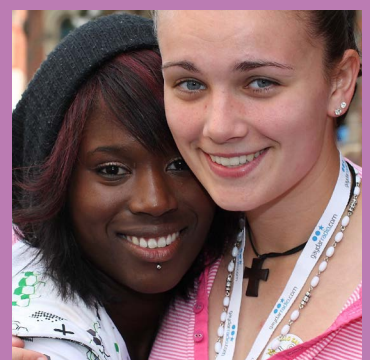


# Best practice in providing healthcare to lesbian, bisexual and other women who have sex with women



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# Foreword



## Baroness Barker

The first principle of the NHS Constitution states that, “the NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights.”

This report, which follows on from *Beyond Babies & Breast Cancer: Expanding our understanding of women’s health needs* published in 2013, demonstrates how wide is the gap between principle and practice.

Lesbian, bisexual and other women who have sex with women (LBWSW) lack acknowledgement both in mainstream society and LGBT communities, and to the NHS we are largely invisible. It is unacceptable that LBWSW continue to experience discrimination and that thoughtlessness compromises our healthcare.

I had the privilege to lead the first debate in the House of Lords on lesbian, bisexual and trans women’s health in December 2014, so I am pleased to acknowledge leadership of the Department of Health, NHS England and Public Health England’s Health in making this report possible through the Health and Care Strategic Partnership Programme.

Change will happen when we lesbian and bisexual women have the confidence to challenge prejudice in practice which is exclusive. Change will happen when NHS practitioners understand as minority communities we need services which include us. Change will happen when organisations responsible for education, training and professional of staff at all levels include the needs of LBWSW along with everyone else.

This report shows LBWSW’s experiences of the healthcare service, both good and bad. In highlighting good practice as well as things to avoid, it can be used as practical guide to commissioning and providing services to LBWSW. Let’s use this wisdom to end the prejudice and extend the pride in our NHS.

# Acknowledgements

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# Introduction



Lesbian, bisexual and other women who have sex with women (LBWSW) have too often been an invisible group within health care. Their needs can be doubly hidden, both within the topic of women's health, which often focusses on reproductive health, and in the health needs of the lesbian, gay, bisexual and trans\* (LGBT) community in general. A significant evidence base, both from academic literature and 'grey' literature such as *Prescription for Change* (Hunt and Fish, 2008) and *Beyond Babies and Breast Cancer: Expanding our understanding of women's health needs* (LGF 2013) highlight both experiences of lesbian and bisexual women using health care services and also the range of health care concerns impacting on lesbians and bisexual women. Evidence is now emerging about the differing needs within this group, for example poorer mental health among bisexual women and those from ethnic minorities. Public Health England is currently undertaking a systematic review of all the published evidence on LBWSW healthcare needs, and the National LGB&T Partnership is keen to support the development of an action plan, similar to *Promoting the Health and Wellbeing of Gay, Bisexual and Other Men Who Have Sex with Men* (PHE, 2014).

It is nearly a decade since the publication of *Prescription for Change* but the experiences women shared for this report suggest that little has actually changed in inclusive healthcare provision for LBWSW. How we receive services as LBWSW impacts on our willingness to use services and their effectiveness, and therefore the impact and outcomes of our healthcare. This report aims to highlight women's experiences of both good and poor practice in healthcare provision, and make recommendations for both practice and strategy in order to improve women's health overall.

This document is intended to be used both by those who provide services and those who commission services to support them to work with LBWSW. It is a resource to assist in designing and providing care and support that is successful in meeting LBWSW's needs in a way that is inclusive of their sexual orientation, and achieves better outcomes for patients and communities. This report aims to raise the visibility of a group within health care that has remained invisible for too long.

This report has been produced by the National LGBT partnership, which is part of the Department of Health, NHS England and Public Health England's Health and Care Strategic Partnership Programme.

\* Trans is an umbrella and inclusive term used to describe people whose gender identity differs in some way from that which they were assigned at birth; including non-binary people, cross dressers and those who partially or incompletely identify with their sex assigned at birth

# Terminology



Throughout this document we have used the term lesbian, bisexual and other women who have sex with women (LBWSW). The definition of lesbian women refers to those that are sexually, romantically or emotionally orientated to having same gender relationships, i.e. women having relationships with women. The term bisexual refers to people that are sexually, romantically or emotionally orientated to have attractions to more than one gender. Some women may be having or had had relationships with women but not identify themselves as lesbian or bisexual, hence the term 'women who have sex with women'. This report does not focus on trans women specifically, but information can be obtained through the National LGB&T Partnership's Trans factsheets series, available at [www.nationallgbtpartnership.org/publications/trans-health-factsheets](http://www.nationallgbtpartnership.org/publications/trans-health-factsheets).



