was often overlooked or not questioned at all. While this a positive sign on one hand, as it means there was no bias or stigma aimed towards femme queerness experienced by neither of the participants in the research, including myself, it also brings the issue of femme-specific tests and care, such as Pap smears or swabs for mycoplasma or bacterial vaginosis, not being administered, which can pose a significant threat to those with vaginas in the long term.

Part of the issue of accessibility is also how available sexual healthcare is for queer femmes in terms of time, that is how long do they have to wait to be both acutely treated and/or routinely tested. Unfortunately, based on my findings, the waiting time for a non-acute appointment tends to be around a month in Berlin, prior to and during the COVID-19 pandemic. The possibility of walk-ins is very rare in general, and was even more limited due to the pandemic. This lead me to not being able to visit as many sexual healthcare centers as I had initially planned.

Physical accessibility, something that was rated as very important during the initial questionnaires, turned out overlooked very often. Information about accessibility, such as on which floor the center is located, whether there is a lift or a ramp for wheelchair users, layout of the space or general description of the dimensions of the space (to estimate whether there is enough space for a wheelchair to go through and such), or access to reading devices or information in Braille, was rarely shared on the sexual healthcare facilities’ websites. Of course, such information can still be obtained by phone or e-mail, but the simple act of not including it when promoting the center signalizes a certain level of ableism and exclusion of people with disabilities, which, as the literature I reviewed pointed out, are very vulnerable to sexual assault and therefore need access to sexual healthcare (as well as they are simply also sexual beings, and thus require sexual healthcare even if they do not experience any assault or similar). My visits also proved that accessibility was not specifically ensured at most places.

Another factor of general accessibility is the requirement of insurance and pricing. As I mentioned earlier, having a public German insurance allowed me to access a significantly higher number of facilities than if I was not insured. Both my comparison of information found on the centers' websites and the interviews of queer femmes showed that there are differences in the care offered even between public and private insurance, with those with the latter having to pay extra for sexual healthcare otherwise covered by public insurance. The selection of spaces offering sexual healthcare services for those uninsured is greatly limited, and with the exception of people with low income, the tests carried out at these centers have to be paid for as well, with the costs being around twenty-five euros for a full "testing menu," meaning both smears and bloodwork.

Since so many centers rely on the requirement of insurance, one's anonymity is often compromised. This can be seen as problematic as there is still so much stigma attached to not only receiving STI-confirming results, but to testing for it as well. Anonymity can also be important for those folks who not "out" with their queerness. However, it was only allowed at the centers that did not require insurance, such as Checkpoint BLN (only for testing but not treatment though), Fixpunkt, Gesundheitsamt Charlottenburg-Wilmersdorf, Mann-o-Meter, and Berliner AIDS-Hilfe.

While queer-friendliness was ranked as a very important factor to the queer femmes that participated in the questionnaire, my research demonstrated that it was not so common in the sexual healthcare centers I visited. Visible queerness of the spaces was rare, and they were all largely dominated by masc people, as was already pointed out.

5. Discussion

Before I move onto the conclusion of my thesis, I would like to include a chapter that focuses on reflecting upon the course of my research, on its drawbacks as well as benefits, and on possible next steps stemming from the information found through my analysis in order to create applicable solutions to the current situation of sexual healthcare (not only) in Berlin. First, I will mull over the limitations my choice of research brought me, and how it differed from my expectations, what it lacked, and which obstacles I met throughout the way. Then, I will present my recommendations that could tackle the lack of access to sexual healthcare, not only for queer femmes, but all of society, and will also introduce my personal sex educator plans for new content influenced by this thesis. These recommendations will not be derived from my autoethnographic research only, but will include what I learned through the literature review I had performed as well.

5.1.Limitations

While I already discussed both the negatives and positives of pursuing the kind of research I decided to engage in, the methodology section addressed more general characteristics of, mainly, autoethnography, and now I will focus more on the concerns and matters that directly came from the research I myself partook in.

