The National LGBT Partnership

VCSE health & wellbeing alliance

Incognito Mode: The Reality of LBT+ Women & Femmes' Sexual & Reproductive Health

July 2024

Table of Contents

Acknowledgements

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Special thanks go to Black Beetle Health, elop, London Friend, MindOut, Opening Doors, ParaPride, The Proud Trust, TransActual, Yorkshire MESMAC, the NHS England LGBT Health Team, and all the LBT+ women and femmes who shared their stories and experiences.

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Foreword

I have worked in the sexual health and relationship & sex education (RSE) worlds for the past nine years. During this time, I've had the pleasure of working alongside passionate, dedicated educators and health professionals. There are truly incredible people working in these fields. Yet, as this report highlights, it's still likely that LBT+ women and femmes will interact with professionals who carry fear, shame, and misinformation into their work. This report outlines the direct impact this has on LBT+ women and femmes and what we can do to address it.

I also have personal experiences as a queer service user. I've come up against difficult situations that mirror many of the accounts in this report: from being asked inappropriate questions during appointments (no, I won't explain why I like having sex with women!), to condoms not being given to me under the assumption that I wouldn't need them, to misinformation about what STI testing I should have access to. There's so much that must be done to improve services.

In isolation, one person having a negative experience may not seem so bad, especially within the context of a collapsing NHS. But the impact is felt reading this data: these are not isolated incidents. This report speaks to a culture of misunderstanding and sexualisation of queer women and femmes, which creates significant barriers to accessing essential education and healthcare, including services for sexual health, pregnancy, menopause, mental health, and beyond.

These barriers begin at a young age, with RSE that doesn't speak to LBT+ women and femmes' experiences, and continue as we grow through life. Reading this report, I was particularly shocked by the findings that only 35.5% of participants feel able to disclose their sexuality to healthcare professionals, and that rates of Chlamydia and/or Gonorrhoea in LBT+ women and femmes are over eleven times higher than the UK average. There's a lot of mistrust and unease about medical services, and it's no wonder when there's the threat of misunderstanding, ignorance, and discrimination around sexuality, gender, or any other marginalised part of our identities.

The resulting recommendations are insightful and timely, with the emphasis resting on political decision-makers to address these issues. Many of us have been crying out for a more inclusive and informed approach to RSE and sexual health services, and this report provides solid data to back this up. And the emphasis on staff training is an important one — we can't rely on professionals' personal knowledge to inform their work; information on LGBTQIA+ identities must be woven into initial training, and something that's topped up as we gain new knowledge and terminology.

This report marks a clear path for how we can improve the accessibility and inclusivity of services for queer women and femmes. My hope is that collectively we are able to turn these recommendations into a reality and that those in power will listen and start taking action.

Ruby Rare (she/they)
Sex & Relationships Educator, Author, and Presenter

Photo Credit:
Stephen Daly (@stephendalyphotography)

Introduction

Incognito Mode is a comprehensive study into the sexual and reproductive health of LBT+ women and femme-aligned people. We carried out a survey to gain insight into the experiences of queer women and femmes, conducted between August and December 2022, mostly asking them to reflect on their experiences over the past 12 months.

The title — *Incognito Mode* — refers to the simultaneous hypersexualisation and fetishisation of LBT+ women and femmes (often due to pornography) and the invisibility that they experience within healthcare spaces. These themes are explored throughout this report.

The report is split into a report section, which will examine these experiences, and a recommendations section, which includes recommendations for practitioners and services that support LBT+ women and femmes.

The report section covers eleven key areas of sexual and reproductive health and wellbeing:

- Relationships & Sex Education
- Access to Sexual & Reproductive Health Services
- STIs, HIV and Sexual Health
- Contraception
- Reproductive Health
- Menstrual Health
- Menopause
- Relationships
- Pleasure
- Sexual Violence
- Substance Use

The recommendations are based on the key aspects covered by the report. They identify needs in these areas and make suggestions to improve LGBTQIA+ experiences.

The list of support services, found at the end of the report, forms a toolkit of organisation websites and helplines that individuals can use to support their own sexual and reproductive health and wellbeing or that of friends, family, and members of their communities.

Content Warning

This report takes a deep look into some sensitive topics, including sexual violence, substance misuse, queerphobia, and other types of discrimination. Please read with caution or avoid the report altogether if these topics are likely to affect you.

Who We Are

The National LGBT Partnership connects a group of thirty-nine LGBTQIA+ organisations across England committed to reducing health inequalities and challenging homophobia, biphobia, and transphobia within public services, improving access to health and social care for LGBTQIA+ people. The Partnership is led by LGBT Foundation and Consortium. To view a full list of the thirty-nine partners, visit https://www.consortium.lgbt/nationallgbtpartnership/about-the-partners/

The Partnership is a Sector Strategic Partner of the Department of Health, Public Health England, and NHS England, collaborating with a wide range of organisations as part of the Health and Wellbeing Alliance, influencing policy, practice, and actions of Government and statutory bodies.

𝕏: @LGBTPartnership

Laura Clarke (she/they), the writer and researcher of this report, is an award-winning LGBTQIA+ specialist as well as an accredited sex and relationships educator. Laura works with young people and professionals alike, in an attempt to make the world a more queer-friendly and sex-positive place for all.

𝕏: @mybodyandyours

Background

“ People with multiple marginalised identities experience unique, and often additional, forms of discrimination within healthcare settings and are disproportionately impacted by poor health. ”

LBT+ women and femmes do not only experience misogyny and queerphobia, but a distinctive blend of these prejudices that often manifests as hypersexualisation and fetishisation. When LBT+ sex is seen or discussed, it is often done so with the intent of male gratification rather than with a focus on the clinical needs and sexual wellbeing of women and femmes. This has led to a societal neglect of LBT+ women’s health, from limited academic research to a lack of medical training, the result of which is that LBT+ women and the professionals who treat them are more prone to misinformation, and that women and femmes themselves are at greater risk of poor physical and mental health and of sexual violence and harassment.

The National LGBT Partnership has explored the health of LBT+ women and femmes through our annual LBT+ Women’s Health Week for 5+ years and conducted a number of research projects into the health and wellbeing of queer women. We felt it was time to create a comprehensive report on LBT+ sexual and reproductive health that covers all aspects of sexual wellbeing, from the information we receive in school to less medicalised aspects of wellbeing, like pleasure.

This report draws upon a number of other studies that have been conducted on LGBTQIA+ people, focusing specifically on women and femmes where possible. By compiling this information and conducting our own research, we are aiming to shine a light on the current state of LBT+ sexual and reproductive health in England, and propose strategic ways to support queer women and femmes.

This research aims to identify challenges faced by LBT+ women and femmes relating to their sexual and reproductive health and wellbeing. With this resource, we hope to provide recommendations for service providers, healthcare workers, and other practitioners who are supporting LBT+ people, as well as a direct resource for those who identify as LBT+ women and femme-aligned people who wish to better support their own sexual and reproductive wellness.

Terminology

This report uses the acronym LGBTQIA+ and the term "queer" to collectively represent those who identify as lesbian, gay, bisexual, transgender, queer, intersex, and asexual, as well as those with other non-heterosexual, non-cisgender identities, such as unidentified, pansexual, questioning, genderqueer, or agender.

We use "LBT+ women and femme-aligned people" or "LBT+ women and femmes" to represent queer women, queer people who identify with femininity or womanhood in any way, and queer people who experience misogyny. Some people with non-binary identities are included in this report, but only those who have themselves identified with the term "LBT+ women and femme-aligned people". In the survey information provided to participants, we listed the following definition:

"This survey is open to LBT+ women (lesbians, bi women, trans women, ace women, pan women, etc.) and anybody who in some way relates to this identity. For example, you may be non-binary but identify as a demigirl, or femme, or in some other way relate to the concept of womanhood. Basically, if you feel like this survey is for you, it is."

The acronym LBT+ is used to collectively represent queer and trans women and femmes. Our decision to remove the "G" (for "gay") from this popular acronym is not intended to erase women who identify as gay (as many do), but to create a distinction between conversations about queer women and the LGBTQIA+ community more generally. We use the "+" to include all queer women who may not identify as lesbian, bisexual, or trans but still hold non-heterosexual, non-cisgender identities, including gay women.

"Trans" is used as a general term that refers to anyone whose current gender identity is different from their gender assigned at birth, including binary and non-binary trans people. We also recognise that some non-binary, genderqueer, or otherwise gender-diverse people may not identify as trans; we hope to recognise this in the report by using the term "trans and non-binary people".

In the report, the term "people of colour" is used to refer to people who are Black (including Black African, Black Caribbean or another Black heritage), Asian (including Indian, Pakistani, Bangladeshi, East Asian, Pacific Island, or another Asian heritage), Latinx, mixed heritage, or of another non-white heritage.

We recognise the social model of disability, which understands that people are disabled by ableist structures and barriers in society rather than by their personal impairment or difference. Therefore, we use the term "disabled people" rather than "people with disabilities" throughout this report.

We acknowledge that people prefer a variety of different terms to describe their identities, and many find it hard to fit their experiences into a category. As language is fluid, the terms we use in this report may not remain the preferred terms of the group to which they refer. We hope to be respectful of all the groups mentioned by using person-first language. A full glossary can be found at the end of the report on page 120.

Methodology

The report draws from a survey that we distributed between the 17th of August and the 31st of December, 2022. The survey received 551 responses from LBT+ women and femmes (16+) who were living in England. For the most part, we asked participants to reflect on the past 12 months at the time of taking the survey. While we weren't able to compensate each survey participant individually due to budget and logistics, everyone who entered the survey was invited to put their name into a prize draw to win a £100 shopping voucher. Participants also had the option to remain anonymous.

In addition to the survey, we also conducted three virtual roundtables with a total of 14 LBT+ women and femmes. These people declared their interest in the roundtables as part of the survey and were selected based on their free-text survey responses, which displayed a variety of experiences that we wanted to explore further. Roundtable participants were compensated for their time and expertise with a £20 shopping voucher.

Partners of the National LGBT Partnership were consulted on structure and the priorities of the report, namely our Equity Representatives: Black Beetle Health, elop, London Friend, MindOut, Opening Doors, ParaPride, The Proud Trust, TransActual, and Yorkshire MESMAC.

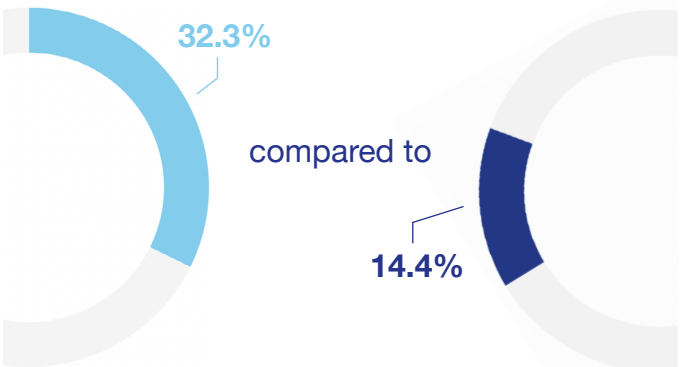
It should be noted that certain demographic groups among the respondents had significantly small sample sizes; namely people over the age of 55 (n=24), people aged 16 or 17 (n=11) and people living with HIV (n=23). These small sample sizes may mean that our insights are less able to reflect the general experiences of those groups. In some cases, we have chosen not to examine the responses of a particular group because the sample size was too small to provide meaningful insights. However, we recognise that the experiences of these missing demographics are just as important as those that have been included in the report.

For further notes on demographics, please see page 116.

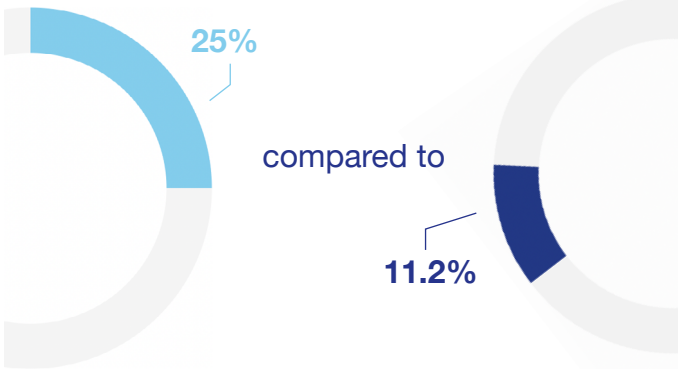
Key Findings

Relationships & Sex Education

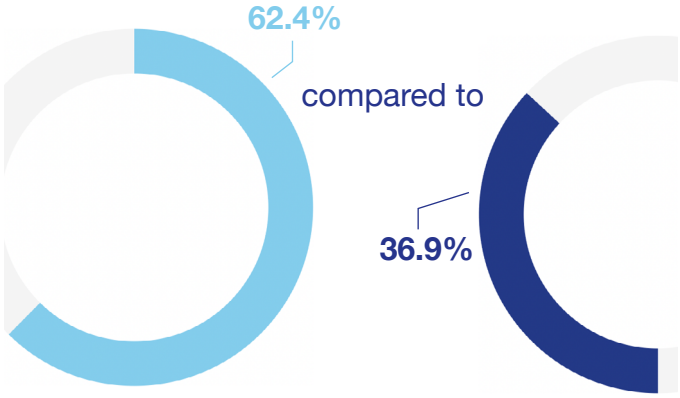
Relationships & Sex Education (RSE) plays an important role in a young person's journey with their identity, relationships, and sexual health. Our research found that participants who hadn't received RSE in school were more likely to have contracted an STI in the past 12 months,



who did receive RSE, were twice as likely to feel at risk of harm during a sexual encounter,



and were less likely to reliably achieve orgasm with a partner



Of the participants who received any RSE in school, only

4.4%

remember being taught about LGBTQIA+ identities as part of their education,

leaving over half of LBT+ women and femmes (**51%**) feeling that their RSE wasn't relevant to them.

The vast majority of our participants would have been taught under Section 28, due to their age, but even those who attended school after this law was repealed felt that its impact affected the way their RSE was taught:

> "Growing up in a "post" Section 28 world (repealed when I was in my last year of primary school), I believe that this heavily impacted, and continues to impact, the poor LGBTQIA+ relationship and sex education."
>
> *- (Survey participant)*

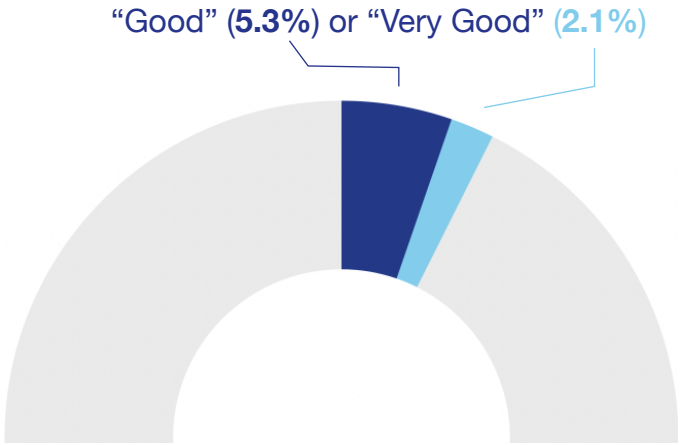
It seems that when LGBTQIA+ identities were mentioned, they were often spoken about negatively or only in relation to HIV.

The impact that a lack of queer-inclusive education (or discriminatory education) had on LBT+ women was clear. Participants felt that being taught LGBTQIA+ topics may have helped them to sooner realise their queer identity and protected them from trauma and dangerous situations and relationships:

> "I think if I had known more about queer relationships I might have had one sooner."
>
> *- (Survey participant)*

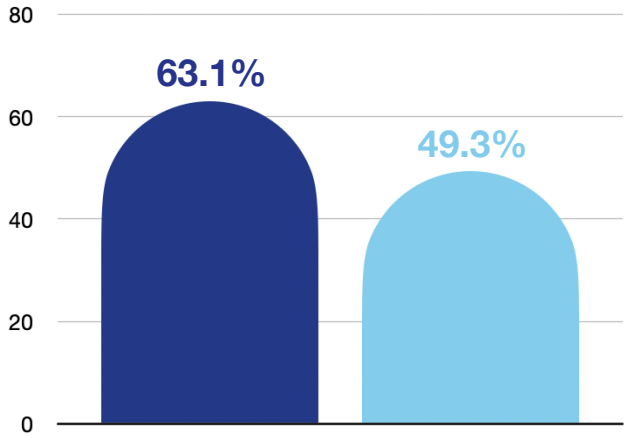
Participants shared that inclusive sex ed felt like a lottery, depending on what teacher you had. Several LBT+ women and femmes reported themselves or other students self-advocating for LGBTQIA+ RSE.

Of those who received RSE, only **7.4%** of survey participants rated their relationships and sex education as



Access to Sexual & Reproductive Health Services

Cisgender LB+ women were more likely to have accessed sexual health care in the past year (**63.1%**),



than trans women and femmes (49.3%). Our findings showed that

25.8% of LBT+ women and femmes

who accessed sexual or reproductive health care in the past 12 months felt that they were asked inappropriate questions due to their LGBTQIA+ identity.

Queer erasure appeared to be an experience that many women and femmes shared when accessing sexual and reproductive healthcare.

Nearly half (**47.2%**) of respondents who had accessed sexual health or reproductive health care in the past 12 months felt that their healthcare worker didn't fully understand their LGBTQIA+ identity. Many participants reported hetero- and cis-normativity during appointments.

Coming out was a challenge for many LBT+ women and femmes, with only

35.5%

of participants feeling able to disclose their LGBTQIA+ identity to all of their healthcare professionals.

A lack of or inadequate data monitoring means that LGBTQIA+ people must repeatedly come out, which many say can feel awkward or nerve-wracking. Many people choose not to come out altogether for fear of negative consequences:

> "I simply haven't come out to my GP about my gender or sexuality. I wouldn't be comfortable telling her."
>
> *- (Survey participant)*

We found that this lack of data monitoring also presents challenges when it comes to health screenings, especially for those whose anatomy doesn't "match" their gender marker. Women who have sex with women reported receiving misinformation about their need for cervical screenings. Over a quarter

27.5%

of respondents with a cervix

who were eligible for an NHS cervical screening had not been for a smear test in the past three years. Disabled cervix-owners and people of colour were even less likely to have attended a cervical screening with

32.9%

of disabled people and

50.8%

of people of colour

reporting that they had not received a smear test within the past three years.

For trans and non-binary people, accessing cervical screenings was a challenge due to the often gendered nature of the procedure and gender dysphoria:

> "I'll go for a cervical screening when I get a letter that doesn't treat me like a woman."
>
> *- (Roundtable participant)*

Nearly one in five (**18%**) of our survey respondents had been made to take a pregnancy test to access healthcare in the past year. **29.2%** of these participants informed their doctor that there was no risk of pregnancy but were still made to take the test. LBT+ women and femmes felt frustrated by this procedure, and many felt it was unnecessary.

40.6%

of survey participants

felt that they had been discriminated against when accessing sexual or reproductive healthcare in the past twelve months. Anti-blackness, medicalised fatphobia, and Autism discrimination were most frequently mentioned in the free-text responses.

STIs, HIV and Sexual Health

Of those who had engaged in sexual activity in the past year,

44.6% of LBT+ women and femmes surveyed

had been tested for STIs during this period.

Over a quarter (26.6%) of people surveyed had been diagnosed with an STI or intimate infection in the past 12 months.

Of our 551 survey responses,

4.4% of LBT+ women and femmes

had received a diagnosis of Chlamydia and/or Gonorrhoea in the past year — over eleven times the percentage of the general population in England (**0.39%**).

Of those who were diagnosed with an STI or intimate infection, over a quarter

(28.9%)

did not seek further health support and did not take medication to treat the condition.

Several participants expressed difficulty accessing both in-person and online sexual health testing:

> "I'm nonbinary trans (AFAB) and when ordering STI test kits online, I've had it before where there are multiple gender options, one being trans, but then the kit is quite clearly aimed at someone with AMAB biology."
>
> *- (Survey participant)*

4% of our survey respondents had a diagnosis of HIV.

Of those with a HIV diagnosis, **9%** of participants had been diagnosed in the past 12 months. Several participants expressed frustration that HIV is still mostly seen as an issue that only impacts men who have sex with men, while LBT+ women and femmes are still at risk:

> "I've found the general assumption seems to still be that HIV is still an exclusively men-loving-men thing; I know that trans women are a significant demographic for HIV, but this really isn't talked about."
>
> *- (Survey participant)*

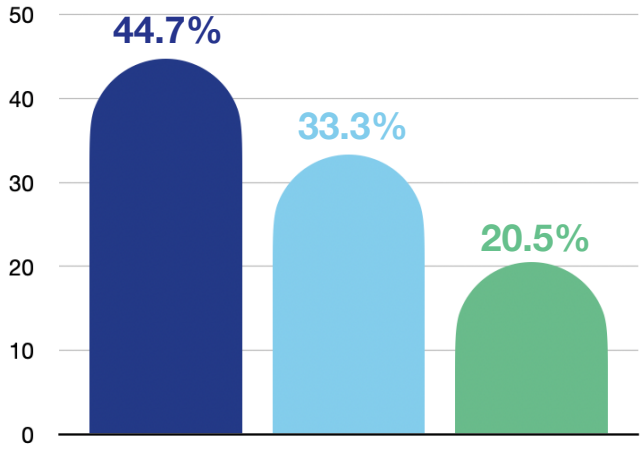
Cisgender women were nearly three times as likely to have taken PEP (post-exposure prophylaxis, a drug to prevent the transmission of HIV) in the past year

9.2% of cis participants compared to

3.6% of trans and non-binary participants.

Contraception

Of the LBT+ women and femmes who have tried to access contraception in the past 12 months, nearly half (**46.6%**) have found access to be difficult.



44.7% reported long waits for medical appointments, **33.3%** reported a lack of availability, and **20.5%** reported difficulty due to the price of contraception.

Women who have sex with women reported difficulty accessing hormonal contraception to manage menstruation and period-related medical conditions due to being refused on the basis that there was no risk of pregnancy:

> "My GP referred me to get the Mirena coil because of a health condition, and because I said that I was in a same-sex relationship, they turned me down for it."
>
> *- (Roundtable participant)*

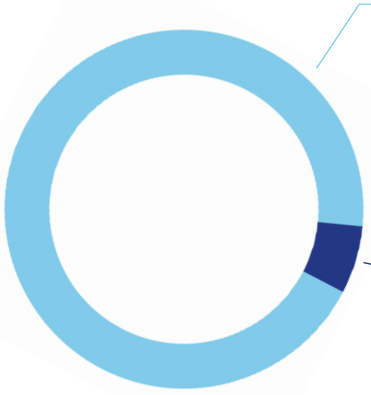
A large portion of participants brought up dental dams, and the lack of access and education surrounding dams was criticised. Out of 551 LBT+ women and femmes surveyed, only **0.4%** had used a dental dam in the last 12 months, despite many more expressing a desire to use them:

> "I'm in a long-term lesbian monogamous relationship, so don't use contraception. However, I have wanted to purchase dental dams but have never seen them for sale and don't know where to get them."
>
> *- (Survey participant)*

Generally, it was found that accessing both hormonal contraception and barrier methods was a difficulty for LBT+ women and femmes having sex with other women and femmes.

Reproductive Health

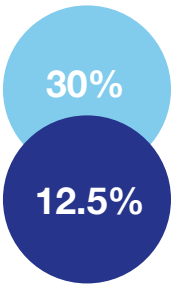
Of the LBT+ women and femmes who experienced pregnancy in the past year,



93.9% accessed pregnancy-related care during their pregnancy.

The remaining **6.1%** (3 people) didn't receive any pregnancy-related care. Of these three people, two identified as trans or non-binary.

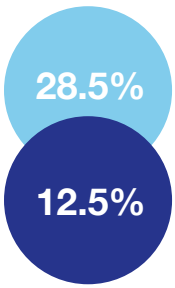
Disabled respondents were more likely to find accessing reproductive healthcare "difficult" or "very difficult"



of disabled respondents compared to

of non-disabled people.

Additionally,



of neurodivergent people rated accessibility as "difficult" or "very difficult", compared to

of neurotypical people.

LBT+ people who were seeking to get pregnant via IUI or IVF reported a lack of information, resources, and funding for this type of conception. **62.1%** did so without success, and **63.2%** of those who attempted IVF were also unsuccessful.

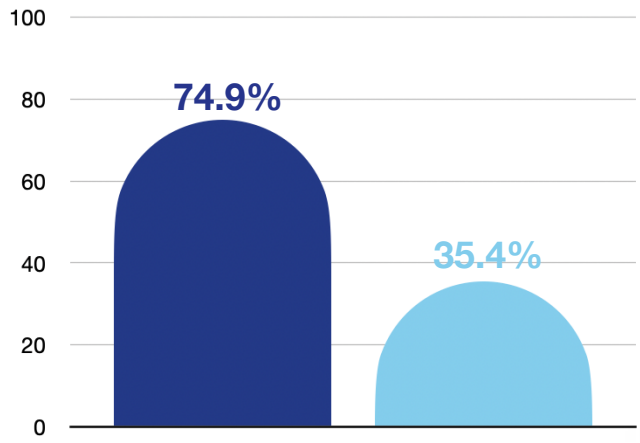
Non-birthing parents and trans and non-binary parents found getting recognised as a legitimate parent difficult and often felt ignored or disrespected:

> “ [My partner] was [...] made to feel quite awkward during maternity care as the non-biological parent and referred to as my birthing partner at some points.”
>
> *- (Survey participant)*

Several people also reported not wanting children and attempting to take steps to avoid this but not being supported by their healthcare professionals.

