



 Equitas Health
Institute

**LESBIAN HEALTH
NEEDS ASSESSMENT**



Lesbian Health Needs Assessment

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EXECUTIVE SUMMARY

Purpose

Lesbian-identified individuals* face unique challenges that have direct effects on their health, so why is addressing these challenges such a radical idea?

The Challenges

- Stigma and discrimination may reduce the access and use of needed healthcare services.
- The intersections of race, gender identity, and sexuality increase these challenges for lesbian-identified people of color.
- Sexual and gender minority (SGM) research often assumes every letter on the LGBTQIA spectrum experiences society and the healthcare system in the same way.

Focusing on the health needs of lesbian-identified individuals is only a radical idea because healthcare systems and research have ignored them for so long.

Methodology

A mixed method study to explore the negative healthcare experiences of lesbian-identified individuals, combining:

1. Quantitative survey data
2. Qualitative 'share your story' responses

Plus

A focus group that explored self-care and healthcare experiences of sexual minorities of color.

**Although most respondents self-identified as lesbian, some also identified, or identified solely, as queer, non-binary, and same-gender-loving.*



EXECUTIVE SUMMARY

Findings:

Mixed Method Study

In their experiences with healthcare, lesbian-identified individuals encountered:

- Lack perception of specific lesbian health needs
- Lack medical knowledge of SGMs
- Shame and ambivalence toward SGMs
- Misclassification of gender identity

Overall

- 26% of those who had not visited a Primary Care Provider (PCP) in 12+ months were uncomfortable discussing their sexual orientation with a provider.

Lesbians of color in the focus group:

- Indicated a strong desire to have a provider who is a person of color
- Reported being open to alternative medicine
- Reported not having a primary care provider due to a lack of cultural humility, competency, instability in health coverage, and a lack of trust in primary care providers

Recommendations

1. There is a clear need for culturally responsive care to address the specific health needs of patients from different cultures, races, sexual orientations, and gender identities.

Benefits: Increasing PCP awareness of the health disparities that result from neglecting these needs would improve overall health for lesbian-identified individuals.

2. Providers must be sensitive to historical stigmatization and assure that care is ethical on all levels.



INTRODUCTION

Intersectional health disparities born out of complex structural factors impact health outcomes for sexual gender minorities (SGMs). Lesbian and transgender populations also report unique health concerns when compared to their heterosexual and cisgender peers. As part of a strategic plan to reduce the prevalence of health disparities among SGMs, Equitas Health Institute conducted this assessment to explore the healthcare experiences of lesbians under the supervision of an Ohio State University College of Public Health faculty member in 2017-18. In addition, an Institutional Review Board (IRB) approved the mixed-method research study, which is the foundation of this assessment.

The lesbian community varies widely in culture, race, orientation, socio-economic status, and access to healthcare. Therefore, this assessment utilizes a two-prong approach. First, a mixed-method study of quantitative survey data and “share your story” qualitative responses explored the negative healthcare experiences of lesbian-identified folks. In the second prong, a community conversation of lesbian people of color focused on how the intersections of race and sexual orientation impact their healthcare experiences and self-care strategies. The assessment found that a series of factors influence the health and social needs of lesbian-identified individuals. Discrimination, stigma, lack of insurance, suboptimal access to specific healthcare services, lack of trust with providers, and lower levels of perceived risk can all impact the access and utilization of healthcare services by lesbian-identified individuals (Hart & Bowen, 2009; Mercier et al., 2013; Qureshi et al., 2018; Rossman et al., 2017; Williams et al., 2020).



LITERATURE REVIEW

Lesbian-identified folks encounter varied experiences in the healthcare system. Transparency with a personal care provider improves overall health for lesbians. For example, compared to SGM folks who believed their provider did not know about their sexual orientation, sexual minority women (SMW) were more likely to report being satisfied when their provider knew about their orientation. Those studied reported higher comfortability discussing their sexual health (Mosack et al., 2013). A survey administered to 57 Midwestern lesbian participants provided insight into interactions with providers. It was found that real and anticipated discrimination by providers play a significant role in lesbian-identified individuals seeking care. The participants from the survey also reported they were less likely to come out to providers. Overall, participants were concerned about avoiding interactions with providers that were perceived as oppressive or harmful to themselves or their families.

According to the Howard Brown Women's Assessment, it was reported that healthcare providers are often inexperienced in caring for sexual minority folk. (Morten et. al., 2017). Findings from this report indicate the need for culturally responsive care. This would help address implications that arise from caring for patients from different cultures, races, and sexuality. Furthermore, this would help increase awareness of health disparities that results from these implications and improve overall health for sexual minority individuals. The interviews from the report also noted that stereotypes, bias, and discrimination are also major barriers that affect a patient's healthcare experiences.

Gonzales and Henning-Smith's (2017) analysis of the 2014-2015 Behavioral Risk Factor Surveillance System (BFRSS) aimed to investigate the health disparities faced by various sexual orientations. A sample of 8,290 adults

who identified as lesbian, gay or bisexual (LGB), and 300,256 adults identifying as heterosexual were used in the analysis. They found that LGB individuals have higher odds of poor physical health, activity limitations, chronic conditions, obesity, smoking, and binge drinking. Compared to heterosexual folks, sexual minority individuals are more likely to report poor physical health and less likely to utilize mental healthcare (Baptiste-Roberts et al., 2017). Sexual minority women also experience more barriers to caring for their mental health than any other group, largely due to prejudice that they face. In addition to this, SMW are also faced with barriers such as a lack of competence by providers, lack of insurance and personal finances, lack of transportation, having to disclose their sexual and gender identity, and experiencing discrimination (Hart & Bowen, 2009; Mercier et al., 2013; Qureshi et al., 2018); Rossman et al., 2017; Williams et al., 2020). A study comprising of 438 LGBT participants, with approximately half identifying as lesbians, bisexual and transgender women provided evidence for underutilization of healthcare services. Out of the sample, 80% of the participants did not seek care regularly and only 39% were out to their healthcare providers (Qureshi et al., 2018).

LESBIAN-IDENTIFIED PEOPLE OF COLOR

“Important for PCP to be Black, with having that, not as concerned with other things.”

“Visibility and representation and mix that with someone who is LGBTQ inclusive or competent.”

“If you see a bunch of Black lesbians in the waiting room, better spread the word.”



Lesbian-identified people of color face unique barriers to healthcare access. This population is impacted by health disparities that are connected to intersectional, structural factors that affect their health. For example, a study was conducted to show the disparity in the rate of mammography utilization among lesbian women of color. Results from the study showed lower mammography utilization among Latina and Asian women in comparison to their heterosexual counterparts. There was also a disparity for African American women due to their sexual orientation (Austin et al., 2012). Another study was conducted to analyze Pap test uptake. The findings showed that an estimate of 59.8% of African-American women who identify as lesbians and 80.6% of bisexual women have received a Pap test in the last three years (Agénor et al., 2016).

