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**Lesbian and Bisexual Women's Human Rights, Sexual Rights and Sexual Citizenship:
Negotiating Sexual Health in England**

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Abstract

Lesbian and bisexual women's sexual health is neglected in much Government policy and practice in England and Wales. This paper examines lesbian and bisexual women's negotiation of sexual health, drawing on findings from a small research project. Themes explored include: invisibility and lack of information; influences on decision-making and sexual activities, and experiences of services and barriers to sexual healthcare. Key issues of importance in this respect are homophobic and heterosexist social contexts. Drawing on understandings of lesbian, gay and bisexual human rights, sexual rights and sexual citizenship, it is argued that these are useful lenses through which to examine and address lesbian and bisexual women's sexual health and related inequalities.

Introduction

In the United Kingdom (UK) the last decade has seen significant legal and social changes affecting lesbian, gay, bisexual and trans (LGBT) communities. Nevertheless, debate continues about ‘the world we have won’ (Weeks 2007), alongside a growth in work relating to LGBT human rights (Kollman and Waites 2009). This has built upon a growing interest in human rights within sociology more generally. According to Woodiwiss, there has been a development of a “‘new universalism’: a broader conception of personhood, so that protection is equally available irrespective of race, gender and sexuality” (Woodiwiss 2005, 121). Equally important to this paper is the addition of ‘well-being’ to conceptualisations of freedom and rights (Woodiwiss 2005).

Work on LGB human rights develops earlier academic interest in theorising sexual rights and sexual/intimate citizenship (e.g. Plummer 2003). As Weeks argued, “without the idea of full citizenship we cannot measure how far we have come; and without the ideal of equal citizenship we have no measure of how far we still have to go” (Weeks 2007, 11-12). Debates have critiqued existing understandings of citizenship based on institutionalised heterosexuality (Richardson 2000a), examined the move of sexuality from the private to public sphere (Carabine 1996a), and increased interest in sexuality within sociology/social policy (Carabine 1996b). Analyses have taken various foci, including examining legal recognition and ‘sexual justice’ (Kaplan 1997) and consumerism as a site for sexual citizenship (Bell and Binnie 2002, Evans 1993), although Evans has been criticised for neglecting lesbian citizenship (Richardson 2000a).

Within this context, this paper presents findings from a research project conducted in the North of England to examine how (heteronormative) social contexts shape and impede lesbian/bisexual women’s sexual decision-making, and their access to appropriate sexual

health information/services. It examines the invisibility of lesbian/bisexual women in sexual health policy (in England and Wales), and experiences of services provided by the National Health Service (NHS), the delivery arm of Government-funded healthcare. Drawing on a human rights perspective provides a way to analyse this social context, in order to help lesbian/bisexual women 'negotiate' and maintain their sexual health. The paper does not conflate sexual rights with reproductive rights, which renders some lesbians invisible within certain human rights discourses (Sheill 2009), but sees sexual rights as human rights. It also draws on a definition of sexual health that explicitly links to sexual rights:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO 2002, 5)

The paper presents (and discusses) empirical findings in the light of sociological literature on sexual rights and sexuality more broadly. By way of context, this follows a summary of previous research on LGB sexual (ill)health and related policy in England and Wales.

Sexual health research and policy

This paper builds upon literature on sexual health which has, and continues to be, a key area of focus regarding gay and bisexual men. By contrast, lesbian and bisexual women's sexual health has been far less recognised and researched, possibly reflecting a long history of viewing sex between women (and without men) as not 'real' sex. A point sometimes overlooked is that sex with men is likely at some point in a lesbian's life, which has

implications for future sexual health/service needs (Bailey et al. 2003). As Richardson noted, “the dominant construction of lesbianism as a monolithic and socially and sexually discrete category... ignores the plurality of lesbian lifestyles that currently exist” (Richardson 2000b, 42).

Since the emergence of scientific research into lesbian and bisexual women’s sexual health in the 1990s (e.g. Skinner et al. 1996), social research has begun to develop which examines lesbian and bisexual women’s experiences, and illustrates the importance of experiences of heterosexism and homophobia in relation to a variety of health issues (e.g. Fish 2006), though less often sexual health specifically. Much sexual health-related research still stems from biomedical and/or (social) psychological approaches, which tend to stress individualised behaviours rather than looking at wider society (e.g. heterosexism and homophobia), which this article seeks to address. In doing so, it is influenced by social research/theorising concerning sexuality that highlights the importance of examining the communities and social contexts in which sexual practices occur (Parker 2009).

