The National LGB&T Partnership

Let's Break the Silence:

A Guide to Lesbian, Bisexual and Trans Women's Health

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Introduction

The National LGBT Partnership was established to reduce health inequalities and challenge homophobia, biphobia and transphobia within public services

The Partnership combines the expertise of ten key LGBT organisations across England, who have a long history of service delivery, working with LGBT people both locally and nationally. The Partnership acts as a catalyst and connector, putting LGBT people and their issues firmly on the agenda of a wide range of decision makers.

The Partnership is a Sector Strategic Partner of the Department of Health, Public Health England and NHS England, collaborating with a wide range of organisations as part of the Health and Wellbeing Alliance. It has experience of successfully influencing policy, practice and actions of Government, statutory bodies, and others. Some of the key objectives of the Partnership are to reduce health inequalities faced by LGBT people, improve access to health and social care services for the LGBT community and ensure LGBT people's voices are heard, so that their lived experiences are used to inform people in

position of power and influence and in direct service delivery.

The National LGBT Partnership instigated LBT Women's Health Week in 2017. For five years the aim of the week has been to raise awareness of LBT women's health inequalities, and to support and empower service providers to address those needs. We continue to encourage organisations to consider what and how they are providing for LBT women, alongside celebrating and promoting LGBT groups and services which support LBT Women. During this week we celebrate existing activity to improve LBT women's health, encourage new activity to improve our health and share facts and expertise to raise awareness of the issues that affect LBT's women's health.

This year our theme of **Let's Break The Silence** for LBT Women's Health Week is about shining a light on the topics for LBT women that are seen as difficult to talk about, or potentially taboo. We are focusing this week on areas such as race inequalities, mental health, poverty, menstruation, pregnancy, the menopause, weight, cervical screenings, disability and domestic & sexual abuse to improve health outcomes for LBT women and non-binary people.

Whilst many of these areas can be difficult subjects for all, through the lens of being a lesbian, bisexual or trans women, or someone who identifies in some way as connected to being a woman, there can be particular nuances that mean different considerations to these areas need to be understood by health providers. Some of these areas are the reasons why LBT women are underrepresented in screening programmes or whose experiences of services mean they are reluctant to seek support. It is, for example, not uncommon for lesbians (who are not having sex with men and may have never had sex with a man) to be asked to take pregnancy tests when having specific treatments despite there being no possibility of being pregnant. Or lesbian or bisexual women who have conceived through the use of fertility clinics with a same sex partner being asked what contraception they are going to use. Or for trans women to not be given the relevant advice about what screenings they need.

For those who have experienced childhood abuse this is often seen as a "reason or cause" for their sexual orientation, again making additional barriers for people to seek help and support and to talk openly about their experiences.

The purpose of this guide is to provide information about key areas where the voices of LBT women is rarely heard, and provide facts and statistics showing the needs of LBT women and how best to address these. This guide is written for all health and social care providers in all sectors as well as for LBT women themselves. Throughout this guide we provide you with links to further resources and organisations that can support LBT women. This guide is focusing on LBT women generally although we have included a specific section focused Trans Women/Non-Binary people's health to recognise the specific needs of this group that may differ for cisgender women.

Case Example

"When I was in hospital overnight having a blood transfusion before an operation to stop excessive bleeding from fibroids, I was instructed to have a pregnancy test. When I said that I couldn't be pregnant as I was a lesbian and had my son via a fertility clinic, the nurse said they will not do the operation without it. She was so embarrassed that she told me about her nieces, both of whom were in same sex relationships – I think to make up for the fact that I was having to do the test and she did not want to be thought of as not understanding what I had told her."

(November, 2019)

LBT Women's Health Inequalities

LBT women experience high rates of poor physical and mental health compared to heterosexual women.

LBT women also experience disproportionately high rates of discrimination, harassment and domestic abuse, and face barriers to accessing support services. Some of the health inequalities faced by LBT women are:

• 27% of lesbians and 42% of bisexual women report a long-term mental health condition (NHS, 2019)

• Patients living with frailty were more likely than average to identify as gay, lesbian or bisexual, or to have selected 'other' (NHS, 2019)

• The teen pregnancy rate is higher for lesbian and bisexual women than for heterosexuals, with adolescent bisexual women being twice as likely as heterosexual adolescent women to become pregnant (Barker et al., 2012)

• 19.2% of lesbian women and 30.5% of bisexual women in one study reported an

eating disorder (Hunt and Fish, 2008).

• Prevalence of all cancers is higher in lesbians (4.4%) and bisexual women (4.2%) than heterosexual women (3.6%) (Saunders, Meads, Abel and Lyratzopoulos, 2017).

