

Lesbian, and Bi+ Women's Experiences of Reproductive Health and Fertility Services in Scotland



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Introduction

In 2019, The Equality Network conducted a survey focusing on the experiences of reproductive health and fertility services of the LGBT population in Scotland. The survey had over 700 responses.

We found that experiences were very different for cis [see note on language below] lesbian and Bi+ (LB+ women), and for trans respondents. For that reason, we have written two reports: one looking at cis LB+ women's experiences and another looking at trans people's experiences. This report looks at the experiences of the 338 cis LB+ women who responded.¹ Of course a significant number of respondents were both trans and LGB+, and their experiences are included in the trans report.

A note on language

In this report we will use the term "LB+ women" to describe all of the respondents to the survey who were cis women who were not heterosexual/straight.

Some of these respondents may have described their sexual orientation in another way, such as 'queer' or 'pansexual'. Where we are referring to specific groups of women — e.g. queer women, lesbian women, or bi women, we will make this clear.

In this report we use the term 'cis' to refer to people whose gender fully corresponds with the sex assigned to them at birth, if it is important to be able to discuss the differences in experiences of trans people and people who are not trans.

This report will qualitatively explore our findings about contraception use, cancer screenings, pregnancy and pregnancy services, fertility treatment, fertility and the law, surrogacy, breastfeeding and abortion services. It will also discuss recommendations for these service providers on how they can better include LB+ women.

¹ Cis gay and bi+ men were included in the survey, although they experienced many fewer inequalities and difficulties than cis LB+ women and trans people of all genders. This is why our two reports focus on these latter two groups.

Demographics

Below is demographic information about our respondents. Percentages have been rounded, so may total more than 100%.

Sexual orientation

All respondents answered this question, and could select more than one term to describe their sexual orientation. Respondents described their sexual orientation as:

Asexual	1%
Bisexual	32%
Gay	8%
Heterosexual/straight	1%
Lesbian	53%
Pansexual	7%
Queer	11%
Prefer not to say	2%
In another way	1%

People with a variation of sex characteristics/intersex people

336 respondents answered the question “Do you consider yourself to be a person with a variation of sex characteristics (VSC) or an intersex person?” Responses were:

No	98%
Unsure	2%

Age

266 respondents answered this question. Respondents were aged:

18-24	15%
25-34	39%
35-44	35%
45-54	9%
55-64	2%
65-74	0.5%
Prefer not to say	0.5%

Ethnicity

266 respondents answered this question. Respondents described their ethnicity as:

African, African Scottish or African British	1%
Black, Black Scottish or Black British	1%
Chinese, Chinese Scottish, or Chinese British	1%
Any other Asian, Asian Scottish, or Asian British ethnic group	0.5%
White Scottish	63%
White British/English/Northern Irish/Welsh	21%
White Irish	0.5%
White Polish	1%
Any other White Ethnic Group	9%
Any other ethnic group	1%
Mixed or multiple ethnic groups	2%

Disability

266 respondents answered the question “Do you consider yourself to be disabled, or to have a long term health problem?” Responses were:

Yes	26%
No	73%
Unsure	0.5%
Prefer not to say	1%

Religion or belief

264 respondents answered this question. They described their religion or belief as:

No religion	62%
Atheist	13%
Buddhist	3%
Christian	10%
Humanist	2%
Jewish	2%
Prefer not to say	3%
Any other religion or belief	6%

Key Findings

Contraception use

Despite contraception generally being marketed for pregnancy prevention, it is also prescribed to treat various health conditions such as painful periods and acne.

Research has shown that bi women are more likely than women with other sexual orientations, including heterosexual women, to use long-acting reversible contraception (LARC), such as the contraceptive implant or the intrauterine device (IUD).²

Amongst our respondents, lesbian women were the least likely to use contraception. This mirrors other research that has found, perhaps unsurprisingly, low contraceptive use amongst lesbians.³

The most common reason to use contraception was to avoid pregnancy. However, using contraception to manage a health condition was also cited by a number of respondents, and was particularly high for lesbian respondents.