In general, I want to express my appreciation of choosing such unusual method, as I find it very interesting and exciting to perform, as well as insightful and beneficiary for both my thesis and my personal work. Being so personally involved in my research allowed to learn and understand a lot of aspects of sexual healthcare, not only from the organizational side, but also in terms of the symptoms and treatments of various STIs and other services under sexual healthcare. To be completely honest, I feel like it was an incredibly important experience that has helped me in figuring out and finding my passion and guiding my work as a sex educator. For that, I am incredibly grateful, and feel that through this the main purpose of getting a Master’s level education was fulfilled – I managed to evolve and mature my thoughts and interests, and deeply broadened my knowledge on topics important to me, that are also part of creating a change in our society and making it a better, more accessible, and less stigmatized environment.

Of course, my choice of methodology had its downsides, and was not completely problem-free. There were several issues or constraints of it that arose during my engagement with it, or after finishing my analysis. I will present them now.

5.1.1.Limits of autoethnography

First of all, I want to address the setbacks of engaging in autoethnography and how it possibly influenced my findings and whole research experience. Already before commencing my research, I was aware of it being a very unusual and in many cases also disbelieved or doubted method. As Wall pointed out, by choosing autoethnography, one automatically puts themself under the peril of potential criticism of the research not being “professional enough,” “objective enough,” or “detached enough,” and also becomes very vulnerable by sharing personal stories and experience in the framework of academic writing and research (2008). Yet, as I had asserted earlier, that was the driving force behind my decision to choose autoethnography, as a way to embrace one's complete embedding in their research instead of attempting to produce an objective work which, in my eyes, is an impossible act, as a person can never truly detach themselves from deeply ingrained biases and societal roles learnt from early childhood. I saw this strategy of rebelling against the requirement of objectivity as a way of queering feminist academic writing and research. However, I have to admit that despite holding all these beliefs and determination, I often found myself striving for "as truthful as possible" retelling of my STI testing visits in my autoethnography diary, or thinking of the interviews and questionnaires I additionally conducted as a way to make my research "more valid." Despite greatly enjoying the autoethnographic process I was carrying out, I still experienced doubts about its value and relevance, giving me anxiety about the thesis as whole in general. Supplementing it with questionnaires and interviews felt both reassuring for me personally, and more holistic in terms of drawing conclusions.

Another issue I was anticipating was coming up with a smaller, less extensive volume of findings due to the nature of autoethnography. By literally using my own body as the instrument of my research, my ability to gather information directly from personal visits was limited by its own boundaries, both physical and mental. The issue of ethics and (ab)use of the medical system also comes into question (which I will further address separately later in this chapter), and played a big factor in how many centers I visited. Yet, again, I tried to make up for this drawback by including an analysis that was based on desk research about other facilities than just those I attended in person, to create a more aware and conclusive overview of the sexual healthcare centers in Berlin.

5.1.2.Ethics of getting tested

Deciding to conduct research that evaluates and reviews the state sexual healthcare, or any healthcare in general, brings up ethical issues as well. I have already touched upon the subject here and there in this thesis, but in this part, I aim to address it fully. It was indeed something that also took up a lot of my mind space when executing the autoethnographic research, and therefore I find it very important to share it too.

The main issue at stake is (ab)using the medical system for research instead of acute needs. While the claim of exhausting healthcare just for the sake of research cannot be disputed, and I fully acknowledge it, I also want to present how I tried to navigate this concern. Thus, while planning my autoethnographic research, I was careful to keep the danger of possible exploitation of medical services other people need more than me in mind. I specifically adjusted the amount and frequency of the visits in order not to cross the line of sensible research and taking up too much space (which, I believe, is especially important to consider as a white, able-bodied person that is able to finance their own public insurance). This, combined with implications of the sudden surge of corona virus, lead to visiting way less sexual healthcare centers than I had initially expected to visit, and even deciding to not visit some of them to make sure the already limited capacity was not even decreased by my research (Gesundheitsamt Charlottenburg-Wilmersdorf). I tried my best to keep my plans and expectations as flexible and open as possible, to adjust to the situation to make sure it felt "right" and not exploitative.