The National LGBT Survey (Government Equalities Office, 2018) **showed:**

16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and

38% had a negative experience because of their gender identity

80% of trans respondents who accessed or tried to access gender identity clinics said it was not easy, with long waiting times the most common barrier

40% of trans respondents who had accessed or tried to access public health services reported having faced negative experiences due to their gender identity

The inequalities lesbian, bisexual and trans women experience in healthcare extend beyond poor treatment. They are more likely to report long-term mental health problems than heterosexual women, and are more likely to binge drink, smoke, and be physically inactive. They also experience inequalities in relation to cancer outcomes, neurological and musculoskeletal problems, and asthma, and have higher rates of teenage pregnancies (Saunders, Meads, Abel and Lyratzopoulos, 2017). Due to a lack of gender identity/trans status monitoring there is limited research into health outcomes for trans women.

Currently the healthcare experience of lesbian, bisexual or trans woman is very much dependent on the individual clinician or healthcare worker in front of them. Previous research conducted by the National LGBT Partnership shows lesbian and bisexual women commonly have negative experiences in hospitals, sexual health clinics, primary care settings and mental health facilities, but have better experiences at dentists and in fertility clinics (National LGBT Partnership, 2017).

Doctors and GPs assuming they were heterosexual was one of the most common complaints lesbian and bisexual women reported in the Partnership's survey, alongside doctors and GPs seeming uncomfortable with their sexual orientation and often ignoring the fact that they had come out. Lesbian and bisexual women were frequently given incorrect information based on their sexual orientation or their gender identity. This research also showed that negative experiences are more prevalent for Black, Asian, and other minority ethnic (BAME) lesbian and bisexual women, who are more likely to be assumed heterosexual than their white counterparts; and lesbian and bisexual women who also identify as trans face additional discrimination such as being misgendered.

Negative experiences like these discourage lesbian, bisexual and trans women from seeking support and accessing healthcare services in the future, which endangers their overall health and wellbeing.

What would support LBT women is for health professionals to feel confident in having discussions with LBT women about their needs and experiences. To know what questions would be appropriate to ask and how to differentiate services where appropriate. This may mean that staff need to receive some training and to have knowledge of local resources available for LBT women. Monitoring your services for sexual orientation and gender identity will enable you to have a better understanding of your service user group. Having information that is reflective of LBT women in waiting rooms and other areas will provide a signal to LBT women that they are welcome and are held in mind.

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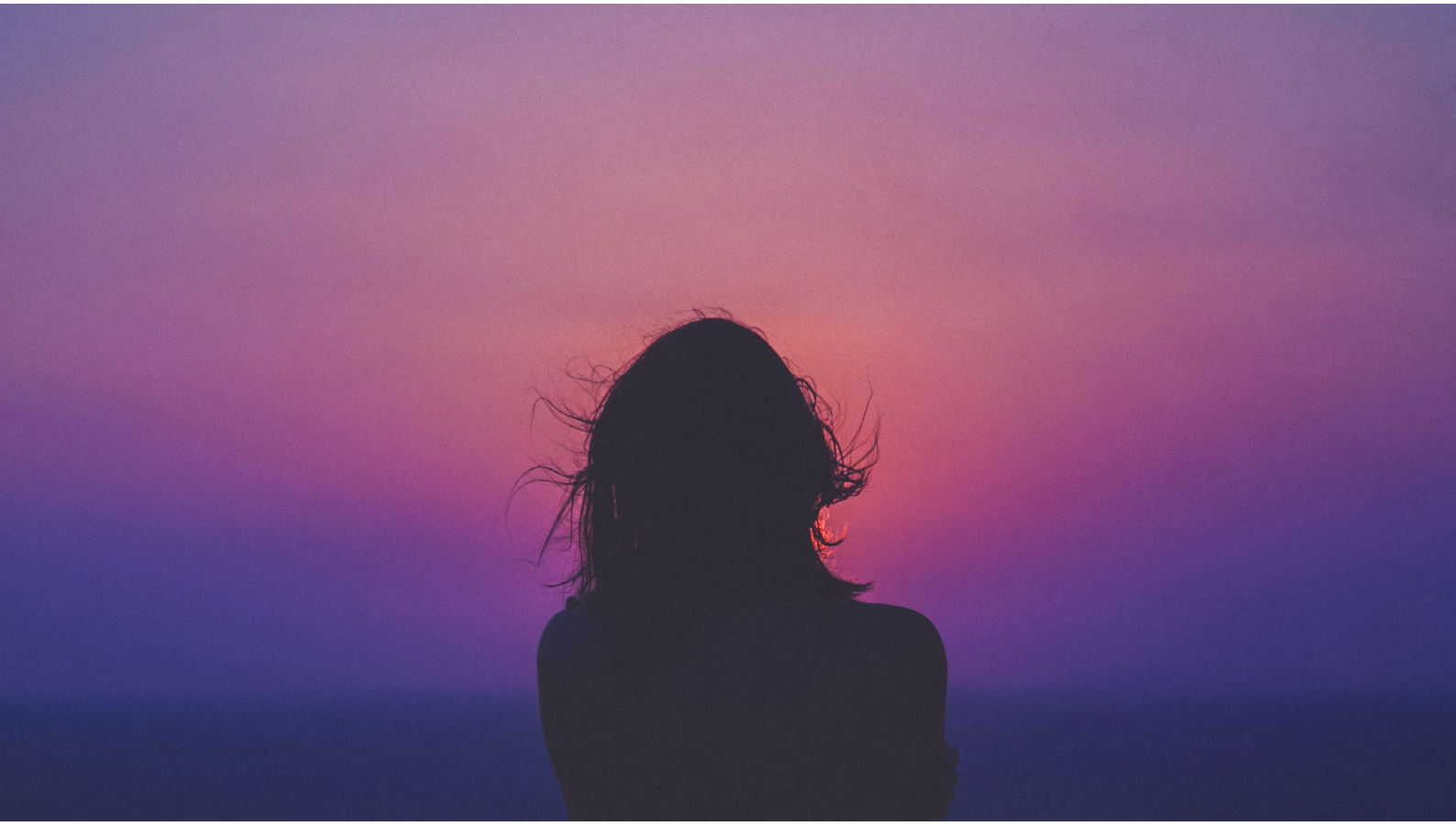