Menstrual Health

A lack of appropriate care for menstrual pain and disorders was highly reported, with LBT+ women and femmes feeling disbelieved and ignored.



Three-quarters (**74.9%**) of respondents who menstruate reported most commonly experiencing moderate to severe pain. **35.4%** of our survey participants had been diagnosed with menstruation-related conditions such as PCOS or Endometriosis.

Some women and femmes felt that the poor quality of care they received related to their queerness:

> “ Tried to get a diagnosis for endometriosis with no success yet. [The doctor] wouldn’t do the secondary internal scan because I’m a virgin and haven’t had penis-in-vagina sex despite having engaged in other “lower” level sexual activities (not oral).”
>
> *- (Survey participant)*

17.9% of the survey participants who have periods identified as trans or non-binary

and a number of these people reported experiencing dysphoria during their periods.

Another concern for several people was the cost of period products.

57.1% of people who had issues accessing period products claimed that this was due to the cost:

> “ I regularly have to choose between food and buying sanitary products. ”
>
> *- (Survey participant)*

People in relationships where multiple people have periods will have to spend more on period products than those in cisgender, heterosexual partnerships.

Menopause

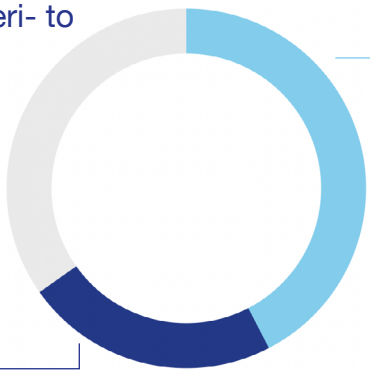
The main theme that surrounded menopause was the lack of information available and a feeling of being unprepared. Only **2.8%** of people who received RSE in school were taught about the menopause:

> “I’ve had no menopause education in my life. I don’t think any woman has. I don’t know when perimenopause occurs, what that looks like, or what happens during menopause and what is available during that time.”
>
> *- (Survey participant)*

Trans and non-binary people especially reported challenges with hormones and the information that is available and relevant to them:

> “I have recently noticed more severe symptoms of menopause and wondered if it’s moving from perimenopause to full menopause. I found queermenopause.com which has been helpful, but there’s so little out there for nonbinary people experiencing menopause. I would really like to understand how HRT might affect me or what it means for a nonbinary person with a uterus — it seems like it helps with the symptoms, but at the same time, given my periods make me dysphoric, do I want “replacement” of hormones I am ambivalent about? I wish there was more information about this available, and in less gendered language (e.g. the assumption that “HRT helps” — is this true for nonbinary people? Is there an alternative?)”
>
> *- (Survey participant)*

Of those who were peri- to post-menopausal,



42.4% were in a relationship where themselves and their partner were experiencing menopause at the same time,

and **22.8%** had experienced this in the past.

Relationships

Those in queer relationships overwhelmingly reported feeling rejected or discriminated against by family members:

> “Being a trans and queer couple, I am not able to come out to my family because they are both transphobic and homophobic.”
>
> *- (Survey participant)*

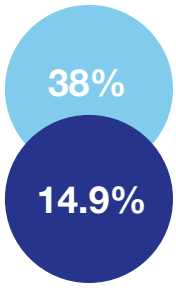
Only a quarter (**26.7%**) of LBT+ women and femmes said that their friends and family were aware of their partner(s).

People in trans, bi+, or polyamorous relationships reported a lack of understanding or additional prejudice surrounding their relationships, as did people from religious backgrounds and people who hold multiple marginalised identities:

> “My friends and family are aware, but due to my girlfriend being a South Asian Muslim, she cannot ever let her family know due to safety of life and being disowned. There are some environments where we need to pretend to be just friends.”
>
> *- (Survey participant)*

Pleasure

Only **0.8%** of people who received RSE were taught about Pleasure as a topic. Just over half of the LBT+ women and femmes surveyed (**52.9%**) said they were



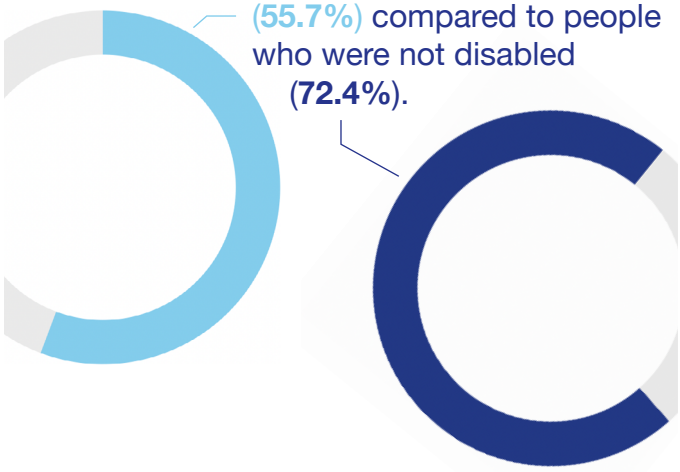
with their sex life (or lack thereof) over the past 12 months.

A number of LBT+ women and femmes reported difficulty with pleasure and orgasm, due to reasons such as dysphoria and mental health. Those living with physical or mental health conditions, or trauma, found pleasure and orgasm harder:

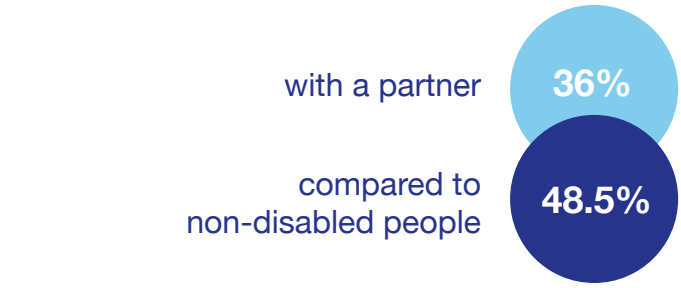
> “I have a chronic illness which causes widespread pain and chronic fatigue. This impacts my sex life.”
>
> *- (Survey participant)*

> “I have a lot of trauma from childhood sexual assault that has had a big impact on my sex drive and what I am comfortable doing.”
>
> *- (Survey participant)*

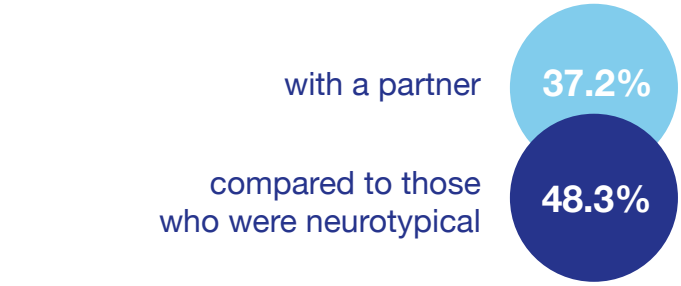
Disabled people were less likely to orgasm over 80% of the time during masturbation (**55.7%**) compared to people who were not disabled (**72.4%**).



Disabled people were also less likely to orgasm over 80% of the time



Neurodivergent people were less likely to orgasm over 80% of the time



Sexual Violence

Nearly half (**42.4%**) of women and femmes surveyed said they'd experienced sexual harassment in the past 12 months,

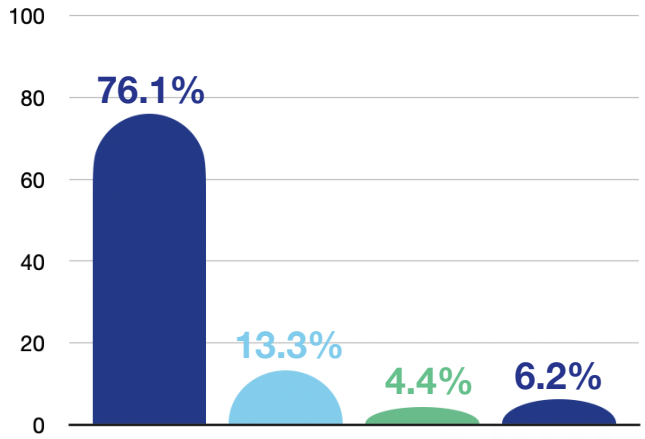
with a further 8.9% saying they didn't know if they had.

People who identified as asexual or aromantic were more likely to be victims of sexual abuse, sexual assault, and rape. LBT+ people of colour were also at higher risk.

A high number of the free-text responses on the subject of sexual violence addressed the issue of gender, with a number of women and femmes identifying men as the problem:

> "When I have experienced sexual violence in my past pre-my current relationship, it has always been from men and often has a lot to do with my bisexuality and the preconceptions surrounding it."
>
> *- (Survey participant)*

Of those who had experienced sexual violence in the past 12 months,

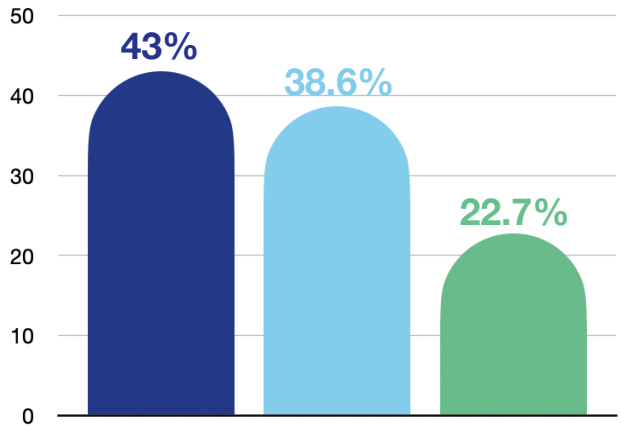


76.1% of LBT+ women and femmes said that the perpetrator(s) was of a different gender than themselves, 13.3% said that the perpetrator(s) were a mix of genders, 4.4% said that the perpetrator(s) were of the same gender as themselves and **6.2%** said they didn't know the gender of the perpetrator(s).

Of those who had experienced sexual violence in the past 12 months, a third of survivors (**31.9%**) didn't seek support from anyone.

Substance Use

For survey participants who regularly took drugs or drank alcohol prior to sex, common reasons were related to sexual improvement such as:



confidence (**43%**), relaxation (38.6%) and help with arousal (22.7%):

> "Alcohol can amplify the sensory sensations, and sex will be more harmonious under the catalysis of alcohol."
>
> *- (Survey participant)*

However, over one in ten (**16.9%**) admitted to using drugs or alcohol before sex to combat feelings of shame:

> “They help with suppressing religious trauma, which can affect [my] ability to engage in sex properly.”
>
> *- (Survey participant)*

A number of LBT+ women and femmes identified risks to using substances before sex, saying it made them feel more vulnerable to being taken advantage of, and several people reported abstaining from drugs and alcohol to aid their safety and enjoyment.

Key Recommendations

Improving LBT+ sexual and reproductive health outcomes is everyone's responsibility, which is why these key recommendations target a variety of decision-makers, including government officials, policy leads, healthcare services, and charities.

1) Relationships and Sex Education (RSE)

RSE should be LGBTQIA+ inclusive and teach young people age-appropriate and timely information about sexual orientations and gender identities to better equip young people to have healthy sex lives in the future. Schools should always refer to the statutory guidance and reliable organisations such as Brook.

RSE should include information and advice around physical sexual health, such as STIs, how to avoid them and where to access STI testing and treatment, in addition to social wellbeing topics such as consent and healthy relationships.

RSE should be taught by qualified (ideally external) speakers and educators rather than from teachers for whom it isn't their specialty. This should be a mandatory requirement of RSE.

2) Queer-Inclusive Sexual & Reproductive Health

Primary care services must ensure they are LGBTQIA+ inclusive by supporting staff with training on LGBTQIA+ inclusive care , and referring to reliable resources such as "BASHH Recommendations For Integrated Sexual Health Services For Trans, Including Non-Binary, People"

Sexual health services should work with and/or co-deliver services with LGBTQIA+ community organisations to ensure their services are promoted and delivered in an LGBTQIA+ inclusive way

Sexual health services should seek to provide clinic times that are LGB- and trans-specific alongside their regular service to cater to those who may feel uncomfortable accessing usual service hours or need specialist care.

3) Inclusive Health Screenings

Services that provide sex-specific screenings such as cervical smears, mammograms and prostate screenings must ensure that trans and non-binary individuals are accommodated respectfully.

Healthcare professionals must be equipped with up-to-date knowledge on performing tests on post-operative trans and non-binary bodies, and all materials and resources must be written in inclusive, additive language (i.e. women and people with a cervix).

4) LGBTQIA+ Staff Training

All healthcare professionals working in sexual and reproductive health, gynaecology, fertility, perinatal and menopause services should receive mandatory LGBTQIA+ training as part of their formal training and at regular intervals throughout their career. As a minimum this should cover the difference between sexual orientation and gender identity, pronouns and language and discrimination in healthcare.

5) Data Monitoring Reform

Data collection in healthcare settings should be designed to capture detail on sexual orientation, gender identity and trans status, as well as information on sex, and allow people to select which body parts they have. This would deliver a more inclusive approach, allow for collection of clinically relevant information for both cisgender and trans gender people and enable people to be appropriately called for health screenings. We recommend following the principles outlined in the LGBT Foundation report “If We’re Not Counted, We Don’t Count”.

6) Inclusive Language in Materials and Resources

Information, health promotion materials and resources (leaflets, posters, websites, apps, etc.) from healthcare services that are typically gendered (menstruation, menopause, pregnancy, etc.) should be designed with inclusive and additive language (e.g. “women and people who menstruate”)

7) Support for Queer Parents

More provisions should be put in place by reproductive health, gynaecology, fertility and perinatal services to support LGBTQIA+ parents, especially trans and non-binary parents and non-birthing parents. Refer to the LGBT Foundation report “Improving Trans Experiences of Maternity Services” for guidance.

8) Period Dignity

Free period products should be provided within all healthcare settings, including sexual health clinics, LGBTQIA+ services, and charities, to support people who menstruate and cannot afford these products off the shelf.

In addition, healthcare services, schools and charities must strive to reduce shame around menstruation, in line with work being done by campaigns like Period Positive and Bloody Good Period.

All period-related care provided by health workers must be trans-inclusive, with any materials or resources using additive language.

9) Menopause Education

Education and resources about menopause should be made more widely available and cater not only to those who are currently experiencing the menopause but also to those who are premenopausal to prepare them accordingly. This must include trans and non-binary people going through menopause, who may have different needs.

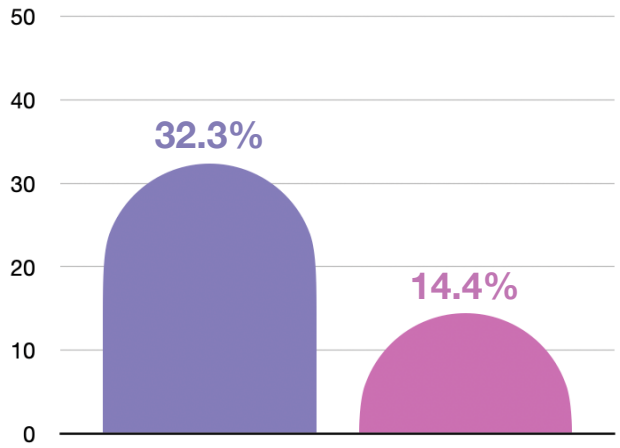
10) Substance Recovery Support

Healthcare services and charities who provide support around substances must ensure that support is inclusive of LBT+ women and femme-aligned people, if possible providing separate queer-specific or female-specific sessions.

LGBTQIA+ entertainment venues should provide sober nights for queer people to allow alcohol- and drug-free meetings to take place. Venues should also be vigilant about sexual violence and coercion and have policies in place to protect drunk and high people from sexual violence.

Relationships & Sex Education

While the focus of this report is health, the relationships and sex education (RSE) that one receives in their youth has an impact on their approach to their own sexual relationships and personal wellbeing. Poor quality, or an absence of, sex education can lead to worse physical health outcomes — our survey found that:



32.3% of people who said they received no RSE in school had been diagnosed with an STI in the past year, compared to only **14.4%** of those who did receive RSE. Further consequences relate to relationships, pleasure, and social wellbeing:

- When asked if they had felt at risk of harm or violation while engaging in a sexual encounter in the past 12 months, survey participants who had not received RSE were over twice as likely to say yes (**25%**), compared to people who did receive RSE (**11.2%**)
- Survey participants who were taught RSE were more likely to reliably achieve orgasm during partnered sex. Of those who had had partnered sex in the past 12 months, **62.4%** of people who received RSE in school reported achieving orgasm with a partner **61-100%** of the time, compared to **36.9%** of those who didn't receive RSE.
- Respondents who didn't receive RSE were more likely to have taken drugs before engaging in a sexual encounter with another person in the past 12 months

(**55.6%**) compared to those who were taught RSE (**30.9%**)

Growing up queer comes with unique challenges, especially when it comes to navigating sexual and romantic relationships, and young people need to receive RSE that is reflective of their identity and experiences.

Hetero- & Cis-Normative RSE

Relationships and sex education in the UK only became mandatory in 2020[1], and while the updated guidance does make reference to LGBT-specific education, how and when this should be delivered to students remains incredibly vague:

> "At the point at which schools consider it appropriate to teach their pupils about LGBT, they should ensure that this content is fully integrated into their programmes of study for this area of the curriculum rather than delivered as a standalone unit or lesson. Schools are free to determine how they do this, and we expect all pupils to have been taught LGBT content at a timely point as part of this area of the curriculum."[1]

The specifics of queer-inclusive RSE seem to be left up to individual schools, as does the timeliness of its delivery. Our research found that, of those who did receive RSE in school,

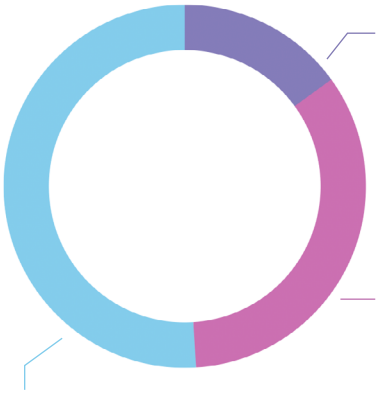
only **20.3%** remembered minority sexual orientations (LGB+ identities) being mentioned, and only **10.6%** reported trans identities being mentioned:

> "I didn't learn about any kinds of sex other than strictly penis-in-vagina, and framed within a heterosexual, cis relationship."
>
> *- (Survey participant)*

> "LGBTQ+ identities were not spoken about whatsoever. My sex education was extremely blinkered, focusing purely on heteronormative identities."
>
> *- (Survey participant)*

> "I specifically remember being told that when I reached puberty I would develop attraction to members of the opposite sex, but there was no mention of developing attraction to members of the same sex."
>
> *- (Survey participant)*

The result of such hetero- and cis-normative education has a clear impact on queer students. Of our survey participants who received RSE in school,



only **15%** felt that the relationships and sex education they received was "very" or "quite" relevant to them, with a further **34%** saying it was only "somewhat relevant" and **51%** claiming it was "not very relevant" or "not at all relevant".

In a 2016 study, the Terrence Higgins Trust found that young people were eight times more likely to rate their RSE as "excellent" if it was LGBT-inclusive.[2] While LGBT-inclusive education may mean the teaching of LGBT-specific matters, such as gender dysphoria, coming out, or transitioning, it also relates to broader topics being taught in an inclusive way, for example, contraception and safe sex:

> "There was no talk about how same-sex couples can have safe sex. It was very heavily focused on having sex to conceive rather than to strengthen a relationship or for fun."
>
> *- (Survey participant)*

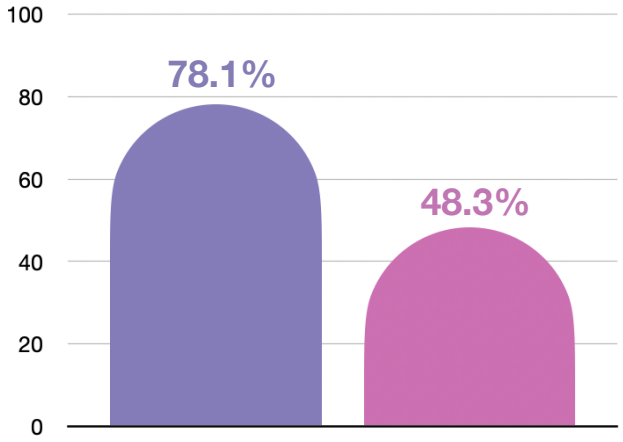
> "Focus was on hetero[sexual] sex and practising putting a condom on a penis model. For queer people in my class who may not have had any desire to have sex with a penis this was an awkward exercise with no alternative. I did not learn about dental dams or other protection."
>
> *- (Survey participant)*

> "Most of it was very conservative and not about anatomy and protection from a sense of LGBTQIA+. It was assumed that you were straight."
>
> *- (Survey participant)*

The assumption that all students in the classroom are heterosexual was a strong theme in our research. This assumption can further contribute to the exclusion of queer students:

> "We were once asked to draw the "man" of our dreams — everyone else was drawing men, so I did too — but I don't think I really wanted too deep down."
>
> *- (Survey participant)*

Heavily gendered RSE may also isolate LGBTQIA+ young people. It's not uncommon in the UK for students to be separated by sex for RSE lessons and taught the parts of RSE that are deemed relevant to their assigned gender. Of those who attended a mixed-sex primary school and received RSE lessons,



78.1% of survey participants reported being separated by sex for all or part of their RSE. For those who attended a mixed-sex secondary school, **48.3%** were separated for lessons.

Sex-based separation has the potential to make RSE less relevant for trans and non-binary students:

> "As a closeted trans girl, the sex education I was receiving was very much focused on the interpretation of me as a boy. So what I was hearing was just not relevant to my own experience of my body, and looking forward to my future and where I was going to be in relationships was all very heteronormative. That had a huge influence on my life because I tried to fit that heteronormative mould. I tried to be a husband, and, of course, it was always going to fail. A lot of that was down to the expectation that was set for me through sex education."
>
> *- (Roundtable participant)*

Of those who received RSE in mixed-sex schools, survey participants who reported being separated by sex for relationships and sex education were:

Less likely to rate their sex education as very good or good

8.9%

than those who were taught in mixed-sex groups

13.3%

45.2%

Less likely to be taught about anatomy that did not match their own

57.8%

than those who were taught in mixed-sex groups

Less likely to be taught about trans identities

7.8%

than those who were taught in mixed-sex groups

28.9%

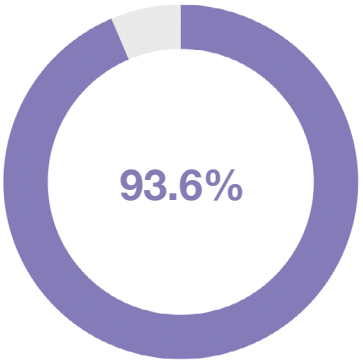
Section 28 & Aftermath

Section 28 of the Local Government Act was enacted by the Conservative Government in 1988, prohibiting the "promotion of homosexuality by local authorities"[3] making it illegal for LGBTQIA+ identities to be discussed by teachers.

The UK Prime Minister at the time, Margaret Thatcher, famously said:

"Children who need to be taught to respect traditional moral values are being taught that they have an inalienable right to be gay. All of those children are being cheated of a sound start in life."[4]

Section 28 was repealed in 2000 in Scotland and in 2003 in the rest of the UK. At the time of our survey (2022), anyone aged between 24 and 52 would have received education under Section 28.



of our survey responses came from people between the ages of 18 and 55, meaning that the vast majority of LBT+ women and femme-aligned people who contributed to our research would have been taught under Section 28.

> "I went to school under Section 28, so I didn't know it was possible to have same-sex relationships."
>
> *- (Survey participant)*

> "I went to school during Section 28, so there was nothing about LGBTQIA+ identities by law."
>
> *- (Survey participant)*

> "I went to school under Section 28, and we didn't have any kind of education about queer identities."
>
> *- (Survey participant)*

> "There was no information given on queer relationships, consent, pleasure, or anything other than the bare minimum. In high school, it felt as though [RSE] was only done due to rising teen pregnancies in my school. I was 14-15 at the time the only session was given, and that would have been within Section 28."
>
> *- (Survey participant)*

Despite the repeal of Section 28, LGBT-inclusive education still appears to be lacking in UK schools. In a 2021 survey commissioned by the LGBTQIA+ charity Just Like Us, one in five (**17%**) teachers reported

feeling uncomfortable teaching LGBT+ topics.[5] Hesitance, discomfort, or a lack of training in teaching LGBT-inclusive RSE may come from the lingering effects of Section 28.