Of course, another important and dubious matter of this kind of autoethnography is the issue of chronicling experience about the functionality of medical centers and the behavior of their staff without them being specifically aware of my actions. Describing one's demeanor on a somewhat publicly accessible source without their consent and agreement is undoubtedly unethical in many ways. That is why I was very cautious not to include any personal details of the employees of the clinics or any other involved people who could not consent throughout the process. As I already indicated, when possible, I tried to at least share that I was writing my thesis about sexual healthcare centers in Berlin with providers, who were often very interested in the topic and asked about the process, which I happily elaborated on. At the same time, my autoethnography that is, in its essence, a collection of client assessments is not much different than customer/patient reviews shared with other people on public websites and such.

Furthermore, the fact that I myself had to be treated for gonorrhea during the time of my research meant that I actually really needed to get repetitively tested for STIs to ensure the infection had cleared up (especially after I could not receive the intended intravenous treatment), which "validated" my research in some ways too – instead of visiting the same center repeatedly, I tried a new one each time.

It is also important to note that my autoethnographic research would not be possible at all without my public insurance with Techniker Krankenkasse, which is one of the most comprehensive and all-encompassing insurances in Germany.

This allowed me to engage in STI testing and treatment without having to pay out of my own pocket, or experience any significant difficulties with booking my appointments or presenting them to a private insurance company, unsure whether they would be approved or not. If I had focused my research on options of STI testing for those without an insurance (which would be significantly more unethical, as I, a person already insured, would really be taking up space and opportunities of those without any other options), my research would be incredibly small and limited.

5.1.3.Researching amidst a pandemic

While the limitations I described in the previous two sections were something I had been expecting, the emergence of COVID-19 and its significant influence on all aspects of life worldwide was something I had no chance of predicting. It cannot be denied that coronavirus turned the way our society functions upside down in an instant, and adjusting to it, without a surprise, is a still ongoing process. Of course, such precarious situation also affected me and my research.

First and foremost, it meant that many facilities suspended their operation for long periods, waiting for the highest wave of infections to subside. This lead to, as I already mentioned, less sexual healthcare centers to choose from and examine in person. Furthermore, even the places that had stayed open operated with new rules and increased regulations and safety precautions, and it is thus reasonable to ask whether my findings are thus true to how the clinics function regularly, or whether they were influenced by the higher level of stress and general public restraints the pandemic brought.

The issue of exhausting the medical system has already been addressed in the previous sub-chapter, yet it became even more urgent during the times of COVID-19. While there was, and continues to be, an undeniable shortage of medical staff in all aspects of healthcare, especially during the initial spike of infections, sexual healthcare is not particularly a department that is strongly touched by it. Rather, it meant precautions or reduced operating times, as pointed out in the preceding paragraph.

Still, even if most centers were not significantly swayed by the pandemic in terms of having to change their medical focus, physically visiting them meant a significant hazard of exposure to the virus to me as well, and vice versa – me being a possible threat to both the patients and the staff. Like I already mentioned, there were two instances during which I was put under quarantine, and I even undertook three tests for COVID-19 throughout the testing period, which halted some of my research plans in many ways.

To sum up, not only conducting a form of research that requires a lot of personal contact, but also simply attempting to write a thesis during a time in which the whole world is paralyzed by a pandemic of such strength, which disrupts all the ways of existing and coping as we have known so far, was a very difficult feat. While the societal values of being productive, outgoing, and self-oriented were crumbling, proving to be threatening to the public health, it was sometimes hard to focus on following through with the thesis as such. Towards the end of my research/thesis writing, the Black Lives Matters protests and riots emerged, attempting to dismantle the current racist, oppressive hierarchy of most of the world, and the charged atmosphere accompanying again made the writing process seem redundant or simply strange at times – "why be writing a thesis when there is social justice to fight for and societal roles to rebuild?" While this paragraph might be a very unexpected and perhaps unprofessional, non-academic element to include in a thesis, as I pointed out earlier, with this work, I strived to be as honest and intimate as possible, and I find it very beneficial and meaningful to ponder over the personal aspects and limitations, which were highly influenced by the health crisis and the highly needed movement for racial justice, I faced throughout the process of producing this paper.