Mental Health

UK and international research has demonstrated higher prevalence of stress, anxiety and depression among lesbian and bisexual women.

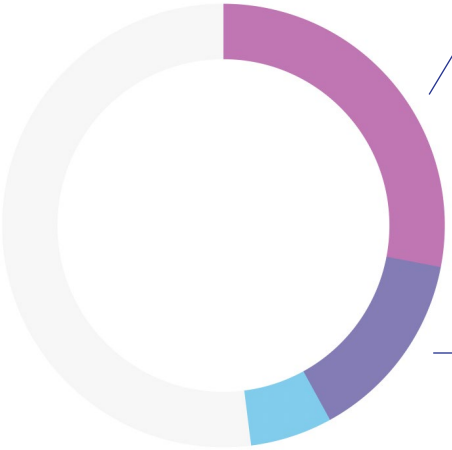
Population surveys have demonstrated consistently higher levels of mental health issues among lesbian and bisexual women compared to heterosexual women (Public Health England, 2018) and bisexual women have worse mental health compared to lesbian women (Public Health England, 2018). The Bisexuality Report (2012) links this difference to the experience of biphobia and bi-erasure, the invisibility of bisexual people.

Being lesbian, bisexual, or trans does not cause mental health difficulties in itself but instead these difficulties are impacted by growing up in a world that is not accepting of, and often hostile to, our identities. Minority stress, a repeated exposure to discrimination, of anticipation or fear of rejection, and of anticipation or fear of experiencing homophobia, biphobia and transphobia is a way of understanding this. For those with intersectional identities this is often enhanced.

The National Institute of Economic and Social Research (2016) report cites a range of studies pointing to higher prevalence of mental health issues amongst LGBT people than the general population in the UK. In the National LGBT Survey just under a quarter of respondents to the survey (24%) had accessed mental health services in the 12 months preceding the survey. This figure was higher for trans people (30% for trans women, 40% for trans men and 37% for non-binary people) and cisgender bisexual people (29%) (Government Equalities Office, 2018).

The National LGBT Survey also showed a higher prevalence of mental health issues amongst LGBT people, who are more prone to suicide attempts, self-harm, anxiety and depression than heterosexual and cisgender people. Long waiting times for a referral to Gender Identity Clinics also adversely affect the mental health of trans people. Trans respondents in the survey (36%) were much more likely than cisgender respondents (21%) to have accessed mental health services. Trans respondents (14%) were also more likely than cisgender respondents (7%) to have tried to access mental health services without success.