# Methodology

A set of questions for a survey was drafted with input from the National LGB&T Partnership's lesbian and bisexual women's workstream and Stakeholder Engagement Manager.

The survey was made available online between 13 November 2015 - 20 January 2016. During this time the survey was promoted through the National LGB&T Partnership and the Partners' communications channels including Twitter, Facebook and each Partners' electronic news communications.

"Lesbian & bisexual women: we want to hear your healthcare experiences. Chance to win £50 vouchers! <https://lgbt.foundation/surveys>"

## **Example Partner tweet**

The survey asked women who identified under the umbrella term of lesbian, bisexual and other female-partnered women to tell us about positive or negative experience in their healthcare encounters. The survey was taken 332 times, but of these only 101 were complete answers and could be used in the findings. As an incentive, participants of the survey were entered into a prize draw to win £50 worth of shopping vouchers.

In addition to the online survey three focus groups were held. Each focus group was led by one of the Partners from the National LGB&T Partnership and promoted in their local area.

The focus group recruited a small but diverse group of LBWSW to come together for a round table conversation to share their experiences of accessing healthcare. Each focus group lasted 90 minutes. All attendees received a £15 shopping voucher as a thank-you for attending.

Participants in the focus groups were asked a series of topical questions similar to those in the survey which participants discussed in detail. The focus groups yielded data that gives the survey data further depth.



## **Questions to the focus group participants included:**

What are the factors that you consider in choosing which healthcare service to access?

Do you feel that mainstream healthcare services meet your needs as a lesbian, bisexual or other female partnered woman?

What kind of services would you like to be able to access?

Have you had any negative reactions relating to the fact you are a lesbian, bisexual or other female partnered woman when you've accessed health services?

# Research Findings



Data was organised into various demographic categories and then negative and positive experiences were layered with comments from participants. The analysis extracted small case studies to highlight individual participants' experiences and was compared to evidence available from previous studies. Of the 101 experiences, 56 were described as 'negative', 33 were described as 'positive' and 12 were marked as 'other', however, it's worth noting that even those marked as positive sometimes contained negative elements.

Participants were asked to identify the health care setting in which the experience took place and were then asked to rate it as positive, negative or 'other'. It is notable that negative experiences were more likely to take place in a mental health setting, hospital, sexual health clinic or GP/Primary Care.

| Health Care Setting   | Positive experience | Negative experience | Other |
|-----------------------|---------------------|---------------------|-------|
| Dentist               | 100%                | 0                   | 0     |
| Fertility Clinic      | 50%                 | 50%                 | 0     |
| GP/Primary Care       | 33%                 | 47%                 | 19%   |
| Hospital              | 24%                 | 66%                 | 9%    |
| Mental Health setting | 16%                 | 66%                 | 16%   |
| Sexual Health Clinic  | 35%                 | 57%                 | 7%    |

The rate of positive, negative and other experiences was measured against how participants identified their sexual orientation. Lesbians were most likely to report a negative experience.

| Sexual Orientation | Positive experience | Negative experience | Other |
|--------------------|---------------------|---------------------|-------|
| Lesbian            | 25%                 | 61%                 | 14%   |
| Bisexual           | 45%                 | 50%                 | 5%    |
| Gay                | 50%                 | 30%                 | 20%   |
| Other              | 33%                 | 50%                 | 20%   |



Participants were asked when the experience they described happened. Nearly half of experiences reported took place in the previous six months.

| When the experiences took place | All responses | Positive experience | Negative e | Other |
|---------------------------------|---------------|---------------------|------------|-------|
| 0-6 months ago                  | 41%           | 46%                 | 42%        | 12%   |
| 6-12 months ago                 | 17%           | 29%                 | 64%        | 7%    |
| 1-2 years ago                   | 24%           | 29%                 | 62%        | 8%    |
| 3-5 years ago                   | 11%           | 27%                 | 54%        | 18%   |
| Over 5 years ago                | 8%            | 0%                  | 75%        | 25%   |

Participants were asked to describe their experiences as positive, negative or other (e.g. neither positive nor negative or a mixture of both). Common themes emerged from the experiences and so experiences have been categorised thematically in the table below (note that some experiences covered multiple themes). Assumption of heterosexuality was the most common negative theme. Also commonly experienced was clinician discomfort with the patient’s sexual orientation; the patient’s coming out being ignored; the patient being given incorrect information based on their sexual orientation; and poor treatment based on sexual orientation. The most common positive theme was that the patient felt listened to, while other themes covered the patient’s sexual orientation being acknowledged.