The above studies confirm the low level of mammography and Pap test uptake among this group. Factors acting as barriers to these disparities include poverty, unemployment prevalence, sexual orientation, and low level of health insurance coverage (Agénor et al., 2016).

Studies conducted using African American women as the focus group found that women of color (WOC) are under-represented in breast cancer research and thus, the results may not be generalizable. This lack of proper representation in breast cancer research, for instance, might be a result of mistrust, which might have originated from potential homophobia and racism among healthcare providers (Malone et al., 2019).

Overall, there is limited data and research on the health and sexual needs of lesbian-identified people of color. This group continues to experience oppression based on their gender identity, race, and sexuality, which has affected and framed their experiences. Despite this group utilizing different strategies to voice their needs and concerns, there is little to no research in the United States that is exclusively focused on them. The lack of research catering to the needs of lesbians of color further proves the sad reality of inequality and the concerns of WOC being considered invalid (Alimahomed, 2010).

Note: Responses collected from the community conversation, not from the mixed-method study.

MATURE LESBIANS

Many mature lesbians did not come out or openly share their gender identity for a great part of their lives to avoid homophobic discrimination. In comparison to their heterosexual counterparts, mature lesbians may experience amplified adverse health outcomes due to aging. Little literature has explored how their minority status could be associated with their health outcome as they enter the later stages of their lives. Older lesbian and bisexual-identified women exhibit higher rates of smoking, poor mental health, and excessive drinking rates (Fredriksen-Goldsen et al., 2013). Despite having similar rates of receiving a flu shot, older sexual minority women were less likely to have a mammogram when compared to their heterosexual counterparts. In addition, older lesbians and bisexual-identified individuals are more at risk for being uninsured or have a financial barrier to accessing healthcare services.



<p>65+, White or Caucasian, Woman</p>	<p>Medicare assigned me a new one, and I haven't had occasion to try her out. My previous one was kind of a fill-in, because before that, my Dr. dramatically failed to diagnose lymphoma, though I returned often at a (nurse) colleague's urging Cuz something was wrong!</p>
<p>55-64, White or Caucasian, Woman, Butch</p>	<p>This healthcare system is broken and I don't wish to over-identify with it.</p>
<p>55-64, White or Caucasian, GNC, Tomboy, Two Spirit</p>	<p>My PC is a good person, very nice. So, it's not her attitude. It's me who feels like she doesn't quite understand me. I feel that I keep my gender squarely in the 'girl' column every time I see her. It's more a gender ID issue than a lesbian issue.</p>
<p>55-64, White or Caucasian, Woman,</p>	<p>She's heteronormative and awkward about it (sexual orientation) I don't have the desire or energy to educate either her or my gynecologist who is over the moon uneducated about lesbian woman born woman needs.</p>

YOUNG LESBIAN ADULTS



Data analysis from the national longitudinal study of adolescent health found that sexual minority women aged 24 to 32 years were more likely to rate their health status to be fair or poor in comparison to their non-SGM peers. Young sexual minority women (YSMW) face similar and unique adverse health outcomes and were found to have significantly increased rates of being diagnosed with asthma, depression, anxiety, ADHD, and lifetime STIs. YSMW were also found to have an increased rate of being uninsured, having forgone care, and having received psychological counseling. In contrast to previous findings, YSMW's BMI, diagnosis of high cholesterol, and blood pressure were not significantly different when compared to non-SGM peers (Cochran et al., 2001; Gonzales & Henning-Smith, 2017; Strutz et al., 2015).

YSMW face many of the same barriers to utilization of care as adult sexual and gender minorities. Sexual and gender minorities do not disclose their sexual identity to their providers for several reasons. A qualitative study comprising of 206 participants was conducted. Results from the study showed that 63% of the sample reported not being comfortable disclosing their sexual orientation to their provider. Some of the reasons they posed as barriers for non-disclosure include privacy, trust, and the perception that their sexual identity is not associated with their health (Rossman et al., 2017). Gay and lesbian-identified participants were less likely to receive a medical checkup (Macapagal et al., 2016). Gay or lesbian-identified and racial and ethnic minority participants also reported a lower rate of insurance coverage when compared to white

YOUNG LESBIAN ADULTS

and bisexual identified participants (Macapagal et al., 2016). The majority of participants indicated that disclosing their sexual or gender identity to their providers had a neutral (61.5%) or positive (30.8%) impact on their healthcare experience (Macapagal et al., 2016).

Many studies have shown that sexual orientation does not always predict sexual behavior. Data analyzed, using information from the Youth Risk Behavior Survey (2005-2015) reported 22% of lesbian-identified women and 38.9% of bisexual-identified women reported only having male sexual partners. According to the National Survey of Family Growth, adolescent women who identify as bisexual and report attraction to both males and females have higher odds of pregnancy when compared to their heterosexual counterparts who are exclusively attracted to males. The data also stated that lesbian or bisexual-identified adolescent women are more likely to engage in risky sexual behaviors. These risks include first intercourse at a young age, exchanging money or drugs for sex, and having more than three lifetime sexual partners (Paschen-Wolff et al., 2018).

Note: Responses from the mixed method study, not the community conversation



25-34, White or Caucasian, Woman	I just keep putting off finding someone I like after my last doctor moved because it's hard to find a PCP who isn't fat shaming and is queer friendly.
25-34, White or Caucasian, Woman,	Because you never know how someone will react or their comfort level with dealing with queer issues, and my doctor has never made it explicitly clear to me that he is accepting or welcoming.
18-24, White or Caucasian	I don't want to be shamed for who I am.

BREAST/CHEST HEALTH



Recently, there appears to be a growing interest among practitioners to engage in cancer care that targets and is sensitive to the unique needs of the SGM community. A recent study conducted by select oncologists found that 70% of study respondents desired more education on the specific needs of SGM individuals in cancer care (Schabath et al., 2019). There is still a gross lack of research and funding in this area for lesbian-identified folks.

One of the earliest studies that accounted for cancer among SMW was the Boston Lesbian Health Study (BLHS). The BLHS explored cancer

risk and behavior data and reported that while some SMW were receiving mammography, the rates were not close to that of their heterosexual peers. Studies have since shown that SMW has a higher risk for breast cancer in comparison to Non-Sexual Minority Women (non-SMW). This difference was found to be due to a higher prevalence of alcohol use, smoking, and obesity (Malone et al., 2019).

SMW were more likely to report mammogram usage due to breast distortion or noticing a lump. In comparison to non-SMW, SMW received screenings when a problem is perceived and

BREAST/CHEST HEALTH



not as a preventative measure. Reports from this assessment indicate that SMW may not be participating in routine screenings due to stigma within the health care system, which could have a negative impact on their health status (William et al., 2020).

In terms of Black sexual minority women and breast cancer screening, black women were more likely to receive a diagnosis at later stages of breast cancer. This disparity results from lower frequency screening and a lack of follow-up after abnormal test results. Overall, Black lesbian-identified minority women are often under-represented in breast cancer research despite these disparities. Studies noted that homophobia could be at play in the disparity of engaging in breast/chest care among Black SMW (Malone et al., 2019).