Here is a snapshot of some of known statistics about mental health in relation to LBT women:



28% of bisexual women and

14% of lesbians said they had deliberately harmed themselves in the last year

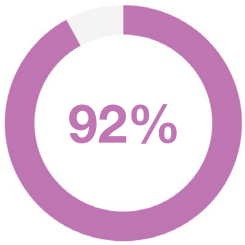
compared to around **6%** of adults in general (Stonewall, 2018)

• Transgender people have statistically higher rates of mental ill-health than their LGB counterparts (Williams et al., 2016)

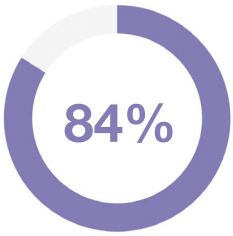
• Young people who experience transphobic, biphobic or homophobic bullying have worse mental health than those who have not experienced bullying (Stonewall, 2017)

• 19.2% of lesbian women and 30.5% of bisexual women reported an eating disorder. 8.5% trans respondents had received an ED diagnosis, while 19% believed they had one without diagnosis (McNeil et al., 2012)

92% of young transgender people have thought about suicide and

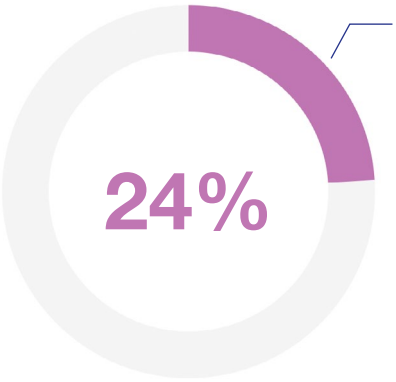


84% have self-harmed (Stonewall, 2017)



• 50.5% cis women and 53.5% trans women found accessing MH services “not easy” or “not at all easy” in the last year (Government Equalities Office, 2018)

• Lesbians are 1.38 times, and bisexual women 2.23 times, as likely as heterosexual women to be anxious or depressed (Semlyen, King, Varney and Hagger-Johnson, 2016)



of trans women felt their specific needs in relation to their gender identity were ignored or not taken into account when accessing healthcare in the last year (Government Equalities Office, 2018)

What would support LBT women is to know that healthcare practitioners have attended training to support them to have knowledge of the needs of LBT women. This training should support practitioners to gain confidence in communicating in a non-discriminatory way, without making assumptions about sexual orientation, to create a safe and respectful environment for everyone.

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Maternity and Pregnancy

The numbers of lesbian, bisexual and trans people having babies is largely unknown.

In the UK, data from fertility clinics (Darwin and Greenfield, 2019) and birth registrations show that that lesbian couples are one of the fastest growing groups within maternity services. The number of same-sex couple families has grown by more than 50% since 2015, with more than four times as many same-sex married couple families in 2018 (Office for National Statistics, 2019).

There is limited research in relation to pregnancy and maternity for lesbian and bisexual women. A systematic review showed that lesbian and bisexual adolescents are at greater risk of unwanted pregnancies and terminations (National Institute of Economic and Social Research, 2016) and adolescent bisexual women are twice as likely as heterosexual adolescent women to become pregnant (Barker et al., 2012). Lesbian women undergoing assisted reproduction have lower rates of previous pregnancies, but higher success rates compared to heterosexual

women as lesbian women have 'social', rather than medical infertility (Hodson, Meads and Bewley, 2017).

A US study found that sexual minority students are almost twice as likely to experience youth pregnancy and that it was often assumed that these students did not need reproductive education and their needs were ignored in the education provided. Stigma and discrimination, lack of support resources and fewer connections to school and family were additional factors that contributed to increased risk of pregnancy amongst sexual minority students (Lindley and Walsemann, 2015).

A recent study showed that fear of childbirth is worse for LGBT people than straight cisgender people, due to fear of discrimination (Malmquist, Jonsson, Wikström and Nieminen, 2019). This study showed that for many lesbian and bisexual women and transgender people, trust never developed with healthcare staff. Whilst fear of childbirth is a common feature for all, there is an added dimension for lesbian and bisexual women and trans people, who are additional afraid of being questioned or facing discrimination because of their identity.

A review of studies in the US showed that homophobic or heteronormative assumptions and a lack of knowledge regarding the health needs of lesbian women may negatively impact lesbian women's experiences and interactions with their maternity healthcare staff (Gregg, 2018). Language used that is often heterosexist may marginalize same-sex couples. Negative experiences with healthcare practitioners may discourage lesbian women from obtaining necessary healthcare, including preventive care. Lesbian women can face lack of community and family support compared with their heterosexual counterparts that can impact on their journeys to becoming mothers. A common form of exclusion experienced by lesbian couples was the incidence of heteronormative exclusion, in which non-biological mothers were excluded from care because of their gender and assumptions about family makeup. Examples of this include healthcare providers asking about the father, referring to the biological mother's partner as her sister or friend as opposed to mother or co-parent. These situations led to feelings of exclusion and not being seen as a legitimate parent.

Often maternity records in the UK only have spaces for the expectant mother and the baby's father.