Medical research is useful, however, in identifying lesbian/bisexual women’s sexual health needs, serving to highlight the related omissions and ignorance often present in much current policy and provision that women experience. Bisexual women appear more likely than lesbians to be diagnosed with Papanicolau (Pap) smear abnormalities, but lesbians who report no heterosexual intercourse still have occurrences of Pap smear abnormalities, hence both are advised to attend screening¹ (Bailey et al. 2004). Despite this, lesbians are refused or advised against Pap tests due to doctors’ lack of knowledge about their needs (Hunt and Fish 2008), potentially exacerbating women’s perceptions of their ‘low risk’ (Fish 2006). Similarly, studies have documented sexually transmitted infection among lesbians, including genital warts and genital herpes (Bailey et al. 2004). Although the (theoretical) likelihood/risk

¹ Known as cervical smear abnormalities/screening/tests in the UK.

of acquisition has been debated (e.g. Richardson 2000b), epidemiological research suggests that HIV transmission between women is rare, though studies have documented instances, and some even suggest higher rates of HIV infection among lesbian/bisexual women compared to heterosexual women, potentially because of drug use, low condom use and/or more (potentially anal) sex with gay, bisexual or HIV+ men (Farquhar, Bailey and Whittaker 2001, London 2006).

Scientific research also suggests that lesbian and bisexual women (including those self-identifying as 'exclusively lesbian') tend to have higher rates of bacterial vaginosis than their heterosexual counterparts (Bailey et al. 2004, Skinner et al. 1996), but there has been little research to explore this. Referring to the lack of research in this area, Marrazzo argued:

Some common beliefs... are that lesbians: 1) never have sex with men, 2) are too 'clean' to get an STD [sexually transmitted disease], and 3) do not really have sex anyway – so why bother studying STD in women who have sex with women? (Marrazzo 2005, 570)

She suggested that support for research into the sexual health of women who have sex with women (WSW) can be hindered by heterosexism, homophobia, a lack of funding, and disinterest from academic journals (Marrazzo 2000). Nevertheless, a growing body of work is beginning to address this gap (e.g. McIntyre, Szewchuk and Munro 2010, Power, McNair and Carr 2009).

Linking this health-related research to broader work on sexualities and equalities, this paper contends that fears of discrimination in relation to sexuality in sexual health-related encounters are particularly key for two main reasons. First, as sex/sexual health is widely experienced as embarrassing or stigmatised (Formby forthcoming, Dolan and Davis 2003), and sexuality seen as 'private' for some (Carabine 1996a), having to 'come out' and seek sexual health advice in the same encounter may make some people doubly reluctant to attend

or disclose. Second, sexuality may directly relate to sexual health advice, diagnosis or treatment (unlike, for example, a broken leg), which may prevent LGB patients passing as heterosexual. It therefore also means there is a need for medics to have specific knowledge of lesbian/bisexual women's needs. As many lesbian/bisexual women may not come out to their doctor (Fish 2006), it is hard to imagine how their sexual health/needs can be met, recorded, and ultimately improved.

The UK policy context for this article is one of rising concern about sexual health, particularly in relation to increasing rates of sexually transmitted infections (STIs) (Evans 2006). There are currently no routinely collected data in UK health services concerning transmission of STIs between women (unlike men), although woman-to-woman transmission of STIs has been documented elsewhere. Similarly, no official statistics exist on HIV/AIDS among lesbian/bisexual women in the UK, which disregards HIV+ lesbians in contact with services, and minimises the significance of HIV to lesbian/bisexual women (Richardson 2000b). In failing to acknowledge the potential for future HIV infection in lesbian/bisexual women, official recording of data on HIV/AIDS may fuel complacency and/or ignorance among both health practitioners, and lesbian/bisexual women (see also Power, McNair and Carr 2009).

The content of current sexual health policy documents for England and Wales suggests that lesbian/bisexual women are invisible in policy planning and implementation (despite the existence of growing research in the area). National Department of Health (DH) policy is central to guiding/determining local NHS provision, yet the terms 'lesbian' or 'women who have sex with women' do not appear in key policy documents, including The National Strategy for Sexual Health and HIV (DH 2001) and The National Strategy for Sexual Health and HIV Implementation Action Plan (DH 2002). This is despite the fact that both documents set out the aim of:

a nationwide programme of investment and reform, to modernise services around the needs of patients and service users, tackle inequalities, and ensure that the NHS works to prevent ill-health as well as treating problems once they arise. (DH 2002, 2, emphasis added)

Effective Sexual Health Promotion: A Toolkit for Primary Care Trusts contains twenty-four references to work with 'gay men' or 'men who have sex with men', but says: "the needs of certain groups – for example those of lesbians and bisexual women... are not specifically addressed here" (DH 2003, 3). There is no explanation for this omission, and notably no signposting to where the needs of lesbian/bisexual women are addressed in English (or Welsh) policy.