Note: Response from the mixed method study, not the community conversation

55-64, White or Caucasian, GNC, Tomboy, Two Spirit

I went to see my OBGYN for my yearly pap and mammo. She was out due to giving birth and I was seen by the other doctor in the practice who was a young (mid-thirties) doctor who was established in the practice. She came into the room and took one look at me and realized I was a lesbian/tomboy and to give her credit, she tried to hide her repulsion. She was professional in all her dealings while she examined me, but I look back on that and realize I had a choice that I did not take. I should have called her on it because I felt uncomfortable with her touching me. She was rushed (not rude) and she did perform her duties. But everytime I go into that practice I think about that incident and how I will never accept that again. With respect and compassion, I will ask to be seen by someone else at a later time. I just wanted to get it over with, you know? And I deserved better than that.

SEXUAL AND REPRODUCTIVE HEALTH

One key conversation from this assessment is the issue of sexual and reproductive health among lesbians. A retrospective chart review study reported that, from 2004 to 2015, 41% of patients at a university-based fertility center in Connecticut were lesbian couples. This is a big increase compared to the fertility treatment utilization at the same facility among lesbian couples prior to this timeframe (Carpinello et al., 2016). Nevertheless, there is a limited amount of literature exploring fertility consideration among lesbian couples, and lesbian-specific obstetrical care is largely missing in midwifery textbooks (Bushe et al., 2017).

Data from the literature reviewed journals assessing sexual and gender minority women's health reported that women with female lifetime partners have lower odds of receiving a Pap test when compared to their counterparts with male lifetime partners (McCune & Imborek, 2018). Additionally, the National Survey of Family Growth reported lower rates of birth control usage. Nulliparity (never carried a pregnancy) is also a risk factor. All of these disparities in turn

put lesbian-identified women at a higher risk for cervical cancer. Previous studies also indicate that HPV is transmittable between women (Greene et al., 2018).

Provider-related factors may also impact sexual minority women's use of cervical cancer screening. For instance, an integrated review on cervical cancer screening among sexual minority women identified the importance of provider recommendation. The review found that comfort level with providers, good communication, and sexuality disclosure are positively associated with cervical cancer screening utilization. Thus, clinicians and healthcare providers can help improve and promote screening rates for SMW by making screenings available at health facilities and prevent discrimination that arises from sexual orientation (Greene et al., 2018). Overall, this assessment indicates that physician recommendation is a very crucial factor in SGW's screening behavior.

Responses in italics from the community conversation, others from mixed method study

<p>18-24, White or Caucasian, Woman," I am a woman, but I am not "cis" because I do not feel comfortable identifying with every stereotype associated with womanhood."</p>	<p><i>I am somewhat uncomfortable because although she remembers why I don't take birth control, every single doctor I've ever been to cannot answer questions about STI transmission between women and gets extremely uncomfortable when I bring it up. I've just stopped bringing up my sexual health concerns because of that.</i></p>
<p>18-24, White or Caucasian, Woman, Womyn, Femme</p>	<p><i>With previous primary care providers, they have not taken my sexuality seriously or they have dismissed it. I have told doctors that I am not at risk for pregnancy as a female homosexual and they did not believe me & treated me as if I was destined to one day end up engaging in heterosexual penetrative sex.</i></p>

MIXED METHOD STUDY

METHODOLOGY: Cross-sectional mixed method design

This assessment used a cross-sectional mixed method design to identify the experiences of lesbian-identified individuals. A mixed-method study design comprises collecting and analyzing both quantitative and qualitative research approaches. Surveys with open-ended questions (“share your story”) and community conversations were conducted for this assessment. The pilot study analyzed 233 surveys collected online and in-person with lesbian-identified folks residing in Ohio in 2018. The study design consisted of demographics, a Likert survey, and open-ended questions (“share your story”). Qualitative answers were collected for assessing negative health experiences, and thematic analysis was used to analyze the data. Though not all respondents were of Ohio, individuals that identified as lesbians and resided in Ohio were selected for analysis.

It was useful to consider the current health status, the relationship between the respondent and their primary care provider (PCP), and the degree to which respondents were out to their providers about their sexual orientation and/or gender identity. This information is useful due to the mass disparities experienced by lesbian identified-individuals.



MIXED METHOD STUDY

SURVEY QUESTIONS

The survey asked respondents to self-identify their gender identity, and those choices were nonexclusive.

Woman, transgender woman, genderqueer, non-binary, gender nonconforming, tomboy, womyn, femme, butch, self-identify (open)

“Do you consider yourself a lesbian?” (Yes or No)

GENDER ID

Respondents could select multiple gender identities as they viewed themselves. The top four gender identities selected by respondents included:

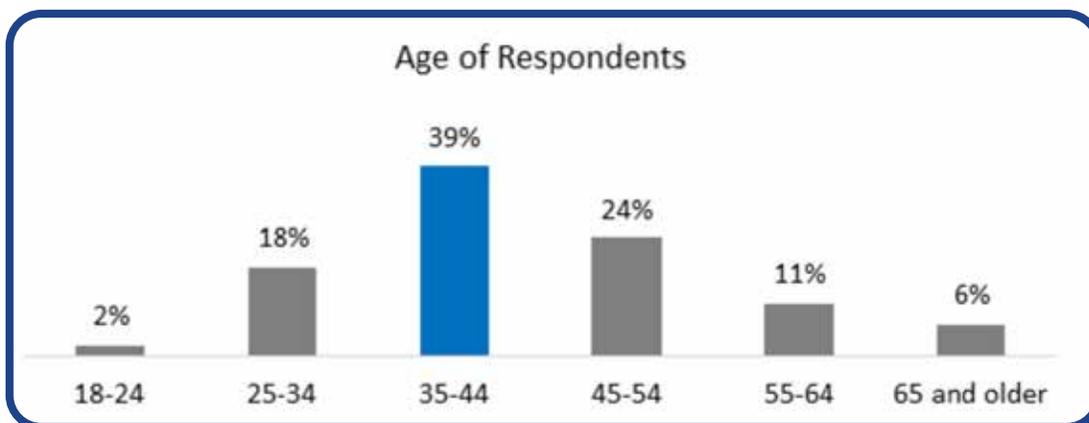
1. Woman (76%)
2. Femme (9%)
3. Womyn (7%)
4. Tomboy (6%)

RECRUITMENT

There were 475 responses to the survey. To be included in the analysis, respondents must have indicated they lived in Ohio in 2017 and identified as a lesbian. Two hundred thirty-three (233) respondents (49%) met the criteria to be included in the analysis. It should be noted that while 233 individuals met the criteria to be included in the data set, the number of responses to most health-related questions was as low as 196. With the average number of responses being around 210 (about 90% of respondents). Survey responses were self-reported and participation was voluntary.