> "Growing up in a "post" Section 28 world (repealed when I was in my last year of primary school), I believe that this heavily impacted, and continues to impact the poor LGBTQIA+ relationship and sex education."
>
> *- (Survey participant)*

A point that was raised repeatedly throughout our research was that the inclusion of LGBTQIA+ identities in RSE depended heavily on who was teaching you:

> "It's just luck — whether or not you get education that's relevant to you and inclusive for you. It's a complete lottery."
>
> *- (Roundtable participant)*

This notion further suggests that the government guidance referenced on page 26 is too vague. What one school might consider "appropriate" or "timely" may vary drastically from that of other schools, meaning that students of the same age and developmental stage may receive quite different information.

A few survey responses referenced specific teachers taking it upon themselves to teach LGBTQIA+ identities and the suspected backlash from the school:

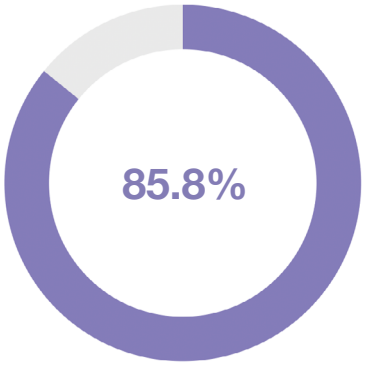
> "We only had LGBTQIA+ identities mentioned as my teacher figured that not all of us were straight. She told us what she could, which was minimal, and then disappeared for the rest of the year."
>
> *- (Survey participant)*

> "The only reason that my RSE was even vaguely queer-inclusive was because the teacher decided to go off-piste from the school's guidance. And then the teacher mysteriously disappeared for the rest of the school year, and I got a brand new biology teacher. So I don't think the school liked that one."
>
> *- (Roundtable participant)*

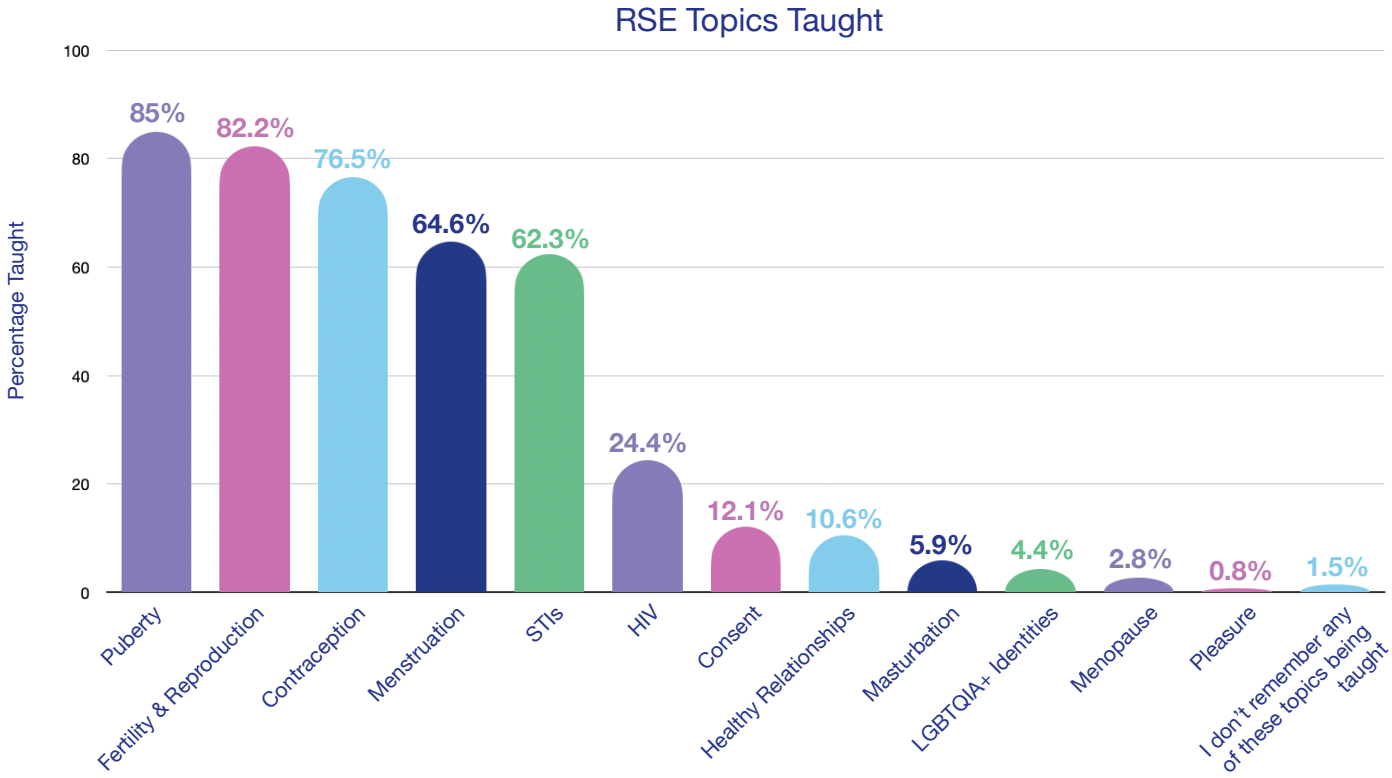
Sex education that accurately reflects your own identity and experiences should not be left to chance, luck, or a postcode lottery. An absence of comprehensive and inclusive RSE can have detrimental effects on young people — effects that they carry with them beyond their school years and into their adult relationships.

Gaps in Education

Not all sex ed topics are created equal. Our survey found that while



of respondents received some level of sex education, some topics within that education were far more commonly taught than others.



Of those who received RSE, the most common topics taught were Puberty (**85%**), Fertility & Reproduction (**82.2%**), and Contraception (**76.5%**). Topics taught to less than 10% of survey respondents include Masturbation (**5.9%**), LGBTQIA+ Identities (**4.4%**), and Pleasure (**0.8%**). One could posit from this chart that the topics that are deemed more important are the ones considered impactful on physical health (puberty, menstruation, STIs), while the lesser taught topics (healthy relationships, pleasure, etc.) are deemed less relevant as their inclusion only benefits social or mental wellbeing.

> "I did not receive any education about consent, pleasure, or masturbation."
>
> *- (Survey participant)*

> "Absolutely no mention of sex in any way other than the physical reproductive act. No pleasure was discussed, nor were any LGBT+ concepts spoken about."
>
> *- (Survey participant)*

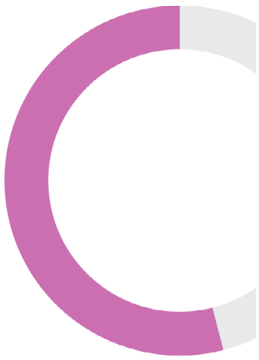
> "Nothing was taught around different types of relationships, different identities, orgasm/ pleasure, consent, sexual/pregnancy difficulties, healthy/abusive relationships/consent, alternative families, period problems, masturbation, etc."
>
> *- (Survey participant)*

On the basis of this theory, it seems strange that Menopause sits so low on the chart (**2.8%**). It feels like this topic would fit more naturally with subjects like Menstruation or Fertility. This may connote that, on the whole, students are taught topics that are perceived as being relevant to them at their current age (puberty, menstruation) or subjects that act as

potential damage control (contraception, STIs) rather than being provided with sex ed that will last them a lifetime.

Evidence proves that teachers are less comfortable teaching certain RSE topics than they are others. In a study by the NSPCC and the National Education Union, it was discovered that:

61% of secondary school teachers did not feel confident teaching the impact of pornography



54% of secondary school teachers were not confident teaching lessons on female genital mutilation (FGM)[6]

We know from the Just Like Us study[5] referenced on page 28 that LGBTQIA+ identities are one of the areas where teachers report feeling discomfort. For our LBT+ participants, a lack of education in this area left significant questions unanswered. Survey respondents reported turning elsewhere for information and education, such as the internet:

> "I found out that what I was had a name from the internet — the word "trans" wasn't mentioned once [in school]!"
>
> *- (Survey participant)*

Several participants specifically reference porn as a source of their LGBTQIA+ education:

> "There are certain bits of queer sex that I'm quite naïve about. I ended up watching porn to try and get the information I needed because I couldn't find it anywhere else."
>
> *- (Roundtable participant)*

> "I had to use the internet to find out about LGBT sex, and usually the information about it was in the form of porn or forums that were frequented by predatory straight men. What made it even worse was that I had no idea what healthy looked like [in order to] know that my experiences online were wrong."
>
> *- (Survey participant)*

> "My relationship with porn was extremely unhealthy — that was my context for people like me. I think it nurtured a lot of the attitudes I had when I was trying to figure out that I'm a trans woman and what that actually means for me."
>
> *- (Roundtable participant)*

While the internet can prove to be an incredibly powerful source for LGBTQIA+ people seeking to discover their identity and community, it is not without its dangers. Harmful, degrading and prejudiced attitudes can be found in porn and across the wider web, making inclusive RSE by trained educational professionals a necessity. However, in many instances, harmful, degrading, and prejudiced attitudes exist not only online but also in the classroom.

Prejudice & Discrimination

Many of our research participants reported a discriminatory atmosphere within schools, both among students and teachers. There were several instances where LGBTQIA+ identities had been taught but were mishandled or done so in a way that perpetuated negative ideas about LGBTQIA+ people.

A few participants mentioned that they felt othered as queer people:

> "When LGBTQ identities were mentioned,

it was almost always done in a way that assumed that no one in the room was queer — it was a very othering experience, even though LGBTQ people were still technically being included."

- (Survey participant)

"The fact that LGBT identities are so sexualized makes it very difficult to have positive conversations about queer sex."

- (Roundtable participant)

These experiences speak to myths held by many: that LGBTQIA+ people exist, but not within our own circles. Or that LGBTQIA+ identities and experiences are inherently sexual and therefore always inappropriate or lewd. The purpose of inclusive sex education is to disparage these myths, not to enforce them.

While the above experiences are more insidious, many LBT+ women and femmes reported instances of overt prejudice and discrimination in school:

"Complete absence of relevant information, coupled with a casually homophobic and sexist school environment."

- (Survey participant)

"The word "lesbian" was used as an insult quite freely."

- (Roundtable participant)

"Teacher used the T-slur when talking about gender identity, even with a trans student in the classroom [in] 2014. "There are men, women, and sometimes transexuals, also known as "tr*nnies"" *laughter from class*."

- (Survey participant)

A number of participants referenced attending a religious school in the free-text responses. And while not all religious people or institutions are queerphobic, and not all queerphobic people are religious, several survey responses referenced LGBTQIA+ identities being ignored or outright condemned within the context of religious schools:

"My sex education was via a Christian school and therefore did not talk about gay relationships."

- (Survey participant)

"I went to a Christian school. There was no mention of LGBTQ+ content as this was not perceived as aligning with the school's values."

- (Survey participant)

"For the first three years of secondary school I attended a private evangelical school where we learned that homosexuality was an abomination and AIDS was the wages of sin."

- (Survey participant)

"Attending a part-church-funded school meant the sex education was biassed and very limited. I recall a religious studies teacher saying that HIV was punishment for people being gay."

- (Survey participant)

Several participants reported the use of HIV as a scare tactic in school, a tactic seemingly aimed at the gay community. The use of scare tactics within STI education is ill-advised by many professionals and has the risk of backfiring and instilling a stigma within young people that may result in them avoiding care. One study found that young adults with higher levels of shame and stigma around STIs were less likely to have been tested for gonorrhoea

and HIV in the past year.[7]

Only a fifth (**22.8%**) of those who took our survey remember being taught about HIV as part of their sex education, and that learning was not always positive:

> "I have a distinct memory of watching a video where two girls kissed, and the rest of the class was in uproar, so the video got switched off. And there ended any LGBTQIA+ education, other than "gay sex kills because of AIDS""
>
> *- (Survey participant)*

> "The sex and relationship education offered to me was in the late 80s and early 90s. There was no reference to same-sex relationships that I recall. And then the AIDS TV ads hit, and homophobia and fear were ingrained in most of us."
>
> *- (Survey participant)*

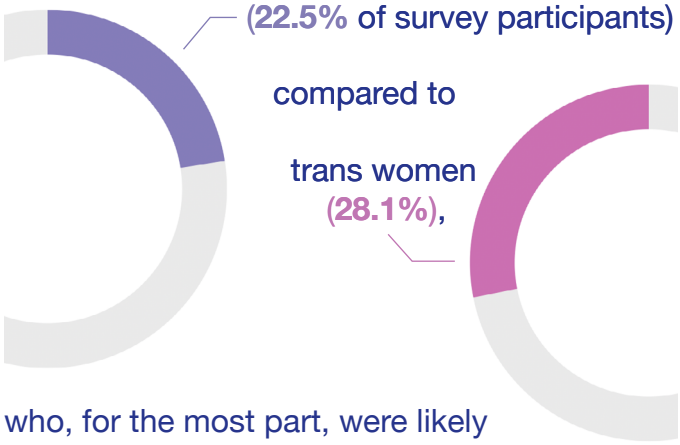
> "We had one day of learning about drugs and sex and that kind of stuff. During that [day], AIDS was mentioned, and the queer community was demonised because of it."
>
> *- (Roundtable participant)*

Furthermore, a number of responses specifically referenced conversations about HIV being disproportionately targeted towards gay men, while lesbian women and other LGBTQIA+ people were entirely neglected within their education on STI transmission:

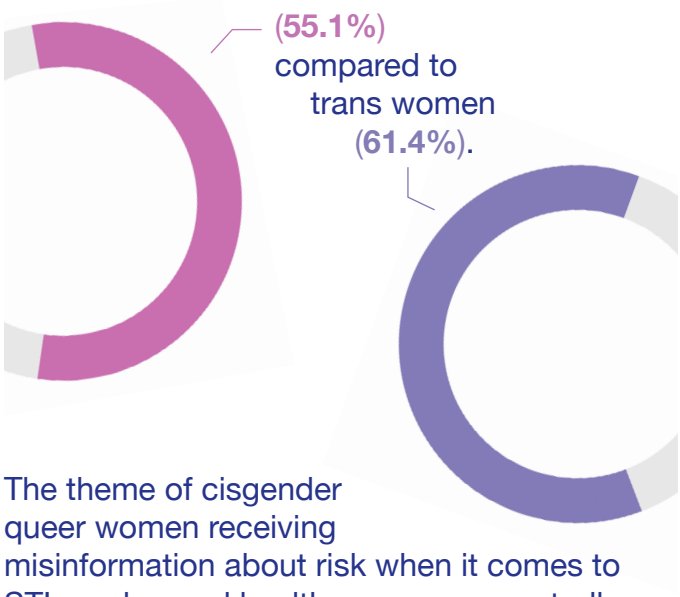
> "Lesbians were erased; gay men came up homophobically in relation to the tiny time spent on HIV."
>
> *- (Survey participant)*

> "It was very heavily implied that lesbians either didn't exist or just didn't have sex, and there was absolutely no mention of trans people or intersex identities. When we were taught about STIs, there was only one brief mention of HIV, where it was described as a "gay men's disease" so we didn't have to worry about it since we were all "girls"."
>
> *- (Survey participant)*

Our study found that cisgender women were less likely to have received education on HIV



who, for the most part, were likely perceived and socialised as boys at school age. Cis women were also less likely to receive any education on STIs more generally



The theme of cisgender queer women receiving misinformation about risk when it comes to STIs and sexual health came up repeatedly throughout our research, and can be read about further in chapters "Access to Sexual & Reproductive Health Services" on page 37 and "STIs, HIV & Sexual Health" on page 55.

Self-Advocacy

As our knowledge of LGBTQIA+ identities and experiences improves, and alternative learning sources such as the internet become more readily available, young people are recognising the gaps in their education. While a fifth (**20.3%**) of students who received RSE remember LGB+ identities being mentioned, and a tenth (**10.6%**) remember trans identities being mentioned, it appears for some that these subjects were only ever delivered in response to students' requests for them:

> "LGBTQIA+ identities and relationships were only mentioned very briefly after a pupil asked a question of that nature."
>
> *- (Survey participant)*

> "The only time we ever got taught about LGBTQIA+, contraception, masturbation, and basically anything other than how to have a baby, was through this one citizenship teacher. And only because we asked for specific lessons, not because the school required it."
>
> *- (Survey participant)*

More and more young people are self-advocating for queer-inclusive RSE and resources. In a video essay on homophobia in schools, queer British YouTuber Rowan Ellis describes her experience of attempting to get LGBTQIA+ websites unblocked from her school's computers.[8] Rowan recounts years of campaigning and meetings with her former headteacher, only to be met with insinuations that LGBTQIA+ content is inappropriate for students under the age of 16.

So while young people shouldn't have to self-advocate for representative and inclusive RSE, many are doing just that. But, just like in Rowan's case, asking doesn't always mean getting. Several survey respondents recalled their requests for queer-inclusive education going unanswered:

> "I argued with teachers for LGBTQ+ RSE, and they never delivered it. I felt very alone as a young person in the sense that I had to advocate for myself because none of the adults at my school were willing to."
>
> *- (Survey participant)*

> "[There was] nothing LGBTQ+ — we requested this and were ignored."
>
> *- (Survey participant)*

> "We would have sex ed on PSHE days, and at the end of the day we were always asked to fill in a form. One of the questions was always, "what could we do better?" and every time I would write "include LGBT sex ed". It was never included."
>
> *- (Survey participant)*

Young people know that the education they are missing out on is important, and that gaps in knowledge could have long-standing effects on their journey with sex and relationships. For the people who completed our survey and attended our roundtables, they were able to articulate the impact all too well.

Impact

For several people in our study, the lack of queer-inclusive RSE resulted in them not having the language to articulate and understand their own queer identity:

> "Although I didn't have the words for much of my time in RSE, I was definitely aware that I was asexual and gender non-conforming. Neither of these things were ever touched upon, unsurprisingly,

given that this was in the mid-2000s. It made me feel very isolated."

- (Survey participant)

"I deeply wish that sex education had covered anything about identities, queerness, and consent. It would have helped me understand things that I already knew but had no words for and would have saved me a lot of trauma — not to mention a lot of money spent on therapy."

- (Survey participant)

"I wish I'd learned about trans lives. Because I thought I was the only one for so long, I wish I'd learned that trans people are normal and that it's okay to be trans."

- (Roundtable participant)

Understanding that you are not alone, that you are not abnormal, and that there is a community of people just like you can combat feelings of isolation and confusion about your own identity. For many in our study, the lack of education surrounding queer identities and relationships resulted in a delay in recognising their own identity:

"The lack of education on trans identities meant that I did not realise my own transness until my forties. I resent my school for keeping vital details from me when I needed them to make sense of myself."

- (Survey participant)

"I didn't figure out my bisexuality until my early 20s; I thought queerness was about loving people of the same gender, so even though in retrospect I found some girls at school attractive, I didn't think that counted. [...] If we'd had sex ed that hadn't been so focused on love but had allowed space to talk about attraction (and maybe even discussion of the concepts of differing sexual and romantic attraction), it might have made things easier for me growing up and made me more open to experiences rather than trying to force myself into heterosexuality until I actually fell in love with a woman and I allowed myself to count as bi."

- (Survey participant)

"There was no mention of other sexualities. I'm asexual, and I didn't even know that was a thing until I saw it online."

- (Roundtable participant)

Not knowing or understanding your orientation can not only lead to confusion but can also result in the delay or absence of fulfilling sexual and romantic relationships. Many participants reported the impact that not understanding their identity had on their relationships:

"I think if I had known more about queer relationships, I might have had one sooner."

- (Survey participant)

"If I had been taught that asexual identities existed or if myself and my peers were taught about consent, my early relationships would have gone very differently."

- (Survey participant)

"My entire education took place under Section 28, so it was limited to heterosexual relationships only. I attribute this partly to why it took until my mid-30s, after ten years of marriage, and when my wife came out as trans, to realise I wasn't

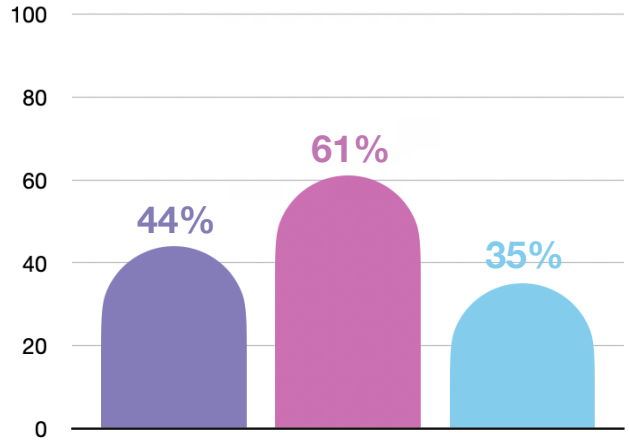
actually straight after all. Because I'd never been taught about things like asexuality and panromanticism."

- (Survey participant)

"The lack of education meant that I just defaulted to having straight sexual relationships dictated by the other person because they seemed to know what they wanted and I didn't know what I wanted."

- (Roundtable participant)

The risks that accompany a lack of inclusive sex education were made clear in the free-text responses to our survey. LBT+ women typically have higher rates of sexual and domestic violence — one US survey found that



44% of lesbians and 61% of bisexual women had experienced rape, physical violence, and/or stalking by an intimate partner, compared to 35% of heterosexual women.[9] Several of our own survey participants claimed that a lack of queer-inclusive sex education left them vulnerable to unhealthy relationships, behaviours, and abuse:

"More focus on diverse relationships and sex would have prevented me from taking risks I was mostly unaware of as a teenager regarding sexual health."

- (Survey participant)

"Had I received more information about consent and also about LGBT+ [people], it could have saved me from a toxic relationship and helped me to understand my bisexuality instead of me being very confused."

- (Survey participant)

"The lack of mention of queer identities negatively impacted me by making us feel rarer than we are, and made me more vulnerable to conversion therapy."

- (Survey participant)

"I had to do all of my learning on the internet, which caused me significant harm as the representation of bisexual women online is extremely hypersexualised."

- (Survey participant)

Our findings indicate that regulated, LGBT-inclusive sex education is not only desperately wanted but needed for queer young people to feel confident in navigating their physical, mental, and social wellbeing when it comes to sex and relationships. A lack of such RSE may have a long-standing impact on sexual health, sense of identity, and relationship satisfaction.

Access to Sexual & Reproductive Health Services

LGBTQIA+ people have been proven to experience additional barriers when accessing healthcare services.

The Government Equalities Office's 2018 LGBT Action Plan states that:

*"At least **16%** of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and at least **38%** had a negative experience because of their gender identity."*[10]

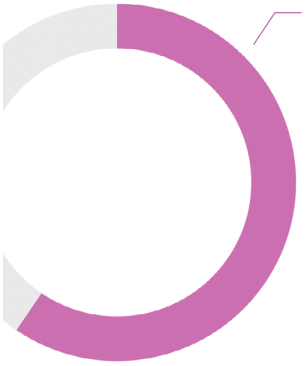
Additionally, the intersection of being both queer and a woman means that many LGBTQIA+ women and femmes must contend with sexism as well as queerphobia when accessing services.

Experiences of accessing sexual health care differ between LBT+ women. One study found that lesbian women were

70% less likely to access sexual health services than bisexual women

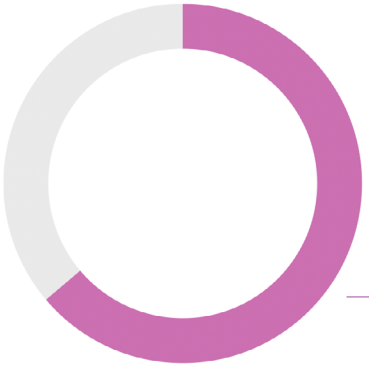
but bi women who accessed or attempted to access sexual health services were twice as likely to report that they were unsuccessful compared to lesbian women.[11]

Of our survey respondents,



59.5% had received care for their sexual or reproductive health in the past year.

This number was lower for women and femmes who identified as gay or lesbian (**49.4%**)



and higher for those who experience multi-gender attraction (bisexual, pansexual, etc.) (**63.8%**).

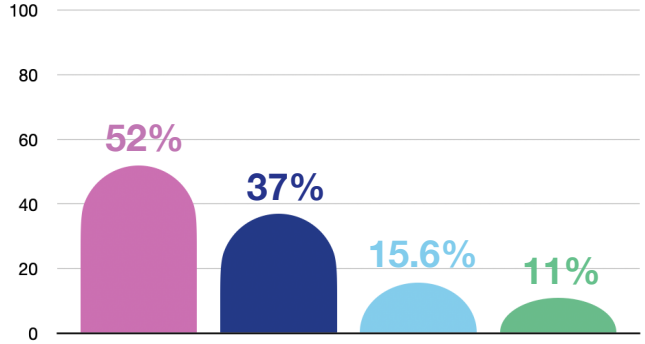
Cisgender LB+ women were more likely to have accessed sexual health care in the past year:

63.1%

than trans women and femmes:

49.3%

Of the LBT+ women and femmes who accessed sexual health care,



most did so via their GP (**52%**), with the second most common response being a sexual health clinic (**37%**), the third being a gynaecologist (**15.6%**), and the fourth being maternity services (**11%**).