² Charlton et al., 2019. “Contraceptive use by women across different sexual orientation groups”. <https://www.ncbi.nlm.nih.gov/pubmed/31082396>

³ Ibid.

Managing menstruation was a significant concern for LB+ women and the majority of respondent's comments related to this when asked why they use contraception:

I suffered from horrific periods all throughout my teenage years that left me bed-ridden and addicted to opiate painkillers. I got the hormonal coil inserted to stop my periods and it has.

I experience bad PMS so using hormonal contraception helps me to track it easily and manage the irregularity.

I'm a sex worker so find condoms to reduce risk of STIs vital.

When asked whether their sexual orientation or gender identity had affected experience of using or accessing contraception, participants told us that they often faced prejudice:

[I] always get a slightly funny look when staff see my sexual orientation is queer, but I'm asking for contraception. Queer women use contraception too!

Received queries as to why contraception is required after changing GP (after explaining that I am in a long-term lesbian relationship).

At an outpatient appointment, the gynaecologist kept referring to my wife as "my friend" despite me introducing her as my wife.

The majority of LB+ women did not feel that their sexual orientation or gender identity had affected their experience of obtaining contraceptives. However, half of lesbian respondents did feel that their sexual orientation or gender identity affected their experience of obtaining contraceptives.

LB+ women were mostly satisfied with their experiences of contraception related services; however, bi women were the most dissatisfied. Some shared their experiences:

It is a shame how ill-informed staff at sexual health clinics can be about bisexuality and polyamory.

[There is] no understanding of same sex relationships.

Requiring my spouse to give permission for me to be sterilised is unacceptable.

[I] have been accused of sleeping around by a doctor in a sexual health clinic. It was altogether an uncomfortable experience where whatever I said was taken as a joke.

When I have taken emergency 'morning after pills' previously, I found pharmacists to be quite cagey and stressed about it.

Experiences of pregnancy and pregnancy services

LB+ women experience a full range of family planning outcomes including, for those that can conceive, both intended and unintended pregnancy. Legal, societal, and medical advances have enabled increasing numbers of LB+ women to build their families in ways they choose, including assisted and non-assisted reproduction.

Of those who answered our survey, bi women were the most likely to have had a pregnancy before their 18th birthday amongst those that had been pregnant. Other research has found that there is a statistically significant higher rate of pregnancy in adolescent lesbian and bi women, with bi adolescent women twice as likely to become pregnant compared to heterosexual adolescent women.⁴ Of all those LB+ women who said yes to having had an unplanned pregnancy, most were bi, followed by lesbian. Some who identified as being queer or having another sexual orientation also said that they had had an unplanned pregnancy.

Respondents were asked to give details if they felt comfortable doing so. Several comments related to sexual assault and rape as the cause of the unplanned pregnancy.⁵ This reflects the high levels of sexual

⁴ Public Health England, 2018. “Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women”. <https://www.gov.uk/government/publications/health-and-wellbeing-of-lesbian-and-bisexual-women-lbws>

⁵ If you have experienced sexual violence or rape, and would like to access support, you can call the Rape Crisis Scotland Helpline every day, between 6.00pm and midnight, on 08088 01 03 02: <https://www.rapecrisisscotland.org.uk/help-helpline/>

violence experienced by LGBT+⁶ people. Our Scottish LGBTI hate crime report (2017) found sexual assault to be the fifth most prevalent form of hate crime experienced by LGBTI people.⁷

Out of all those who felt that their sexual orientation or gender identity affected their experience of pregnancy, lesbian women reported this at the highest rate.

Comments on this experience:

I am a queer cis woman and my partner is a trans man. As such, we appear to be a heterosexual couple. Being pregnant and having a child emphasises this and increases assumptions regarding sexuality and marital status.