This presents difficulties for lesbian and bisexual women and trans people if this does not reflect their family. The numbers of those outside of the traditional model of a heterosexual couple having children has increased.

Research shows that perinatal depression is not less common and may be more common among lesbian and bisexual women relative to heterosexual women (Ross, Steele, Goldfinger and Strike, 2007). This may also be true for non-biological lesbian mothers (Abelsohn, Epstein and Ross, 2013).

There are many misconceptions about transgender pregnancies. A trans woman can not become pregnant unless she received a uterine transplant which has not yet been successfully performed in XY-subjects. There are often deep-seated assumptions that only women can be pregnant which means that trans men are often ignored in discussions on pregnancy. Many trans men are informed incorrectly by health professionals that taking testosterone will make them sterile, which can result in unplanned pregnancies or a lack of knowledge that a desired pregnancy is possible. One study has shown that up to 30% of trans man have had unplanned pregnancies (Brandt, Patel, Marshall and Bachmann, 2019).

Another 2019 study showed that trans men receiving in vitro had egg quality and quantity similar to cisgender women (Leung et al., 2019).

There is a serious lack of up-to-date and nation-wide research into lesbian and bisexual women, and other women who have sex reproductive health. The reproductive health needs and experiences of women who have sex with women are predominantly invisible. Research from a London fertility clinic suggests that 80% of lesbians, compared with 32% of heterosexual women had poly-cystic ovaries on ultrasound examination (Agrawal et al., 2004).

No assumptions should be made in relation to lesbian and bisexual women's desire or not to have children. Clinicians should provide appropriate information to all women, without assumptions about lesbian and bisexual patients' desire for, or rejection of, fertility and childbearing. Heterosexuality should not be assumed in young peoples' sexual and reproductive health services as, if anything, there are greater risks of unwanted pregnancy at this time for lesbian and bisexual women.

Healthcare staff need training in understanding minority stress and how this impacts on lesbian and bisexual women and trans people and should have better training on treating LGBT+ pregnant people. Healthcare staff need better knowledge in relation to trans healthcare at pregnancy and fertility.

"In our counselling session for fertility treatment we were asked "what would happen if we had a boy?" – it was worded like this, not "had we a gender preference?" – did we think we would find one gender easier to raise than another, which might be a question perhaps you would ask any would-be parents, but it felt like there was a clear message behind this question. We did have a boy – and when he was 17 months he needed a biopsy – and my partner signed the consent form which stated she had parental responsibility and the hospital refused to accept her signature on the form – we were highly anxious that we did not delay the procedure any longer as he had not eaten for hours so did not make a fuss and I re-signed the form – but it made us put on all his medical notes, in all hospitals where he has treatment, copies of the PR form so we are never in that situation again. Health visitors would ask us what they should write when we went for his check-ups as they did not know how to write both mums attended the clinic. However, we have had great A&E experiences when both nurses and doctors have just asked what our relationship is to our son, and then would say things like "Mums would you like to step this way?", just automatically accepting the situation and making it easy for our son."

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!"

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Trans Women

“I had to send three letters to my GP before they changed my name and title. The receptionist said they needed proof before they would change it, which I now know isn’t actually true they were just being unnecessarily difficult.”

- Christina

There is a lack of comprehensive research around the specific healthcare needs of trans women, as most work in this area focusses largely on trans people as a group. It is accepted that trans women navigating through the healthcare system can often be faced with unnecessary obstacles. A major barrier for trans people is the difficulties they face when trying to affect a name change on medical records. This can be particularly distressing for trans and non-binary people.

A gendered approach to healthcare often results in a lack of understanding around the medical needs of trans women, leading to decisions made, or not, about the care required. If a trans women has had a vaginoplasty, for example, she will still have a prostate and still require screening. Her doctor will need to understand this.

Evidence shows that there is a gap in the provision of screening as GP surgeries are

not always extending invitations to attend screening appointments to trans women and this, accompanied by a reticence from trans women to attend appointments due to fear of negative reaction, has an impact on diagnosis.

“I have never been for a sexual health screening. I tried once but the woman at reception asked me if I was a ‘man or a woman’ in front of a waiting room full of people, it was humiliating. I turned around and walked out of the clinic as fast as I could.”

- Kai

From a sexual health perspective, there is anecdotal evidence to suggest a likelihood that many trans women may at some point engage in sex work. This is, in some circumstances, due to barriers in gaining employment and the need to find money to access healthcare privately.

There is evidence to propose that trans sex workers may be nine times more likely than cis sex workers to be living with HIV. Given this, the HIV medication prescribed should be tailored to work alongside any hormone treatment underway.