5.1.4.Navigating the space with privilege of an able-bodied person

Even though I tried my best to focus on the issue of physical accessibility of Berlin's sexual healthcare centers in Berlin, I myself have no physical or cognitive disabilities, therefore my experience or reflections are, of course, not of such value and clarity as if they were done by someone with disabilities. That way, I could only attempt to review the facilities based on the requirements previously voiced through the questionnaires I conducted, and research of literature about spatial accessibility. At the same time, I was very aware about being able to cross the thin line and turn my "good intentions" into talking over people with disabilities and inciting my own misinformed assumptions about their needs instead.

Still, as I myself struggle with chronic mental health issues, which very much fuels a big amount of anxiety about receiving healthcare, I used my own experience in evaluating the factors I myself have always found important in navigating and easing my own “crip”[5] identity – such as the importance of being able to schedule appointments online (without having to call in person), offer of walk-ins, or knowing information about the tests, treatment, or the location and general rules beforehand.

5.2.Real-life application

In several parts of this thesis, I expressed my intention to turn the results of my research, especially the autoethnographic part, into sex education content I can use on my personal channels, and as a way to bring this thesis to conclusion, I would like to share them with the readers as a way on a positive and somewhat motivational note. Furthermore, as I would like continue to focus on more academic or institutional approach to access to sexual healthcare, I will start by offering a few suggestions I believe should be implemented to make STI care and treatment more accessible and less stigmatized in general. These will be based on both the analysis of all the three methods I executed, and the theory I had presented earlier.

5.2.1.Ways of making sexual healthcare more accessible

By reflecting over my findings, I have created a list of demands for more accessible sexual healthcare:

1. STI inclusive sex education from early age is essential.

Saying that youth’s access to comprehensive sex education is insufficient is almost an understatement – and even when it is present, often it does not accurately depict the risks of being sexually active without being overly judgmental or sharing misinformation (Keller, 2020). Most sex education is based on preaching about abstinence (Keller, 2020), and often, STIs are framed as terrifying and long-lasting illnesses that can ruin one’s whole life. But in order to elevate the stigma of STIs and to ensure STI testing becomes a regular, no-frill, widely appreciated practice, it must start from the earliest stages of discussions about sex and what it involves outside of pleasure. Thus, it is crucial the sex education is not only queer-inclusive and includes conversations about consent, assault, and rape culture, but that it also covers the topic of sexual healthcare completely free of

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[5] https://www.wright.edu/event/sex-disability-conference/crip-theory#:~:text=Crip%20theory%20considers%20disability%20to,with%20all%20other%20identity%20variables.

shame, and instead presenting the “things,” that is various STIs, in an informative and pragmatic way. Only if testing is seen as normal and vital from early age, positive actions improving public sexual health can be reinforced and kept in the long run.

2. Preventive care over solution-based care.

While this is common in many other aspects of caring about health, unfortunately, dealing with STIs is often rather in the form of acute problem solving instead of taking precautions to minimize the risk and/or seriousness of them (Barry and Sherrod, 2014). Ways to tackle that could be recommending preventive STI checkups that are free and done for free, following the model of yearly preventive gynecological checkups for which one even gets reminders by their doctor, common in the Czech Republic, including full STI tests (that mean swabs from all orifices and blood tests) as part of gynecological preventive checkups or checkups by general practitioners, performed at least once a year.

3. De-mystifying the process fo testing and treatment.

Many people are aware of the importance of regular STI testing, yet have no knowledge of either what to get tested for, or how these tests are carried out. Thus, I see as beneficial sexual healthcare centers including information about the testing and treatment process they partake in at their facility on their websites and promo materials, as well as offering a basic rundown of the most common STIs and their symptoms. This not only helps with advancing public sex education, but also helps in elevating some of the fear of unknown that is undoubtedly attached to STIs and sexual healthcare.