More recently, a set of briefings has been produced for health and social care staff (Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People), including one on lesbian health and one on sexual health (Fish 2007). The lesbian health briefing includes limited information on cervical cancer/screening and references to sexual health, whilst the sexual health briefing is dominated by discussions on gay men and HIV, with the implication that lesbian/bisexual women are not at risk of acquiring HIV. Although it states that "HIV testing is needed if men are to know their HIV status" (Fish 2007, 3), there is no recognition that it is also needed for women (lesbian or otherwise) to know theirs.

Nevertheless, the production of these briefings is a step forward by the Department of Health. It remains unclear, however, to what extent, and in what ways, these will impact upon sexual healthcare practice, as experienced by lesbian/bisexual women. Where key policy documents ignore or neglect the needs of lesbian/bisexual women, the services they relate to are unlikely to fully address their specific needs. There is a need to build upon recent developments and provide more detailed routine and/or widespread information on sexual

health as it relates to lesbian/bisexual women. The evidence presented below suggests there are still clear information gaps among both healthcare workers and lesbian/bisexual women.

Methods and participants

Data in this paper derive from a research study with women who self-identified as lesbian, bisexual or women who have sex with women in a city in the North of England. It was commissioned by a local sexual health service and used detailed self-completion questionnaires. The survey was based upon a convenience sample (with additional snowballing), with questionnaires and/or a web link disseminated electronically (via email and online advertising by the commissioning health service) and in hard-copy (approximately 310 distributed), using personal and professional networks of the researcher and service/staff members involved, including distribution at a local Pride event. A dedicated, secure web space for online survey completions was set up and all completed questionnaires were returned to the researcher, either electronically or in pre-paid envelopes. The majority were returned in hard-copy, with many women taking the opportunity to write detailed responses to open-ended questions. Researcher contact details were provided in case participants wanted to discuss the research; information was also provided about local support regarding sexual health. Questionnaires were anonymous and participants were assured that the research was confidential; all data was stored securely according to university guidelines.

The survey used both closed and open-ended questions, covering a number of themes, including: access to sexual health information; sexual health knowledge; sexual practices and decision-making; experiences of health services; suggestions for future services, and views on the local context as a lesbian/bisexual woman. Completed questionnaires were received from 54 participants. Responses to closed questions were used to produce descriptive

statistics (the sample size was too small to allow more complex statistical analysis, such as cross tabulation). Open text responses were subject to thematic analysis by identifying/categorising recurring themes as they arose throughout the survey. This article focuses on this qualitative analysis, where three dominant themes emerged: invisibility and lack of information; influences on decision-making and sexual activities, and experiences of services and barriers to sexual healthcare. These themes, and issues contained within them, are explored below, integrated with additional research evidence (where possible, from England), and supported by extracts from the data, chosen to illustrate a range of responses from a variety of participants. Quotes are labelled with pseudonyms and, where they first appear, demographic information provided by participants.

The majority of participants described themselves as lesbian (66%), with 6% bisexual, 6% WSW², and 22% 'none of these'. 72% of respondents were currently in a relationship with a woman. In the last twelve months, the majority had had sex only with women (80%), although 63% had had sex with men in the past. Respondents were from a wide age range (18-64 inclusive), although a majority were in younger age categories (54% were 34 years and under). A majority described their ethnicity as white (94%), and 8% recorded a disability. Respondents were also asked their social class: whilst 33% did not answer, of those that did, 19.5% self-identified as working class, 69.5% stated middle class, and 11% responded 'other'. 94% were living in an urban setting. Respondents were also asked if they felt able to be 'open' about their sexuality in a variety of settings: the majority responded positively (between 80% on official forms and 96% at home and when socialising).