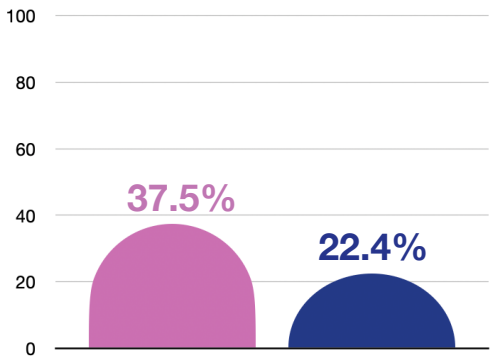
10.6% of people accessed sexual health care from other sources, and free text responses included:

- "Pharmacy"
- "A&E"
- "Gender Identity Clinic"
- "Online STI Test"
- "Charity"
- "Therapist"

25.8%

of LBT+ women and femmes who accessed sexual or reproductive health care in the past year felt that they were asked inappropriate questions due to their LGBTQIA+ identity.

Trans respondents were more likely to report this (**37.5%**) than cisgender LB+ women (**22.4%**).



In addition, exactly half (**50%**) of participants who identified as asexual and/or aromantic reported experiencing inappropriate questions, as did

54.5% of intersex people compared to

19.9% of endosex people.

It is clear that accessing healthcare as a queer woman/femme-aligned person can come with a unique set of challenges and barriers.

Queer Erasure

As with education, our survey found that many people's issues with healthcare services stem from a sense of cis- and hetero-normativity. The LBT+ women and femmes who contributed to our research felt unseen — their queer identities erased.

Nearly half (47.2%) of respondents who had accessed sexual health or reproductive health care in the past 12 months felt that their healthcare worker didn't fully understand their LGBTQIA+ identity.

Trans respondents were more likely to report this **66.7%**

than cisgender LB+ women **41.7%**

In addition, **70.3%** of participants who identified as asexual and/or aromantic felt this way, as did **70.9%** of intersex people, compared to **42.4%** of endosex people.

Several participants recounted their experiences with healthcare workers who were uninformed on how best to treat LGBTQIA+ people:

> "I think my GP is trying relatively hard to be LGBT+ inclusive in theory (there is, for example, a designated LGBTQIA+ page on their website with commitments to LGBT+ inclusion), but in practice they are still wobbly on terminology and could very much use training to gain more knowledge on the myriad of experiences within our communities."
>
> *- (Survey participant)*

> "LBT+ women or femme-aligned people are always assumed to be heterosexual. Continually, I am asked if there is a possibility I could be pregnant (even though I am in a same-sex female relationship). My conditions are stigmatised or I am assumed to be promiscuous or lying. When you disclose your sexuality, at best you get a moment of "oh, right". Healthcare professionals don't know how to treat LGBTQ+ individuals in healthcare settings."
>
> *- (Survey participant)*

The assumption among healthcare workers that all of their patients are cisgender and heterosexual was a shared experience among our research participants. While many professionals ask inappropriate questions about gender or sexuality, others ask no questions at all:

> "I felt that the providers assumed that I was in an opposite-sex relationship (always asking about contraception before asking about sexual practices); some had strange reactions to me saying I was in a same-sex relationship ("how modern", etc.) that made me feel uncomfortable."
>
> *- (Survey participant)*

> "[My] gynaecologist suggested the pill to manage abnormal bleeding. I explained that I was going through the process of starting a family, and he immediately assumed "my husband" and I were trying for a baby, and I had to correct him that my wife and I are starting this long process. He shut down the conversation and was very

dismissive of any further questions I had."

- (Survey participant)

"I have attended upwards of fifteen health appointments in the last year and can only recall two times where my sexual orientation data was collected and none for gender identity."

- (Survey participant)

Assuming, or misunderstanding, one's gender identity or sexual orientation has the potential to not only be uncomfortable for the patient but can also result in inappropriate care or treatment:

"Due to a cancer prone genetic disease, I am likely to develop gynaecological cancer in the future. For early detection, I started to have colposcopies (invasive biopsies of the uterus) from age 16. However, I found out this year (when going to a new gynaecologist at a different hospital) that I in fact did not need colposcopies unless I was having penetrative sex with someone with a penis. I'd unnecessarily had yearly procedures that put me in great pain and discomfort for no reason. The reason they began the screening when I was 16 is because in the guidelines book for the disease I have, it states that from 16 it is expected that young women become sexually active. And it is automatically assumed [that] sexual activity [involves] penetration. Every time I had this procedure, I was asked if I was sexually active — [it was assumed] that if I said yes, it was with penetration with a penis. This is still written in the guidelines and completely ignores women having sex with women [and] GNC [gender non-conforming] folks."

- (Survey participant)

"As someone who is asexual, the few times I have been to GPs about something sexual or reproductive in nature, it has devolved into the GP asking if my partner is satisfied, asking if I had any sexual trauma because I should want sex, asking/insinuating I'm depressed, and recommending my partner and I go to couples therapy."

- (Survey participant)

Additional barriers may be faced by queer people whose sexual activity may not align with their orientation — for example, people who experience multi-gender attraction (bisexual, pansexual, polysexual, etc.). Some bi+ women and femmes who responded to our survey expressed concern that their non-monosexuality is disregarded when they are in straight-passing relationships:

"As a pregnant person and then a mother with a baby in a heterosexual relationship, I feel like my bisexuality is almost erased or irrelevant when it is still incredibly important to me."

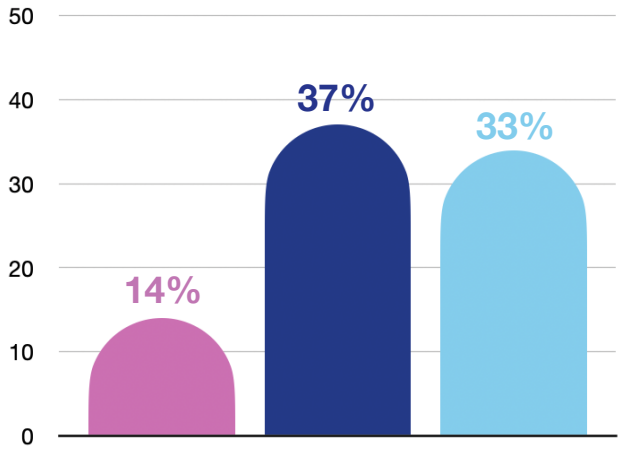
- (Survey participant)

"I have not yet accessed any reproductive or sexual healthcare; however, when I do, I'm worried that because I have sex with males, my identity as bisexual will be ignored and the care will only focus on heterosexual sex."

- (Survey participant)

Experiencing a cis- and hetero-normative healthcare system, either firsthand or through stories and anecdotes, is likely to be off-putting to queer people in need of care, leading to the avoidance of such systems.

A Stonewall report found that:



one in seven LGBT people (14%) said that they'd avoided treatment for fear of discrimination because they're LGBT. This rose to **37%** of trans people and 33% of non-binary people.[12] By centering cisgender and heterosexual identities, we exclude those who don't fit this mould:

> "I'm demisexual and haven't had sex but have felt unable to approach medical professionals about potential reproductive health/vaginal health because I'm virgin by "straight" standards (no penis-in-vagina sex)."
>
> *- (Survey participant)*

Once this parapet has been established, it is left to queer people to decide if it is safe to raise their heads above it.

To Come Out or Not To Come Out

In theory, coming out to a healthcare worker should lead to more tailored, appropriate care and support. But unfortunately, for many LGBTQIA+ people, it can have the opposite effect, resulting in blank stares, awkward questions, and even overt discrimination. For this reason, many queer people avoid coming out at all:

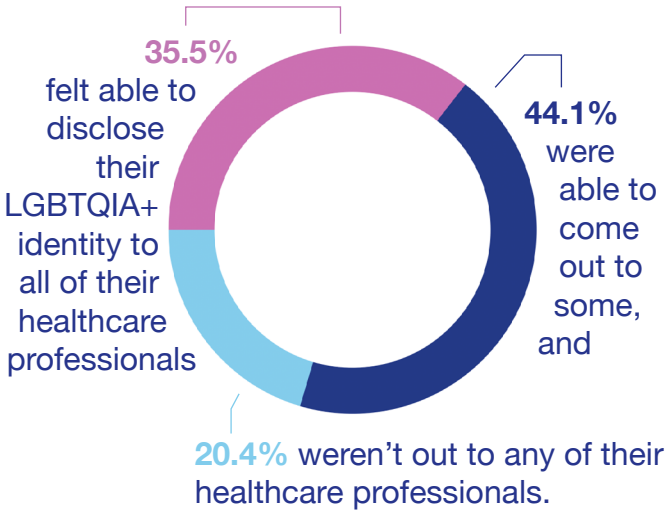
> "I do not disclose my sexuality or gender identity to healthcare providers. I already find I am rarely taken seriously."
>
> *- (Survey participant)*

> "I simply haven't come out to my GP about my gender or sexuality. I wouldn't be comfortable telling her."
>
> *- (Survey participant)*

> "I've not faced discrimination due to my gender or sexuality when seeking sexual or reproductive healthcare, but that's because I didn't feel comfortable disclosing that information in the first place."
>
> *- (Survey participant)*

> "As a non-binary, female-assigned, and female-presenting person, I don't feel able to mention my non-binary identity. Was I discriminated against? No. Did I feel generally uncomfortable with healthcare professionals? Yes."
>
> *- (Survey participant)*

Of the survey participants who received sexual health care in the past 12 months, only



Participants who identified as asexual and/or aromantic were significantly less likely to be out to all of their healthcare workers (**19.2%**).

Of those who have come out to a healthcare professional, many found that this led to uncomfortable situations or that their identity was simply ignored:

> "I always find that I am assumed to be cis and straight, so any conversations about sex or reproductive health mean I have to come out as queer. There is sometimes a bit of hesitation around me identifying as bisexual, as if people aren't sure how this works."
>
> *- (Survey participant)*

> "I have had healthcare providers wrongly assume that pansexuality equates to promiscuity and forcefully push me into STI testing despite being in a monogamous relationship for over a decade. It is painful to do so, but, unless specifically necessary, it is easier, faster, cheaper, and safer just to pretend to be heterosexual most of the time."
>
> *- (Survey participant)*

> "As a non-binary person who has an ovarian system, it's very hard to "come out" to health professionals, so I usually just ignore the misgendering. My GP didn't even have an option for gender identity, and so I wrote "non-binary" in, but everything is still "Miss" this and "she" that."
>
> *- (Survey participant)*

Data monitoring for sexual orientation, gender identity, and trans status is essential for this very reason. As well as having a better understanding of the issues disproportionately affecting the queer community, it also "takes the onus off the service user to come out to the worker, enabling them to raise issues relating to their [LGBTQIA+ identity]".[13] While sexual orientation monitoring has recently been made mandatory across the NHS, gender diversity is not monitored, although the NHS Data Model & Dictionary has a useful set of rules for surveys that want to be more inclusive.

Sexual orientation and trans status are likely to be even more relevant when accessing sexual health care. Having to repeatedly come out to healthcare workers is additional emotional labour for LGBTQIA+ people, on top of the potential stress and anxiety of accessing healthcare in the first place:

> "Health professionals assume heterosexuality, so when discussing sexual health and contraception, I have to come out over and over."
>
> *- (Survey participant)*

> "I am always assumed to be heterosexual, and so I have to come out every time I am with a health professional."
>
> *- (Survey participant)*

> "I'm so exhausted from having to come out at every appointment. I don't want to be assumed to be straight and given unwanted heterosexual safe sex advice. I wish the question could be asked once and recorded on my medical record, or if healthcare professionals could receive training to not make assumptions."
>
> *- (Survey participant)*

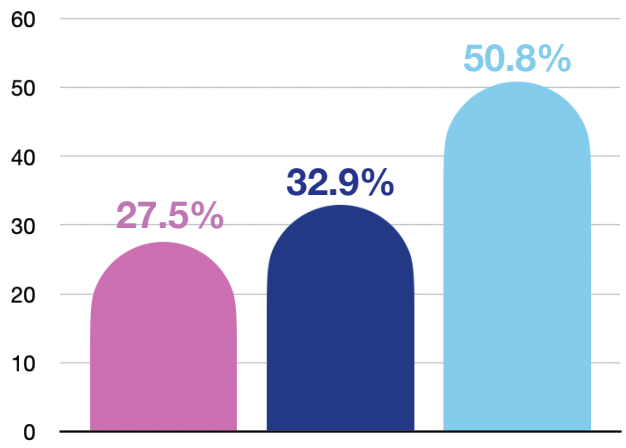
One participant articulated the strategy that accompanies coming out:

> "If I do decide to advocate for myself in terms of gender or sexuality, it's like you're strategizing and thinking, "how do I do this in the best possible way so that I still get the care that I deserve or that I don't come across as rude?""
>
> *- (Roundtable participant)*

The implication is that coming out is such a delicate process that getting it "wrong" could offend the healthcare worker and negatively impact one's quality of care. Queer people shouldn't have to experience this level of anxiety when being open about their identity, and healthcare workers should be trained to know how to respond in situations such as these, in a way that puts the queer person at ease. This, in addition to good sexual orientation and trans status monitoring, is likely to take some of the anxiety and emotional labour away from LGBTQIA+ individuals.

Health Screenings

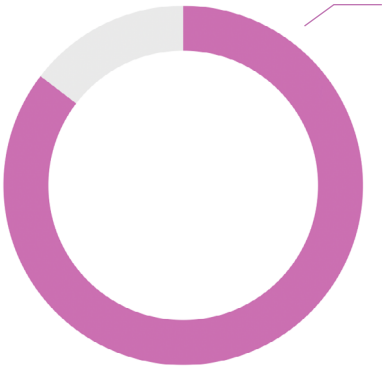
Some of the health screenings that patients receive are based on sex-specific body parts, such as cervical screenings (smear tests), breast screenings, and prostate screenings. Due to the often gendered nature of these tests, LGBTQIA+ people experience additional barriers to accessing them.



A quarter (27.5%) of respondents eligible for a cervical screening had failed to attend one in the past three years. This percentage rises to **32.9%** of disabled cervix-owners and 50.8% of cervix-owners who are not white.

54.5% of those who were eligible for a mammogram had not attended one in the past three years.

There is currently no routine prostate screening programme in the UK, and when asked, only



85.4% of participants with a prostate said that they had not received a prostate exam in the past year. Older people were more likely to have received a prostate exam, with **25%** of those over 55 saying they had attended one in the past three years.

Many of our research participants mentioned sex-specific health screenings in the survey free-text responses and at the roundtables. Often, this was related to cervical screenings due to our demographic being younger, with more cisgender female respondents. Past research has found that lesbian and bisexual women are up to ten times less likely to have received a cervical screening than heterosexual women[14], while one study found that **14%** of eligible lesbian and bi women had been actively refused a smear test due to their sexual activity.[15] Women who have sex with women are regularly misinformed that they do not need a cervical screening:

> "Loads and loads of [lesbians] have not had smear tests. We chose to avoid them because we didn't feel we were at risk."
>
> *- (Roundtable participant)*

> "A nurse advised me that I didn't really need a smear test because I was a gay woman."
>
> *- (Survey participant)*

> "In the past, when I was in my early 20s, I received a letter calling me for my cervical screening test. When I attended the appointment, because I hadn't had intercourse with a man, I was told I didn't need to have the screening. [...] It was a number of years before I realised that I should have a smear test, regardless of whether or not I had had sex and with whom I had had sex with."
>
> *- (Survey participant)*

This misconception comes from believing that HPV (the virus that cervical screenings are testing for) can only be transmitted by having sex involving a penis, when in reality the virus can also be spread via fingers, hands, and sex toys.

Unfortunately, it seems that many doctors are uninformed and untrained when it comes to providing sex-based health screenings to those who have queer sex or whose gender doesn't match the sex they were assigned at birth:

> "[I went for a] cervical screening, [and] the nurse was unsure what the protocol is for women who sleep with women."
>
> *- (Survey participant)*

> "One of the health things I need to do is get a prostate screening. And that's very difficult for a post-surgical trans woman. I went for the screening, and the GP had no clue what to do at all."
>
> *- (Roundtable participant)*

Such screenings can be additionally challenging for trans people, not only due to uninformed doctors but also due to the fact that sex-specific services are often heavily gendered. Generalisations about body parts can be made based on gender markers, or presentation:

> "The issue is having the binary categories of sex used as shorthand for having certain needs, which aren't always the case. You need a cervical screening if you have a cervix and you need a prostate screening if you have a prostate — not because you're a man or a woman. That's where the disconnect is."
>
> *- (Roundtable participant)*

Communications with patients often use gendered language such as "woman", which can be excluding for trans and non-binary people whose anatomy aligns with the criteria for the screening, but their gender identity differs:

> "I'll go for a cervical screening when I get a letter that doesn't treat me like a woman."
>
> *- (Roundtable participant)*

And many trans and non-binary people need to self-advocate for their identity to be seen and validated in such spaces, which can be nerve-wracking:

> "In a year and two months I turn 25, which means I'll be eligible for my smear tests. And I'm scared of having to go in and ask to be referred to with neutral language."
>
> *- (Roundtable participant)*

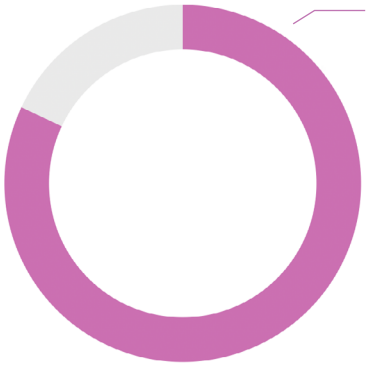
In addition to navigating language, many trans and non-binary people may experience gender dysphoria when accessing sex-specific health screenings due to their gendered nature and the potential discomfort of having undesired body parts touched or examined:

"As a [non-binary person] who's femme-leaning, it's hard to access care that isn't jarring and dysphoric. Yes, I have a uterus, but no, I'm not a woman. Although recently I've seen leaflets for pap smears that state that all guys, gals, and non-binary pals with a uterus need to go for check-ups, which is affirming."

- (Survey participant)

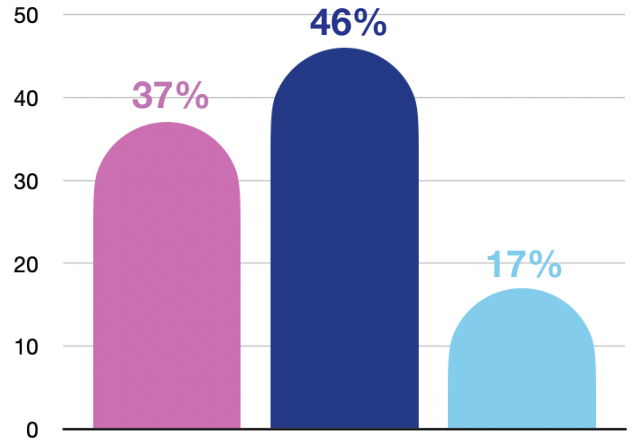
"[I] could not disclose to healthcare professionals that part of my fear of having a cervical screening was due to triggering dysphoria. [I] felt unable to discuss [this]."

- (Survey participant)



One study found that **82%** of trans men and non-binary people experienced genital dysphoria surrounding cervical screenings.[16]

Another form of discomfort or distress may come from previous sexual trauma. While this also affects cisgender, heterosexual women, LBT+ women are statistically more likely to experience rape or sexual assault.



37% of trans women have experienced sexual assault at some point in their lifetime[17] and nearly half of bisexual women (**46%**) have been raped, compared to **17%** of heterosexual women.[9] Therefore, trauma triggers at smear tests may be something that queer people are more likely to experience, making such appointments more difficult to manage and creating more opportunity for things to go wrong:

"I have had a smear test (despite not being over 25) and was misgendered throughout. Alongside that, I am a sexual assault survivor and wasn't given space beforehand to explain that to the healthcare professionals and ended up having a horrendous flashback."

- (Survey participant)

"I was raped at 19 (my first sexual experience), so I didn't go for a smear until I was 30. I explained my situation and past, which had resulted in me fearing being touched or entered. When the nurse tried to do my smear test and wasn't successful, she told me that I should have more penetrative sex with my girlfriend. I'm 40 now and have never gone back for a smear because of that."

- (Survey participant)

Assumptions about sexual behaviours (such as penetration) purely based on sexual orientation should not be made by healthcare professionals, as they can be inaccurate, reductive, or simply invasive. However, some LBT+ women and femmes may be more likely to engage in penetrative sex, meaning that pain or discomfort may be heightened during cervical smears:

"I only recall going to a smear test lately, which was incredibly painful, possibly due to the fact that my sexual practice doesn't always involve penetrative sex, but it might also be because speculums and their

design are really outdated."

- (Survey participant)

"I always find attending cervical smears difficult, firstly because I find them painful, but secondly because of the requirement to navigate questions about contraception first, and feeling uncomfortable outing myself before having such an intimate and anxiety-provoking procedure. I wish that there were more options for accessing specialist LGBTQIA+ sexual health and gynaecological services."

- (Survey participant)

Rather than assuming somebody's sexual practice or behaviours, healthcare workers should instead ask the patient if there is anything they can think of that may make the exam cause additional discomfort, physical or mental. This gives the patient the opportunity to discuss gender dysphoria, trauma, or unfamiliarity with penetration. The worker should then be able to tailor the appointment to better serve the patient, whether this is helping mental discomfort by taking breaks, allowing the patient to listen to music in headphones, or reducing physical discomfort by using a smaller speculum or more lubricant.

Either way, appointments need to be guided by the needs of the LBT+ person to ensure minimum distress, and higher likelihood of returning for future exams.

Pregnancy Assumptions

For many AFAB LBT+ women and femmes navigating healthcare involves being questioned about your chance of pregnancy. Of course, inquiring about pregnancy in certain cases (particularly when somebody is accessing certain medications, scans, or tests) is important to protect the health of the person and, if they are pregnant, their foetus.

However, it is the way this question is approached that is often the issue. People who have a vulva are expected and assumed to be involved in a sexual relationship with somebody with a penis, due to heteronormative societal standards. This assumption leads to a follow-up assumption that all people with a vulva of a certain age could, at any time, be pregnant.

At best, LBT+ women and femmes find these constant heteronormative presumptions to be annoying or irritating, while at worst they may be embarrassing, anxiety-inducing, or triggering:

"I had my coil removed in May of this year. I was informed that my partner could now get me pregnant. I informed my GP that my partner couldn't get me pregnant, and they turned bright red, stopped eye contact, and just swiftly moved on because they were so embarrassed."

- (Survey participant)

"I often feel like I have to come out when questioned about whether I am having sex and whether I could be pregnant. When getting the COVID-19 vaccine, the person giving me the vaccine got very defensive about me being confident that I definitely wasn't pregnant."

- (Survey participant)

"There are often assumptions made about if you can or may be pregnant. When I was in a long term relationship with my female partner this was quite triggering and annoying as it was impossible, even though we wanted children."

- (Survey participant)

When assumptions are not made and instead the question is asked, it is often asked in a way that is confusing and, in itself, heteronormative:

> "Are you having sex?" [is used] to mean 'could you be pregnant?". The presumption that my partner and I could "just get pregnant" and therefore birth control should be taken alongside other medication."
>
> *- (Survey participant)*

> It is very much assumed — as a cis woman — that if you have a partner, they must be a cis man. Being sexually active as a cis woman doesn't mean you have a chance of being pregnant. I think asking if there's a chance you're pregnant is appropriate, but asking if you're sexually active when they basically mean that is not the best."
>
> *- (Survey participant)*

Instead of asking, "is there a chance you could be pregnant?" healthcare professionals may instead ask, "are you sexually active?" and use the answer "yes" as an indication that there is a pregnancy risk. However, the answer "yes" could cover any of the following:

- Yes, but not with someone who produces sperm
- Yes, but not involving vaginal penetration or sex that could result in pregnancy
- Yes, but myself or my partner(s) are infertile
- Yes, generally, but not since my last period

There are any number of reasons why this question may confuse the patient, and not provide the clarity needed for the healthcare worker. Similarly, "are you sexually active with men?" also needs more clarification beyond a simple "yes" or "no" response. Answers could include:

- Yes, but I have sex with trans men who do not have penises/produce sperm
- No, but I could be pregnant because my partner is a trans woman/non-binary person who produces sperm
- No, but I could be pregnant, as I am currently trying to conceive using a sperm donor
- No, but I could be pregnant as I was recently raped/sexually assaulted

The importance of clear and precise language benefits not only the patient, but also the healthcare worker in providing the best care. Further survey responses included experiences of contraception being promoted without first knowing the type of sex the patient was having or who they were having it with:

> [I am] forever baffled why medical professionals can't comprehend how I don't use contraception but am not pregnant."
>
> *- (Survey participant)*

> The constant conversation that you're sexually active and not on contraception and don't need to be which brings up the same conversation that you should be to avoid pregnancy."
>
> *- (Survey participant)*

Additionally, it's a common experience for LBT+ women and femmes who are not having sex with men and may have never had sex with a man to be asked to take pregnancy tests when having specific treatments despite there being no possibility of being pregnant.[18] Not only is this frustrating and time-consuming, but it can also contribute to a feeling of mistrust from your doctor:

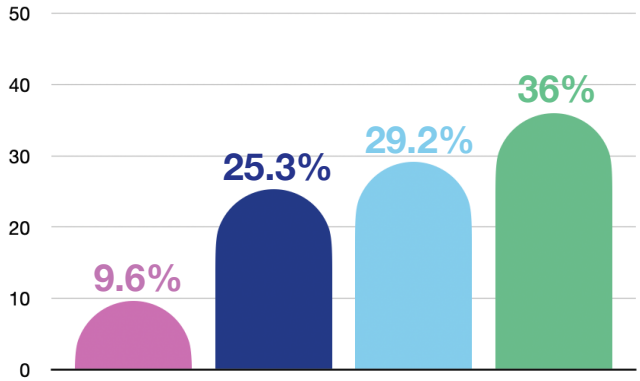
> I was treated for a UTI gained through perfume irritation and was forced to take a pregnancy test even after disclosing that my relationship at the time was with another woman."
>
> *- (Survey participant)*

> Insisting I needed regular pregnancy

tests for a life-saving medication to be given to me despite the fact I've been in monogamous same-sex relationships for ten years."