AGE

81% of survey respondents fell between the ages of 25 and 54, with nearly 40% between the ages of 35 and 44.

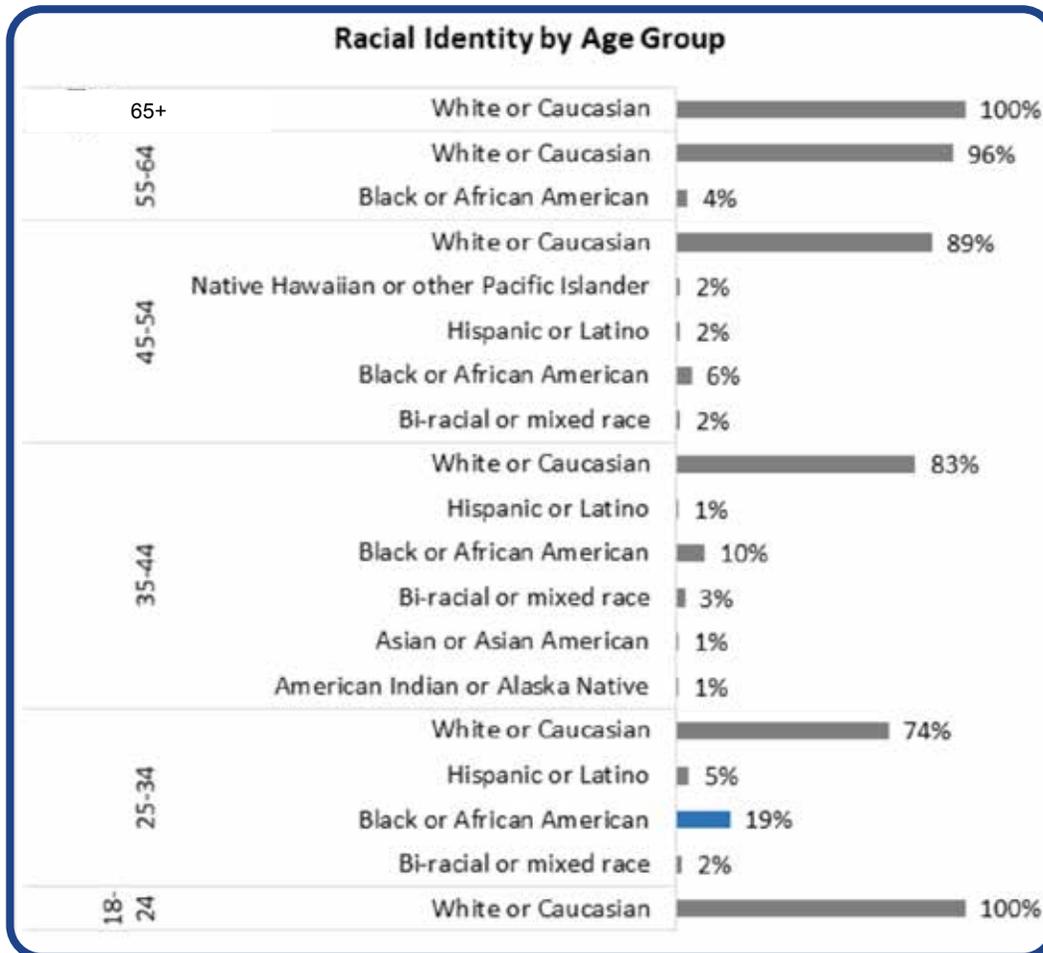


MIXED METHOD STUDY

RACE

The majority of respondents identified as white (84%). 16% of respondents identified as non-white (9% Black/African American).

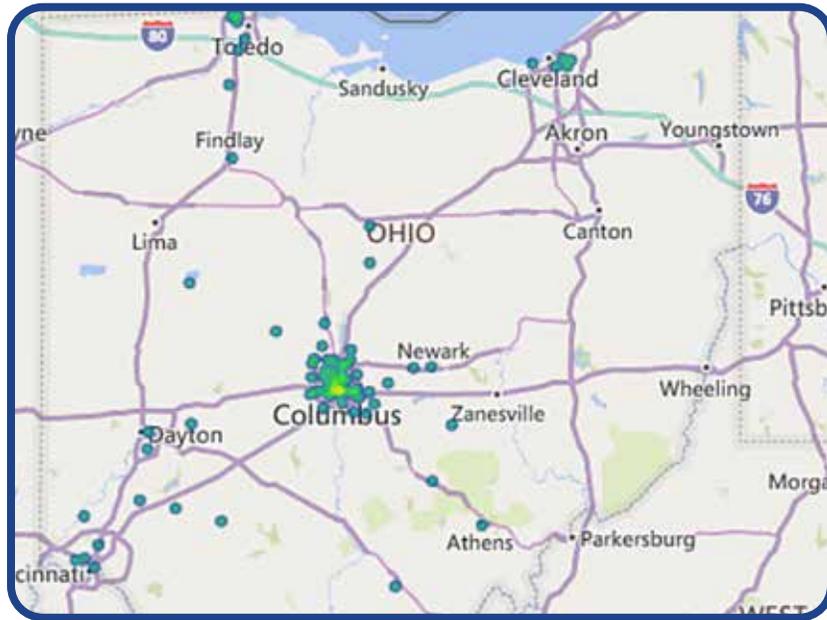
There was a higher percentage of non-white populations represented in the 25 - 34 age group.



MIXED METHOD STUDY

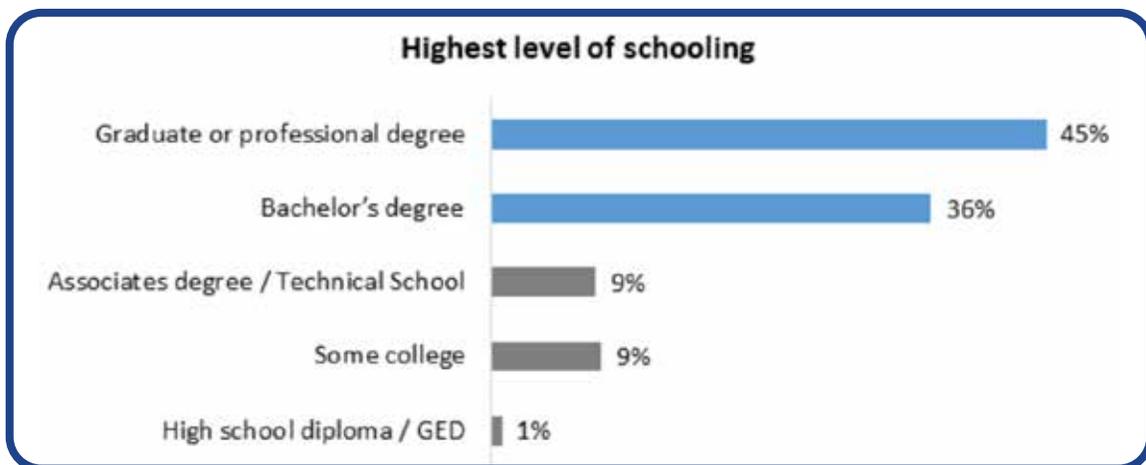
GEOGRAPHY

Respondents were predominantly from central Ohio. The heat map represents the zip codes reported by respondents.