Healthcare professionals who deal with pregnancy are very heterocentric in their language and assumptions.

To conceive a child — i.e.: access IUI services via the NHS, I was subjected to a long waiting list, but, because of my age, I was concerned about the length of the wait for an NHS consultation (years) and had to self-fund my conception privately. I had to take out a loan (which I'm still paying back to do so).

⁶ Galop, 2018. "LGBT+ people's experiences of domestic abuse". https://galop.org.uk/wp-content/uploads/2021/05/Galop_domestic-abuse-03a-low-res-1.pdf

⁷ Equality Network, 2017. "Scottish LGBTI hate crime report 2017". https://www.equality-network.org/wp-content/uploads/2017/10/en_hc17-full_final1alores.pdf

When my female partner and I first went along to the Glasgow Royal Infirmary assisted conception unit we were “interviewed” by one of the consultants and asked what male role models our baby would have. We seemed to pass the test and we were allowed to be added to the waiting list.

Bi pregnancy and parenting experiences are rarely acknowledged, even within research on LGBT families. Bi parents are often conflated with lesbian and gay parents in research samples and/or are only included if they are in a same sex parenting relationship.⁸ There can be important differences in experiences of discrimination between, for example, a lesbian and a bi parent within a family. More research is needed on bi pregnancy and parenting experiences.

Reasons for dissatisfaction with pregnancy services included:

During the antenatal class the leader kept saying “men and women” and “guys and girls”. I felt really left out as a female spouse and birth partner. I didn’t interrupt the class but I looked upset and the straight couples around me rolled their eyes. I couldn’t really focus on what was going on because I felt so embarrassed and left out. My wife talked to the leader after and she said she knew she was supposed to use inclusive language but keeps forgetting. It was a small class — how could she forget when we were right in front of her?

⁸ Ross and Dobinson, 2013. “Where is the “B” in LGBT parenting? A call for research on bisexual parenting”. <https://psycnet.apa.org/record/2012-30040-006>

The midwife could not comprehend that my female partner was in actual fact my partner and not just my “birthing partner”. When I pointed to my partner and said her name, she asked and said to me, twice, “No no, not your birthing partner, your partner or husband?!”. Following this she went on to say that we shouldn’t worry because one of the midwives was “like us”. It was dreadful, this was our first child together, and we were already worried about the midwives’ perceptions. My partner and I did not attend any antenatal classes, and I attended all my antenatal appointments on my own because of this experience.

Post-birth on the ward when my wife had recently given birth I was made to feel dismissed and excluded by ward staff. I was holding our new baby in a quiet area of the ward following a hearing test when I was told to take the baby back to its mother! The nurse then proceeded to wake my wife to ask if she knew where our baby was. There was a lot of equal and non-discriminatory treatment but these incidents undermine the positive experience and led to us discharging ourselves from hospital early.

A significant proportion of respondent comments related to homophobic and sexist discrimination experienced by same sex female couples at antenatal classes and antenatal midwife appointments. The findings indicate a crucial need for inclusive and affirmative language use in pregnancy services. Several respondents reported deliberately not attending antenatal classes and self-discharging from hospital to avoid discrimination related to being two mothers in a same sex parenting relationship. Such avoidance mechanisms could potentially have negative health implications for both parents and children.

Breastfeeding

The majority of LB+ women who had carried a pregnancy to term breastfed and others reported trying breastfeeding but having difficulties.

Respondent's comments largely related to a general lack of lactation support, rather than being connected to sexual orientation. More research is needed on access and barriers to lactation support for LB+ women.

Consideration must be given to equalities competency and awareness in developing and providing this support to new parents who are breastfeeding or wish to breastfeed.

Though satisfaction appeared high with experiences of breastfeeding, some respondents also told us of their dissatisfaction with their experience.

I didn't really advertise how I was feeling to health professionals. I didn't trust that they would understand. My friend who was breastfeeding her older baby came and showed me some tips, and my wife provided emotional support. I got through. It was scary though.