- (Survey participant)

Nearly one in five (18%) of our survey respondents had been made to take a pregnancy test to access healthcare in the past year. Of those participants:



- **9.6%** had no risk of pregnancy but didn't inform their healthcare worker of this and simply took the test anyway
- **25.3%** informed their doctor that there was no risk of pregnancy and, as a result, didn't have to take the test
- **29.2%** informed their doctor that there was no risk of pregnancy, but were still made to take the test
- **36%** took the test because there was a genuine risk of pregnancy

This means that, of those who told their doctor that they couldn't be pregnant, over half

53.6% were still made to take a pregnancy test to access the care they needed.

These unnecessary hoops to jump through and feelings of mistrust can lead to some LBT+ women and femmes avoiding in-person care altogether:

"A routine question for women in lots of health appointments is "could you be pregnant?" before asking anything about partners/sexual partners. I probably am more likely to use online sexual health services to avoid interactions with people who don't understand my identity."

- (Survey participant)

Trans Healthcare

While trans and femme-aligned women will likely experience a lot of the issues discussed so far when accessing sexual and reproductive healthcare, there are also additional and unique barriers that can accompany accessing care as a trans, non-binary or gender non-conforming person. Through their own experiences and hearing the experiences of others, trans people know that, sadly, accessing healthcare may present extra challenges for them:

"I fear that if I ever need to access sexual health services, it could be made difficult or uncomfortable because of my trans status."

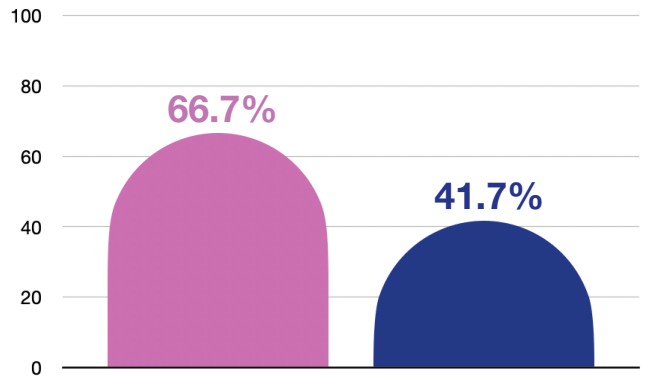
- (Survey participant)

"I only trust one GP at my medical centre. I have been to others and have been misgendered — they use my dead name and I just feel uncomfortable talking about my trans identity or sexual health."

- (Survey participant)

As mentioned in the introduction to this chapter, trans survey respondents were more likely to report that their healthcare professional did not understand their LGBTQIA+ identity (66.7%) compared to

cisgender LB+ women (**41.7%**).



This lack of understanding can stretch beyond the identity itself, but also as to how to provide appropriate gender-affirming care:

> "Regular challenges to getting hormone treatment in the past few years. GPs lack of knowledge borders on arrogance due to their ignorance."
>
> *- (Survey participant)*

GPs who have not had a trans patient before (or been aware that they'd had one) may not know the avenues that need to be taken when a trans person presents asking for gender-affirming care. But even beyond that, in systems that are specifically set up to help trans people, patients still report discomfort or dissatisfaction:

> "Being interrogated about my sex life and history with sex for the GIC [Gender Identity Clinic], which was rather humiliating."
>
> *- (Survey participant)*

Gender and sexuality are two different things that don't necessarily impact one another; however, often someone's sexual history may be (wrongly) used to "prove" their transness. Both in and out of healthcare settings, this can mean that inappropriate questions are asked about trans people's sex lives. This is in addition to questions about private information such as genitals, hormones, dead names, surgeries, coming out stories, etc. that some cis people feel entitled to ask trans people.

In sexual health settings specifically, many sexual health professionals will lack training in trans bodies and relationships, which can confuse not only the professional and result in inappropriate care but also the trans person themselves as to how to best navigate an appointment in a cis-focused space:

> "There's an assumption that trans women are more or less the same as gay men when it comes to sexual health."
>
> *- (Survey participant)*

> "I'm non-binary and I'm going out with a trans non-binary person. It can be a little bit hard to know what to label your relationship to get the right information."
>
> *- (Roundtable participant)*

One trans participant summed it up by saying:

> "When you pass as a cis-het white man in the healthcare system as a patient, healthcare's a breeze. As soon as you fall outside of that, everything is a barrier. I've had to fight so hard for my gender-affirming care."
>
> *- (Roundtable participant)*

Further Marginalised LBT+ Women & Femmes

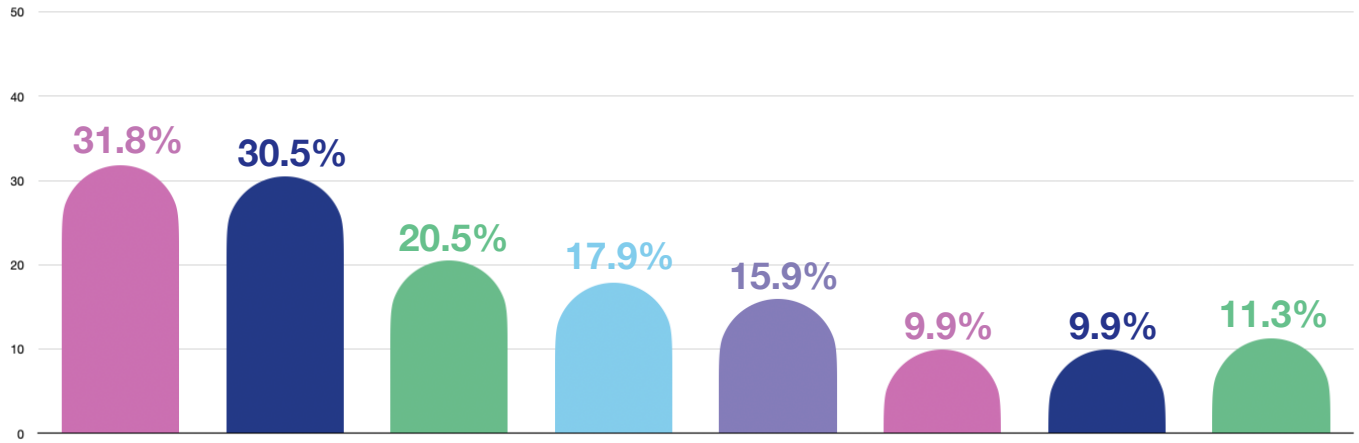
While trans people experience additional barriers to accessing care, so do LBT+ women and femmes with intersecting marginalised identities. To be queer and also a woman is to already hold two marginalised identities, the result of which may mean you are taken less seriously by healthcare workers. But if you're also a person of colour, disabled, neurodivergent, fat, working class, Muslim, or possess any other marginalised identities, your barriers to accessing care may multiply or

become bigger.

Further marginalised Queer people are often left "picking their battles" — knowing they will experience multiple levels of oppression but having to focus their energy or time on the identity for which they experience discrimination the most frequently:

> "I've had a few weird comments or expectations about non-monogamy, but nothing compared to how much sh*t I get for being disabled."
>
> *- (Survey participant)*

40.6% of survey participants felt that they had been discriminated against when accessing sexual or reproductive healthcare in the past twelve months. Of those who felt that they had been discriminated against:



- **31.8%** believed that this was due to their gender
- **30.5%** believed that this was due to their sexual orientation
- **20.5%** believed that this was due to their age
- **17.9%** believed that this was due to their race
- **15.9%** believed that this was due to their disability (including long-term physical and mental health conditions)
- **9.9%** believed that this was due to their trans status
- **9.9%** believed that they were discriminated against but were not sure why
- **11.3%** believed that their discrimination was due to a reason that was not listed — open-text responses to this question included:
  "Weight"
  "Religion"
  "Sexual lifestyle"
  "As the partner of a trans person"
  "For saying I had no desire to be pregnant and have children"

The fact that the above percentages do not add up to a neat 100% is a clear indicator that discrimination is happening on multiple levels for certain people.

Three of the main characteristics that were mentioned in the free-text responses and during the roundtables were race, neurodivergency, and fatness.

Queer people of colour may be more prone to additional or unnecessary sexual health testing due to both queerness and Blackness being hypersexualised in our society. Both LGBTQIA+ people and Black people are also seen as higher-risk groups for HIV, meaning that Black queer people may be more prone to prejudice on the basis that they are seen as more likely to "spread" the disease. This stigma may be more commonly associated with Black men who have sex with men (MSM)[19], but it still affects LBT+ Black women:

> "One of my partners is a Black African woman, and every time she's ill, whatever is wrong with her, they always ask to test her for HIV. There is definitely some sort of racial profiling going on. Even when she was in a monogamous relationship with me, they were always trying to test her for HIV."
>
> *- (Roundtable participant)*

Women are less likely to have their pain and symptoms taken seriously in healthcare settings[20], but being queer and a person of colour may add to healthcare workers' disbelief of the patient:

> "Trying to pursue a diagnosis in Endometriosis/PCOS [my] competency to communicate levels of pain [was] doubted by medical professionals, [which] I attributed to racial discrimination (i.e. anti-Blackness)."
>
> *- (Survey participant)*

And as assumptions are made about queer people, additional assumptions may be made about an individual's experiences when they are a queer person of colour:

> "[I've experienced] assumptions about FGM based on my perceived ethnicity and experience of gender."
>
> *- (Survey participant)*

It seems as though the experiences of Black LBT+ women are often dismissed or disregarded unless they fit a stereotypical, often stigmatised, view of Blackness (HIV-carrier, FGM survivor, etc.) held by the healthcare worker.

A similar sentiment was communicated by Autistic people who completed our survey. From the free-text responses, it felt as though some healthcare professionals' view of Autistic people lacks any kind of variation and instead relies on stereotypes. In some cases, Autism may be used as an excuse to write off or ignore the symptoms that Autistic people are struggling with:

> "As a woman, especially an autistic one, I tend to get dismissed very quickly. I've been [to the doctor] a few times about extremely painful periods, and I've just been ignored. It gets worse after telling them I'm autistic because they just jump to "[you've] got a low pain tolerance", but even a low pain tolerance shouldn't make you pass out and throw up because of it."
>
> *- (Survey participant)*

Autistic queer people exist in a cross section of opposing stereotypes. While queer people are seen as hypersexual, Autistic people are often desexualised, seen as not wanting sex or unable to participate in it:

> "Since I am autistic, I often have the reaction of healthcare workers being surprised that I am capable of having a sex life. I then regularly get asked a set of incredibly intrusive questions about being trans/lesbian and how it's possible for me to have sex. At one time, a healthcare worker implied that my partner should find someone who isn't autistic because it

would be better for them to have someone who could make sex enjoyable for them (as if an autistic person isn't capable of that?) and have also had people imply that, due to neurodivergency, I am not capable of consenting."

- (Survey participant)

While some neurodiverse people may have limited capacity to consent to sex, this doesn't by any means apply to every Autistic person, and for healthcare workers to assume this creates unnecessary safeguarding and can be patronising or dehumanising for Autistic people seeking sexual health care.

Another identity that is inherently desexualised is fatness. Western beauty standards mean that fat people in the UK are less likely to be perceived as sexual beings or capable of confidently enjoying sex with a partner or partners. These assumptions aren't left at the door of healthcare settings:

"Though my most recent cervical screening went smoothly, I have in the past had poor experiences. At one test, the nurse looked me up and down (I am a plus-sized, femme-presenting woman) when I said I was reporting for my smear and said, "do you even have sex?""

- (Survey participant)

Medicalised fatphobia — when fat people are denied care based on their weight or their symptoms are blamed on their fatness without thorough investigation — is also rife in sexual health spaces:

"I'm fat, so I actively avoid healthcare settings at the moment because, unfortunately, I know that the first thing I'm going to get told is to lose weight."

- (Roundtable participant)

Some sexual and reproductive health conditions, such as endometriosis and PCOS, cause weight gain. But patients who try to access treatment for these conditions are often told that they need to lose weight before they can be treated for the condition that is causing their weight gain. The flaws of this proposal are not realised by doctors:

"My experiences are tied up in medicalised fatphobia as well. I have polycystic ovaries, and the best treatment is hormonal contraception. I can't have the combined pill because I'm at increased risk of stroke. So my doctor sent me to the sexual health clinic to receive the implant because that seemed like the best option for me. When I got there, they refused to do it. They said, "if you're not using this to prevent pregnancy, we can't give it to you". This was with a referral from my doctor; she had sent me there to help me with a medical condition. But they refused to give it to me. And when I finally managed to sort of push and push the doctors to try and get an alternative option, I was just told to lose weight first. So I'm 40 years old, and I'm not being treated for a condition that I've been having bad effects from since I was 17 because of the combination of not being taken seriously because of fatphobia and because I tried to get hormonal contraception when I was in a relationship with a woman."

- (Roundtable participant)

The above response is a clear example of how marginalised identities intersecting can result in a unique experience where the patient cannot get care. In this case, due to the fact that the patient is both fat and queer, they are left out in the cold with no options for treatment.

Positive Experiences

We were happy to see that, when asked for further comments about sexual health care as a LBT+ woman/femme-aligned person, a number of participants opted to highlight positive experiences of care they had received. Several people gave examples of what affirming and inclusive care looked like within services that aren't LGBT-focused:

> "I think in general I've had good experiences with my GP surgery. I was encouraged to do an STI test a couple of years ago (not realising I could get an STI from a female partner as it wasn't taught at school!). My GP told me it was. My GP is aware of my sexuality, but when they were not, they would ask if I was in a relationship and the gender of the person I was in a relationship with."
>
> *- (Survey participant)*

> "[I] had a really lovely experience with a professional at a sexual health clinic recently — we were talking on the phone and she asked me for my partner's name; I gave her the name (which is a name typically given to girls), and she went, "am I correct in thinking that you don't use condoms with them?" I appreciated that she double-checked and didn't automatically assume that my partner was cis. I generally feel a lot more comfortable talking about my identity with sexual and reproductive healthcare professionals compared to GPs, etc."
>
> *- (Survey participant)*

> "I went to a sexual health clinic a few years ago in London, and one of the first questions I was asked there was, "who are you having sex with? Are you having sex with a man or a woman, or both, or neither?" And that made the whole experience a lot easier."
>
> *- (Roundtable participant)*

These experiences highlight the importance of inclusive language and asking questions instead of assuming someone's sexuality, gender, or sex life. A service doesn't have to be LGBT-specific to use language that is inclusive of all types of people and relationships.

Using clear and inclusive language doesn't only improve the care of LGBTQIA+ people. Refusing to accept that a sexually active woman cannot be pregnant not only erases women who have sex with women but is also inconsiderate and insensitive to heterosexual women who may be infertile. This is just one example of how more inclusive healthcare for queer people can mean more inclusive healthcare for everyone.

When seeking inclusive services, many LGBTQIA+ people opt for sexual health clinics that advertise themselves as LGBT-friendly or are exclusively for queer people:

> "My wife and I specifically sought fertility care from a clinic that advertised itself as LGBTQ+ positive to avoid having a negative experience."
>
> *- (Survey participant)*

> "As a transfeminine person who has sex with men, I'm in a high-risk group for certain STIs, but so little information is directed at me (apart from in LGBT sexual health charities). I only feel safe accessing services in an LGBT-friendly environment."
>
> *- (Survey participant)*

> "I'm currently being treated by CliniQ,

who are treating my gender healthcare and sexual healthcare together. They're supporting me for my HIV, and I thought that was going to be difficult for them to accommodate, but I found it consistently a really inclusive environment, and nonjudgmental."

- (Roundtable participant)

"[56] Dean Street has been fantastic for access to sexual health information and the provision of care."

- (Roundtable participant)

LGBTQIA+ clinics can allow queer people to relax a little, to know that their identity and experiences are more likely to be understood, and that the professionals will know more about what treatment is best.

However, unfortunately, not all LGBTQIA+ people have access to queer clinics. Such services are more likely to exist in large cities known to be more "LGBT-friendly", such as London, Manchester, or Brighton — places that are unaffordable to many queer people. Location and the privilege of living in a certain location were mentioned by a number of survey participants, specifically in reference to Brighton, a city sometimes referred to as the "LGBTQIA+ capital of the UK":

"The services I have accessed in Brighton have been specifically for trans people."

- (Survey participant)

"I was able to access sexual health services in Brighton, which are fully LGBTQ+ inclusive, and I could have accessed Clinic T if I wanted to. I've also been able to access specific vaccines as I'm non-binary which is great."

- (Survey participant)

"I've got the privilege of being queer and living in Brighton, where we even have Clinic T which is a sex clinic specifically for trans people, which is fantastic."

- (Survey participant)

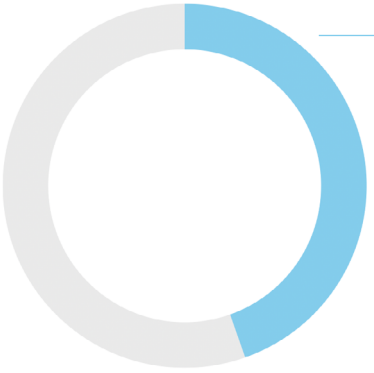
So while it's great that some LBT+ women and femmes can rely on a queer-focused service, this perhaps doesn't benefit those who live in more rural areas or less LGBT-friendly cities. Nonetheless, the importance of queer-focused and queer-friendly spaces was clear from this research. For some, inclusive questioning and informed guidance may be the difference between actively seeking care for your sexual health or avoiding it altogether.

STIs, HIV & Sexual Health

Misinformation about STIs for LGBTQIA+ people is rife, particularly when it comes to sex not involving a penis.

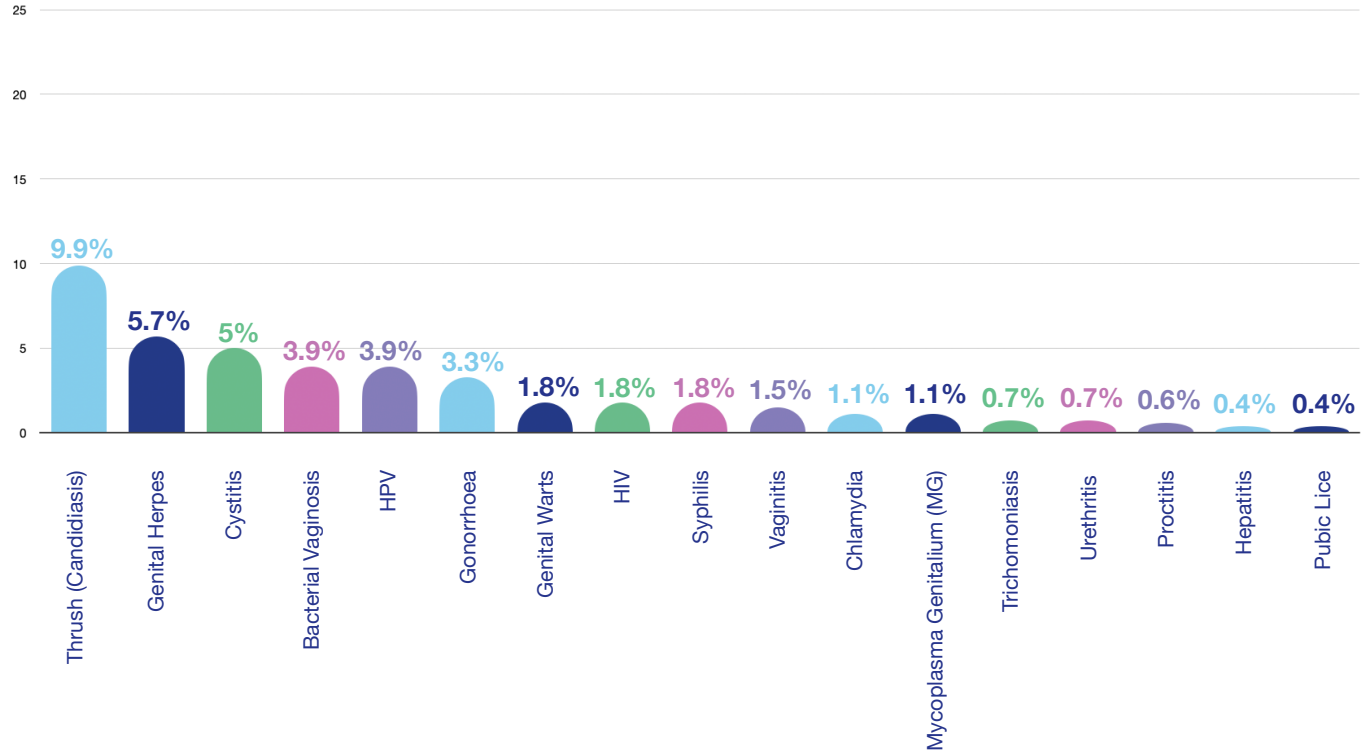
As seen in the chapter on Relationships & Sex Education on page 25, the information LBT+ women and femmes receive about safe sex often focuses on penis-in-vainga penetration with little or no discussion of other types of sex. For many, this means beginning to participate in queer sexual encounters with limited knowledge of how to protect yourself and your partners from sexually transmitted infections.

Of those who had engaged in sexual activity in the past year,



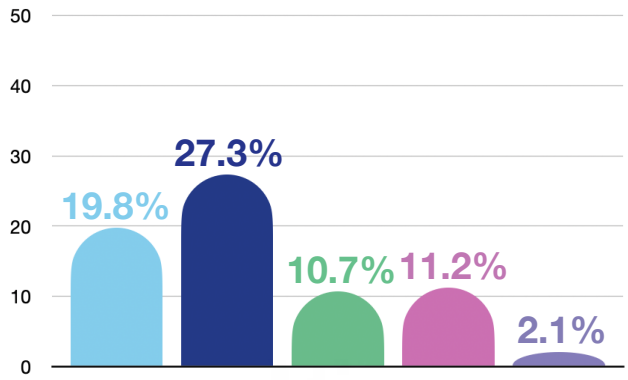
44.6% of LBT+ women and femmes surveyed had been tested for STIs during this period.

Over a quarter (**26.6%**) of people surveyed had been diagnosed with an STI or intimate infection in the past 12 months, with the most commonly diagnosed conditions being Thrush (9.9% of survey participants), Genital Herpes (**5.7%**), and Cystitis (5%):

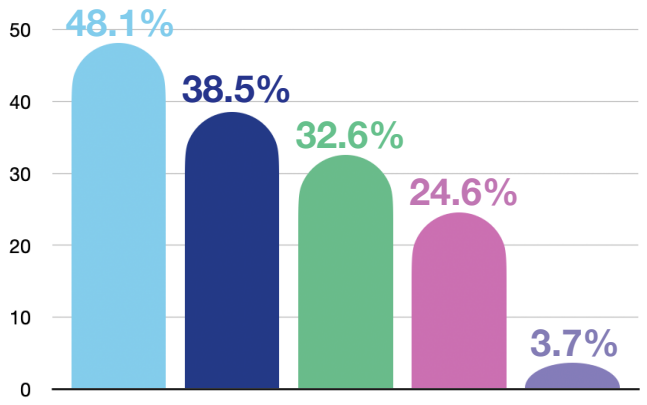


Two of the most common STIs in the UK are Chlamydia and Gonorrhoea. In 2020, 161,672 people were diagnosed with Chlamydia or Gonorrhoea in England[21] — **0.39%** of the population (roughly 56,500,000 according to the 2021 census[22]). Of our 551 survey responses, **4.4%** of LBT+ women and femmes had received a diagnosis of Chlamydia and/or Gonorrhoea in the past year — over eleven times the percentage of the general population.

Of those who were diagnosed with an STI or intimate infection, over a quarter (28.9%) did not seek further health support and did not take medication to treat the condition. 19.8% took medication prescribed by a healthcare professional, **27.3%** took medication purchased over-the-counter or online, and 10.7% took a combination of prescribed and over-the-counter treatment. 11.2% did not take medication because they were told by a healthcare professional that it was not needed, and 2.1% did not take medication despite being prescribed it.



When it came to informing others about their health conditions, a fifth of respondents (**21.9%**) chose not to tell anyone.