EDUCATIONAL LEVEL

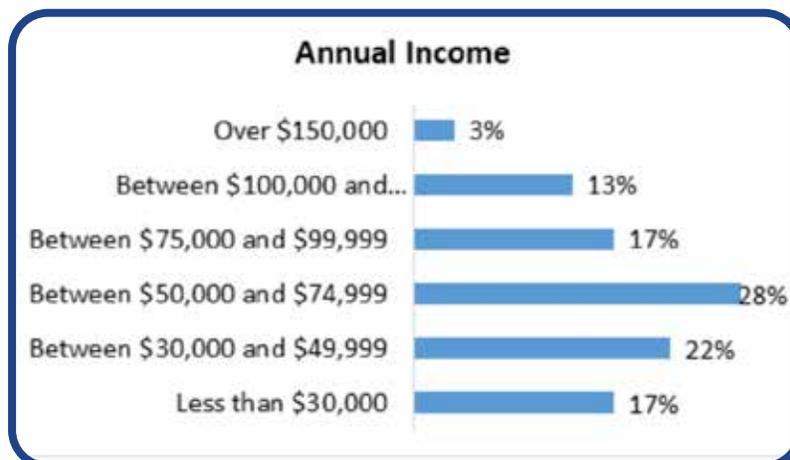
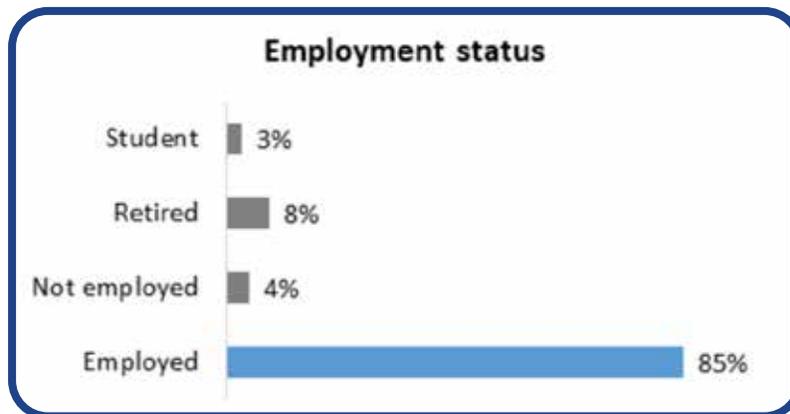
81% of respondents reported having completed at least a bachelor's degree. Nearly 50% reported completing a graduate or professional degree. Respondents have a high level of education when compared to the general population. According to Census.gov, 27.8% of Ohio residents (ages 25+) have completed a bachelor's degree or higher.



MIXED METHOD STUDY

EMPLOYMENT STATUS AND ANNUAL INCOME

85% of respondents reported being employed, and 61% of respondents reported an annual income of over \$50,000. According to Census.gov, the median household income in Ohio in 2018 was \$54,533.



MIXED METHOD STUDY

PRIMARY CARE PROVIDER MOST RECENT VISIT

Overall, 88% of respondents stated they have a primary care provider (PCP). Research has consistently shown the physical, emotional, and social benefits of utilizing a primary source of healthcare. A recent study found that adults from the general population with primary care were significantly more likely to fill more prescriptions, have preventative cancer screening, and have a routine preventative visit in the past year. Unfortunately, gross health disparities continue to persist among lesbians even with the obtainment of a medical home. Also, 79% of respondents reported having seen their PCP within the last year. This may indicate an activated and engaged patient population responded to this survey. The health and self-advocacy behaviors of an activated patient population may be different from those of a less activated population.

It was found that 95% of survey respondents are out to their PCP about their sexual orientation. Disclosure of sexual orientation is associated with improved health outcomes and receipt of more appropriate health services. Research supports the importance of disclosure of a patient's sexual orientation in providing medically and culturally appropriate medical care and in fostering greater satisfaction and comfort with that care.

Survey Questions include:

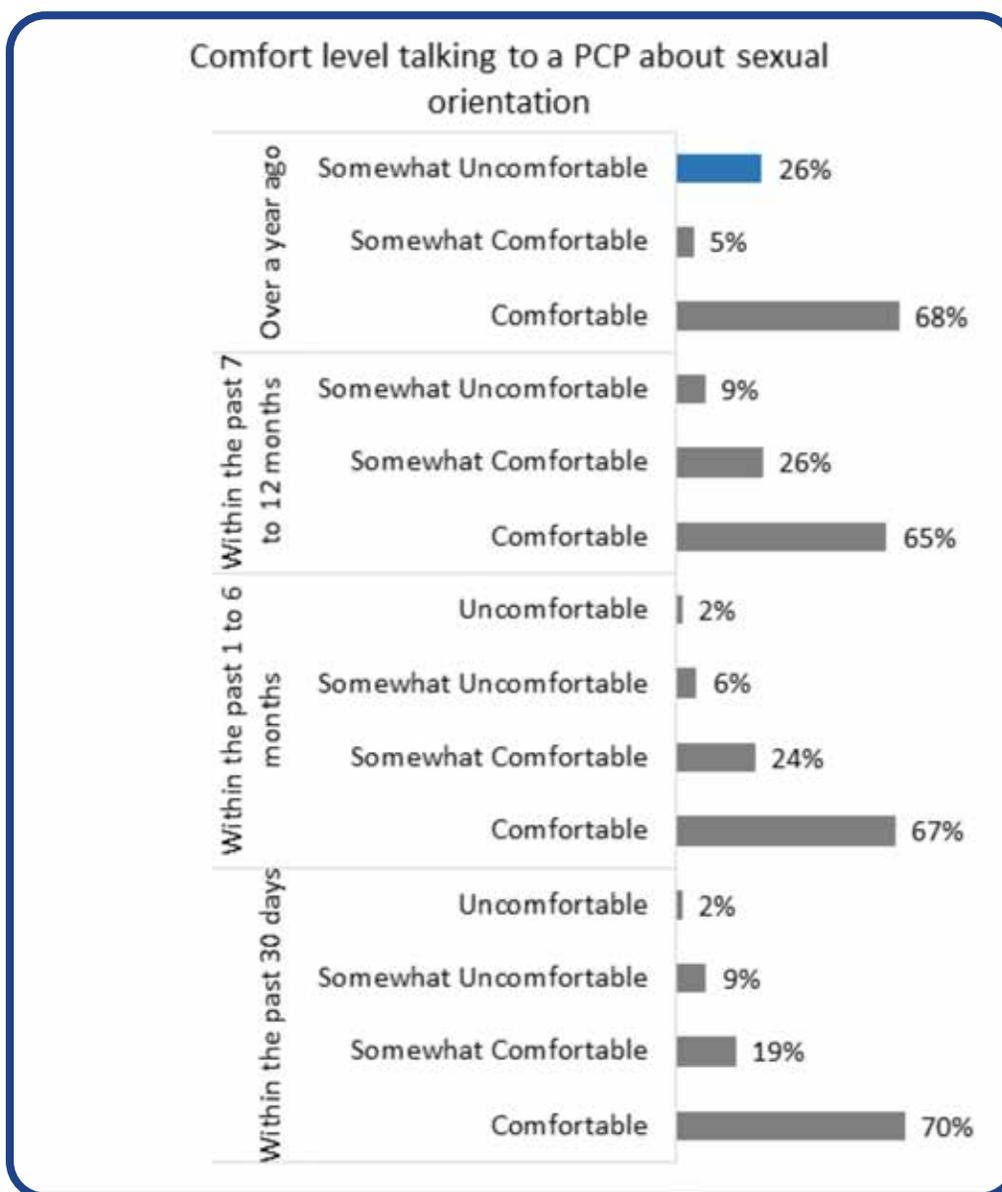
1. Do you have a PCP?
2. Last visit to a PCP?
3. Are you out to a PCP?
4. Frequency of preventative services (mammography, pap smear)