| Negative Themes                                       | % of participants that selected theme |
|---|---------------------------------------|
| Assumption of heterosexuality                         | 18%                                   |
| Clinician seemed uncomfortable with patient’s SO      | 11%                                   |
| Ignored the fact patient came out                     | 10%                                   |
| Given incorrect or incomplete information based on SO | 10%                                   |
| Bad treatment (possibly) not related to SO            | 10%                                   |
| Partner not acknowledged                              | 5%                                    |
| Homophobia or biphobia                                | 4%                                    |
| Patient felt they had to educate clinician            | 2%                                    |
| Lack of understanding of trans issues                 | 1%                                    |
| Positive Themes                                       |                                       |
| Patient felt listened to                              | 10%                                   |
| Clinician(s) was comfortable with SO                  | 7%                                    |
| Did not make assumptions about SO                     | 5%                                    |
| Partner was acknowledged                              | 5%                                    |
| Treatment/advice took patient’s SO into account       | 2%                                    |

Evidence from multiple studies show that healthcare settings are often not LGBT-friendly, which has the effect of discouraging LGBT people from seeking help and accessing basic services (LGF, 2013). This includes those who have had negative experiences in the past as well as those who believe they will encounter hostility if they were to attempt to seek help in the future (LGF, 2013). For example, a study conducted by Stonewall in 2008 found that “Half [of the LB women surveyed] have had negative experiences in the health sector in the last year, despite the fact that it is now unlawful to discriminate against lesbian and bisexual women” (Hunt and Fish, 2008).

Experiences of LBWSW responding to our survey show that negative experiences of healthcare are common, with 55% of respondents reporting negative experiences. It is worth noting that many of experiences which were categorised as primarily 'positive' or 'other' still described negative elements within their overall experience. For example, one respondent categorised her experience as 'other' and yet described a situation where a nurse, upon hearing her same sex sexual history, told her she did not need to have cervical screen test. Another participant described a positive overall health care experience but noted that she felt that she experienced bisexual invisibility.

*The LGBT Public Health Outcome Framework Companion Document* notes that trans and non-binary people are less likely to access preventative healthcare services, particularly gender-specific screenings (National LGB&T Partnership and Public Health England, 2013). Additionally, the Metro Centre's 2008-09 *LGBT Needs Assessment for Tower Hamlets* noted that many trans people report facing opposition from healthcare providers when trying to access information about transitioning (Metro Centre, 2009).

Lesbian and bisexual women in particular are more likely than gay and bisexual men to report experiencing discrimination in healthcare (Hunt and Fish 2008). For those healthcare practitioners looking to improve their ability to serve LBWSW, research has shown that "Good relationships [between lesbian and bisexual women and their healthcare providers] were attributed to professionals who listened to the information women provided and to open attitudes." In general, lesbian and bisexual women have emphasised, "...the need for appropriate language and terminology, for the inclusion of lesbian and bisexual women in assessment and demographic forms and for raising awareness among all healthcare staff." Additionally, the best practitioners prove to be those who "...have developed skills in communicating appropriately with LB women: they are not embarrassed or silent when a woman discloses her sexual orientation; they are able to use appropriate terminology and know about the relevant questions to ask; their attitudes are open and non-judgmental and do not pathologise LB women." (Fish and Bewley, 2010) Overall, it is important for healthcare providers to understand the benefits LGBT-friendly healthcare services can offer LB women service users.

# Case Studies



The following case studies have been taken from the online survey submissions and focus group discussions, and illustrate the commonly occurring themes and experiences reported.

## Assumptions made around sexual orientation

When healthcare providers assume that all their patients are heterosexual it can have a negative effect on the quality of care they provide to LGBT patients, particularly for LBWSW. For example, a recent survey found that “two in five lesbian and bisexual women said that, in the last year, healthcare practitioners had assumed that they were heterosexual, and this meant they did not receive the appropriate advice” (Hunt and Fish 2008). A study published in 2010 reports that heteronormative assumptions “...were most routinely made in relation to sexual history taking, contraception, and cervical screening.” When LBWSW are victims of heteronormativity, they are then forced to choose between correcting their healthcare provider’s mistake or letting the assumption lie uncontested. This can be a difficult decision when one considers that healthcare providers often “...lack knowledge of lesbian and bisexual women’s specific health needs and are sometimes embarrassed with lesbian and gay patients” (Fish and Bewley 2010)

One participant, Rachel (34) described an experience in which she felt that the practitioner had very little knowledge of what sort of sexual health advice to give to her as a lesbian woman. She described being disappointed with the experience saying, “I felt that I wasn’t normal because all of the wording and assumptions were made that I would be having sex with men. In this ignorance and assumption of heteronormativity, I felt many of my needs were missed.”