Whilst in-depth/face-to-face methods can explore these issues in greater detail than a survey permits, lesbians and bisexual women are not a homogenous group and factors other

² Unless otherwise stated, for shorthand, the term 'lesbian' is used from here on in to describe all participants, including those who identified as lesbian, bisexual and WSW.

than/in addition to sexuality (e.g. class, age, ethnicity) will have informed participants' responses to this questionnaire, and have significant implications for health inequalities (Fish 2008) and emotional well-being (McDermott 2006). Reflecting the recent growth in academic interest in intersectionality, particularly regarding sexuality and class, the survey asked respondents if/what other factors impacted on their life as a lesbian: class, ethnicity, nationality, disability, religion, age, not being 'out', and confidence were all named. One participant noted:

“I am white, middle class and professional, so have much more privilege and can be much more open about my sexuality and relationship than less privileged lesbians.” (Anne: white, British, middle class, aged 55-64)

However, whilst acknowledging the potential importance of 'difference' to experiences of health, access to services, and decision-making processes, this study was unable to fully explore these issues. The findings are not presented as universal or representative, but as a small study to begin to explore lesbian sexual health in the context of literature on human/sexual rights and sexual citizenship.

Findings

Invisibility and lack of information

Given the lack of NHS information and advice suitable for lesbians, it is perhaps not surprising that participants identified a lack of sexual health information appropriate for their needs. Overall, nearly two-thirds of participants did not find it easy to find much/any relevant information about sex and relationships between women.

“I want to feel a normal part of sexual health information, be evident on leaflets when needed, discussed at school sexual health lessons; anything other than currently ignored, forgotten or marginalised.” (Helen: white, British, class not provided, aged 35-44)

The internet was identified as key to accessing sexual health information (used by 88%), followed by books (78%), friends (76%), partners (73%) and television (73%). Noticeably, all health service options were chosen less than other choices. Just over half of respondents did not feel they had enough relevant information about sex and relationships between women, and none had experienced school sex and relationships education that included lesbian/bisexual women.

Whilst the majority of respondents did not express concerns about their sexual health, there was evidence of knowledge gaps and/or misunderstandings in relation to STI transmission: 11% did not know or thought that there was no risk of STI transmission, and 26% thought they could not get any/many STIs/HIV from sex between women. Some women did identify gaps in their own knowledge, and identified information they would like to access:

“Basic information about what sort of sex transmits what sorts of infections between women would be a start! Alongside what actually IS safe sex between women.” (Jane: white, British, lower middle class, aged 25-34, participant’s emphasis)

Some participants also linked lack of knowledge with widespread assumptions about ‘low risk’ amongst lesbians, which might subsequently impact upon their sexual decision-making and health-seeking practices:

“There should be more information for women on STIs. From my experience, they don't think they can catch anything because we're a low risk group. This also means that most won't get tested for STIs because they think they're invincible.” (Cathy: mixed race, English, middle class, aged 25-34)

This ‘lens of invincibility’ (Dolan and Davis 2003), potentially linked to lack of information/knowledge, has also been identified in other research with lesbians (McIntyre, Szewchuk and Munro 2010, Power, McNair and Carr 2009). Some participants expressed concern about the role of health professionals in (mis)informing lesbians:

“Doctors should have more information on the subject. I have come across doctors who seemed to assume STIs cannot be transmitted at all between women.” (Tilly: white, British, middle class, aged 18-24)

Although currently lacking knowledge, women did suggest potential sources of future sexual health information, including LGB(T) organisations, local health services and pharmacies/chemists, and commercial gay venues.

As shown, the current level of invisibility/marginalisation meant the NHS was used less than other resources as a source of sexual health information for WSW, and led to some misunderstandings/presumptions of ‘low risk’ among participants. The availability of information and corresponding knowledge levels can influence decisions about sexual activities, together with wider social forces, as identified below.

Influences on decision-making and sexual activities

The questionnaire explored understandings of safer sex, unsafe sex, and influences on decision-making, with (open-ended) data gathered suggesting that biomedical understandings shared by many respondents directly influenced their sexual decision-making. The majority of participants understood safer sex to involve barrier methods (condoms, dental dams, latex gloves) during sexual encounters, which demonstrated a focus on the prevention of fluid

exchange and (STI) risk reduction within a narrow disease or negative model of sexual health:

“Being careful about any exchange of bodily fluids. Not sure what else I need to worry about.” (Helen)

This contrasts with the definition used by WHO, which suggests sexual health is much broader than the prevention of STIs.