Abortion services

The LB+ women (and their partners) who had had an abortion did so for a range of reasons. These included those who did not want children at the time, and others who never wanted to have children. Some had an abortion because the pregnancy would have exacerbated health problems and others did so because the pregnancy was not in fact viable. A further group had an abortion due to feeling financially unstable and others due to relationship problems.

Some LB+ women had an abortion due to the fact that the pregnancy was as a result of rape. This reflects the high levels of sexual violence experienced by LB+ people highlighted previously.⁹

Reasons for having an abortion can be complex and interrelated, although inappropriate timing or planning, as well as financial status or low income, and broken or disruptive relationships, have been found to be common reasons for requesting a termination of pregnancy.¹⁰ ‘Other’ reasons for having an abortion included being too young, housing instability, experiencing domestic violence, and a partner not wanting to have a child.

Bi women were mixed on whether their sexual orientation or gender identity had affected their experience of having an abortion. None of the lesbian women who had had an abortion said their sexual orientation or gender identity had affected their experience.

⁹ If you have experienced sexual violence or rape, and would like to access support, you can call the Rape Crisis Scotland Helpline every day, between 6.00pm and midnight, on 08088 01 03 02: <https://www.rapecrisisscotland.org.uk/help-helpline/>

¹⁰ Wokoma et al., 2014. “Reasons provided for requesting a termination of pregnancy in the UK”. <https://www.ncbi.nlm.nih.gov/pubmed/24916478>

All respondent comments related to dissatisfaction with abortion services. They included:

After the abortion I was asked if it was ok with me if trainee doctors came in... they had me squat and insert a cap in front of everyone to prove I knew how to do it. Unacceptable. The aftercare was horrific and deliberately shaming and it took a long time to ever mention it again.

I feel I was treated like I was doing something wrong. The staff, one in particular, was cold and harsh in manner when it was already a difficult time.

Fertility treatment

The majority of LB+ women said they would like to have a child in the future, with some answering no and some undecided. Lesbian respondents were the most likely to report wanting to have a child in the future.

The largest proportion of respondents said it was not important to them that any future children are biologically related, with some saying it was and some undecided. There is little research on the importance of biologically related children for LGBTI people, although the research there is found that LB+ women may think it is less important to be biologically related to their children than heterosexual women.¹¹

Most LB+ women had not had fertility treatment to try and become pregnant. Some had, and a further number were currently waiting for fertility treatment. Lesbians were significantly more likely to have accessed fertility treatment, than other respondents.

Many respondents felt that their sexual orientation or gender identity had affected their experience of fertility treatment services.

¹¹ Goldberg et al., 2014. "Research Report on LGB-Parent Families". <https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Parent-Families-Jul-2014.pdf>

We had to involve professionals. First it was medical professionals, then when we switched to a known donor we wrote an affidavit with our donor to ensure we all had proof that he wouldn't have paternity. So had to involve lawyers.

The NHS provision for fertility is shared as a couple. This means if we spilt up in the future neither of us can attempt fertility treatment on the NHS with a new partner, as we have used up all our quota as a couple. We both feel this is unfair, especially given one of us has had no NHS fertility treatment at all. Provision should be per person. Current service is like not being able to have a divorce.

When visiting the GP due to issues with side effects of fertility treatment, the GP did suggest giving up and adopting and I doubt this suggestion would have been made at such an early stage due to mild side effects if I was in a heterosexual relationship.

Once my partner was misgendered which was pretty uncomfortable — particularly given that I was in the middle of getting examined at the time. In our first meeting with a consultant he asked several times if I'd had sex with a man. I eventually asked why and he said it's difficult to use a speculum if I've not had penetrative sex. Afterwards I thought: 'does he think that women in a relationship just sit about braiding each other's hair'. Overall though the nurses really do go out of their way to make you both feel comfortable. It's just that some of the male doctors are a bit old school.