4. Encouragement of safe(r) sex needs to be more than just a talk.

Safe(r) sex methods are necessary in minimizing the spread of STIs. Yet if their use is promoted—by sexual healthcare centers, public campaigns, the government—without making them accessible to all, such efforts are meaningless. Therefore, sexual healthcare clinics, of all places, should offer free access to condoms, dental dams, gloves, and lube, to boost and reinforce their use.

5. Anonymity is important.

Until there is virtually no stigma attached to STIs and testing for them, being able to receive sexual healthcare anonymously and without the fear of repercussions is crucial. Anonymity needs to be ensured not only at clinics where one’s insurance is not needed (like it was not at Checkpoint BLN or Fixpunkt), but even at those centers that require one’s insurance card and personal details to be able to provide sexual healthcare. This is not such a difficult task – the same number code/nickname system as many public sexual healthcare centers use can be simply applied even after patients disclose their name and other personal information to the reception, nurses or doctors, in order to protect their privacy around other patients, such as when waiting in common areas of the facilities and such.

6. Accessibility is not an afterthought.

During my research, I discovered that most sexual healthcare centers did not prioritize accessibility in all of its aspects. Information about the space's physical accessibility as well as its layout, was rarely shared in the clinics' promotional materials, yet such thing is the first and foremost "must" of creating sexual healthcare more accessible. Of course, disclosing information about the location's (in)accessibility is not enough, and it needs to be insured that specific needs and requirements of people with physical disabilities, cognitive limitations, or simply those dealing with past sexual trauma or needing any other particular demands are addressed and met in every part of how the center functions. Accessibility is not just "a nice add-on," it is requirement ensuring that, again, public sexual health is protected and improved. Furthermore, considering and catering to people that are "othered" by our society because of the deeply ingrained ableism or other forms of discrimination is simply basic human decency.

7. STI testing is not for MSM only.

As was pointed by both my literature review and my research, many sexual healthcare centers often prioritize services directed at men who have sex with men, or queer men in general, and they rarely offer tests specifically needed by people with vaginas. Such centering of male sexuality and its risk can also be harmful to not only individuals, but to the sexual health of our society as whole, and thus it is very important for sexual healthcare to be more femme-inclusive. I believe that, for example, Pap smears, swabs for mycoplasma, screening for HPV, and optional full genital exams should be offered by sexual healthcare facilities as well.

8. Making STI testing financially accessible.

As my research showed, STI testing options for folks without insurance are only available after payment, which is rarely too expensive, but it is a payment nevertheless, and even as "small" amount as twenty-five euros can be a big investment for many. Therefore I would like to suggest an option that I once saw being offered on Fixpunkt’s website, but which is no longer advertised – pre-paying for other people’s tests by donating to a special fund. Just like some cafés offer an option to pre-pay for the next person cup of coffee, sexual healthcare centers can implement this system as a way to collect financial resources for those who otherwise cannot afford their services. Redistribution of wealth is a vital and necessary part of working towards social justice and change in oppressive classist and racist hierarchies of our society, and this could be a way of participating in it.

5.2.2.Sex education content

The way I see my sex education practice is as sharing information “I wish I had known earlier.” Staying true to this idea, I intend to also rework the contents of this thesis and transform it into content more palatable and accessible to general public, as I believe I came across many findings that can be very useful for other people than just me and the readers of this paper. While this is still something I have not planned out entirely, I want to quickly outline some of the ideas I want to pursue.

Throughout my autoethnographic research, I was documenting my experience with each sexual healthcare center I visited by sharing Instagram stories, which are more instant posts that stay on one’s account only for one day and later disappear, where I talked about how my appointments were going and detailed the steps I went through (Appendix nr. 6). However, as such format has its obvious limitations, I now intend to create more comprehensive text-based posts that are easier to find and engage with.