For those women who do attempt to correct their providers, it can be difficult to find an appropriate time to breach the topic of sexual orientation, as many practitioners do not allocate time to discuss such issues with their patients. *Prescription for Change* (Hunt and Fish, 2008) found that “one in five [LB women] felt that during the last year there was no opportunity to discuss sexual orientation, and they had sometimes had to stop mid-procedure to correct assumptions.” This is characteristic of the healthcare experiences many of our respondents described. Another common barrier to LBWSW women being ‘out’ to their healthcare providers is a lack of awareness of the provider’s confidentiality policies and a subsequent fear that their sexual orientation, once revealed, will be shared with others outside of their individual healthcare practitioners. Although many respondents commented that they wanted their sexual orientation permanently recorded on their notes to ensure they receive appropriate care, many expressed concern about how this information would be treated.

Our research shows that very little has changed since *Prescription for Change*, with 36% of online respondents saying that assumptions have been made about their sexual orientation and gender identity.

Many examples detailed assumptions of heterosexuality when LBWSW were asked about their sexual history, specifically questions concerning use of contraception. Tamsin (35) and Simone (27), for example, separately described instances in which they were asked if they used condoms with their sexual partners. When they explained that they had not, they were subsequently berated by their healthcare provider until it was ultimately established that they were lesbians. Simone described an incident that took place during a health check after at a new doctor; “I was continuously pressured into discussing my sex life as I said I didn’t use condoms. I was made to feel dirty until I finally caved and said “I’m a lesbian” bearing in the mind the nurse was an older lady. After my declaration she soon shut up and finished the consultation sharply.” Tamsin felt that sexual health clinics designed specifically for lesbian and bisexual women may be a way to address the issue of heteronormativity within healthcare settings.

While Hayley (35) described a positive overall health care experience, she noted that she experienced bisexual invisibility, feeling that assumptions are made by healthcare providers that all people are either heterosexual or lesbian/gay. Hayley was assumed to be a lesbian based on the fact that she has a same-sex partner; she described this as a minor annoyance given the otherwise respectful treatment she received but added, “it shouldn’t be assumed that all female-female couples are lesbians.” Hayley’s experience reveals that bisexual people can face discrimination even from those healthcare providers that “...are affirmative in terms of lesbian and gay issues.” The Open University’s report (2012) on bisexual people advises that healthcare providers can work to be more inclusive of the entire LGBT spectrum by making, “...sexual health promotion literature more inclusive of a range of sexual practices...[and] specifically target[ing] bisexual [people]...in health campaigns, rather than subsuming them in lesbian and gay categories.”

Anna (28) described a positive experience when she attended her GP; “I went to discuss my mental health. I had been experiencing a lot of stress and anxiety and needed to be signed off work for a while. The Dr I saw was amazing. She was soft, considerate and non-judgemental. My sexuality did come up and it did not phase her.”

Anna also goes on to say that some assumptions about her were made but that to her, they felt like a recognition that not all lesbian and bisexual women are the same, “[the clinician] prescribed me with medication and asked if I was pregnant. I explained that I am gay and she asked “so there’s no chance you could be pregnant?” Some people may feel differently about this question but I appreciated it. It acknowledged that women who identify as gay can also sleep with men.”

Connie (35), a bisexual women living in London, described a positive experience when she had sought medical advice after contracting a sexually transmitted infection from a same-sex sexual encounter. “The doctor who saw me was great; non-judgmental, reassuring and able to prescribe me medication straight away. She asked me questions, listened to me and I felt really comfortable. It made me feel like healthcare has moved on a lot in this country because I remember as a young woman always being asked how many partners I’d had and feeling really ashamed and judged. And doctors would always assume I am straight! These days you are asked whether you have had female partners, it’s better.”

## Coming Out

*Beyond Babies and Breast Cancer: Expanding our understanding of women’s health needs* (2013) found that many are not ‘out’ to their healthcare providers, either by choice or because of a lack of opportunity to do so.

However, even when LBWSW do come out, they often report having their sexual orientation ignored by their healthcare providers. This attitude coincides with Stonewall’s 2015 *Unhealthy Attitudes* report which observed that 57% of the healthcare practitioners surveyed said they did not consider sexual orientation to be relevant to a patient’s healthcare needs. The report so found that a number of healthcare practitioners interviewed reported not knowing how to, or even in some cases not wanting to, meet the needs of LGBT patients.



One participant, Rachel (34), describes going to a sexual health clinic and finding herself frustrated at a lack of communication on her healthcare provider's end resulted in her having to come out to multiple different nurses in the course of one visit, besides feeling as if she was not being listened to.

Nicola (43) experienced issues with the fact that her sexual orientation, once disclosed, was ultimately ignored by her healthcare providers. Having gone to the A&E department at her local hospital, she was given three pregnancy tests within an eight-hour period, despite the fact that "on five occasions during this episode of care I explained I was gay and there was no chance I could be pregnant. On each occasion it felt as though my sexuality was ignored and dismissed."