We were given an appointment with a private consultant who it turned out wouldn't treat lesbians. That was at the Nuffield. We switched to the Glasgow Centre for Reproductive Medicine, who were always excellent.

Reasons for dissatisfaction with fertility services included:

[They] didn't have appropriate paperwork for same-sex couples. Had to score out the word 'father' for wife to sign consent forms. Insisted we went to egg donor clinic as wife 'donating' to me. She had to legally sign over eggs to me. This didn't feel right to us. Again comments about sister rather than wife.

Our GP suggested we ask a friend for sperm as the UK sperm bank did not have a lot of donors. Would he have asked a male to ask his friend to get his wife pregnant?

The homophobia we experienced destroyed the possibility of our having a child. It was hellish, awful, and rife throughout everyone we worked with in NHS and private clinics and resulted in painful medically invasive procedures, without the joy of a baby in the end. Our entire experience as lesbians undergoing fertility treatment in Scotland was awful, and I deeply hope this serious issue is addressed so that other women do not have to go through the repeated traumas we went through.

Terrible treatment by NHS Lothian which put me off public healthcare and was so unhelpful that we left and went abroad for treatment.

Probably the worst thing was the 'counselling'. We were reassured it wasn't an assessment but it was. We were asked about our last sexual relationships with men, even though we had been together for 9 years. Do straight couples get asked about their previous sexual relationships? At the end she said and I quote 'You are so normal'. We were absolutely furious but had to be compliant etc to go through the hoops. All of the paperwork was set up for man and woman. And I know from lesbian friends that is still the case.

Several respondent comments related to receiving good private fertility treatment but poor NHS treatment. Some couples accessed private fertility treatment as the NHS waiting lists were too long and/or they experienced homophobic discrimination within the NHS. There is obviously a financial cost involved to access private healthcare, which is not attainable for everyone. A few respondents went abroad for fertility treatment, often referred to as 'fertility/reproductive tourism', which again, has significant financial cost. The findings also highlighted the lack of available information on NHS fertility treatment, both online and GP knowledge.

Many LB+ women also reported experiencing sexism from medical professionals during the fertility treatment process, with invasive and unnecessary questions about their sex lives and discriminatory comments about having a baby without a father. This sexism and discrimination is reflected in fertility treatment policy with provision provided per couple, as opposed to on an individual basis, meaning both members of a same sex female couple are unable to access fertility treatment on the NHS. This also has implications for single women wanting to access fertility treatment. Some respondent comments highlight that there are additional barriers for single women trying to access fertility treatment, with GPs acting as gatekeepers and refusing to make a referral based on the woman's single status.

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Gamete storage

Lesbian women were by far the most likely to have used gamete storage.

Respondents were asked to give details if they felt comfortable doing so. Comments included:

We have considered this but the financial implications are too significant for this to be an option for us.

[I] wanted to gain more information on how to start the process for freezing eggs for the future. Was told by a NHS local doctor that unless something was medically wrong with me I could not receive any help.

Those most likely to report that their experiences of gamete storage treatment were affected by their sexual orientation or gender identity were lesbian. Some were bi and a few were queer.

A significant proportion of respondents reported satisfaction with their experience of gamete storage services, although it should be noted that a similarly significant number of respondents were neutral about their experiences. Satisfaction levels were highest for lesbian respondents. All respondent comments related to dissatisfaction with gamete storage services. Many comments related to the cost of gamete storage and the confusion around eligibility for accessing it on the NHS. Whilst funding is not automatically available for this care on the NHS and differs between health boards, applications for 'exceptional funding' can be made. NHS Scotland should urgently make available correct and comprehensive information about fertility preservation for all potential patients.

Fertility and the law

Half of LB+ women who responded were not aware of their rights under the law in relation to parental status for a child born as a result of fertility services.

Comments included:

As a gay woman, I just don't know. It would be good if this information were to be readily available but I guess it is only available when actively searching for it.