Additionally, I wanted to follow up on a new format of my sex education posts I had already tested out during my research, which was a short summary of the findings from the literature review I performed for this thesis (Appendix nr. 7), which proven to be very successful and welcomed by my audience.

During my testing visits, I also filmed short videos with explanation of, for example, how to do self swabbing (for gonorrhea or chlamydia) correctly, which I am determined to edit and publish as soon as possible.

5.2.3.Online database

The ideas I presented in the previous part are types of content I already generally engage in and produce, but during the process of working on this thesis, another idea sparked me that would require more work and expertise outside of sexual healthcare. Gathering so much information about Berlin’s sexual healthcare centers is something I believe to be very beneficial and helpful in easing the public's access to STI testing and treatment, and therefore I would like to make sure more folks have access to it.

Thus, my idea, and hopefully a future project too, is to create a website which essentially makes the information spreadsheet I presented earlier accessible to wider public. The Google Map I created to help me with navigating myself around the my STI testing visits could be featured too, and, with further work and by collaborating with other people, the website could also include other sources of information, such as educational content from sex educators, people sharing their reviews of visiting sexual healthcare centers, or the centers themselves being able to share updates themselves, making it somewhat of a sexual healthcare online center for Berliners.

6. Conclusion

In this thesis, I attempted to present an alternative approach to feminist research and address several concerns and questions related to queer femmes' access to sexual healthcare services in Berlin. I saw this way of engaging in unusual, perhaps even controversial for some, way of conducting research and thesis-writing as form of queering the academic practice and molding it to become more approachable both for me and potential readers outside of academic circles.

In the very beginning of this paper, I explained what the main aim of this thesis was – to evaluate the current situation of sexual healthcare in the German capital, where I myself reside, and how easy to access local providers of sexual healthcare were. This topic came as a natural choice to me because of my work as a sex educator, and throughout the whole thesis, I believe it was very obvious how close the issue is to me, and how I passionate I am about it. At several parts, I also addressed how this closeness to the subject was both a great advantage, allowing me to stay connected to it and eagerly learn more and more about it, and a significant concern, due to my entanglement and previous knowledge related to sex education.

The structure of this thesis followed the chronological order of my work process: I started off by presenting the research questions that guided my work and and analysis. They were the following: 1) How many sexual healthcare centers are in Berlin, where are they located, and how do they function? 2) How many of Berlin's sexual healthcare centers specifically cater to queer femmes? 3) Is it necessary to have a German insurance in order to get tested for STIs in

Berlin? What options do people without insurance have? 4) Are Berlin's sexual healthcare centers accessible to queer femmes, especially in the sense of physical and financial accessibility? 5) How can I use my own experience with STI testing at Berlin's sexual healthcare centers as a method of feminist research? 6) Will repeated STI testing through blood drawing help me get rid of my fear of blood tests? Then, I narrowed down the span of my research, explaining that the choice to focus on sexual healthcare centers in Berlin only was guided by the scope and requirements of the Diploma thesis itself, by engaging in autoethnography, and by my wish to be able to delve deeper into more specific and real-life aspects of the sexual healthcare accessibility issue. I also tried to clarify what I meant by using certain terms, such as "femme" (which I used instead of the word "women") or "queer/ing," in order to prevent misconceptions in understanding the main points of this paper.

Once the focus of this thesis was laid out, I moved onto introducing a necessary theoretical overview of the topics related to sexual healthcare, STI testing and treatment, and general barriers to healthcare that queer folks can experience. I presented the concept of minority stress theory and how it can be brought up by seeking sexual healthcare too, making the queer folks tried to get STI tested or treated vulnerable to stigmatization of their identities that then leads to physical and mental stress. Furthermore, I described the specific needs of queer femmes when it comes to sexual healthcare, and how they are often not met or approached with a lot of misinformation even from the side of medical practitioners. I talked about the importance of routine screenings for HPV via Pap smear, about debunking the myth that lesbian sex is "less risky" than gay or heterosexual sex (while I also questioning these rigid categorization of sexual acts itself), and assessed how being a sex worker or someone with disabilities (or both at once) puts queer femmes at even more risk of contracting STIs and subsequently not receiving sufficient care. Based on my literature review, I identified these obstacles to STI testing: 1) lack of insurance, 2) bias in sexual and reproductive healthcare, such as racism, classism, or ableism, as well as queerphobia, 3) (lack of) of access to genital-specific STI testing methods, and 4) the issue of disclosure and stigma (associated to STI testing and treatment).