Negative experiences will often result in a long-term reluctance to seek medical attention which in turn results in late diagnosis.

How To Help

Refer to your patient using their preferred name and/or title

If you don't know, ask your patient what pronouns they use

Respect your patient's request to change gender on their medical records – they do not need to provide a Gender Recognition Certificate or an updated birth certificate

Ask your trans patient how they would like you to refer to their body parts

Train your staff to avoid making assumptions – trans women's voices may sound masculine on the phone

Be informed of the kinds of medical support your trans patient may require

Have gender neutral toilets – a huge percentage of trans people are too scared to use public toilets for fear of backlash

Domestic Abuse

Trans women are more likely to experience verbal and emotional abuse from family members than cisgender women.

Lesbian and bisexual women's experience of domestic abuse may present as similar to those of heterosexual, cisgender women (coercive control, financial abuse, coerced isolation), but they require a specific and sensitive response in order to address intersectional inequalities that may compound an already traumatic situation.

Victims/survivors were most likely to disclose ongoing experiences of emotional and verbal abuse, which included name-calling and insults, lying, belittling, and undermining self-esteem, manipulation, threats of suicide and behaviours that constitute identity abuse, such as undermining gender identity or sexuality or threatening to out a partner. In the case of trans victims/survivors, deliberately misgendering, withholding medication or preventing treatment needed to express the victim's gender identity, for example, hormones or surgery (Magić and Kelley, 2018).

Sexual violence is often regarded as a heterosexual experience, usually perpetrated by a man to a woman, and lesbian and bisexual women have received inappropriate responses when reporting upon it.

In 2018 LGBT Foundation Women's Programme created the Sexual Wellbeing Survey aimed at addressing the glaring lack of data around the sexual needs and desires of lesbian and bisexual women (Cunningham, 2020). They analysed 1,896 responses. One of the survey's questions was:

Have you ever experienced sexual violence?
59% of the survey base answered this question and, of those:

42% said that they had experienced sexual violence

8% were unsure

From this concerning percentage people from certain minority groups were disproportionately more likely to have experienced sexual violence, this includes:

55% of people from any Asian background and

52% of people from any Black background compared to

42% of people from any white background

"In order to receive support for sexual violence, I (and we as a society) need to be believed that to be raped by a woman is rape… I would not feel able to access support until this is given the same level of disgust, intolerance and sympathy that penis rape gets. To be told "oh but you weren't actually raped, just assaulted" is really insulting and devalues everything."

From the survey, of those who had experienced sexual violence, just 7% said their need for support was met by the service they accessed.

It is clear that the mainstream support systems in place make little provision for lesbian and bisexual women's specific experiences with some services not recognising it as a legitimate concern.

From the wider LGBT+ community it is estimated that 60% to 80% of LGBT+ victims/survivors have never reported incidents to the police or attempted to find advice or protection from services (Hunt and Fish, 2008).

How To Help

If a patient is disclosing domestic abuse or an experience of sexual violence don't assume that the perpetrator is a man

Have an appropriate referral route to offer: there is provision available for:

- Free one-to-one counselling
- Advice and safety planning
- Housing advice, including options on finding safe accommodation
- Support and assistance when dealing with the police and criminal court system
- Advice on child safety and child contact issues

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Substance Use

Substance use is four times higher among lesbian and bisexual women compared to heterosexual women.

Despite this, there is a deficit of research relating to the needs of LB+ women and barely any studies focusing solely on substance use among trans women.

Substance use primarily refers to recreational drugs, which can be taken with or without alcohol. It is estimated that:

29% of lesbian and bisexual women binge drink compared to only

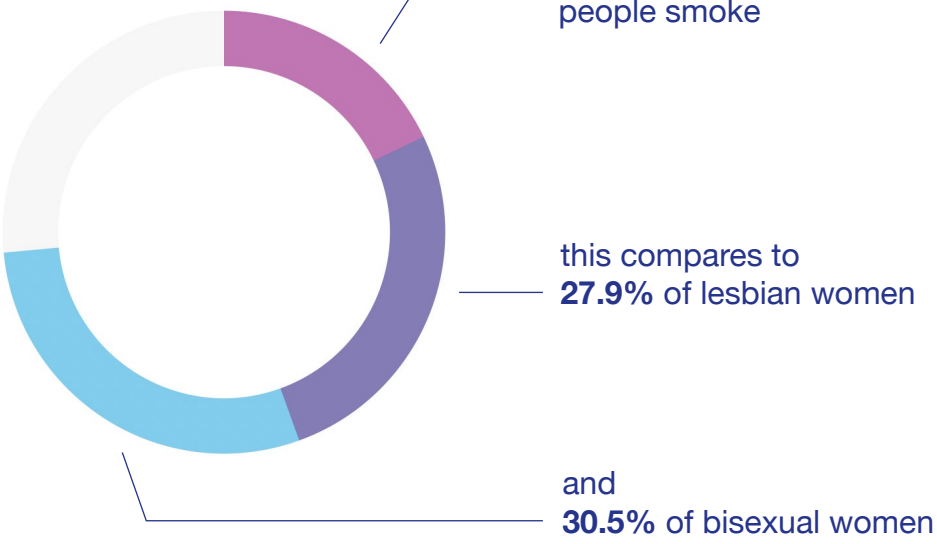
12% of heterosexual women

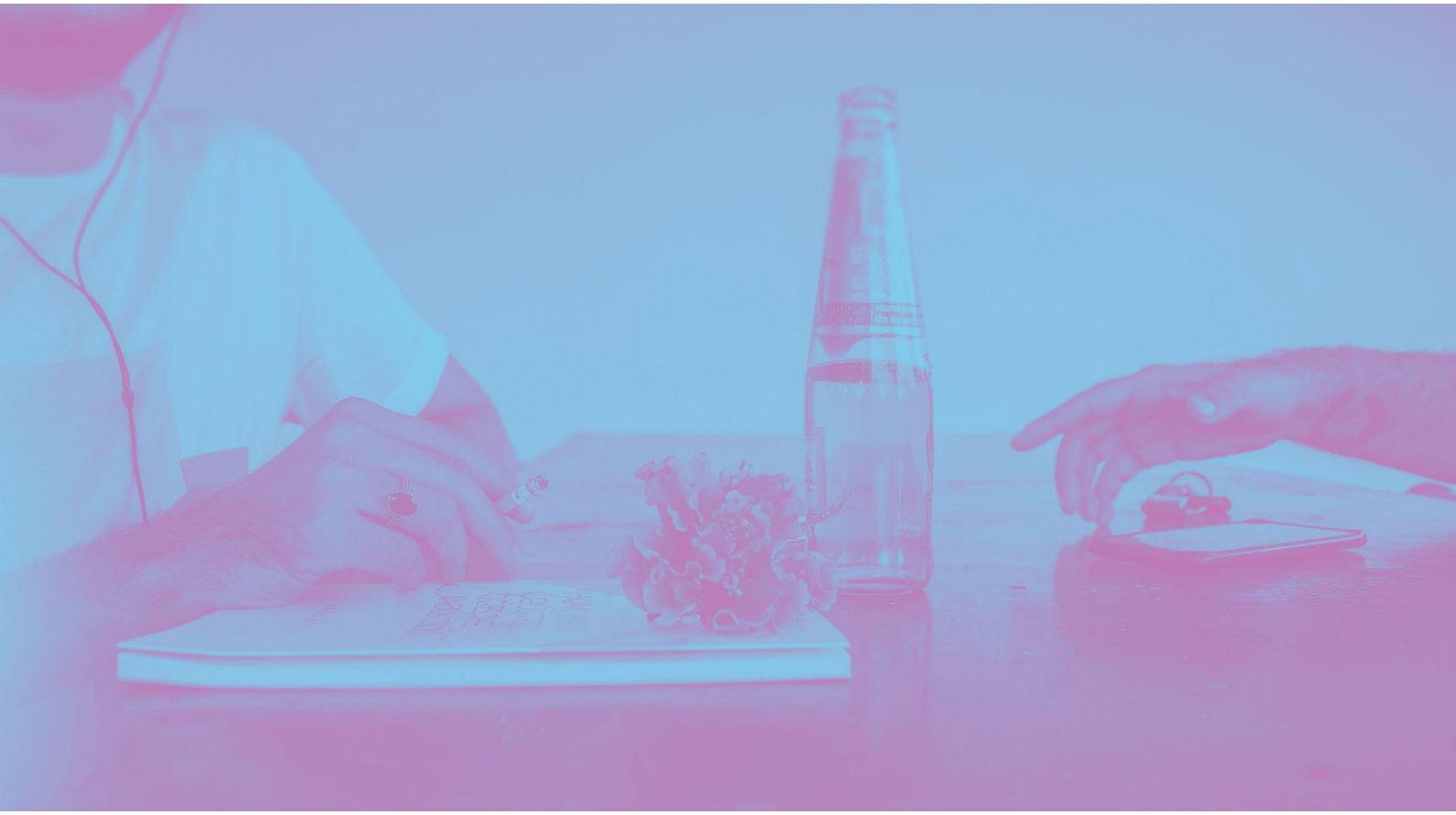
A 2012 study into trans health found that:

62% of trans people were either abusing alcohol or categorised as alcohol dependent.