Sexual health provision for lesbians, where it exists, also tends to draw on a biomedical discourse of sexual health that is determined by lack, for example a lack of heterosexual intercourse or genital infection (Farquhar, Bailey and Whittaker 2001). More broadly, Carabine, drawing on Foucault, suggests homosexual sex is not viewed as normal or natural (Carabine 1996b). These social constructions of sex between women may directly relate to the lack of acceptance, understanding, knowledge and/or low priority on the part of medics and policy-makers. As Richardson notes:

The idea that men are the ‘active’ and women the ‘passive’ partners in sexual activity serves to render sex more invisible within lesbian relationships... This is compounded by the culturally dominant view of sexual activity as intercourse which means that other activities can be more easily discounted... and the ‘risk’ of sexually transmitted diseases more easily ignored. (Richardson 2000b, 40)

A biomedical model may not be the most helpful for (holistic) sexual health provision/information, not least because of the way it renders lesbians invisible.

Stemming from the narrow view of sexual health evidenced in my own research, choice of partner was raised as an important issue in relation to sexual decision-making. The assumption here was that sexual (ill)health is somehow visible (see also Dolan and Davis 2003), and therefore choice of partner or level of acquaintance (where ill-health or risk can be ‘seen’) can ‘protect’ against sexual risk, alongside, or often instead of, barrier methods

described in definitions of safer sex. Whilst the notion of sexual ‘dirtiness’ has a long history (Piercy 2007), it is worrying that women approach sexual encounters believing their perception/choice of partner(s) is as reliable as their choice of sexual activity/safer sex method.

Women described some (un)safer sex decisions based on long-term monogamous relationships, but casual sex encounters appeared equally likely to result in unsafe practices:

“Negotiation of previous sexual partners and whether they have had a recent sexual health check up is... beneficial... but... those things aren’t talked about until a few weeks/months into the relationship and already having sex.” (Kate: white, British, middle class, aged 18-24)

In addition, some women defined casual sex as unsafe in itself, regardless of choice of sexual activity, again highlighting a focus on the (unknown) person rather than the sexual practice. There were low levels of safer sex among all participants, supporting other recent research (Bailey et al. 2003, Power, McNair and Carr 2009). The clear majority of respondents did not report practicing safer sex during sexual encounters, with the exception of washing sex toys between uses (‘always’ done by 71%). Dental dams and latex gloves were disliked and rarely used (85% and 91% respectively reported never using them), suggesting a shared lack of acceptance and/or view that they are ‘unsexy’, ‘clinical’ and/or impersonal.

“The horribleness of the things... gloves for godsake!! Who the hell are going to use gloves? It has some form of clinical/diseased connotation to it. I think if I ever pulled these gloves out on someone they would run a mile and I certainly would not feel comfortable.” (Kate)

Another study found that “women agreed that [gloves] are not commonly used because of inconvenience, discomfort and a perception that only ‘promiscuous’ women use them” (Marrazzo, Coffey and Bingham 2005, 9). Dolan (2005) also noted that safer sex

techniques were reported to be bothersome, awkward, not readily available, expensive, confusing, less enjoyable, and potentially offensive and/or stigmatising by implying someone might have an STI.

For some participants, a lack of information contributed to a ‘culture’ of not practising safer sex within their ‘community’³:

“Culture of not always considering need to have safe sex.” (Alice: white, British, professional, aged 35-44)

“I certainly don’t think I would ever use them [dental dams] as they are not the norm amongst lesbians.” (Kate)

As Wilton commented, “For lesbians, then, identity and a sense of community have not supported the development of a confident safer sex discourse as has been the case with gay men” (Wilton 1997, 49).

In the present study, reasons given for not practicing safer sex included trusting partners, and lack of confidence/comfort with safer sex resources. Whilst an assumption of low risk was not explicitly discussed by many participants, evidence from elsewhere (Hunt and Fish 2008) suggests this may also be a factor in women’s lack of safer sex. Richardson concluded that there is a lack of knowledge on HIV risk among lesbians, related to a corresponding lack of HIV prevention targeted at lesbians, which has produced “a false sense of security among lesbians who are not taking appropriate steps to prevent HIV transmission” (Richardson 2000b, 45). This argument is supported by participants in this study:

³ Whilst I acknowledge the uncritical nature of the term LGBT ‘community’ (Wilton, 1997), a fuller examination of ‘culture’ and ‘community’ was beyond the scope of this research.

“[I would have safer sex if I had] more information about the risks of having unprotected sex which clearly states how using certain items reduces risks of transmitting diseases.” (Rachael: white, British, middle class, aged 25-34)

Other influences on sexual decision-making included alcohol/drug consumption, and confidence around negotiating safer sex, possibly related to broader cultural/attitudinal barriers to initiating/discussing (safer) sex (Formby forthcoming). The majority of respondents (78%) also said that they did not find it easy to get suitable safer sex items locally, with 90% saying that they would like to be able to.