Moving onto the methodological part, I presented the three methods I had decided to pursue: questionnaire, autoethnography, and interviews. I devoted a significant portion to introducing the practice of feminist methodology as whole, glossing over its origins, advantages and disadvantages, and the reason behind my implementation of it. I connected it to the struggle against the normative, andro-centric way of thinking of common science and academia, and its attempts to challenge it by embracing methods otherwise seen as unprofessional or built on emotions rather than facts. This is a sentiment that was deeply embodied in my choice of methodology and subsequent research execution, and was greatly displayed in my decision to engage in autoethnography. As it is a very unusual method veiled in a lot of mystery, since it does not follow traditional ways of conducting research, I dedicated a large section to dissecting what autoethnography can be, pointed out several examples of feminist autoethnographic works, and, mostly, discussed the risks of building one's research on it – such as poor reception by mainstream science, general novelty of it, or the extreme level of one's personal involvement and the vulnerability it brings. Yet, as I indicated, these challenges of autoethnography were the reasons behind my choice, mostly as a way to navigate the issue of the researcher being required to be as distant, objective, and uninvolved as possible, and instead doing the exact opposite to dispute the idea that such ultimate objectivity and bias-free consciousness is even possible. Rather, I went for an incredibly intimate, detailed, personally involved method, autoethnography of my own visits of sexual healthcare centers and my experience with STI testing there, and supplemented it with additional questionnaires inquiring about queer femmes' sexual healthcare needs and requirements, and interviews with people who partake in STI testing or treatment in Berlin too.

Embarking on the research part of my work, I started with online questionnaires through which I wanted to gain knowledge about what queer femmes want from sexual healthcare, which factors are important to them, and what has their prior sexual healthcare experience been so far. I carried out two different questionnaires, one assessing “Queer femmes' STI testing experience” (answered by seventy queer femmes), another exploring “Disabled queer femmes' STI testing experience” (answered by five disabled queer femmes) to learn more about specific needs of those with disabilities. While the questionnaires were similar in many aspects—the second one focused more on evaluating the importance of various factor of physical and cognitive accessibility —, the findings were not as much. Opinions about their prior experience with STI testing were largely shared by both groups, yet when it came to determining the most important factors of how sexual healthcare was conducted, they differed a lot. For those replying to the questionnaire for queer femmes, the top five factors were queer-friendliness, acceptance of one's insurance, price, possibility of walk-ins, and if there is info about the tests, treatment, accessibility etc. available online; while for disabled queer femmes, it was anonymity, location being close to public transport, possibility of walk-ins, clearly marked areas (which room is which, where to go, etc.), and if there is info about the tests, treatment, accessibility etc. available online.

These findings served as guiding points for my autoethnographic visits, during which I specifically assessed the factors marked as important in the questionnaire analysis. To ease my orientation in the local sexual healthcare system, I created a Google Map, where I pinpointed the location of sixteen different sexual healthcare centers, and an information spreadsheet, in which I logged data available through the centers' websites. In this spreadsheet I gathered information about each facility's location, target group, prices, insurance acceptance/requirement, STI testing offer, possibility of treatments, or its accessibility. Perhaps the main and most crucial finding for my thesis was that there was not a single center specifically targeting queer femmes, and while many offered services to people of all genders, there was also a high number that prioritized treatment of MSM. Furthermore, it turned out that many centers require health insurance in order for the patient to be even tested, and that those clinics that do not rely on insurance charge fees for their services, mostly from five to twenty-five euros depending on the scope of tests performed. Anonymity of the clients is rarely allowed. The testing offer is large and differs from a center to center, with all of them performing tests for HIV, often supplemented by tests for syphilis, chlamydia, gonorrhea, and differing types of hepatitis. Treatment is offered at most places (but is dependent on insurance), and some facilities offer PrEP and PEP as well. Information about accessibility was difficult to obtain, with thirteen out of sixteen sexual healthcare centers not including any details about it on their websites.

