Health barriers for lesbian and bisexual women

Evaluation of Marginalized Women: Lesbians

Lesbian and bisexual women are typically an invisible minority in the healthcare system due to the assumption of heteronormativity, which typically results in poor management of their sexual health needs. Lesbian and bisexual women are defined as women who are disposed to experience sexual or romantic desires for, and relationships with other women (Johnson & Nemeth, 2014). The relationship between the healthcare provider and the patient is dependent upon the delivery of quality and comprehensive sexual healthcare (Munson & Cook, 2016). The discussions on safer sex, reproduction, or significant other inclusion in women's healthcare may be different based on a woman's sexual orientation. Per Johnson and Nemeth (2014), lesbian and bisexual women often encounter insensitivity, discriminatory, biased, and deficient knowledge from providers who are not attuned to the needs of lesbian and bisexual women. This paper will discuss the background and significance, socio-economic, social justice and its relationship to health disparities and health care, ethical issues, and plan of action for lesbian and bisexual women.

Background

Despite the recent shift in society towards same-sex relationships, lesbian and bisexual women continue to facemultiple barriers to equitable healthcare services. These barriers include lack of a welcoming environment, lack of health insurance, lack of communication, and lack of high-quality research and evidence-based guidelines, which leads to a delay or avoidance of seeking proper healthcare. There is a difficulty in quantifying the number of lesbian and bisexual women in the United States

due to the self-reported sexual identity not always correlating with sexual behavior (Knight & Jarrett, 2017). Although the prevalence of same-sex behavior in women is estimated at 7. 1%-11. 2%, the number of women self-identifying as a sexual minority is lower, where one study showed that only 1. 3%-1. 9% of women in the United States are identified as lesbians and 3. 1%-4. 8% are bisexuals (Knight & Jarrett, 2017).

In the area of sexual health, Human Immunodeficiency Virus (HIV) and sexually transmitted infections (STIs) are predominately the focus among homosexual men, however, very little is known about the sexual health of lesbian and bisexual women because they are largely excluded from research and preventive health interventions (Corcoran, 2017). Although the risks of HIV and STIs are lower in lesbian and bisexual women in comparison to homosexual men, there are 17. 4 million women who are living with HIV globally, which accounts for half the adult population living with HIV (Corcoran, 2017).

Socio-Economic Issues

Women who identify themselves as lesbian and bisexual are susceptible to socio-economic disadvantages. Socio-economic factors such as in education, in workplaces and income can have a major impact on health (Corcoran, 2017). Evidence from a study shows that lesbian and bisexual women are more vulnerable to the conditions of poverty, when compared to heterosexual people and couples (McGarrity, 2014). McGarrity (2014) also states that the socio-economic status (SES) is fundamentally related to the quality of life, rights, and general well-being of lesbian and bisexual women. In addition, discrimination may be related to the SES of women who identify

themselves as lesbian or bisexual. Among women between the ages of 18-44 years old, 23% of lesbian women and 29% of bisexual women are living in poverty compared to 21% of heterosexual women (MGarrity, 2014).

There are many cases where discrimination against and unfair treatment of lesbian and bisexual women remains legal. According to McGarrity (2014), the U. S. legal system does not prohibit discrimination on the basis of gender identity and sexual orientation, which includes the workplace. Discrimination in the workplace is a significant factor in socio-economic differences among lesbian and bisexual women, which is often associated with harassment and mistreatment due to gender identity (McGarrity, 2014).

Social Justice

A rich tradition in nursing that began with Florence Nightingale is the provision of social justice and advocacy for marginalized group. The struggle to obtain quality healthcare by lesbian and bisexual women is often due to the complex conditions such as fear of disclosure and homophobic attitudes from healthcare professionals (Johnson & Nemeth, 2014). Lesbian and bisexual women are found in every socioeconomic category and all racial and ethnic groups, yet they are known to underutilize the resources and services available in healthcare, in comparison to heterosexual women (Johnson & Nemeth, 2014).