48.1% informed their sexual partner(s), **38.5%** told a healthcare professional, 32.6% shared this with a friend, 24.6% told a family member, and 3.7% told a colleague.

Hetero- & Cis-Normative Healthcare

Sadly, hetero- and cis-normative information about sexual health isn't limited to school-age RSE. Survey participants reported dissatisfaction with the sexual health guidance that is available via healthcare services, highlighting how heterosexual penis-in-vagina sex is still considered the default and the lack of information for LBT+ women and femmes:

> "Sexual health information for lesbian relationships is woefully inadequate. It is difficult to find and limited in scope despite being relevant and important."
>
> *- (Survey participant)*

> "I feel that I've only been educated on the STDs I could contract from heterosexual sex and not on the risks of STDs from having sex with another woman [or the] appropriate barrier methods for homosexual sex."
>
> *- (Survey participant)*

> "All focus is on condoms, long-term birth control methods (i.e. the pill), and assumptions that I'm having sex with men or someone with a penis. Some professionals clam up and are unsure what to do when I establish I am a lesbian and are unable to offer advice."
>
> *- (Survey participant)*

> "LGBTQ+ sexual health knowledge is limited. We are assumed to have engaged in heterosexual sex at some point. The nuances of our identities and our sexual relationships are not understood. Moreover, the biggest issue is the lack of understanding around asexuality and people not having sex. I have friends who have been told they are mentally ill for not wanting sex!"
>
> *- (Survey participant)*

A focus on pregnancy prevention, a lack of clarity on how STIs can be transmitted between vulva-owners, and assumptions of heterosexual sex all contribute to the heteronormativity of our sexual health services.

However, heteronormativity is only part of the battle. Cisnormative systems leave trans people navigating additional barriers to receiving the appropriate care. For trans people whose gender marker doesn't "match up" with their anatomy, receiving sex-specific health screenings (such as cervical smears, prostate exams, etc.) can be even more difficult:

> "Routine checks for trans people should be more easily accessible. I'd like to be able to tick a box for each check I wish to have (prostate exam, breast exam, etc.) rather than my medical record dictating which examinations I am excluded from.

It's annoying to have to repeatedly tell staff I do or don't need certain routine examinations."

- (Survey participant)

"Change of gender and new NHS number mean all old records have now gone, so no automatic call for prostate test."

- (Survey participant)

And when these services are accessed, healthcare professionals themselves are not always knowledgeable about how to perform certain screenings or tests for trans people:

"[My] GP did not know how to perform a prostate exam on a post-operative trans woman."

- (Survey participant)

When hurdles are encountered at every turn, from booking the appointment itself to actually receiving the treatment, it's easy to see why LBT+ women may avoid accessing the care they need.

Accessibility

Accessible care looks different for everyone, as everybody has different needs. Some LBT+ women and femmes experience physical barriers to accessing healthcare (disability, geographic location, cost, etc.), while for others the difficulty may be more mental or emotional (gender dysphoria, mental health, previous poor experiences, etc.).

Several of the people in our study reported difficulty getting an appointment for sexual or reproductive healthcare:

"[It's] so hard to get an appointment in my area; [it] often feels like they just don't care."

- (Survey participant)

"It is SO DIFFICULT to book an appointment for an STI test, especially recently with monkeypox. They are not answering the phones, and I have to either travel far out [of] my area or do [a] home test with the LGBT Foundation."

- (Survey participant)

"Testing seems really hard to access outside of London."

- (Survey participant)

Many people opt for ordering at-home STI tests online, either because of the difficulty of receiving an in-person appointment or just out of personal preference. Of the **33.9%** of survey participants who had done an STI test in the past 12 months,

66.1% used an at-home STI test.

The benefit of accessing an online service is that the questions you're asked will have been set and agreed upon in advance, possibly resulting in a more equal standard of care for everyone accessing testing. Unlike in-person appointments, the care is not dependent on a "lottery" of which healthcare professional you get to see and their personal level of knowledge:

"[The] SHL online experience was very good as they ask a lot of questions about

if you have a sex with lots of other people (i.e. do sex parties, etc.), if you have anal sex as a woman, are bi, etc."

- (Survey participant)

However, some LBT+ women and femmes also experienced access issues with at-home testing, from getting the test in the first place to it actually being the right one for them:

"It has been hard to access at-home STI testing where I live. It would be helpful as I have a disability and attending a clinic is difficult."

- (Survey participant)

"I'm nonbinary trans (AFAB), and when ordering STI test kits online, I've had it before where there are multiple gender options, one being trans, but then the kit is quite clearly aimed at someone with AMAB biology."

- (Survey participant)

HIV

4% of our survey respondents had a diagnosis of HIV. Of those with a HIV diagnosis,

9% of participants had received it in the past 12 months.

While queer people typically receive more stigma surrounding HIV and are considered higher-risk for contracting it, this usually focuses on cisgender, queer men. LBT+ women and femmes engaging in sexual activity with men who have sex with men (MSM) may experience more scrutiny of their health:

"I'm a polyamorous person, and a few years back I was dating two queer AMAB people, and my parents basically just got, like, AIDS panic."

- (Roundtable participant)

But generally, the focus on MSM and HIV means that women and femmes, particularly cisgender women, aren't receiving the support they need to protect themselves against the virus. LBT+ survey and roundtable participants were very vocal about the difficulty they've had in accessing testing due to not being deemed at high risk:

"I've found the general assumption seems to still be that HIV is still an exclusively men-loving-men thing; I know that trans women are a significant demographic for HIV, but this really isn't talked about."

- (Survey participant)

"Lack of willingness to test for HIV; in the STI kit routine [they do] not test for it. I had to request this. I was surprised they didn't automatically test for it."

- (Survey participant)

"There are people out here that are fighting to get HIV tests because they've actually had sex that could have put them at risk, and they're being denied it because they don't meet certain criteria. And then you have certain people who are just being thrown HIV tests based on nothing really. Just racial profiling or assumptions."

- (Roundtable participant)

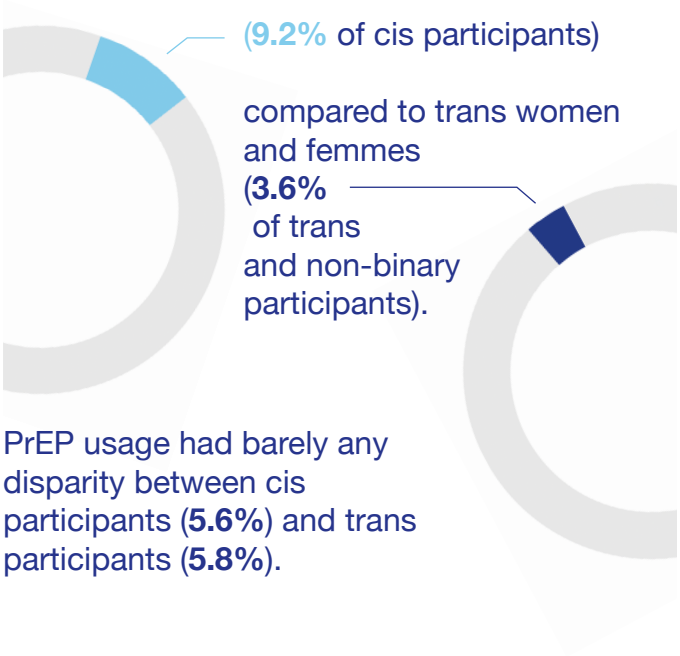
This lack of HIV testing combined with inadequate information on safe sex leaves LBT+ women and femmes at risk.

Alongside contraception and HIV testing, another way to protect yourself against HIV is by taking HIV prevention medications such as PrEP (pre-exposure prophylaxis) or PEP (post-exposure prophylaxis). When asked about PrEP and PEP use,

5.6% of survey participants said that they'd taken PrEP in the past 12 months, and

7.7% said they'd taken PEP in the same time period.

Cisgender women were nearly three times as likely to have taken PEP in the past year



(**9.2%** of cis participants)

compared to trans women and femmes (**3.6%** of trans and non-binary participants).

PrEP usage had barely any disparity between cis participants (**5.6%**) and trans participants (**5.8%**).

Contraception

Despite misinformation, LBT+ women and femmes are at risk of sexually transmitted infections...

...and (for some women and femmes) there is a also risk of pregnancy — many queer women have sex that involves both a penis and a vagina (e.g. bi+ women, trans women, etc.) Therefore, contraception is important.

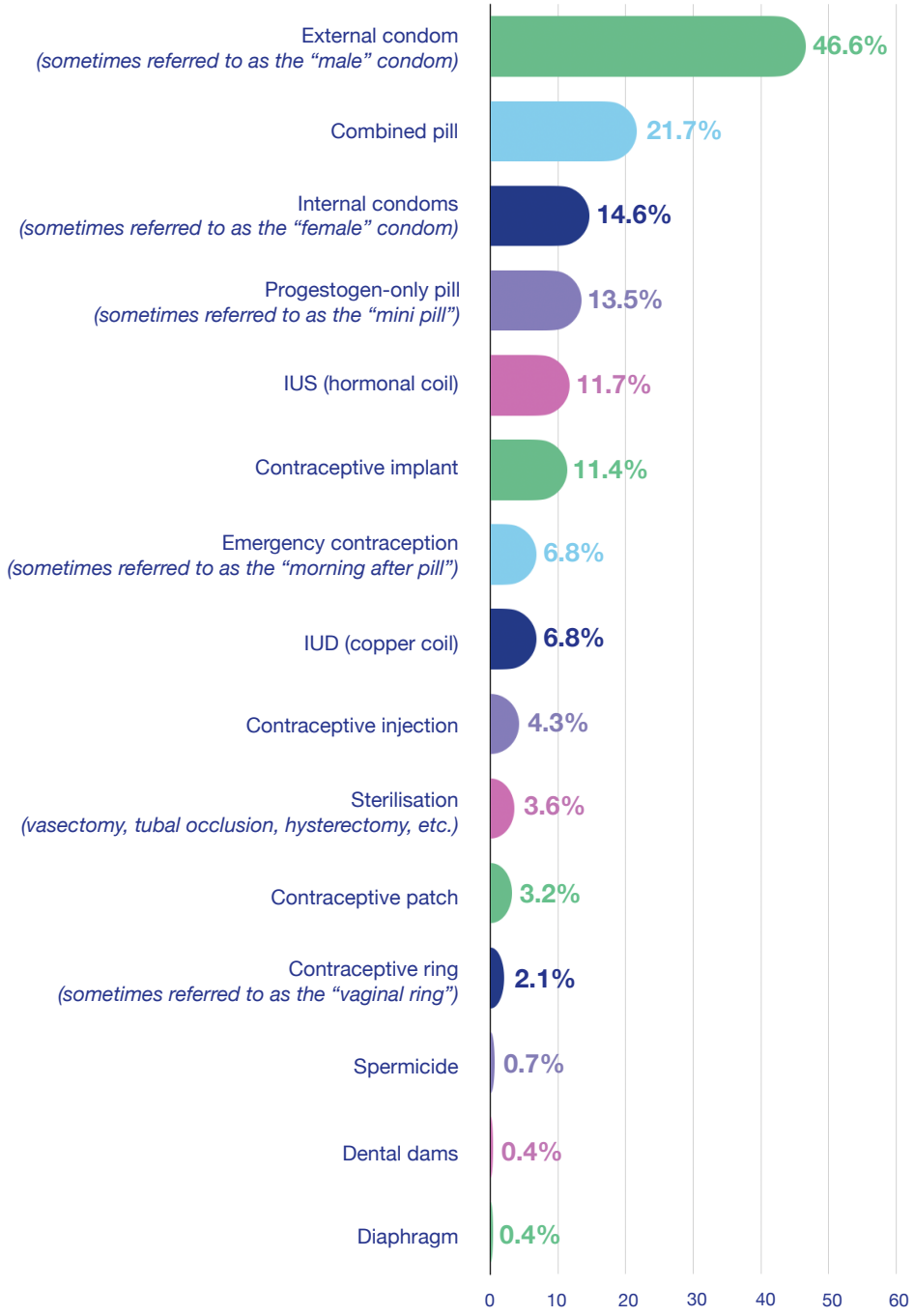
57.4% of survey participants had engaged in unprotected sex (including unprotected oral and anal sex) in the past 12 months —

for **6.7%**, this was only once,

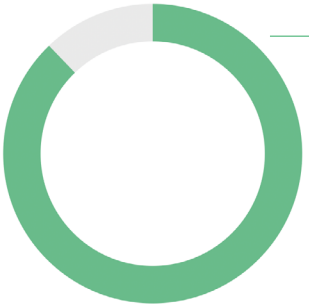
but the remaining **50.7%** had done so more than once.

2.5% of survey participants couldn't remember if they'd had unprotected sex in the past year.

Of those who had used contraception and methods of STI prevention in the past year (**51.7%**), the most common methods were the external condom (**46.6%**), the combined pill (**21.7%**), and the internal condom (**14.6%**):

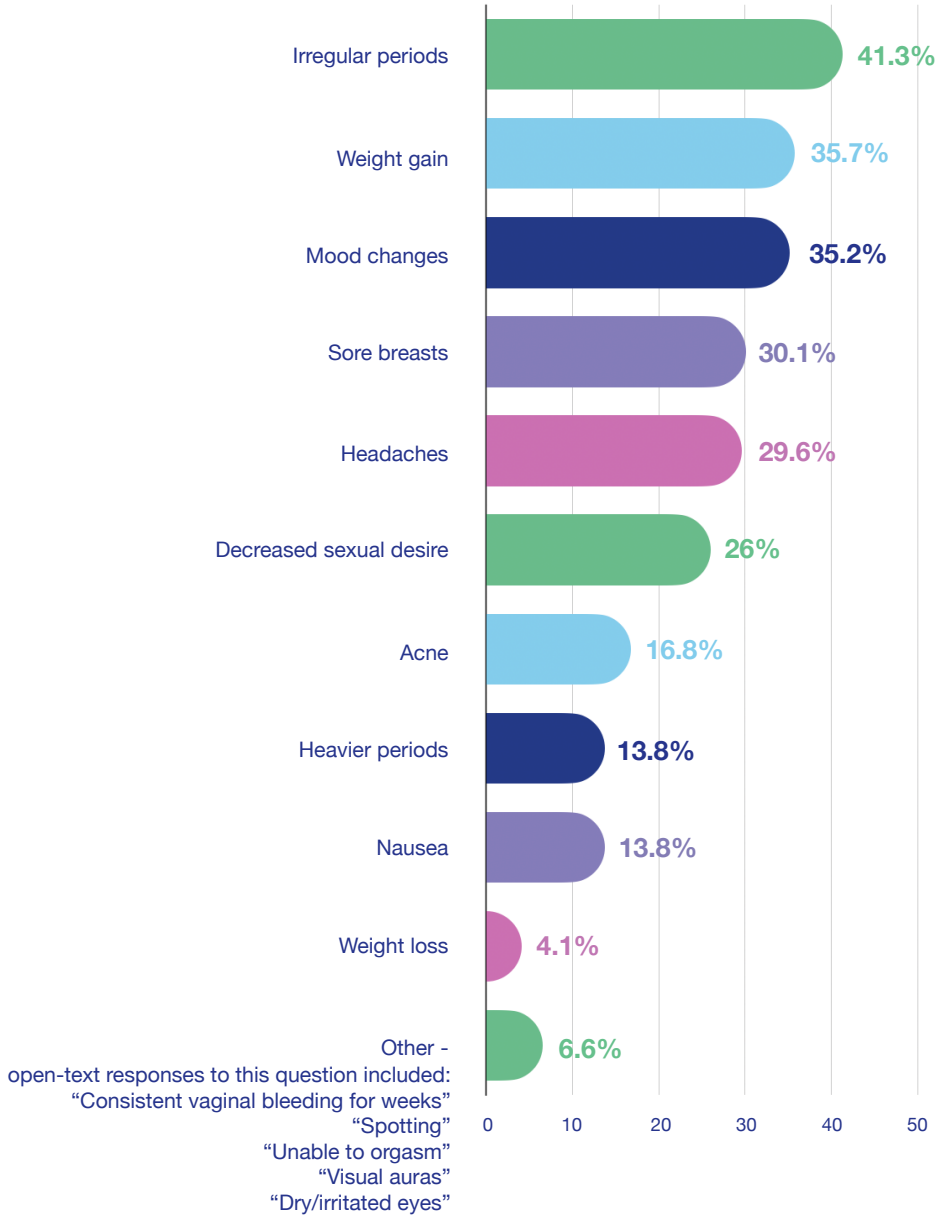


Side effects are common with hormonal contraception — of the survey participants who said they'd taken hormonal contraception in the past 12 months,



87.8% of LBT+ women and femmes reported experiencing side effects.

The most common side effects were irregular periods (**41.3%** of people), weight gain (**35.7%**), and mood changes (**35.2%**):



Of those who use contraception, the majority of LBT+ women and femmes surveyed prefer non-hormonal methods (**56%**), while

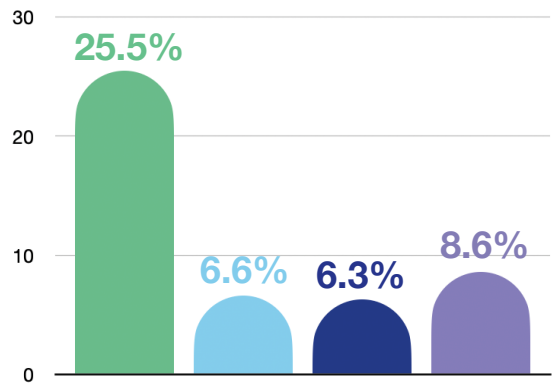
24.7% prefer hormonal methods

19.3% reported no preference.

The preference for non-hormonal contraception may be linked to avoiding unwanted side effects.

Of the LBT+ women and femmes who have tried to access contraception in the past 12 months, nearly half (**46.6%**) have found it difficult to access. The barriers varied:

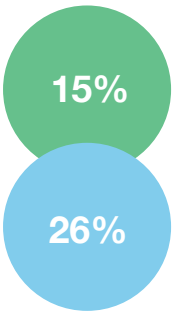
Cost can be a big barrier for people seeking contraception. When asked about the past year, the majority of LBT+ women and femmes surveyed usually accessed their contraception for free via the NHS (**53%**).



25.5% said that they typically pay for it over the counter themselves, while **6.6%** said that somebody else pays for their contraception (e.g. a partner). **6.3%** access their contraception for free, mostly from charities or schemes (e.g. the C-Card scheme). **8.6%** selected "Other", and when asked to provide more information, free-text responses included:

- "Combination — I pay for condoms and get the pill through the NHS"
- "I got it at work (in a healthcare setting)"
- "Sterilised several years ago; no recurring costs"
- "Implant put in before 12 months"
- "My partner has had a vasectomy"

Over half (**59%**) of LBT+ women and femmes sourced their own contraception the majority of the time, while



said that their partner(s) mostly sourced it.

said it varied.

Accessing Contraception While Queer

For LBT+ women and femmes in sexual relationships where there is no risk of pregnancy, access to contraception (especially hormonal contraception) can be difficult. There seems to be confusion among healthcare workers about why hormonal contraception would be used if not to prevent unwanted pregnancy, despite people having other reasons to use it, such as period management.

Many LBT+ research participants reported difficulty accessing contraception as a queer woman/femme-aligned person:

> "I was asked why I wanted to use hormonal contraception as a lesbian in a relationship with a nonbinary person (who couldn't get me pregnant)."
>
> *- (Survey participant)*

> "I got the implant while in a relationship with a girl and was questioned about this by the nurse."
>
> *- (Survey participant)*

> "When I was 16, I had to access contraception because of my periods, and my doctor asked me quite abruptly, "do you plan on having sex?" I said no, and he went, "oh, well, why are you here?" And I had to prove that it was because my periods were debilitating and I was soaking through pads and feeling distracted in school."
>
> *- (Roundtable participant)*

Some respondents reported being denied contraception to treat health conditions, due to the absence of penis-in-vagina sex:

> "I need contraception to help with my endometriosis (I am in a mostly monogamous relationship with my girlfriend, so I don't need it for anything else). Being queer and gender non-conforming has been a significant barrier to me getting contraception, with a lot of disbelief, suspicion, and ignorance from doctors. I was told my GP would not fit the coil if it wasn't for pregnancy prevention."
>
> *- (Survey participant)*

> "My GP referred me to get the Mirena coil because of a health condition, and because I said that I was in a same-sex relationship, they turned me down for it."
>
> *- (Roundtable participant)*

Many cisgender, heterosexual women also use hormonal contraception, such as the pill, to manage painful or heavy periods, but because they are also having sex that could result in pregnancy, this is permitted. Whereas queer women are denied, forcing them to go without the medication they need to reduce their pain and discomfort or to lie about the type of sex they are having to their healthcare workers.

But this isn't the only barrier to accessing contraception for LBT+ women. Due to a lack of funding, services that were previously available are no longer operating, leaving LBT+ women unsure of where to get treatment:

> "I got an implant, and I've never had it taken out because the clinic closed down, and then I didn't know where to go or what to do. Then I came out as trans and I basically avoid medical professionals. So I've now got an implant that's five years out of date."
>
> *- (Roundtable participant)*

As mentioned in the section on Further Marginalised LBT+ and Femmes [page 49], fat people may face additional barriers to accessing sexual health care. A few people within our research mentioned this specifically in relation to contraception:

> "As someone who is larger, accessing contraception is harder as I don't know what will work with my weight. I also feel judged, as I've needed to access emergency contraception twice this year. Once I did it online, which felt good as I was able to feel less judged, but the second time was over the counter, and I felt like I was being judged by the pharmacist. My partner wasn't there, but he paid. The cost was extortionate — £33 for the one I knew was likely to work. I use contraception as I don't want children right now, but I get anxious [about] accessing it as I live in a larger body and feel like I'll be judged or fat-shamed for daring to access it, whilst my partner just has to buy condoms."
>
> *- (Survey participant)*

> "One of the things that stopped me from accessing birth control to help with my periods was that I was terrified of going in and being fat-shamed and also being asked what kind of relationship I'm in. And having to explain the intricacies and seeing if I had the energy to explain the specifics of what's going on."
>
> *- (Roundtable participant)*

Cisgender, heterosexual women can, of course, experience medicalised fatphobia and have difficulties accessing contraception due to their size. However, for LBT+ women who may already struggle to be prescribed contraception due to the type of sex they are having, living in a fat body can be another reason why healthcare workers deny care. These intersecting identities make it even harder for fat, queer women to protect themselves during sexual activity and could put them at higher risk.

The general discomfort with healthcare professionals may also be an additional barrier, especially following previous uncomfortable experiences where identities have been erased or misunderstood:

> "Before being diagnosed with PCOS, I had my implant removed and was told to wait to see if my periods returned to normal after a break from hormonal contraceptives. I was quizzed as to why I was not taking contraceptives by an older male neurologist, who proceeded to ask me if I was trying to get pregnant. Not only was I infertile, but it was assumed that I was having sex with someone with a penis, which (while I was at the time) made me uncomfortable as it was assumed it was straight."
>
> *- (Roundtable participant)*

And some healthcare professionals may still view the need for pregnancy prevention as black and white — either there is a risk because you're in a straight relationship or there isn't because you're in a gay relationship — erasing bi+ and polyamorous relationships altogether:

> "[There is] little understanding of why I, as a bisexual woman, may stop contraception at times."
>
> *- (Survey participant)*

In general, there seemed to be a consensus that information about sex involving only vulva-owners was sparse or completely neglected:

> "I wouldn't know where to access lesbian contraception and haven't learned about it in school or uni, only heard about it through others."
>
> *- (Survey participant)*

Dental Dams

Dental dams are thin sheets of latex or polyurethane that form a barrier between the mouth and the vulva or anus during cunnilingus (oral sex on a vulva) or analingus (oral sex on an anus, or "rimming"). Due to limited research, the efficacy of dental dams in reducing STI transmission is not fully understood, but they are thought to reduce the overall risk and are likely more effective than using nothing at all.

Our research found that out of 551 LBT+ women and femmes, only **0.4%** had used a dental dam in the last 12 months — by far one of the least common barrier methods. However, responses to our survey and roundtables found that many LBT+ women and femmes wish to use dental dams — the issue is that that they are famously hard to find and seldom discussed:

> "Finding dental dams is an absolute nightmare."
>
> *- (Survey participant)*

> "As I am a lesbian and there is little access to barrier methods for STIs, I am worried about having STIs but have little way of preventing these."
>
> *- (Survey participant)*

> "I'm in a long-term lesbian monogamous relationship, so don't use contraception. However, I have wanted to purchase dental dams but have never seen them for sale and don't know where to get them."
>
> *- (Survey participant)*

> "I have only engaged in intimate contact with a woman during the 12 months covered, but it always feels a bit... awkward to try and make things safer. Dental dams aren't commonly sold alongside condoms, etc."
>
> *- (Survey participant)*

Some people turned to looking online, only to find them equally scarce:

> "I looked into getting dental dams (it's all new to me) but couldn't find any easily online. I didn't know how to use them. In the end, I didn't use them."
>
> *- (Survey participant)*

> "Dental dams aren't available. I've heard people say you can only get them online, but that they're really hard to get, even in sexual health clinics. I think because of that, a lot of people don't use them because they're just not available. And because we're fed so much misinformation about the way that STIs are transferred — I mean, personally, I don't use them."
>
> *- (Roundtable participant)*

It seems to be a vicious cycle. People aren't using dental dams because they're not readily available, which contributes to the belief that they are simply not desirable to queer women:

> "I worked for a while in an independent sex shop, and we got a lot of requests for dental dams from queer women. I asked my boss if we could order some dental dams in, because we were selling condoms. And she was like, "I don't think enough people would use them.""
>
> *- (Roundtable participant)*

In the absence of dental dams, people have found creative ways to make them themselves,

with mainstream health websites such as Healthline providing instructions on how to do this[23]:

> "I only found out really recently that you can just make a dental dam by cutting up a condom."
>
> *- (Roundtable participant)*

However, making your own dental dams is still dependent on access to condoms, which, for some people, is its own barrier:

> "I have not used condoms of any kind since my early 20s, when it became difficult to access them for free due to a lack of sexual health clinics, and I could never find dental dams even before then."
>
> *- (Survey participant)*

Dental dams need to be made more accessible for the people who wish to use them, and more research clearly needs to be conducted into their efficacy.