I would love to know more about our rights accessing fertility treatment. We have been together 10 years and I am currently a mother without a child.

I am an immigrant and a naturalised citizen, and I have no idea what my rights are under the law in relation to accessing fertility services!

Surrogacy services

Only one respondent had used surrogacy services. A majority of LB+ women said they would never use a surrogate, with around one in six saying they would consider it, and a third being unsure.

Most respondents were not aware of the law in relation to surrogacy, for example, the law relating to payment for surrogacy, or relating to legal status as a parent after surrogacy:

The UK laws on surrogacy make me uncomfortable as there is such limited protection for surrogate and parents, especially when the intended parents aren't on the birth certificate.

My wife was a surrogate for our friends only this year. It is only through the process and through the help of our NHS assisted conception unit that we are fully aware of the terminology and legal status.

Other reproductive health services

All aspects of reproductive health were important for the LB+ women who responded to this survey, underscoring the importance of meaningful LB+ inclusivity in reproductive and fertility services.

Concerns for respondents included reproductive health conditions such as endometriosis and PCOS, heavy periods, menopause, the negative mental health impacts of hormonal contraception, and infertility.

Almost a third of LB+ women had concerns about their reproductive health. Concerns about reproductive health were highest among queer women. Almost a third of respondents had been diagnosed with or sought treatment for a reproductive health condition.

Lesbian women and those who described their sexual orientation as other were most likely to have been diagnosed with or sought treatment for a reproductive health condition. Not only did women feel that being LB+ affected their experience of having a reproductive health condition but it also affected their experience of accessing treatment for these conditions.

Comments relating to LB+ identity and the experience of reproductive health conditions included:

I was repeatedly asked on multiple occasions if my abdominal pain was due to a potential pregnancy despite telling health professions about my sexuality and female partner.

Contraception that might help with period pain is not allowed to be prescribed to lesbians “as we are not using it for these purposes” (or this is what my GP said).

I was told by a consultant it didn't matter if I had PCOS as my partner would be able to carry a child should I not be able to. Made me feel as though I wasn't allowed to be worried about not falling pregnant.

The experiences of LB+ women in such services are often unsatisfactory, with numerous examples highlighted above of LB+ women being disbelieved, not listened to or taken seriously, mirroring the findings of other research.¹² This is also demonstrated in the invalidating of lesbian women's sexual orientation with a continual, persistent, focus on pregnancy potential. Employing a person-centred approach in reproductive healthcare would mitigate such negative experiences for LB+ women accessing these services.

¹² Morgan, 2019. “Hormonal: a conversation about women's bodies, mental health and why we need to be heard”. (Virago)

Cancer screenings

A third of LB + women felt that their sexual orientation or gender identity had affected their experience of cancer screenings. This was most prevalent for the women who identified as queer.

I was asked if I was sexually active to which the answer was yes (with another woman). The speculum consequently hurt quite a lot and the practitioner was shocked that it would hurt as long as I was sexually active, because it never occurred to her that it could be with anything other than a penis.

I'm a bisexual woman and at the time of one of my screenings was in a long term relationship with a woman. I was asked if I could be pregnant, I said definitely not. The nurse pressed me for more information and refused to believe I absolutely could not be pregnant so I told her I was in a relationship with a woman. She was visibly shocked, perhaps disgusted is the wrong word but she was very uncomfortable. It made the rest of the appointment very uncomfortable for me and I keep my sexuality pretty much secret from most people now because I'm afraid of similar responses.

Rainbow lanyards do not make a practice or centre queer-friendly and I've found very little attention given to making an exam more queer-friendly. My practitioners, both at the local sexual health clinic and my GP practice, clearly have very little experience with, and do not expect, people with vaginas who do not participate regularly in penetrative sex with a penis. Like many other queer people, I'm a survivor of sexual assault, and none of my practitioners have been trauma-informed. In fact, one nurse, when I disclosed that I'm a sexual assault survivor and that sometimes affects how cervical smears go for me, told me it made her nervous. This did not help me at all.