Another participant, Ruthy (25) explained that she did not want her sexual orientation to be on her medical record, instead preferring to be asked about it by her healthcare provider upon each visit in order to prevent being put into a situation in which she was assumed to be heterosexual. She noted that it wasn't always easy to find the chance to come out and that often, when she was able to find an opening to do so "doctors have refused to listen and allow me to explain that I am a lesbian and have only ever had one sexual partner, and when I do tell them, I feel a little uncomfortable because I'm suddenly not what they assumed or expected."

Pauline (30) described an experience in which she saw her GP to discuss an ongoing mental health issue. Pauline explained that when she came out, by mentioning her female partner, that the GP "made no indication that this shocked them or reacted in a way that made me feel comfortable" and as a result she noted that she would go back to that GP with any issues in the future.

## **Experiencing Homophobia, Biphobia and Transphobia:**

Homophobia, biphobia and transphobia can still be seen to be pervasive in the healthcare sector, as evidenced by these lesbian and bisexual women's experiences. Online survey participant, June, described the discomfort she felt when, upon disclosing that her and her female partner had recently had a child, she was met with hostile comments on the part of her sonographer, "queue the remaining 20 minutes of the examination spent with the sonographer telling me that she thought children needed a mother and a father and that she didn't think it was good for a child to have same sex parents." June said that as she felt so shocked and vulnerable during what was an intimate examination, she never made a complaint. This case study demonstrates the fact that LBWSW often feel disempowered to report instances of discrimination and homophobia, biphobia and transphobia on the part of their healthcare practitioners (Hunt and Fish 2008). It illustrates the need for more explicit anti-discrimination policies that educate LBWSW on their rights as patients and more information surrounding complaints procedures from healthcare providers.

Besides not getting specific sexual health advice relevant to LBWSW women, Suki (24) has been the victim of homophobic comments on the part of her practitioners, "in the past one GP told me to pray more, that it would help cure me." Based on this experience, she had begun to seek out LGBT-specific services but discovered they were difficult to find, "I tried contacting a local sexual clinic but all the information they gave me was for heterosexual couples and when I asked for a LGBT specifically lesbian sexual health service they had nothing available." However, she did note that, upon finding an LGBT-friendly sexual health service, its commitment to inclusive promotion and providing LGBT-specific health information was impressive, "in the end my partner and I found a clinic in London to get tested which was not LGBT specific but it had posters and leaflets for LGBT people and it made the process friendlier and the staff were great." This sentiment supports the research which shows that "posters and materials depicting same-sex relationships or lesbian and bisexual issues were...seen as a positive sign [by lesbian and bisexual women] within a healthcare setting." Thus, by making general healthcare setting more overtly LGBT-friendly, "...women will feel [more] able to discuss their health needs with a healthcare worker. (Hunt and Fish 2008).

Many of the homophobic comments respondents had received were based on the assumption that all women engage in penetrative sex and therefore non-penetrative sex was not considered 'real' sex. Those women who were challenged about their sexual activity were subject to embarrassment



and intrusive questioning. For example, some women were classified by their healthcare providers as virgins despite the fact that they had engaged in sexual activity with women. Participant, Olivia (29) described a negative experience she had whilst having an internal examination. Upon being asked if she was sexually active, Olivia replied affirmatively that yes she was in a long term same sex relationship to which the clinician replied “you should have told me you’re a virgin”. Olivia goes on to explain, “obviously this was very embarrassing, it would have been easier if she had asked the questions she needed to (i.e. about penetrative vaginal sex) rather than assuming specifics from a generic answer.”

Emma, a queer identifying woman in her mid-40s explained her experience facing biphobia in the course of a routine visit with her doctor. Upon asking her if she had “switched sides” when she explained that her most recent partner was male, she explains feeling hurt, “in virtually all other sorts of appointments for discussing my mental health, people presume I am in a relationship with a man and I have to repeatedly correct them. Bi-erasure is everywhere.”

Respondents noted feeling most comfortable in healthcare settings in which their practitioner accepted and was sensitive to their sexual orientation. Pauline (30) detailed one positive experience in which, “I spoke about my female partner during the conversation and the GP made no indication that this shocked them.”

Marie (30) explained that her positive experience at a sexual health clinic prompted her to consider asking more questions during her next visit, “she (the clinician) asked me if I was enjoying the sex and the relationships that I am in and also if I needed more information about sexual health and relationships. Overall she was very nice. It was quite jarring to hear someone ask questions and seem genuine. I think next time I will see if they have any information they can share about female-female sex.” Ultimately, this supports the findings of a previous study that reported that “when lesbian and bisexual women said that they had had some positive experiences when accessing healthcare, this made a difference to how they felt about themselves and their relationship with the healthcare sector.” (Hunt and Fish 2008).