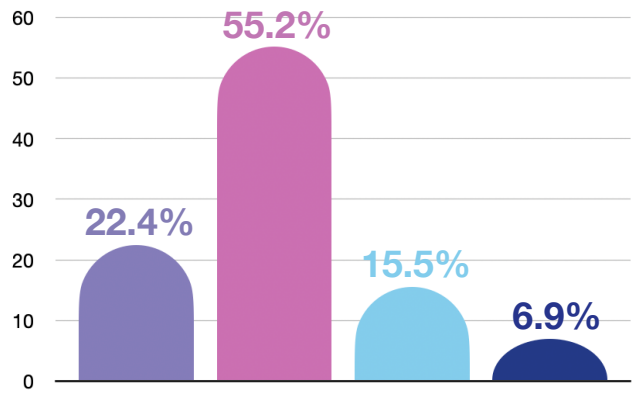
Reproductive Health

9.5% of LBT+ women and femmes surveyed had been pregnant at some point in the past 12 months. Of those,

44% have given birth in the past year.

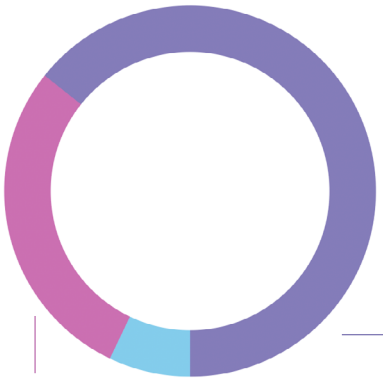
- **22.4%** attempted it themselves and were successful in getting pregnant
- **55.2%** attempted it themselves, with no success
- **15.5%** had a partner attempt it who was successful in getting pregnant
- **6.9%** had a partner attempt it, with no success

11.3% of survey participants had attempted IUI (intrauterine insemination) in the past twelve months. Of those who had attempted IUI:



13% of survey participants had attempted IVF (in vitro fertilisation) in the past twelve months. Of those who had attempted IVF:

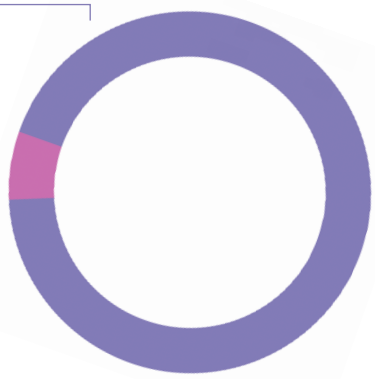
26.5% attempted it themselves and were successful in getting pregnant
48.5% attempted it themselves, with no success
10.3% had a partner attempt it who was successful in getting pregnant and **14.7%** had a partner attempt it, with no success



The most common place for LBT+ women and femmes to give birth was at a birthing unit (64.3%),

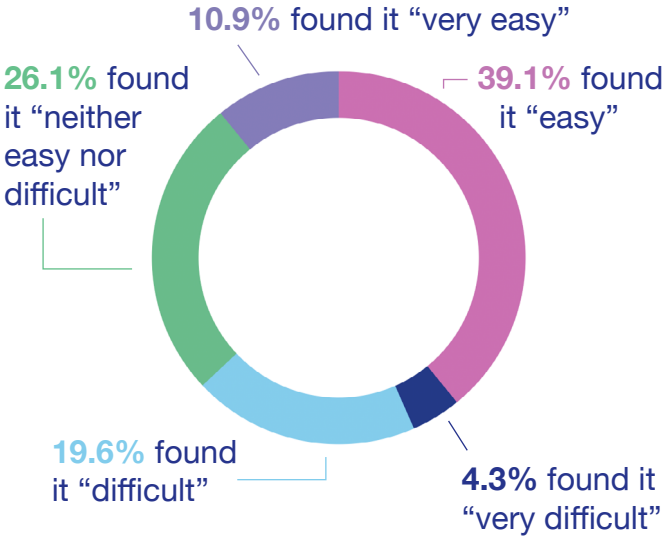
with only a quarter (28.6%) of LBT+ people giving birth in a hospital and 7.1% giving birth at home.

For LBT+ women and femmes who have experienced pregnancy in the past year, 93.9% accessed pregnancy-related care during their pregnancy. The remaining 6.1% (3 people) didn't receive any pregnancy-related care.



Of these three people, two identified as trans or non-binary. Trans and non-binary people may be more likely to avoid pregnancy care and to freebirth (give birth without ever accessing perinatal care) due to transphobia in healthcare and the heavily gendered nature of maternity wards[24].

Of those who did access pregnancy-related care:



Disabled respondents were more likely to find accessing care "difficult" or "very difficult" (30%)

compared to non-disabled people (12.5)

Additionally, 28.5% of neurodivergent people rated accessibility as "difficult" or "very difficult", compared to 16.7% of neurotypical people.

Lack of Resources

One barrier to reproductive care for LBT+ women and femmes is a lack of available information on pregnancy options. Hetero- and cis-normative healthcare in the UK means that most of the advice for conceiving focuses on penis-in-vagina sex, and survey participants reported feeling at a disadvantage compared to different-sex couples:

> "What I struggle with is knowing about reproduction and how to approach this with my GP if my partner and I were to decide to have a child. I don't know what is available and whether my GP would even know this or support us through the process."
>
> *- (Survey participant)*

> “Being same-sex and going through IVF — no funding available and lack of exposure to the path we choose.”
>
> *- (Survey participant)*

> “As a bisexual woman in a same-sex relationship wanting to have a baby, I feel greatly discriminated against compared to heterosexual couples who can access NHS help after trying for a period of time. The fact that we would have to have paid out over £14k to be considered eligible for reproductive support when a mixed-sex couple can try for free is so frustrating. We are currently paying for private fertility treatment as a result.”
>
> *- (Survey participant)*

Our survey opened in August 2022, a month after the UK government announced their plans to remove the requirement for same-sex female couples to pay for artificial insemination prior to being eligible for IVF funded by the NHS[25]. The response from the LGBTQIA+ community was overwhelmingly positive, and this change will reduce an enormous barrier to LBT+ women having children. An 2021 investigation by BPAS Fertility into NHS-funded fertility care “found that the majority (76%) of Clinical Commissioning Groups (CCGs) require same-sex female couples to self-fund a minimum of 3 self-funded AI cycles and frequently up to 12 cycles, which can cost as much as £1,600 per cycle, or almost £20,000 in total”[26].

What is now important is that healthcare professionals are able to provide the same quality of information about pregnancy and fertility options as they do to different-sex couples. Doctors knowing where to signpost, the rights of the patient(s), and the appropriate questions to ask are as important as changes in legislation.

Inappropriate Care

Sadly, financial barriers are not the only hurdles encountered by LBT+ women and femmes when seeking reproductive care. As with other healthcare services, overcoming hetero- and cis-normativity is something that many LBT+ people must do in order to be seen and receive appropriate support.

Reproductive health services perhaps lend themselves more to heteronormativity than others, due to the involvement of a partner. Numerous research participants reported their healthcare professionals making heteronormative assumptions about their partnerships:

> “The midwife in the hospital was homophobic and did not recognise our lesbian relationship and that there could be two mothers and no father.”
>
> *- (Survey participant)*

> “Sometimes I think people are poorly informed rather than deliberately discriminatory. For example, my wife and I have had fertility treatment and were once asked if we got pregnant by accident... I think the person just hadn't thought about the question and the feasibility of getting pregnant by accident as a lesbian female.”
>
> *- (Survey participant)*

> “When I first asked the GP for advice and support on starting fertility treatment with my wife, they didn't read my notes and had a full-blown conversation about how to get pregnant (based on a heterosexual relationship)”
>
> *- (Survey participant)*

> "My partner is pregnant, and if I'm not with her at appointments, it's presumed I'm a man."
>
> *- (Survey participant)*

All too often, the partner of the pregnant person is not only initially assumed to be a cisgender man but, once corrected, healthcare participants still erase, ignore, or discriminate against the non-birthing parent:

> "While I was pregnant, even though my notes said I was in a same-sex relationship, I often had to remind them there was no father/husband. Discussion on contraception after birth was awkward as I had to re-explain that I'm gay and therefore do not need to go on the pill. My midwife, for the first few hours, was reluctant to address my wife."
>
> *- (Survey participant)*

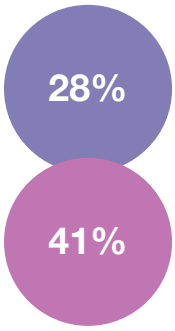
> "[My partner] was [...] made to feel quite awkward during maternity care as the non-biological parent and referred to as my birthing partner at some points."
>
> *- (Survey participant)*

Microaggressions towards the non-birthing parent (such as assuming them to be a friend or birthing partner) can quickly escalate and drastically impact the quality of support provided during an incredibly emotional, difficult, and life-changing period of one's life:

> "[I was] completely forgotten about when one baby died — the only support was for my partner. Then, when [my partner was] rushed into theatre, they forgot about me for the delivery, so I almost missed it."
>
> *- (Survey participant)*

And while many female same-sex couples reported experiencing discrimination in reproductive health care, so did trans and non-binary participants, who may have to contend with heteronormativity and cisnormativity at the same time.

The LGBT Foundation report — Improving Trans Experiences of Maternity Services — found that



of trans and non-binary respondents felt they were not treated with dignity and respect during labour and birth, and only

felt they were spoken to in a way that respected their gender all the time during antenatal care[24].

Several of our research participants identified as trans or non-binary, or had a trans or non-binary partner and reported difficulty accessing pregnancy care. From invasive questioning to misgendering and disrespect of identity, healthcare that is set up to cater exclusively to cisgender women doesn't make for the most comfortable or supportive environment for trans and non-binary pregnant people:

> "[The healthcare worker] couldn't fathom my trans partner being my baby's father and kept writing "other parent" on notes. Struggled with "they/them" pronouns."
>
> *- (Survey participant)*

> "As I started my private medical transition this year, I had discussions with my GP about fertility preservation, which involved some insensitive questioning about my anatomy."
>
> *- (Survey participant)*

> "I found it really hard for myself in a maternity world because everyone talks about the mother and women's health. And you sit in a waiting room just full of signs about how women are great, and you're

like, I'm sure they are, but I don't think I'm that. It felt very invalidating."

- (Roundtable participant)

Assumptions around trans identities have reached the point where trans people are not the only ones discriminated against due to transphobia. Our narrow view of biological sex and modern hyper-vigilance around trans identities means that cisgender women who don't fit a certain mould are inadvertently shut out as well:

"I once worked with a cisgender woman who had a very masculine appearance. When she was pregnant, she went to have an ultrasound scan, and they instantly assumed that she was a trans woman and refused to give her a scan — purely based on assumptions of her appearance."

- (Roundtable participant)

Naturally, the vast majority of people affected by trans-discrimination are trans themselves, and cisgender people should not be viewed as the victims of transphobia. This example just goes to show how the current moral panic surrounding trans people has reached a point where even those with cis privilege are finding it hard to escape speculation and assumptions based on gender norms. If cisgender people are beginning to be impacted by transphobia in healthcare, imagine how much more extreme and terrifying this must be for people who are actually trans.

The fact is, when we improve healthcare for trans people, we improve it for everyone.

Not Wanting Children

While some LBT+ women and femmes simply cannot seem to get support in having a baby, the sad irony is that many other LBT+ people aren't being supported in their choice *not* to have children:

"I have chosen not to have children for health reasons, and yet health professionals often assume that it is something I want to or will do. They won't take me seriously, especially when asking for sterilisation: "too young", "might change mind", "what if I meet someone who wants kids", etc. My existence isn't based on my reproductive organs nor what they could possibly produce. This is my choice and needs to be accepted."

- (Survey participant)

"I have been sterilised by choice, as I do not feel that having children is beneficial to me. I wish that I could choose to have all of my reproductive organs removed, however this is not an option. It was a hard and unpleasant experience persuading the medical professionals that I was allowed to be sterilised."

- (Survey participant)

"When trying to access permanent sterilisation, a doctor tried to deter me more than once on the grounds that I was "young" (despite having biological children already) and also tried to refuse the treatment unless my (here the doctor made several assumptions) "husband fully understood and agreed"."

- (Survey participant)

Not having children is a choice that is made by cis-het and LBT+ women alike; however, LBT+ women and femmes may experience additional difficulties in having this decision taken seriously or in living with the alternative. Some people born with uteruses may experience gender dysphoria during their period and desire to be sterilised as a form of gender-affirming care. But the societal expectation that all uterus-owners wish to have children may prevent this:

> “A while ago, I tried to get a hysterectomy — I was probably about 28 at the time. And it went really badly. They tried to convince me I'd want children.”
>
> *- (Roundtable participant)*

Queer women may also struggle to get care and support for their pain if it is deemed not to pose a risk to their fertility, their future children, or their husband’s desire to have children:

> “I was told by a gynaecologist that there was no point investigating my painful and problematic periods because I was a gay woman who didn't want to birth a child.”
>
> *- (Survey participant)*

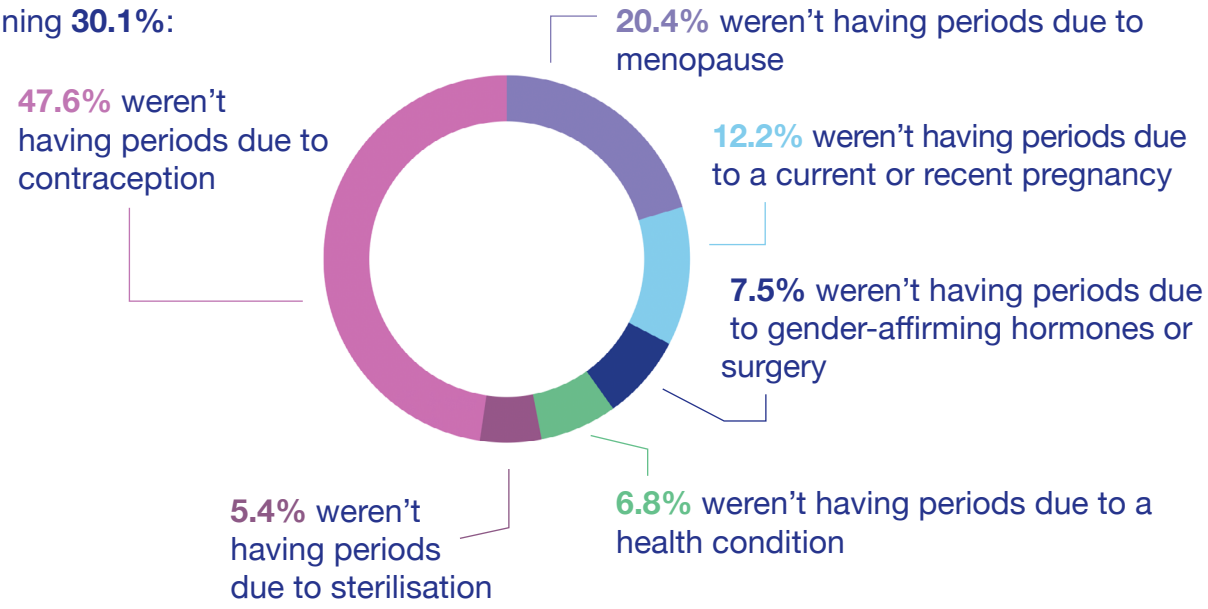
In this way, queer women and femmes experience queerphobia and misogyny at the same time; their experiences are disregarded or minimised because they aren’t serving the patriarchal ideal of being a wife to a husband and a mother to children. There seems to be an “acceptable” path to take for women, and to stray from it is to be deprioritised by the healthcare system.

Menstrual Health

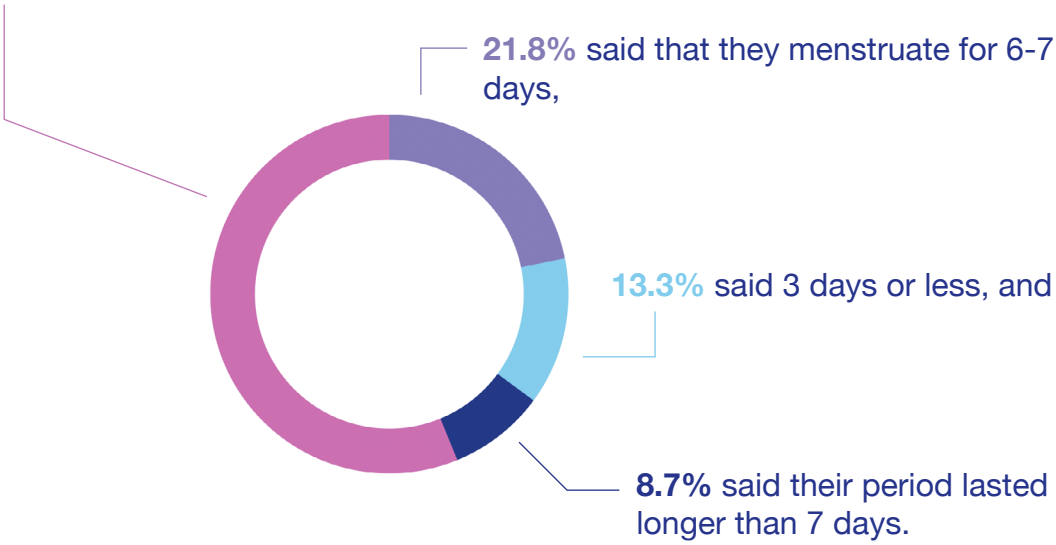
Of the survey participants born with a uterus,

69.9% were regularly having periods at the time of the survey.

Of the remaining **30.1%**:



Most participants (56.2%) reported their period lasting 4-5 days, which is in line with the average of 5 days.

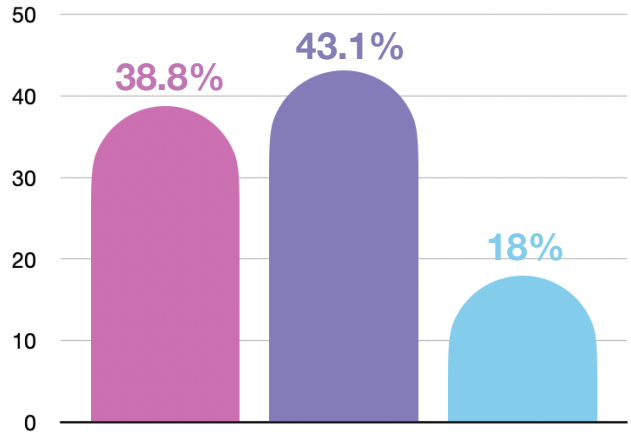


People who have periods and are also in a relationship with someone who has periods may experience additional difficulties. This could be cost-related — more money is being spent on period products in the relationship. Issues could also arise if both partners are menstruating at the same time of the month and experiencing physical and emotional symptoms — partners may be less able to care for one another, or tensions may be higher in the relationship due to mood changes and irritability.

Over a third **36.9%** of our survey participants who menstruate

reported being in a relationship with somebody who also has periods, while a further **3.3%** were in a relationship with somebody who used to have periods but doesn't any longer (due to menopause, HRT, surgery, etc.).

Some people prefer to refrain from sexual activity during their period (due to not being in the mood, mess, not feeling sexy, etc.), and in relationships where multiple partners menstruate, there may be less time in the month where sex occurs.



38.8% of participants who menstruate said that they refrain from all sexual activity during their period, 43.1% refrained from some sexual activity, and 18% typically continued sexual activity as normal.

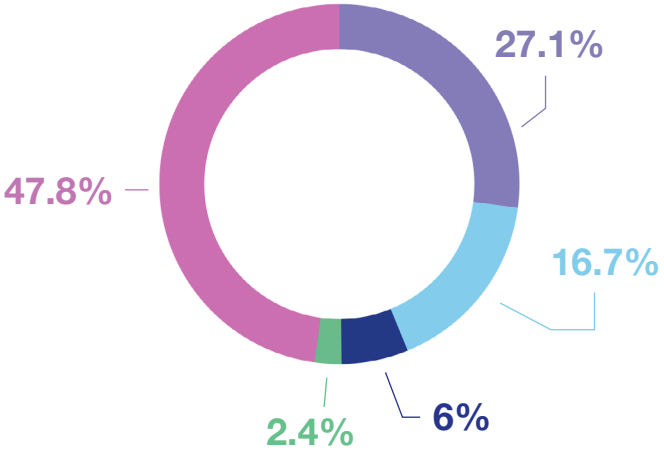
Menstrual Disorders & Pain

Periods can be extremely painful and uncomfortable —

Over a quarter **27.5%** of survey participants

had seen a medical professional in the past 12 months due to menstrual pain or other side effects.

Three quarters (**74.9%**) of respondents who menstruate reported most commonly experiencing moderate to severe pain:

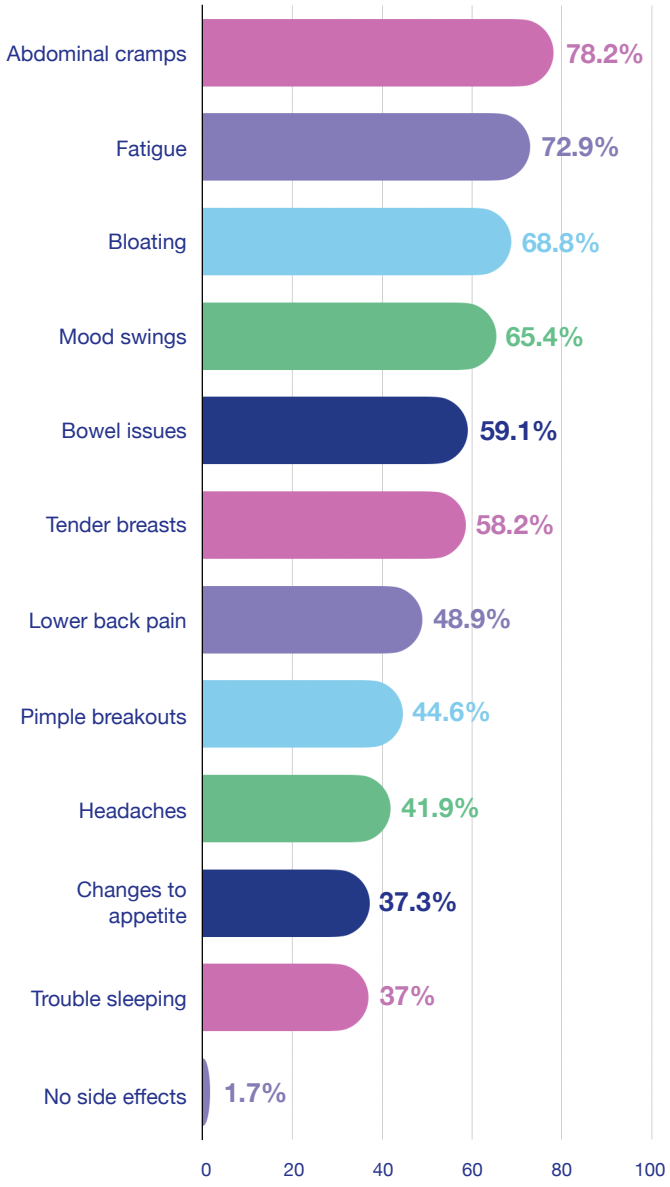


- **27.1%** reported extreme pain (pain that doesn't go away with over-the-counter painkillers, unable to carry on with usual activities such as work, exercise, etc.)
- **47.8%** reported moderate pain (able to carry on with usual activities with the use of painkillers or other pain management, for example, hot water bottles)
- **16.7%** reported mild pain (able to carry on with usual activities without using painkillers)
- **6%** reported no pain but some discomfort
- **2.4%** reported no pain and no discomfort

In addition to pain, **30.6%** of participants said that they regularly experience such heavy menstrual bleeding that it impacts day-to-day life (e.g. not being able to leave the house, go to work, etc.). **11.9%** reported experiencing

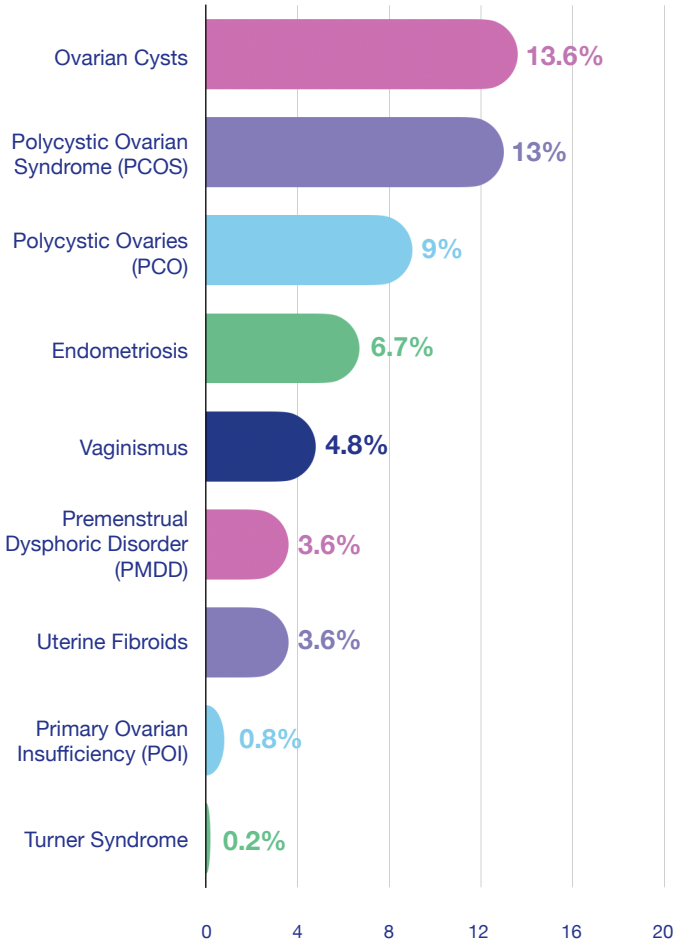
this in the past but having had treatment to help with it since (e.g. the contraceptive pill, the implant, etc.)