Based on this familiarization with Berlin's sexual healthcare centers, I selected several spaces to visit over the course of my autoethnography. In the chapter dedicated to it, I not only presented my main findings, but also included a personal reflection on how my experience with method that is so intimate in its essence was. I discussed the strangeness of discussing my sexual health in an academic form, disclosed certain uncomfortable moments I experienced during my research, and gladly shared the continuous testing helped me in getting rid of my phobia of blood work. Then, I moved onto analyzing my visits, which took place (or were supposed to take place) at the following sexual healthcare centers: Checkpoint BLN, Fixpunkt, Checkpoint BLN (for treatment of oral gonorrhea), Novopraxis, s.a.m health, Infektiologie Ärzteforum, gynecologist Hatice Alkaya, Gesundheitsamt Charlottenburg-Wilmersdorf, and Praxis Prenzlauer Berg. Some of main findings were: 1) Berlin's sexual healthcare centers are dominated by masc people, both as staff and as clients, 2) accessibility is not properly addressed or ensured, 3) it takes weeks to get an appointment at most places, especially after walk-ins were suspended due to COVID-19, 4) I experienced no specific stigmatization due to my identity, but at the same time, the spaces were rarely openly queer-oriented, 5) each center is absolutely unique in their conduct: the way of making an appointment, offering different types of tests and treatments, results being obtained in different ways (over the phone/in person) and after different times. As an addition, I also attempted to review an at-home STI testing kit, which did not end on a positive note, and to get tested at a general gynecologist, where I found out it would only be possible after paying for it despite having a public insurance.

To review on my personal experience and supplement it with the views of other people, I executed interviews of queer femmes that had been tested in Berlin within the past year. I spoke to seven femmes of very differing identities, and with experience from various sexual healthcare centers. In general, their retelling was mostly positive and all of them received the care they requested, but there was also a common thread of identifying the issue of financial access, lack of adjustments to ensure accessibility, and long appointment waiting times.

Taking a step back from the analysis, I then glossed over the limitations of my methodology in the subsequent discussion chapter. I presented the drawbacks of autoethnography, such as the unease I sometimes felt with being so involved and personal in my research, the threat of possible unfavorable reception of the method, or the smaller volume of findings it produces, compared to more traditional forms of research. I also addressed the ethical issue of repeatedly using the medical system just for research instead of acute needs, and meditated on how to navigate this peculiar aspect of my thesis. Furthermore, I included a reflection on how my work was influenced by the sudden surge of COVID-19, and how it, in many ways, maimed my plans as well as general ability to focus on writing this thesis. I also pointed out how my discussion of physical accessibility comes into tension with the fact of me not having any physical limitations, and how my mental health issues played a role in my experience too.

To turn the academic research into something more practical and applicable, I also included a part where I offered some suggestions that could be implemented to ensure sexual healthcare becomes more accessible (sex positive, STI inclusive sex education, focusing on accessibility, enabling anonymity, transparency about the services provided, prioritizing preventive care over solving acute situation, offering safe(r) sex barriers, financial access, and femme-inclusive care), and also shared my personal plans of creating sex education content and possibly also a public website based on the findings of this thesis.

In this thesis, I tried to present a comprehensive view on the issue of access to sexual healthcare and the current situation of it in Berlin. I adopted feminist methods to help me achieve that, and made the research process very personal and adjusted it to my own beliefs and needs. I not only presented findings from the three different methods I carried out, but also introduced ways of how I wanted to bring this work further and mold it into an output that is accessible to general public. As I myself enjoyed the process of researching and writing this thesis immensely, I can only hope the readers found similar pleasure in reading about it, and perhaps become inspired, or at least enlightened, by my efforts.

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