MIXED METHOD STUDY

COMFORT LEVEL TALKING TO PCP ABOUT SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION

Overall, 93% of respondents reported feeling comfortable talking to a PCP about sexual orientation. However, for those that reported not having seen a PCP for over a year, a high percentage reported they were somewhat uncomfortable talking to a PCP about their sexual orientation. About 92% of survey respondents reported being out to a PCP about gender identity or gender expression. In addition, 93% of survey respondents reported being comfortable or somewhat comfortable talking to their PCP about their gender expression and sexual orientation.



COMMON THEMES AND RESPONSES

Of those that reported not having a Primary Care Provider, common themes for not having one include:

1. Not being able to find a PCP
2. Interest in alternative care
3. Not deemed a priority
4. Fear of provider due in part to stigma and discrimination

Of those that reported not having a Primary Care Provider, common responses for not having one include:

"Haven't been able to find a doctor I trust but have regular gynecologist" (25-34, W, Woman)

"Interested in alternative/complementary med" (35-44, W, Woman)

"No major health issues...doesn't seem like a priority" (25-34, Hisp, Woman)

"Afraid of doctors" (25-34, W, Woman)

"Anxious about doctors judging me...although I have insurance I haven't been to a PCP in 4 years" (25-34, W, genderqueer)

Of those that reported not feeling comfortable discussing their sexual orientation with their PCP, common themes in the qualitative responses were:

1. The lack or perception of lack of queer/ sexuality knowledge demonstrated by the health professionals
2. Avoidance of shaming by healthcare professionals
3. Ambivalence of healthcare professionals toward discussions of queer health
4. Lack of comfort of the patient to discuss own queer health/ "I don't know (him/her/them) well"
5. Continuance of asking heteronormative sexual history questions when orientation has been disclosed to the healthcare professional
6. Continued misclassification of gender identity (e.g. butch as transgender or non-binary)
7. Perceived or demonstrated bigotry/ religious bias

COMMON THEMES AND RESPONSES

Common responses about not feeling comfortable discussing their sexual orientation with their PCP include:

“(PCP) are usually very conservative, they wear religious icons and always assumes I’m heterosexually active even if I’ve already come out to them” (25-34, W, Woman)

“My primary doctor is actually queer so it’s my own stuff...plus my sexual orientation seems unnecessary to discuss directly most of the time.” (45-54, W, Genderqueer)

“My doctor (who I have been seeing for years) always assumes I’m straight. So every time I have a sexual health issue, I have to come out again. Every Time.” (35-44, W, Femme)

“I’m extremely feminine and they just assume I am straight. Sometimes they don’t read my chart and ask about birth control...all over again” (35-44, W, Woman)

“Because she can clearly see I am butch lesbian, but she conflates it with being transgender, non-binary, etc.” (18-24, W, Woman/Butch)

“The health discussions are heteronormative” (35-44, AfAm, Woman)

Of those that reported not feeling comfortable discussing their gender identity expression with their PCP, common themes were:

1. Lack of provider’s knowledge of gender identity
2. Dynamic, changing, personalized nature of defining one’s gender
3. No perceived need to share that information with the provider
4. Cultural and religious differences
5. Lack of comfort/hostile environment
6. Structure of the patient/provider visit

Of those that reported not feeling comfortable discussing their gender identity expression with their PCP, common responses were:

“Time. Meaningful time to converse with her instead of a rushed 15 minutes to get to the bottom of my health issue that day” (55-64, W, GNC/Tomboy/Two Spirit)

“There’s no reason to. Plus my doc is an old white guy.” (35-44, Af Am, Butch)

“My PCP tries to be hip, so she has adopted the latest fads...Gender is a box I am forced into. So her faddish adoption of gender identity makes me really uncomfortable. She’s the only lesbian friendly doc in town” (35-44, W, No gender)

SUGGESTED HEALTH AREAS OF CONCERN

Respondents were provided a list of health topics and asked to respond to how frequently the health topic was discussed with their PCP. There may be health topics discussed with a PCP that were not included in this survey.

Top five health topics most frequently discussed with a PCP

- Chronic Disease Prevention & Management (i.e. diabetes, blood pressure, asthma)
- Healthy Lifestyle (diet/nutrition, exercise, meditation)
- Breast / Chest Health (i.e. breast/chest self-examinations, mammograms, breast cancer risks)
- Mental Health (i.e. depression, anxiety)
- Heart Health

Health topics least frequently discussed with a PCP

- Stroke
- Aging Concerns / Elder Care (i.e. mobility, Alzheimer's disease)
- Sexual Health (libido/sexual desire, prevention and treatment of STIs- gonorrhea, chlamydia, Human Papilloma Virus (HPV), HIV, etc.)
- Substance Use (alcohol & drug use)
- Tobacco Use (i.e. cigarettes, cigars, e-cigarettes, chewing tobacco, snuff, vapor machines, jewels)

Respondents were provided a list of health topics and asked to respond to how important the health topic was to them. There may be health topics of importance to this population that were not included in this survey.

Top five most important health concerns

- Healthy Lifestyle (i.e. diet / nutrition, exercise, meditation)
- Mental Health (i.e. depression, anxiety)
- Heart Health
- Chronic Disease Prevention & Management (i.e. diabetes, blood pressure, asthma)
- Sleeping Habits

SUGGESTED HEALTH AREAS OF CONCERN



Respondents were provided a list and asked to respond to how concerned they were about that area affecting their health. There may be areas of concern that impact health that were not included in this survey.