Many lesbians and bisexual women do not disclose their sexual identity to healthcare providers due to past experiences of hostility, sexist and demeaning comments, withholding information, inappropriate jokes, less physical contact with clients, and inappropriate referrals to mental health,

which often led to substandard quality health care (Johnson & Nemeth, 2014). Despite recent laws that bans both the federal government and federal contractors from discriminating against lesbian and bisexual women, the lack of protection at the state and federal level continues (Johnson & Nemeth, 2014). Because there is lack of health outcome data available on lesbian and bisexual women, obtaining support for change is challenging; therefore it is imperative for policymakers and providers to set a trend in collecting data on sexual orientation and gender identity in healthcare practices, organizations, and federal surveys (Johnson & Nemeth, 2014). By quantifying the healthcare disparities of lesbian and bisexual women, gran funders, researchers, policymakers, and providers will progress in identifying and addressing the causes (Johnson & Nemeth, 2014).

Ethical Issues

Recently, there has been many significant and positive civil rights gains for lesbians and bisexual women in the United States, such as same-sex marriages. With the struggles to gain equal rights for lesbians and bisexual women, the central tropes that have emerged are the beliefs of being " born that way" (Powell & Stein, 2014). Sexual orientation cannot change as well as one's orientation is not affected by choice.

According to Powell andStein (2014), whether sexual orientation is the result of choice, issuesinvolving sexual orientation and choice are complicated. There is strong evidence that an individual'sconscious choices do not necessarily lead to the development of sexualorientation (Powell & Stein, 2014). The right simply to have same-sex attractions and not being allowed theright to act on these desires would be a nulled point. The laws do not

push women, racial, andethnic minorities to hide or simplify their identities and therefore the sameshould be true for sexual minorities (Powell & Stein, 2014).

Plan of Action

Avoidance or delay of routine medical care is the most significant risk for lesbian and bisexual women (Curmi et al., 2016). Curmi et al. (2016) also stated that there is a negative association between sexual orientation and receiving healthcare due to heteronormativity, which is evident within the healthcare system. In order to properly reach equality in healthcare for lesbian and bisexual women, all public bodies, which includes all healthcare practitioners, must proactively promote the equality for lesbian and bisexual women through the Equality Act (Corcoran, 2017). To reduce the health disparities, healthcare providers should encourage and ensure a welcoming and nonjudgmental environment to foster trust and open communication among lesbian and bisexual women (Corcoran, 2017). The provider's ability to appreciate diversity will likely promote the feeling of safety that will allow lesbian and bisexual women to come out to their providers. Providers who are knowledgeable about women's sexual orientation are more able to provide quality care and ensure better health outcomes (Munson & Cook, 2016). Lastly, further education on how to appropriately deliver care to lesbian and bisexual women without discrimination should be provided to healthcare providers (Corcoran, 2017). Furthermore, organizations with staff members that are knowledgeable and understands the need of lesbian and bisexual women and can provide tailored and dedicated need by working in partnership with the patients (Corcoran, 2017).

Conclusion

Despite the recent changes and civil right gains toward same-sex relationships, lesbian and bisexual women continue to experience a variety of barriers to quality healthcare. These barriers lead to a delay or avoidance in seeking healthcare, which places sexual minority women at a high risk for multiple health conditions. Discrimination, hostility, sexist and inappropriate remarks are some of the reasons why lesbian and bisexual women hesitate to disclose their gender identity and sexual orientation. Socio-economic factors in education and workplaces plays a major impact on the quality of life, rights, and general well-being of lesbian and bisexual women. Disparities can be reduced or eliminated by providing a welcoming and nonjudgmental environment along with promoting a feeling of safety to allow sexual orientation admittance. Healthcare providers should be furnished with further education on how to appropriately deliver care to lesbian and bisexual women without discrimination. Lastly, public bodies should be proactive in promoting equality for lesbian and bisexual women through the Equality Act.

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