## **Attitude of Clinicians and Medical Practitioners**

Kim (41) described her experience of the poor attitude and clear discomfort on the part of her healthcare provider upon learning of her sexual orientation. Kim had attended for a cervical screen test and was asked what contraceptive methods she was using, on the assumption that she was heterosexual. While she explains that she was not overly bothered by this assumption, Kim did note that the way in which she was dismissed from the appointment caused her discomfort, “she [the healthcare provider] then left the room and didn’t return so I took it the smear was finished and I got dressed and left.” Kim’s case study also shows a lack of knowledge on the part of her healthcare provider about the sexual health needs of LBWSW.

## **Appropriate Treatment, Advice and Knowledge based on Sexual Orientation**

When research has asked lesbian and bisexual women what would improve their healthcare services, a common recommendation is that healthcare providers be educated on the specific needs of lesbian and bisexual women and provide more access to literature discussing risk factors, methods for safer sex, etc. to their patients (Fish and Hunt 2008). Recently, there have also been, “general calls for LB women’s health issues to be included on undergraduate and post-qualification medical curricula, for training in communication skills when asking about a patient’s history and for empirical research into their health needs and risks” (Fish and Bewley 2010). Ultimately, lesbian and bisexual women want, “clear, relevant health information, for themselves and their communities, so that they could make informed decisions” (Fish and Bewley 2010). Much of this misinformation appears to surround fertility services and the sexual health needs of LBWSW more generally.

Keira’s (30) problem arose when she and her wife attempted to seek advice in regards to conception. Keira was frustrated to find that most of her healthcare practitioner’s advice was not applicable to

LBWSW attempting to become pregnant, “the GP told me to try more often...even though we had told him that it was not possible to try more than once with our donor due to logistics – the GP did not seem to be very interested in helping and kept going on about straight couples.”

Gemma (48) describes a similar instance whilst seeking fertility treatment in which her and her partner felt undervalued and were not given sufficient information, “the one [consultant] we dealt with was very brusque and didn’t make much effort to explain or offer alternative treatments. Overall I felt like we were paying out money (over £11,000 over three years) and not taken very seriously. I think a heterosexual couple would’ve been treated better and with more concern for the consequences of childlessness.”

Keri (30) noticed the general lack of knowledge among healthcare providers of sexual health advice specific to LBWSW, “on finally completing the procedure the locum then proceeded to give us sexual health advice – for HETROSEXUAL COUPLES AND WOMEN.” Another participant, Amy (47) noted an instance in which her and her partner were surprised to find that, in the course of their quest to have children, “we were given a print out of a document that would help a straight couple having problems having children, information included for example that ‘you should be having sex regularly’. This clearly does not relate to our situation at all!”

After having been assumed to be heterosexual by her healthcare provider, Rachel was surprised to find that when she asked for dental dams instead of condoms at her local health clinic, her practitioner did not seem to understand what she was talking about, “Again I was asked if I wanted condoms, and I responded with asking if I could have some dams instead. The nurse seemed confused and was unsure what they were and whether they had any.” Hannah (37) also noted having difficulty when trying to obtain dental dams, “I asked the nurse for some dental dams and she didn’t know what I was asking for - she’d never heard of them.”

Claire blames her negative experience of being given incorrect health information on the clinician’s lack of knowledge about LBWSW health, namely that LBWSW do not require cervical screen tests. Upon explaining that she had had sex with men as well as women in the past, the clinician relented and agreed to give her the test. Despairing about the fact that she was forced to take matters into her own hands in order to receive treatment, Claire noted that if her sexual history had been different, she may have been denied the test altogether, “I feel like she would have denied me a smear test if I had only had relationships with women.”

Joanna (30) experienced a similar incident of being told that she did not require a cervical screen test which shows a lack of knowledge from her healthcare provider about LBWSW healthcare needs. Having already made an appointment to get a screen test, Joanna was told that a test was not necessary given that she was a lesbian. Although she was given the test eventually, Joanna notes that “I just felt she [the physician] needed to be more knowledgeable on the subject.”

Diane (30) also reported receiving inaccurate information about whether or not she could benefit from undergoing cervical screenings. She explains that “my GP didn’t advise me of my risk level, she just made a number of blanket statements.”

Experiences these may explain why LBWSW are less likely to access sexual health services than heterosexual women, particularly cervical screen tests. A report conducted by Stonewall revealed that “fifteen per cent of lesbian and bisexual women over the age of 25 have never had a cervical smear test, compared to seven per cent of women in general. One in five who have not had a test have been told they are not at risk” (Hunt and Fish 2008). For those LBWSW who do choose to access sexual health services, they are often forced to make the decision whether or not to come out to their healthcare provider in the middle of the internal examination. Already feeling vulnerable, these cases of bad timing can result in women keeping their sexual orientation hidden; Stonewall’s research also found that “half of lesbian and bisexual women are not out to their GP” (Hunt and Fish 2008).