Top four rated areas of concern that can influence health

- Sexism (prejudice or discrimination based on a person's sex or gender). Sexism in healthcare results in poorer health outcomes. Members of the LGBTQIA+ reported experiencing gender bias and negative attitudes from healthcare professionals due to their sexual identity/orientation. Thus resulting in many LGBTQIA+ folks refusing to seek care even when necessary (Morris et al., 2019).
- Access to healthcare (i.e. health insurance coverage, where to get care, cost). This is a major concern for LGBTQIA+ folks as it is a huge determinant for the overall quality of health. Reports from this assessment indicate that some LGBTQIA+ folks who disclosed their sexual identity experienced negative health outcomes. They experienced reactions such as discrimination and stigma from health professionals (Rossman et al., 2012).
- Homophobia (dislike, fear of, or prejudice toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual, or transgender) members of the LGBTQIA+ community often report difficulty accessing health services due to heteronormative attitudes from healthcare professionals (Albuquerque et al., 2016).
- Racism (prejudice, discrimination, or antagonism directed against someone of a different race, based on the belief that one's race is superior). Lesbians of color report experiencing racism while seeking healthcare. Reports from studies indicate those who frequently report racism in healthcare have worse health outcomes as they are more likely to forgo care (Williams & Mohammed, 2009). Racism was the highest-ranking concern for respondents that identified as non-white.

COMMUNITY CONVERSATION

PROMPTS:

- What is your experience with primary care or other methods that work for you in terms of taking care of self?
- What approaches work for you, outside PCP
- What does queer mean to you?



COMMUNITY CONVERSATION SUMMARY QUOTES AND THEMES

<p>Comfort with provider/ finding provider/ "out" (Main)</p>	<ul style="list-style-type: none"> • "Can't go to a man, has to be a woman, for therapy, prefer that for pap too" • "Important for PCP to be black, with having that, not as concerned with other things." • "Can't agree more; know of a transgender girl in foster care who told: done having to explain my story to a white therapist in all these sessions before I can get to my real problems, if I had a black therapist I could start from where I need to start." • "I have had a black physician early on when I first got to Columbus, but her office wasn't really up to par, like her medical staff was just family, like where is my information going, but I hate to say it but I don't feel comfortable with it. I expect a certain amount of respect. I found someone based on my mental health needs and found her online, but I don't have that for physical health in the same way. That's when you start getting into specialists." • "One good experience, she was a white woman, but she was a good mix of holistic and regular medical whatever. We would try holistic and say well we might need to do this other thing. Medicine wasn't her first go to, would try other more natural things as well which I really liked. Kind of like one you said, where she limited her practice and you paid a certain amount, so the appointments were not rushed. She remembered you, what you talked about. When I got here from Cincy, I tried to find a black care PCP, but I feel like I gave up some of that I had in Cincy." 	<p>Participants shared the importance of PCP being a person of color, knowledgeable about sexual minority health issues, respectful and trustworthy.</p>
<p>Race/gender (Main)</p>	<ul style="list-style-type: none"> • "As far as behavioral health, not seeing POC in the practice, whether or not they are seeing me personally, or going into a room and not seeing people like me, if seeing people of color, I'd feel a little more comfortable." • "If you see a bunch of black lesbians in the waiting room, better spread the word." 	<p>Recommendations improve utilization of health services. Participants reported feeling safe when seeing people like them.</p>

COMMUNITY CONVERSATION

<p>Sexual orientation (Main)</p>	<ul style="list-style-type: none"> • “So I personally identify as queer, so when we are having this conversation, do you feel like there is an importance placed on those identity names, importance there in division or some kind of siloing maybe—how does that conversation look—for me its fluid.” • “Generational, all encompassing” [queerness] • “For me its energy, I’m married to a woman, but I’ve been with a variety of people, it’s more of a gamut and it does invoke a conversation but I’m ok with it and I had to get to that place and I could be in long term relationship with women but not men and people are like so you’re a lesbian, and I’m like not so much” 	<p>It is important for health professionals to understand the procedures and speak to patients in a way that they understand.</p>
<p>Negative experience (Main)</p>	<ul style="list-style-type: none"> • “Agree with everything being said, definitely if I’m being rushed, I will shut down. Feel more comfortable with a black female, I have one for my PCP and dermatologist, but I could not find one as a therapist. I did find some I was interested in, but they weren’t LGBTQ friendly/tolerant. They were very Christian, and it didn’t work. There seems to be this separation with black therapists where there is a strong focus on religion. Wish there was something in Columbus that could be done about that.” • “It took doctor a long time to recognize they can stop asking me about being pregnant. Been going to this doctor for almost five years and this was the first year they got it right.” 	<p>Discrimination can deter patients from seeking care. Providers are required to treat patients with respect and separate their bias/religious beliefs when providing effective care.</p>
<p>Coping mechanisms / self-care (Main)</p>	<ul style="list-style-type: none"> • “I can really pack on, and be under a lot of stress and if certain things going on, I know when I need to reach out externally for help. When I’m super stressed I don’t drink, I don’t smoke weed, I go home after work and go in to myself. But when I go to acupuncture I go in on the table and I say I’m sleeping ok but I’m not getting enough, or my knee been bothering me and she will put the needles where I need them at that time. I pay 55 a visit, but I can’t not go for a month.” • “I meditate, I don’t go to church, but books for me can kind of help me to stay on—I need to be more even keel, because on the inside I’m anxious, but I don’t present anxious to people I think.” • “Some folks have asked me about pride and selling so much alcohol and I wanted to ask you and someone said do you do anything sober and there are all these LGBT women that are sober and recovering and they want a space to go to where they can be safe and not having temptations and how we can have spaces for people to go.” 	<p>It is important for those who are receiving services to feel safe and heard.</p>
<p>Alternative care (Main)</p>	<ul style="list-style-type: none"> • “Use breathing techniques, meditation.” • “Have a Latina female PCP, same with male thing, I just don’t feel comfortable. Her face is consistent, and she’s matter of fact and how do things look to make you healthy in the way that I want, she won’t advise me to take medicine that isn’t in line with that holistic vision. Therapy wise, it’s been reiki and more self-care. Have had the black therapist religion thing too.” 	<p>Participants discussed the issue of not having PCP, someone who is LGBTQ+ inclusive, someone they can trust and be comfortable interacting with.</p>