“[I would have safer sex] if I could find the right equipment when I needed it at my chemist.” (Helen)

This highlights the link between sexual decision-making and (lack of) provision/distribution of resources and services, which has implications for an analysis of women’s human right to appropriate health information, as explored further in the discussion below. Research elsewhere has highlighted the significance of (rural) geography to health service access (Formby et al. 2010), but this was not explored as most participants were living in relatively urban areas.

In summary, influences on decision-making were linked to biomedical understandings of (safer) sex, and conceptions of the visibility of sexual ‘risk’. The limited use of barrier methods such as dental dams and latex gloves also related to accessibility, as explored further below.

Experiences of services and barriers to sexual healthcare

Research suggests that lesbian/bisexual women expect to experience heterosexism during health encounters, may delay treatment because of their sexuality and/or seek sexual health advice/information and access routine health screenings less often than heterosexual women (Fish 2006, Hunt and Fish 2008). As one participant noted:

“I have never had my sexual health checked. I've been sexually active since I was 17 and I'm now 33.” (Jane)

Where women do have negative experiences of healthcare they may be less likely to seek advice/treatment again (Fish 2006), and may share their experiences with other lesbians, which could influence other women's willingness to seek healthcare and/or 'come out' to health professionals. There is evidence that when women do attend for health advice they do not necessarily disclose their sexuality, and may be “silenced by the assumption that they are heterosexual” (McNair 2003, 643).

It has been reported that lesbian/bisexual women may not identify themselves as such with medical practitioners for fear of: being turned away, not offered appropriate/quality healthcare, or facing open hostility/homophobia (e.g. Fish 2006). Wilton argued, “in order to avoid discrimination many women may have little choice other than to allow people to assume that they are heterosexual in order to gain access to certain services” (Wilton cited in Carabine 1996b, 48). They therefore may not receive appropriate health information. However, there is also evidence that even when women do disclose their sexuality, they do not receive specific/relevant advice (Hunt and Fish 2008). This was further evidenced by participants in this study:

“...health professionals... don't know the sexual practice of lesbians and therefore cannot assess risk or offer any advice.” (Joanna: white, British, professional, aged 25-34)

“I regularly come out to health professionals but it is not always acknowledged or taken on board.” (Emma: white, New Zealander, class not provided, aged 35-44)

Confidentiality was also raised as an area of anxiety, with just under half of respondents suggesting they had concerns about coming out in health settings. Other issues mentioned included poor attitudes and/or understanding from staff, lack of visibility of LGBT patients in health materials, and poor supply of appropriate safer sex items.

“I've tried to get dental dams [from health services]... and have had problems from staff not knowing what they are, to being told that I could only have one and then I'd have to buy them from now on.” (Cathy)

Hunt and Fish (2008) found that of those who had disclosed their sexuality to a health worker, 75% said it was not acknowledged, 9% said the information was ignored, and 6% said the practitioner made inappropriate comments. Inappropriate responses were also evidenced in my own research, and less than half of respondents (43%) received information/advice appropriate to their circumstances.

“I have been laughed at for revealing my sexuality by two nurses on the same day.” (Mary: no demographic information provided)

Existing research identifies levels of inequality in the form of heterosexism and/or homophobia experienced by lesbian/bisexual women when accessing health services. In one English study, health services were described by lesbians as inaccessible and inappropriate at best, and offensive and unsafe at worst (Mugglestone 1999). Research focussing on General Practitioners' (GPs, i.e. family doctor) perspectives on dealing with sexual health with lesbian/gay patients identified a number of issues, including GPs not understanding the

mechanics of gay sex, feeling uncomfortable, not knowing the right terminology to use, and lacking knowledge of gay lifestyle (Hinchliff, Gott and Galena 2005). This is illustrated by one of their participants:

[lesbians] make me feel uncomfortable, I find them slightly aggressive; now I don't know whether that's my reaction to them or that's their reaction to me... I'm not trained. I do find them a problem because I think they are pushing me to one side, I'm not part of their world and I'm the outsider. (Hinchliff, Gott and Galena 2005, 348)

These findings clearly indicate that some GPs have an homogenous, 'other' view of homosexuality, in which they believe there is a right language and a particular gay lifestyle.