## **Appropriate Treatment, Advice and Knowledge based on Gender Identity**

Donna detailed two different experiences in which her health practitioner lacked knowledge of trans issues. In one case, the fact that she was trans did not appear to be acknowledged by her clinician, “I explained my full history to him and he then did a very thorough examination internally. After finishing, and bearing in mind I had given him my history, he actually asked me about my periods. My girlfriend of the time, who was with me, suggested maybe we should have a different doctor.” On another occasion, she explains that, “I was scheduled for a small bit of surgery and was asked to give a pregnancy test. I pointed out that I was not only a gay woman but also post-op male-to-female trans. The reply was ‘Well, best to be sure.’”

Laura (30) describes an incident in which her gender identity was completely disregarded by her healthcare provider, “in 2008 I had knee surgery and woke up on a male ward - clearly they had looked at my face and overruled my notes.”

## **Responses to Partners**

Research suggests that how LBWSW’s health practitioners react to their patients’ female partners plays a large role in determining the patient’s perception of the quality of the service they received. In many instances, female partners of LBWSW are ignored or referred to as the patient’s “friend” even in instances where women communicated that they did not want their partner to be addressed this way. This failure to take into account the wants and needs of LBWSW is apparent in many of the case studies described below.

Angela (36) detailed an experience in which she was met with hostility upon requesting that her partner be acknowledged as such in her medical records, “first she [the receptionist] refused to put down my partner’s name as partner/next of kin, kept saying, I’ll just put friend. I said, no, I want you to put partner and she looked at me all lips pursed and said, I’ll just put friend.” Keri (30) described a similar experience, “on the day, the locum firstly ignored my introduction as ‘partner’ and continued to call me ‘friend’ for the rest of the session.” Julia (37) also described an experience where her female partner was consistently referred to as her friend, despite the fact that, “it was documented throughout my medical records that my partner was a female and she was registered as my next of kin.”

Conversely, many respondents reported being pleasantly surprised and reported having a positive healthcare experience overall when their partner was acknowledged appropriately by their healthcare provider. Sue (28) explained that, “I was initially worried about how they would react when I said ‘partner’ when they discovered she was female. However, the receptionist didn’t react in any way.” Hayley likewise considered herself lucky that, “I don’t think I have ever had my female partner dismissed or ignored.”

Kati (62) reported that she had generally had good experience of visiting the GP but highlighted one specific visit when she had a trainee in the consulting room with her. “Following my lead she (the Dr) was open about discussing my family situation with the trainee - i.e. my partner and our two children. It made me feel recognised as a lesbian in a long-term lesbian relationship with two adult children.”

# Recommendations

## Recognition

- ▶ Health and Wellbeing Boards and Directors of Public Health should ensure that the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and other supporting strategies explicitly consider the needs of LBWSW. Where no local data is available, national and international evidence should be used.
- ▶ Healthcare services should consider the stigma and discrimination associated with lesbian and bisexual identities, and actively address attitudes or behaviour from staff and service users that is homophobic, biphobic, transphobic, heterosexist or cissexist.
- ▶ Employers should explore ways to encourage LGBT staff to feel supported and included at work, e.g. LGBT staff networks and equality champions.

## Engagement

- ▶ Commissioners and providers of healthcare services should ensure that LBWSW are actively engaged with in the process of design, commissioning, delivery and monitoring of services as active participants in their own healthcare.
- ▶ Healthcare providers and Healthwatch should ensure that LBWSW are included in patient representative groups, including targeted recruitment if needed.
- ▶ Commissioners and providers of healthcare services should work with local LGBT organisations to facilitate their involvement in consultations, and consider co-production approaches to better meet LBWSW's needs

## Monitoring

- ▶ Commissioners of healthcare services should include a requirement in contracts for service providers to monitor the sexual orientation of service users, and make use of the data collected to improve the design of services for LBWSW. Sexual orientation monitoring will be standardised throughout the healthcare system from April 2017, better enabling uptake of this recommendation.
- ▶ Healthcare service providers should monitor the sexual orientation of service users, and make use of the data collected to improve the delivery of services to LBWSW. Providers should ensure that all staff are comprehensively trained on how to monitor sexual orientation and to communicate about it to staff.