The findings indicate significant barriers for LB+ women accessing cervical cancer screenings. This mirrors NHS Scotland's own research, which shows lower participation among lesbian and bi women.¹³

Considerable work is needed by NHS Scotland to optimise uptake, reduce barriers and ensure all LB+ women who require a cervical screening are able to access this service without judgment. Further education is needed for healthcare professionals regarding the incorrect perceived low risk of cervical cancer for LB+ cis women who do not have sexual relationships with men.

Additional work is also needed to ensure all reproductive health cancer screenings are trauma informed and underpinned by informed consent. As highlighted by several respondents, there are additional barriers to accessing cervical screenings for sexual violence survivors. This is also mirrored in existing research, which shows survivors may be at an increased risk of cervical cancer but avoid cervical screenings to prevent the risk of re-traumatisation.¹⁴

A significant number of comments from LB+ women related to experiencing pain during the cervical screening process, creating a further barrier to accessing this service. Lesbian respondents also reported worryingly high rates of being told by medical professionals that they did not need a cervical screening as they did not have sex with men.

¹³ NHS Health Scotland, 2021. "Cervical screening toolkit: An information toolkit to help GP practices raise awareness and reduce barriers to participation". http://www.healthscotland.scot/media/2230/cervical-screening-toolkit_english_june-2021.pdf

¹⁴ Cadman et al., 2012. "Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study". <https://srh.bmj.com/content/38/4/214>

I went for a cervical smear but the nurse was unable to do it and advised me to speak to a doctor, who said I needn't worry too much since I was low risk as only had sex with women. I think I was advised to try again in a few years. Due to a fear of medical things and the fact it was unsuccessful the first time I haven't returned to try again yet.

I went for my first smear test whilst at uni. The nurse assumed I slept with men and when I said I didn't she stated I didn't and never would require a smear test. Luckily my mum is a nurse so I knew this was wrong and sought a new GP practice after that.

So many lesbian, bi and queer women friends I know have either never been for their smear tests or had really bad experiences when they did, being told they didn't really need them, etc., from actual medical professionals. It's astounding. All women need cervical screenings, regardless of sexual orientation.

Recommendations for these service providers

It is obvious from the data gathered in forming this report that there are considerable important takeaways about services and the experiences of LB+ women. We therefore make clear recommendations as to how these things could be improved for LB+ women in Scotland:

- Healthcare providers across reproductive health and fertility services, (contraceptive services, pregnancy services, breastfeeding services, abortion services, fertility services, and cervical cancer screenings) should have LGBT awareness training to ensure that they can meet the specific needs of LB+ women, and provide them with welcoming, inclusive care.
- Healthcare providers across reproductive health and fertility services should not make assumptions about people's gender identities or sexual orientations, or about their healthcare needs.
- The specific needs of LB+ women should be recognized in the provision of contraceptive services, including a greater focus on and information about using contraception for reproductive health conditions and managing menstruation.
- Information provided across reproductive health and fertility services should be inclusive of LB+ women. This should include redesigning forms and information leaflets to not assume that all parents will be a heterosexual mixed-sex couple.
- Fertility services should ensure that the advice and information they provide are not underpinned by heterosexist assumptions. LB+ women and same-sex female couples should not be asked intrusive questions about their sexual histories that would not be asked of heterosexual mixed-sex couples, and LB+ women and same-sex female couples should have equal access to fertility treatment as mixed-sex couples.

- The law around fertility treatments, gamete storage, and surrogacy should be made clear for all. This should include specific information that is relevant to LB+ women.
- More needs to be done to reduce barriers to LB+ women accessing cervical cancer screening, including by further education to correct the incorrect perceived low risk of cancer for LB+ women who do not have sexual relationships with men, and by providing trauma informed services underpinned by informed consent.
- More research is needed on reproductive health conditions such as endometriosis and PCOS, and how they affect people of all genders.

Other formats

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