COMMUNITY CONVERSATION

<p>Culturally humble care (Secondary)</p>	<ul style="list-style-type: none"> • “Visibility and representation and mix that with someone who is LGBTQ inclusive or competent.” • “Terrific PCP, she is from India, this experience is unique because there is no judgment. When I get on the scale there isn’t a conversation about my number. I don’t want that. Let’s talk about what I’m presenting you with.” 	<p>It is important to have PCP who is knowledgeable about lesbian health concerns/needs.</p>
<p>Safer sex (Secondary)</p>	<ul style="list-style-type: none"> • “But I run into people, I’ll put myself out there, I’ve been with one partner for pass three years and this doctor comes out and says surprise! And it was curable but it blew my mind—and I talked to her and she was like you didn’t get that from me, and I was like well who else did I get it from??” • “Lesbians using protection, it’s a conversation that lesbians don’t have as often as if they were in a “straight” relationship. Like having sex with a man they might automatically use a condom but I can name literally 2 lesbians that say they always use a dental dam.” 	<p>Providers need to be aware that same sex couple can transmit STI’s and educate them on how to practice safer sex.</p>
<p>Access to POC (Secondary)</p>	<ul style="list-style-type: none"> • “It’s important to have providers that understand ghosting but will follow-up. Don’t necessarily need to hear from you every day, but I understand you want to make sure you are in care. Had one doctor follow up that said, clearly something didn’t work out and here are some other folks we recommend to keep you in care. I didn’t take them up on it but still I’d prefer that.” • “I have had a black physician early on when I first got to Columbus, but her office wasn’t really up to par, like her medical staff was just family, like where is my information going, but I hate to say it but I don’t feel comfortable with it. I expect a certain amount of respect. I found someone based on my mental health needs and found her online, but I don’t have that for physical health in the same way. That’s when you start getting into specialists.” 	<p>It is important for providers to respect patient’s privacy and keep information confidential. Checking up/follow up is also essential for patient-provider relationship</p>
<p>Relationships (Secondary)</p>	<ul style="list-style-type: none"> • “I grew up in the Bronx in New York and I remember one place I did an internship in undergrad was at a women’s healing circle and when she was speaking it felt like I was in that space again and that was 20 years ago and it reminded me of that and I just think that that is something.” • “I’ve been in Columbus 14-15 years, came here in 2004, so I was never really, I have had the same friends and its great but people move and migrate and when we get up its great but I’ve never felt like I had a tribe here in CBUS, I’m going elsewhere for that, and the past couple years I’ve met these wonderful women and we PUT THIS on the CALENDAR. We pick those dates and I’ve never had a group of women that would hold me accountable to chill and hangout. I see you working and I’m holding you accountable for keeping your goals and that’s so special and unique and I’ve never had those types of relationships with women before. Its talking and vibing its intentional though. You have to be intentional.” 	<p>Building social relationships, someone who can relate and understand lesbian health needs</p>
<p>Trauma (Secondary)</p>	<ul style="list-style-type: none"> • “Going to health care providers can be a traumatic experience. Just surprised that some people that even look like me can say these things to me.” • “We were packing to move, and I found this jacket I wore in junior high that I wore every day and I buttoned all the way up because I was trying to hide. Hide my body my breasts—seeing posts about women being molested really triggered me were really butch.” 	<p>Negative encounter with a provider can cause traumatic experience for sexual minority women and eventually lead to forgoing care</p>

BEST PRACTICES

The delivery of culturally humble clinical care and patient education may result in reduced health disparities. To improve the quality of care for lesbian-identified individuals, providers need to improve their knowledge of lesbian health needs and avoid shaming LGBTQIA+ individuals. For example, the persistently heteronormative phrasing of sexual history questions, even when patients have disclosed their sexual orientation, makes it difficult for LGBTQIA+ folks to seek medical care.

This assessment highlights some key practices to improve the quality of care for LGBTQIA+ folks. This includes promoting awareness of cultural humility and integrating it into the medical student curriculum. This would help foster sensitive approaches in treating patients (Prasad et al., 2016). Additional practices to improve the overall health of LGBTQIA+ individuals include:

- Informing direct quality clinical care and patient education,
- Informing a better understanding of public health implications,
- Combatting and ending perceived or demonstrated bigotry/ religious bias towards lesbian-identified patients, and

- Promoting best practices in healthcare toward efficiency and effectiveness that differ in need, nature, and scope.

Lastly, it is crucial for health professionals and policymakers to develop innovative interventions to promote preventative health and improve outcomes for individuals with limited access to quality healthcare such as the LGBTQIA+ community (Stephanie et al., 2017).

Overall, when collecting lesbian health data, the research must not collapse the spectrum as if all lesbians have the same needs or sexual and gender identities. Due to the gap in lesbian health research, it is critically important to conduct research that specifically explores the epidemiology and health inequities of marginalized patients' clinical and health experiences. It is also important to bear in mind that marginalized patients are not all marginalized in the same way (e.g. urban/rural, higher-income/ lower income, educational attainment, occupation, history of racism, and discrimination perceived and experienced).



CONCLUSION & LIMITATIONS

CONCLUSION

Lesbian-identified folks are disregarded and overlooked in the healthcare system. This, among other factors, has contributed to the disparities they continue to face. There is a huge gap in research addressing the concerns and needs of lesbians. This lack of research and attention has made it extremely difficult to understand the health needs of these subgroups of sexual minority individuals.

Lesbians of color face even greater challenges because of intersecting nature of race, ethnicity and sexual orientation. Despite lesbians of color experiencing more stigma and discrimination, their concerns and needs are rarely understood or addressed. In order to ensure equitable care for all, there is an urgent need to address the health disparities faced by lesbian-identified individuals. Healthcare providers play a pivotal role in addressing the health disparities experienced by lesbians and therefore, concerted efforts must be made to address these disparities to improve access to and utilization of care. This can be done by educating healthcare providers about lesbian health and promoting policies to make sure they provide effective care that is ethical on all levels. Additionally, there is a need for intervention-focused research exclusively targeting lesbian-identified folks.

LIMITATIONS

There were limitations to both the mixed method study and the community conversation. In terms of the mixed method study, limitations include the limited geographic diversity, the relatively small number of respondents, the limited period for data collection, the language of self-identification, and limited information about transgender, genderqueer, non-binary, and gender non-conforming people. Despite some of the participants from this assessment, identifying

with terms other than lesbians (genderqueer, gender non-conforming, and same-gender-loving) the study may not fully capture the experience of possible participants who do not self-identify as lesbian. The respondent age, race, and education statuses of a cross-section of participants were also limited (White, middle-aged, highly educated, overwhelmingly cisgender, and income of \$30,000 or more).

This group of respondents reported high rates of employment and income and recent contact with healthcare providers (within last 12 months). This may indicate they have employer-sponsored insurance, but that is unknown. Additionally, the health and self-advocacy behaviors of an activated patient population may be different from those of a less activated population.

In terms of the lesbian-identified people of color community conversation, the small sample size limits opportunities to generalize to wider populations. Participants are similar in terms of reported racial identity but may have diverse lived experiences. The responses may be constrained by the questions asked, interpretation of the questions, time restraints, the skill of the interviewer, and social norms. It may be difficult to encourage all people in the focus group to participate. Transcription is not verbatim and this transcription did not track social reactions or group dynamics.

NOTE: Studies from peer-reviewed articles often limit the scope of sexual orientations and gender identities as recruitment study subjects and or allow self-identification beyond "other." Only when applicable, the application of subject labels that are not inclusive to varied identities were used in order to reflect the study designs, collection frames and reported protocols. Elsewhere in the report, inclusive language is used. All quotes are presented here as transcribed.

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