## Service provision

- ▶ Commissioners of healthcare services should consider the specific needs of LBWSW when designing and commissioning healthcare services. Commissioners should also assess whether mainstream services they have commissioned are accessible to and appropriate for LBWSW.
- ▶ Commissioners of healthcare services should consider the provision of specialist services, where appropriate, to address specific LBWSW health care needs. Co-production approaches working with local LGBT organisations should be considered to better meet LBWSW's needs.
- ▶ Healthcare service providers should ensure that staff receive comprehensive training on LGBT issues, including the specific needs of LBWSW. Training should also include communicating in a non-discriminatory way, without making assumptions about sexual orientation, to create a safe and respectful environment for everyone.
- ▶ LGBT organisations in the voluntary community sector should consider how to target their services specifically to LBWSW including providing specialist support where possible.

# Appendix - Online survey participant demographics



## Gender

96% of respondents identified as women. 4% identified their gender as other, which included queer, unspecified, butch dyke, and gender neutral/non-binary.

**Table 1: Gender identity**

| Gender identity | Count      | Percentage |
|-----------------|------------|------------|
| Yes             | 88         | 87.1       |
| No              | 13         | 12.9       |
| <b>Total</b>    | <b>101</b> | <b>100</b> |

**Table 2: Sexual orientation**

| Sexual orientation | Count     | Percentage |
|--------------------|-----------|------------|
| Gay                | 10        | 10.2       |
| Lesbian            | 56        | 57.1       |
| Bisexual           | 22        | 22.4       |
| In another way     | 11        | 11.1       |
| <b>Total</b>       | <b>99</b> | <b>100</b> |

The respondents who chose “in another way” were given a free text box to describe their sexual orientation. The most common term used was queer.



**Table 3: Age**

| Age          | Count     | Percentage |
|--------------|-----------|------------|
| Under 16     | 1         | 1.1        |
| 16-21        | 6         | 6.4        |
| 22-25        | 13        | 13.8       |
| 26-30        | 13        | 13.8       |
| 31-35        | 19        | 20.2       |
| 36-40        | 8         | 8.5        |
| 41-45        | 13        | 13.8       |
| 46-49        | 4         | 4.3        |
| 50-55        | 8         | 8.5        |
| 56-60        | 3         | 3.2        |
| 61-65        | 4         | 4.3        |
| 66+          | 2         | 2.1        |
| <b>Total</b> | <b>94</b> | <b>100</b> |

**Table 4: Religion or belief**

| Religion or belief                       | Count     | Percentage |
|--|-----------|------------|
| No religion (incl. Atheist and Agnostic) | 58        | 64.4       |
| Christian (incl. all denominations)      | 19        | 21.1       |
| Other                                    | 2         | 2.2        |
| Buddhist                                 | 4         | 4.4        |
| Jewish                                   | 3         | 3.3        |
| Humanist                                 | 0         | 0.0        |
| Muslim                                   | 3         | 3.3        |
| Hindu                                    | 0         | 0.0        |
| Sikh                                     | 1         | 1.1        |
| <b>Total</b>                             | <b>90</b> | <b>100</b> |

**Table 5: Ethnicity**

| Ethnicity group                             | Count     | Percentage |
|---|-----------|------------|
| White British                               | 75        | 79.8       |
| Other White Background                      | 9         | 9.6        |
| White Irish                                 | 3         | 3.2        |
| Mixed White and Asian                       | 1         | 1.1        |
| Black or Black British African              | 1         | 1.1        |
| Asian or Asian British Indian               | 1         | 1.1        |
| Asian or Asian British Pakistani            | 1         | 1.1        |
| Mixed White and Black African               | 1         | 1.1        |
| Any other Asian or Asian British Background | 1         | 1.1        |
| Other                                       | 1         | 1.1        |
| Mixed White and Black Caribbean             | 0         | 0.0        |
| Other Mixed Background                      | 0         | 0.0        |
| Black or Black British Caribbean            | 0         | 0.0        |
| Any other Black or Black British background | 0         | 0.0        |
| Asian or Asian British Bangladeshi          | 0         | 0.0        |
| Chinese                                     | 0         | 0.0        |
| <b>Total</b>                                | <b>94</b> | <b>100</b> |

**Table 6: Disability**

| Do you consider yourself disabled? | Count     | Percentage |
|------------------------------------|-----------|------------|
| No                                 | 61        | 75.3       |
| Yes                                | 20        | 24.7       |
| <b>Total</b>                       | <b>81</b> | <b>100</b> |

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The National  
  
LGB&T Partnership

**LGBT**  
foundation

  
stonewall  
housing

  
**METRO**  
Embrace Difference

  
**consortium**  
of lesbian, gay, bisexual & transgendered  
voluntary and community organisations

  
gires

**GMFA**  
the gay men's health charity

**biUK**

**friend** LONDON



**elop**   
promoting health and wellbeing

**GADD**



Birmingham **LGBT**

**Yorkshire  
MESMAC**

GROUP OF SERVICES