The current study produced data on women's experiences of services when 'out' as a lesbian, reflecting the existence and influence of wider social views on health professionals' practice. Most women (65%) felt that their experiences of health services could be improved. A common complaint concerned the assumption of heterosexuality in health encounters, which often made women feel angry, uncomfortable or embarrassed:

"I was embarrassed to explain I was with a woman when I knew the doctor presumed I was heterosexual." (Katrina: white, British, working class, aged 25-34)

Previous experience and/or knowledge of others' experiences clearly impacts upon take-up of services, with fear and/or previous experience of ignorance, judgemental attitudes and/or homophobia from health staff being the most commonly identified barrier to accessing sexual healthcare/advice amongst participants. Fear about attending services was enough to cause some women to delay care/treatment:

"[My] sexual partner had genital warts... [I] wanted to find out more information. Did not seek information because of my sexuality and the

perceived attitude I would receive.” (Sam: white, British, working class, aged 35-44)

“I dread having any kind of sexual health issue, and however educated I may be I would rather ignore an issue than go and get it sorted out for fear of being treated unfairly.” (Jane)

This supports other research (e.g. Mugglestone 1999) indicating lesbians would like to know gay-friendly health services where they could register/attend. Participants said that this would help them: access sexual health services, more likely to seek medical advice/treatment in relation to sexual health, and more likely to come out to a health worker.

“GP surgery could announce that it's gay-friendly instead of me having to find out by experience.” (Dilys: white, Welsh, middle class, aged 55-64)

“More overt expressions of being gay-friendly... visible evidence that I'm even being thought of.” (Helen)

Whilst this suggests a level of confidence in being out, there was also evidence that some women were still aware of their minority status in that they felt they had to think about how doctors' surgeries stating they were gay-friendly might be interpreted by other patients:

“Leaflets in waiting room, rainbow sign on notice board/window sticker. Heterosexuals would have no idea, nor kids, but we would feel better.” (Liz: white, New Zealander, middle class, aged 35-44)

It is striking that some women think about whether heterosexuals or children might be uncomfortable with their sexuality, as if homosexuality is something to be ashamed of, or hide. Similarly, concern for doctors' comfort with homosexuality was also evident:

“...health professionals not being 'comfortable' with your disclosure [is a barrier to my accessing services].” (Julia: white, British, professional, aged 45-54)

Expectation, fear or experience of heterosexism and/or homophobia in health settings is clearly important to women's current and future sexual health; the assumption of the normality or superiority of heterosexuality can influence women's views of both themselves, and their sexual health.

Discussion and conclusions

This paper has explored three dominant themes to emerge from the study data: invisibility and lack of information; influences on decision-making and sexual activities, and experiences of services and barriers to sexual healthcare. In each, heterosexism and homophobia were implicated as important factors, enabled through an analysis of social context rather than solely individual behaviour. A clear example concerned the numbers of women assumed to be heterosexual in health encounters. For some participants, fear, previous experience, or knowledge of others' experiences of homophobic attitudes/responses from health staff acted as barriers to service access, and caused them to delay seeking advice/care. This ongoing effect of fearing heterosexism and/or homophobia has clear implications for women's long-term health (and therefore their human rights), and emphasises the role of social context in shaping (sexual) health.

In a cultural context where lesbian sex remains 'ambiguous' (Richardson 2000b), many health professionals, ill-supported by inadequate training (Hinchliff, Gott and Galena 2005), may view lesbians as low risk and not pursue sexual health advice/examination, or challenge women's own (mis)perceptions. The themes explored in this paper are interrelated in that heteronormative understandings of sex (and hence lesbian invisibility) dominate sexual health information/provision, which can inform women's assumptions about their low

risk and their subsequent sexual practices (see also Power, McNair and Carr 2009). Service provision does not adequately support lesbians who report finding it difficult to access suitable safer sex information/supplies. Such perceptions and practices regarding the sexual health of WSW, tied to wider social attitudes, remain unchallenged in sexual health policy (more often they are invisible altogether). Evidence presented here serves to highlight ‘institutional barriers’ (Dolan 2005) or ‘institutionalised exclusion’ (Richardson 2000b), which directly inform women’s (un)safer sex practices. There is some evidence above to suggest a ‘culture’ of lesbians not engaging with safer sex, poorer take-up of appropriate health screenings, and low levels of disclosure to health professionals (resulting in untailed advice). Until some of the issues raised in this article are addressed, sexual health services (in England) will not be able to effectively cater to the needs of lesbian/bisexual women.