Bars and clubs pose a considerable risk for LB+ women as they are, and have historically been, the safe spaces for LGBT people to meet and connect with others within the community. In turn, concerns regarding social isolation and lack of community is one of the reasons why LB+ women may be reticent to disengage from alcohol and substance use.

Smoking rates are significantly higher among the LGBT population:





How To Help

There are LBT-specific services that offer ongoing support.

LGBT Foundation has on online drug and alcohol intake questionnaire to help people to recognise and measure their substance use:

You can find a copy of the drug intake questions here.

You can find a copy of the alcohol intake questions here.

Cervical Screening for Lesbian and Bisexual Women

Between 2010 and 2013, LGBT Foundation* spoke to thousands of lesbian and bisexual women about their attitudes, experiences and uptake of cervical screening.

*(in association with the University of Salford and the NHS National Cancer Screening Programmes)

51% of LB women of an eligible age had either never had a test, or hadn't had one within the recommended timescales

40% of all the LB women in the study had been told they did not require a test due to their sexual orientation. This directly resulted in over half of them disengaging from screening programmes, believing they were not at risk

14% of the women spoken to had been refused a test or actively discouraged from having a test by a healthcare professional

In 2009, NHS guidance on cervical screening for women who have sex with women changed – they became included in the 25-64 year old national recall.

This means that as little as eleven years ago the medical profession did not consider women who have sex with women to be at risk of cervical cancer, and the effects of this still

impact upon cervical screening attendance rates from lesbian and bisexual women. Many of the lesbian and bisexual women surveyed for the LGBT Foundation report said that healthcare professionals asked inappropriate questions or reacted negatively on learning of a woman's sexual orientation.

"When attending a smear test I felt a lot of pain, as the GP surgery knows I have kids it was commented "you've been through more pain than this you have kids." Which meant whilst in the agony of the test I had to explain I was in fact gay and my wife gave birth to my children. Not a great discussion when in such a vulnerable and painful position."

One factor which could be contributing to coverage being lower may be that people who don't have penetrative sex may find the procedure more uncomfortable and invasive. To reduce this discomfort, lesbian and bisexual women may need a smaller speculum, however they may be reluctant to discuss this.

For the full report of the **'Are You Ready For Your Screen Test?'** project visit: www.lgbt.foundation/women/resources

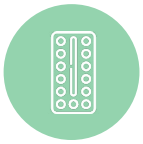
How To Help

What questions do you normally ask someone in a routine consultation or before, during and after a cervical screen?

Do any of them assume heterosexuality?

Are you offering people the option to come out if they want to?

Try to ask questions that are open to all sexual orientations. **For example:**



If a woman says she is sexually active, don't automatically assume that this is with a man or means she will need contraception

Avoid automatically ascribing gender to a woman's sexual partners. You can ask **'What gender are your sexual partners?'**

If you need to ask questions about sexual history, be clear about what you're asking. Questions such as 'are you a virgin?' can be unhelpful as it's not clear whether the person is being asked if they've never been sexually active or if they've just never been sexually active with a man.

Improving the Lesbian and Bisexual Healthcare Experience

It is still quite common for healthcare professionals to believe that lesbian health is the same as women's health

and this position removes the need to consider the identity or sexual orientation of the person seeking medical advice.

It may appear to be a small thing, but for many lesbian and bisexual women the thought of dealing with the heterosexual assumption, and the subsequent awkward conversation required to correct it, has led to a reluctance to seek out medical assistance.

Your lesbian or bisexual patient may have experienced a negative reaction before they reach you – they may have been misgendered by your administration staff for example – and so they may already be anxious before they take a seat.

How To Help

Avoid the assumption of heterosexuality

Avoid common assumptions about lesbian and bisexual women (e.g. that lesbians have never had or don't continue to have sexual relationships with men).

Use gender-neutral words such as "partner" to facilitate disclosure

Specifically encourage disclosure of sexual identity, orientation and behaviour if they are relevant to the health issues presented

Be willing to involve partners in decision-making

Be aware of additional barriers that increase stigmatisation, including ethnic minority status, disability, age, or economic status

When taking a sexual history, be aware of the fluidity of identity and sexuality (e.g. the gender of your patient's partner may change)

If talking to a trans patient, ask how they would like you to refer to their body parts

It is all our responsibilities to ensure that lesbian, bisexual and trans women feel comfortable accessing healthcare and are treated with respect, dignity, and warmth when they do so.

For more information on LBT health, and to explore the work we've done for LBT Women's Health Week in previous years please visit: https://www.consortium.lgbt/nationallgbtpartnership/