Drawing on the WHO definition of sexual health, I argue that lesbian and bisexual women’s sexual (human) rights are neither respected nor protected within much DH/NHS policy and practice. Currently, many women experience their (sexual) health and well-being within an outdated, heterosexist framework of healthcare provision in England. It could be argued that at present public health policy and practice infringes upon lesbian and bisexual women’s ability to make ‘informed choices’, and to have a positive sexual health. As Petchesky argued, “How is decision-making autonomy over sexuality possible without full information about safer sex, sexuality... and ways to avoid STDs? How is sexual health possible without access to preventative, caring, and quality services?” (Petchesky 2000, 95). Drawing on a conceptualisation of sexual citizenship with a focus on consumerism (Bell and Binnie 2002), I argue that the NHS denies lesbian/bisexual women equal citizenship through its absence of appropriate information/resources for safer sex.

It could be argued that a human rights perspective can, and should, be used to inform future health service provision. Lesbian and bisexual women should have the same quality of

preventative and therapeutic sexual healthcare as other women in England. Indeed, the National Strategy for Sexual Health and HIV stressed the importance of access to appropriate sexual health information for everyone, yet this is difficult when the specific needs of lesbians are not even addressed in the strategy itself. Lesbians effectively have three choices when making decisions about accessing sexual healthcare/advice. First, they can choose not to disclose their sexuality, meaning they do not receive specific advice for their needs, but in doing so protect themselves from potentially negative experiences. Second, they can delay access to services for fear of negative consequences that their sexuality may bring. Third, they can attend medical services, and identify as lesbian/bisexual, but in doing so risk the potential for judgement and/or inappropriate responses.

This paper seeks to place women's experiences of sexual health within the context of broader social science literature on sexualities, arguing that a sociological analysis of sexual health (and sexuality) is imperative if we are to understand the social influences and contexts for individuals' experiences and management of 'sexual health', whatever that means to them. As Keogh et al. argue, "any analysis of sexual risk and sexual negotiation is enriched by an understanding of social interaction and social norms" (Keogh et al. 2006, 32). It is precisely regarding sexual health where sexuality might have increasing significance to the provision of advice/care, as argued earlier. Taking a human rights perspective highlights the need for improvement in sexual health service delivery. As Miller (2001) argued, establishing a human right to health plays an important role in wider equality claims, though this does not mean that good health can be guaranteed, rather that conditions for (potential) good health be provided. If everyone shared an equal human right to adequate sexual healthcare, women would not need to be told services are gay-friendly.

The intention here is not for lesbian/bisexual women to feel that their sexual (health) activities are being dictated to them, but rather to highlight the invisibility of lesbian/bisexual

women's sexual health amongst policy-makers and healthcare practitioners. Discrimination on the grounds of sexual orientation in the provision of goods, facilities and services (including health services) is now outlawed in the UK. However, it will take some time for this to improve lesbians' confidence in accessing appropriate/adequate sexual health services. For lesbian and bisexual women to have greater confidence in sexual health service provision, and to have the faith to attend without fear or apprehension, efforts need to be made within the NHS to allay fears about confidentiality, quality and appropriateness of care, and attitudes of staff. Workers need to be welcoming, understanding and knowledgeable about lesbians' needs. Elsewhere, lesbians have reported wanting targeted services, which are perceived to offer safe, well-informed, and non-judgmental support (Muggleston 1999). There is also a need for greater sex and relationships education and sexual health promotion materials to include, and be targeted at, the specific needs of lesbian/bisexual women. What is ultimately needed is widespread, routine training and information provision for healthcare workers on lesbian and bisexual women's sexual health, which has obvious funding and resource implications for the NHS.

More adequate (pre- and post-qualification) training for healthcare staff is one potential solution, but practitioners need to be aware of, willing and able to engage with LGB needs. As the NHS struggles to cope with financial pressures, and sexual health is often not prioritised (THT 2008) and/or funding frequently diverted to other areas (Evans 2006), it seems unlikely that training will improve in the short-term, if at all. Whilst there is widespread unease with (homo)sexuality within society, and therefore policy-making (Carabine 1996a), wider equality gains for LGB communities may be experienced less in the sexual health field where sexual identities (and the practices of sexuality) become more identifiable, potentially heightening discomfort for both practitioner and patient. Healthcare

provision for lesbian and bisexual women, and public policy within the Department of Health, is therefore failing to keep up with current UK equalities legislation.

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