Side effects were heavily reported, with the most common side effects being abdominal cramps (**78.2%**), fatigue (**72.9%**), and bloating (**68.8%**). Only **1.7%** of participants reported no side effects.



While period pain and discomfort are common among all people who menstruate, including heterosexual and cisgender women, LBT+ women and femmes who seek healthcare for their symptoms may be less likely to be taken seriously or receive a good quality of care. They may also be denied hormonal contraception to manage symptoms on the basis that they are not having sex with someone who could get them pregnant.

While some pain and discomfort are considered normal for people who have periods, complications can arise, and there are a number of conditions that are linked to menstruation and vaginal health that may cause further pain and distress. **35.4%** of our survey participants had been diagnosed with such conditions:



The effects of such conditions can be dramatic on a person's life:

> "I am currently six months into a waiting list to have a phone call with a gynaecologist about trying to get diagnosed with endometriosis. I have to take a ridiculous amount of medication to not be in pain. I've tried everything allowed to be prescribed to me without a diagnosis, and once I cap out the amount of codeine they're allowed to prescribe me, my only option will be morphine. It's incredibly disruptive to my life; I have to take time off work for it, and it's also impacted my mental health a lot with being afraid of when the pain will come

and also fearing that this will just be my life."

- (Survey participant)

"Doctors and healthcare professionals have limited knowledge of periods and, in particular, PCOS. Beyond an understanding that it can cause irregular periods, infertility, and weight gain, there is no knowledge of the ways it can impact your experiences of depression, anxiety, low sex drive, etc. These symptoms therefore go unsupported, leaving people such as myself feeling bereft and alone."

- (Survey participant)

And, as mentioned, while these conditions do not solely affect queer women and femmes, LBT+ people may experience additional complications in accessing support or understanding from healthcare professionals due to their queer identity. Patients may be subjected to heteronormative care or denied care based on sexual activity:

"It took 17 years of going to doctors regularly (probably an average of 1-2 times per month) before receiving my endometriosis and PMDD diagnoses. I have lost jobs and dropped out of university due to the impact on my health, but I was repeatedly turned away without treatment or much of an answer. In response to my diagnosis of vaginismus, instead of asking how I felt, it was assumed that I'd want to stretch to be able to have sex with men, so I was given tools to help with this via prescription."

- (Survey participant)

"[I've] tried to get a diagnosis for endometriosis with no success yet. [The doctor] wouldn't do the secondary internal scan because I'm a virgin and haven't had penis-in-vagina sex despite having engaged in other "lower" level sexual activities (not oral)."

- (Survey participant)

Some patients may be deprioritised or not taken as seriously due to assumptions about their future family plans:

"I have PCOS and was finally diagnosed in the last year. I had a male doctor who made assumptions about my symptoms and made horrible passing comments about the fact that it may affect my fertility being unimportant."

- (Survey participant)

And some people may be denied healthcare on the basis that it's "gender-affirming care", even when the patient is in severe physical or emotional discomfort:

"I was having really heavy, unpleasant periods, and they were making me feel suicidal. I ended up getting a letter accusing me of wanting a hysterectomy because I was trans and trying to cheat the system."

- (Roundtable participant)

Furthermore, LBT+ women and femmes may be less likely to have their pain taken seriously due to a mix of misogyny and queerphobia, resulting in improper care or a lack of support altogether:

"I was diagnosed with vaginismus when it was a cyst. I was later told it would have been found easily if the GP had listened to where I was feeling the pain."

- (Survey participant)

"I have periods that make me pass out and throw up with pain, and every time I've been to the doctors, they just dismiss me

and say I have a low pain tolerance."

- (Roundtable participant)

"I went to the doctors about my period pain and was told it was normal and to just take painkillers. It literally gets so bad to the point where I can't stand up and vomit, and I'm just expected to get on with it."

- (Survey participant)

Whether navigating a menstrual condition or simply attempting to manage pain and discomfort during periods, those who are marginalised due to their gender or sexuality are more likely to have to advocate for themselves in the face of disbelief and dismissal:

"It is very, very hard to be taken seriously by doctors when complaining about period pain and getting help from them, especially when you are queer and butch/non-binary. They just assume you're making it up and/or that you shouldn't go on birth control."

- (Survey participant)

"I have spent 15 years trying to get support for my periods (since I was 11; I am now 26). I have experienced professionals refusing me treatment and tests because of my sexuality."

- (Survey participant)

"Questions the gynaecologist asked were not inclusive of queer relationships, so I had to explain myself and specific sexual activities and how this relates to pain and symptoms."

- (Survey participant)

And for those who are multiply marginalised, such as fat LBT+ people who experience medicalised fatphobia, it can be even harder to be heard:

"I've also been told that my reproductive issues (i.e. not having a cycle, irregular cycles, bleeding for months, and hormonal issues) were down to my weight, and if I just lost weight, all my issues would go away. This reductionist and harmful view of my reproductive health has caused me to avoid visiting my GP unless ABSOLUTELY necessary."

- (Survey participant)

Pain that is disruptive to everyday life is not something that anyone should have to live with, but for people who bleed, it's considered a normal part of the experience, which makes advocating for care and support even harder.

Dysphoria

17.9% of the survey participants who have periods identified as trans or non-binary. While not all trans and non-binary people will experience gender dysphoria in relation to their period, many do, and it can be an additional challenge to an already physically and emotionally draining time of the month:

"Periods can play a part in dysphoria or general gender-related anxiety, but it's hard to talk about this with anyone else."

- (Survey participant)

While dysphoria can occur from simply having a period, there may also be certain aspects of menstruation that can trigger feelings of dysphoria, such as using or buying period products:

"I use various period products, as

sometimes inserting cups or tampons gives me gender dysphoria."

- (Survey participant)

"Buying menstrual products feels very dysphoric, and I wish there were more gender-neutral options."

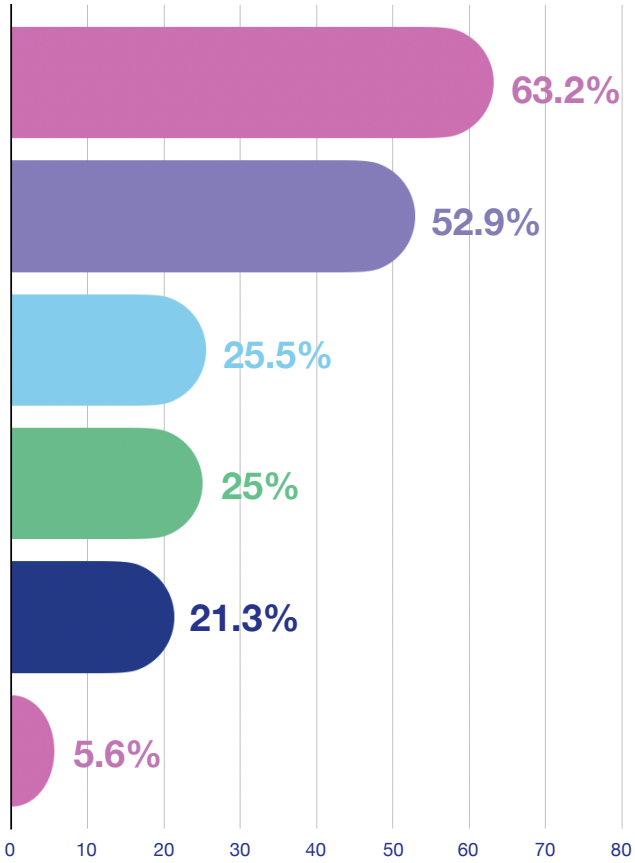
- (Survey participant)

Period products, resources and apps are mostly heavily gendered — pink packaging, flowers, photos or illustrations of only cisgender women. While, for some trans people, nothing will fully stop their dysphoria, reducing the hyper-feminine associations that accompany periods may help. Period-tracking apps like Clue have been applauded by trans and non-binary people for their gender-neutral interface, inclusive language, and helpful blog guides for trans people who bleed[27].

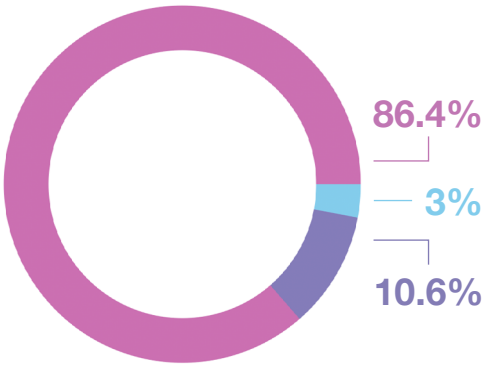
Healthcare providers could better support trans people by reviewing the language they use when discussing periods, along with any leaflets or resources that may have strong feminine associations. A better understanding of what dysphoria is and how it can be supported would also go a long way in helping trans and non-binary people manage their periods in the best way possible.

Cost

As well as being painful and messy, periods can also be expensive. In certain places, period products are taxed as luxury items (nicknamed the "tampon tax"), and even when they aren't, the products themselves aren't cheap. The charity Bloody Good Period estimates that the average person who menstruates spends £4,800 on period products over the course of their lifetime[28]. For a cisgender, heterosexual couple, that's a combined cost of £4,800. For a same-sex lesbian or bi couple, it's £9,600. When asked what period products they had used in the past 12 months, participants seemed to favour disposable products over reusable ones:



- **63.2%** had used disposable pads
- **52.9%** had used tampons
- **25.5%** had used period underwear
- **25%** had used a menstrual cup
- **21.3%** had used reusable pads
- **5.6%** had not used any period products/ opted to free-bleed



The vast majority of people in our survey (86.4%) paid for their own period products, while 10.6% said that they were paid for by a partner, family member, or friend. Only 3% of respondents accessed period products for free (via charities, food banks, schemes, etc.).

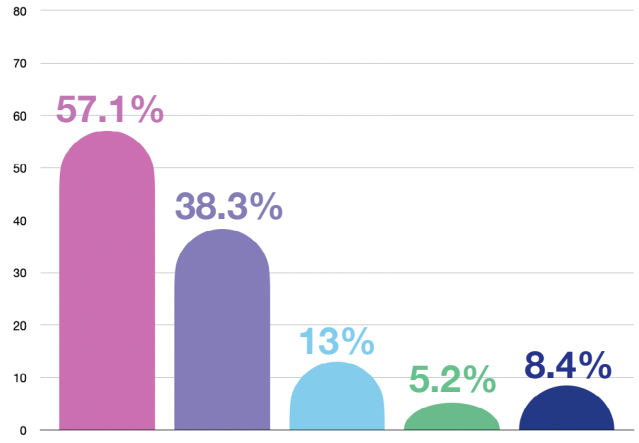
Cost was a clear issue among survey participants, with several people sharing that they struggled to buy products or found them too expensive:

> "I regularly have to choose between food and buying sanitary products."
>
> *- (Survey participant)*

> "I stay on the hormonal contraceptive implant because I can't afford pads/ tampons and it stops my periods."
>
> *- (Survey participant)*

> "Period products are very expensive, and there is still a lot of stigma about being seen buying/carrying them, as if periods are something shameful, private, and dirty."
>
> *- (Survey participant)*

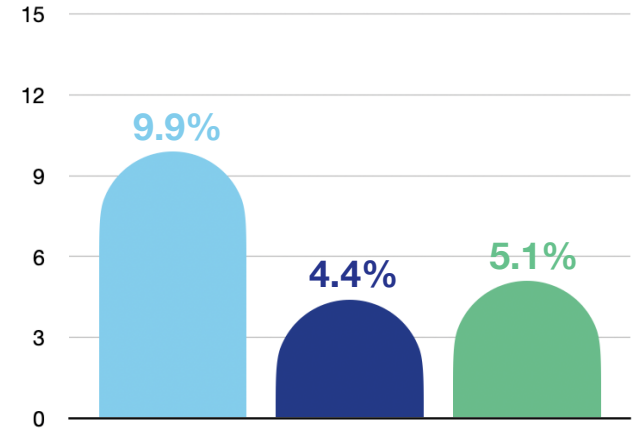
Over a third **37.7%** of participants had struggled to access period products in the past 12 months. Of those:



- **57.1%** said it was due to the price of products
- **38.3%** said it was due to a lack of availability
- **13%** didn't know what products were right for them or what options were available
- **5.2%** didn't know where to go to access products
- **8.4%** had other reasons — open-text responses included:
  "I am disabled and can't leave the house on my own, so I have to rely on my family taking me out to the store or buying them for me."
  "I became allergic to pads and struggled to work out a new plan."
  "I have medically heavy bleeds and can't find the pads I need in most stores."
  "I have very heavy periods, and sometimes the level of protection required isn't in stock."
  "Neurodivergence means it's hard to keep on top of whether I have enough, and then I realise when it's too late or I don't have time to go and get some right away."

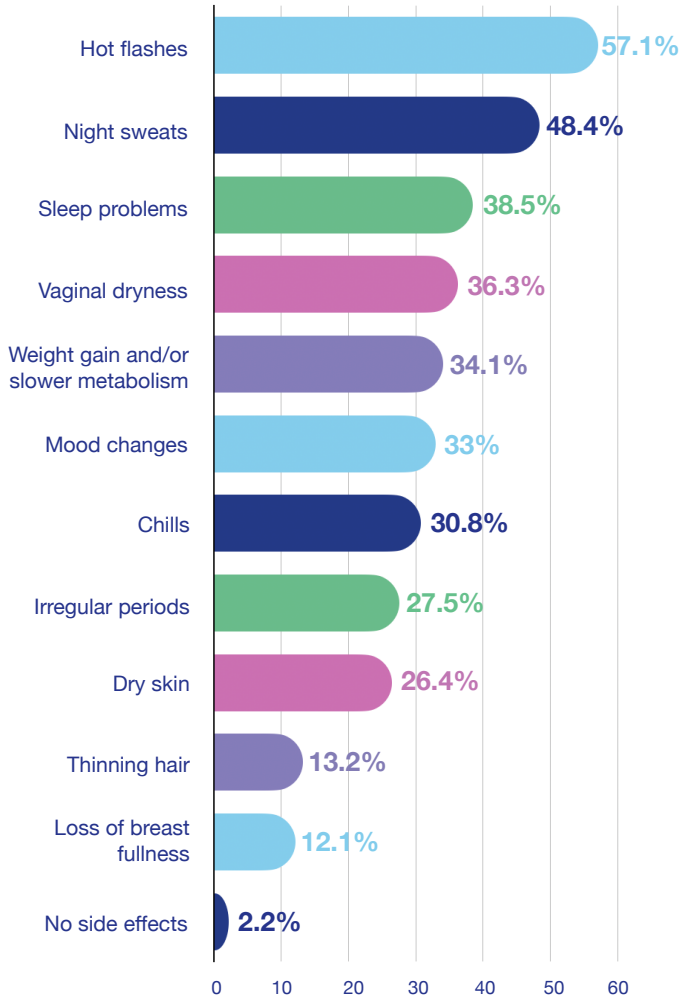
While accessing period products is an issue for people of all sexualities and genders, the additional barriers faced by LBT+ people who menstruate need to be taken into consideration by healthcare professionals.

Menopause



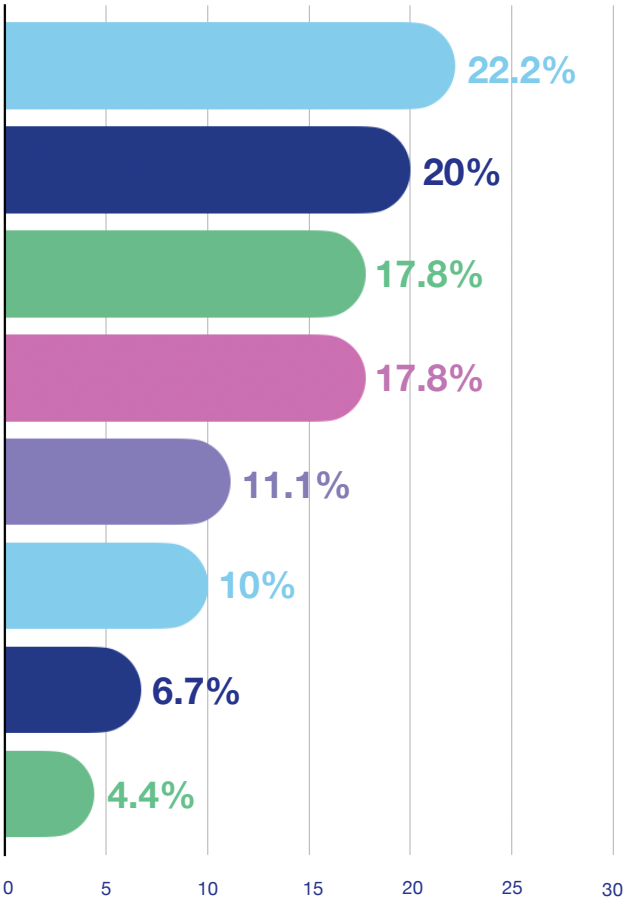
9.9% of survey participants reported currently experiencing the menopause, **4.4%** said they were perimenopausal, and 5.1% were post-menopausal. Of those who were experiencing the menopause or the perimenopause,

52.8% had seen a medical professional in the past 12 months to discuss this.



For those who reported experiencing the menopause (either now or in the past), the most common side effects experienced were hot flashes (57.1% of participants), night sweats (**48.4%**), and sleep problems (38.5%). Only **2.2%** reported no side effects.

Of those currently experiencing the menopause or the perimenopause, just over a quarter (**26.7%**) had not taken any medication or treatment for symptoms in the past 12 months. Meanwhile:



- 22.2% had used testosterone gel for reduced sex drive
- **20%** had received hormone replacement therapy (HRT)
- 17.8% had taken antidepressants for mood symptoms
- 17.8% had used oestrogen for vaginal dryness and discomfort
- 11.1% had tried herbal remedies or other alternative treatments
- 10% had taken Clonidine or Gabapentin for night sweats or hot flashes
- **6.7%** had tried cognitive behavioural therapy (CBT)
- 4.4% had used other methods to help manage symptoms — open-text responses included:
  "Diet and exercise"
  "Homoeopathy"
  "Menopause magnet"

Lack of Education & Challenges

Something that came up a lot in the survey and roundtables was the lack of education surrounding the menopause. As seen in the section on Relationships & Sex Education on page 25, only **2.8%** of those who were taught RSE remember being taught anything about the menopause:

> "I've had no menopause education in my life. I don't think any woman has. I don't know when perimenopause occurs, what that looks like, or what happens during menopause and what is available during that time."
>
> *- (Survey participant)*

> "I have really limited knowledge of the menopause in general. It wasn't particularly discussed at school other than "women will experience the menopause"."
>
> *- (Survey participant)*

> "One of my friends is 21, and she's going through the menopause now because of a hormonal condition she's got. And she's terrified because it's not spoken about."
>
> *- (Roundtable participant)*

As a topic, the menopause is still considered taboo, meaning that it simply isn't talked about as much as it should be. And not only does a lack of knowledge about menopause affect the people who are experiencing it, it also extends to medical professionals themselves:

> "I was talking about it at a working day in an NHS mental health service, and I was speaking to my colleagues about working with people going through the menopause. We realised that, actually, we didn't have any kind of professional training or knowledge of how to support people who are menopausal. It's a massive blind spot in healthcare."
>
> *- (Roundtable participant)*

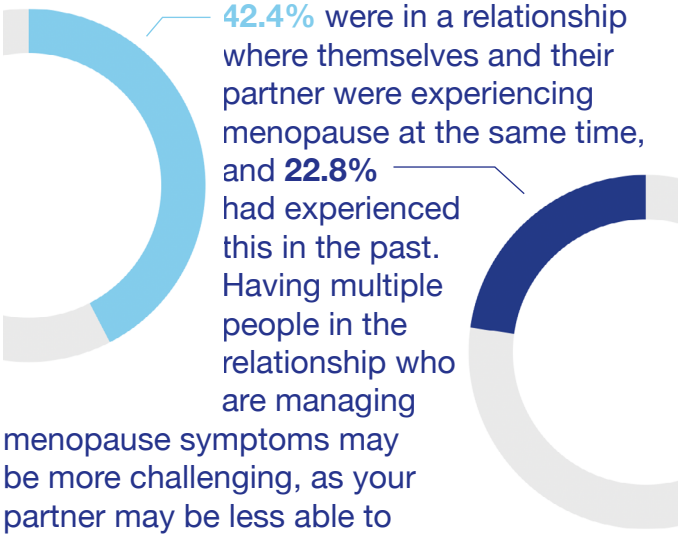
When menopause is brought up, it's often done in jest, and conversations centre around misogynistic stereotypes, erasing the difficult and challenging experiences of real menopausal people. People going through menopause may feel hesitant to talk about it or ask for support for fear that they will be treated differently or experience sexism:

> "Menopause was not something considered at work. If it was mentioned by a menopausal woman, it was always as a joke. No one used the word or even mentioned any understanding of the problems going through the menopause brings, such as increased anxiety, poor memory, and loss of confidence. You also become invisible as a menopausal woman."
>
> *- (Survey participant)*

And while most women and people who experience the menopause face challenges in being seen and understood, this is only exacerbated for queer women and femmes who already face invisibility and prejudice.

Queer Menopause

As with periods, LBT+ women and femmes may be in relationships where multiple partners are going through menopause. Of those who were peri- to post-menopausal,



42.4% were in a relationship where themselves and their partner were experiencing menopause at the same time, and **22.8%** had experienced this in the past. Having multiple people in the relationship who are managing menopause symptoms may be more challenging, as your partner may be less able to help care for you if they're also struggling.

For trans and non-binary people experiencing menopause, dysphoria may rear its head. Like periods, menopause is a heavily gendered experience within our society, and accessing gender-neutral and trans-friendly menopause services and resources may be an additional barrier. Factoring in hormones and HRT can also be a challenge:

> "I have recently noticed more severe symptoms of menopause and wondered if it's moving from perimenopause to full menopause. I found queermenopause.com which has been helpful, but there's so little out there for nonbinary people experiencing menopause. I would really like to understand how HRT might affect me, or what it means for a nonbinary person with a uterus — it seems like it helps with the symptoms, but at the same time, given my periods make me dysphoric, do I want "replacement" of hormones I am ambivalent about? I wish there was more information about this available, and in less gendered language (e.g. the assumption that "HRT helps" — is this true for nonbinary people? Is there an alternative?)"
>
> *- (Survey participant)*

> "I'm having a really difficult time getting treatment for menopause symptoms. I've

been on testosterone for about two years, and about six months in, I started getting hot. I remember turning up to places covered in sweat. So I Googled it, and Google said you could get medicine. So I asked my doctor for the medicine, and he said, "all I can give you is hormones", which wasn't correct."

- (Roundtable participant)

Menopause and transition can have a lot of symptoms in common due to hormonal changes. One trans participant described how this created a feeling of bonding between themselves and cisgender menopausal women:

"When I was in my late forties and early fifties, a lot of my colleagues were of a similar age and were approaching menopause or starting menopause. And it was interesting how much my experiences as a trans woman (going through surgery, having to stop taking hormones, and effectively having the symptoms of menopause), became a bonding activity between myself and cisgender women. That was a lovely experience to have, to find common ground between trans women and cis women."

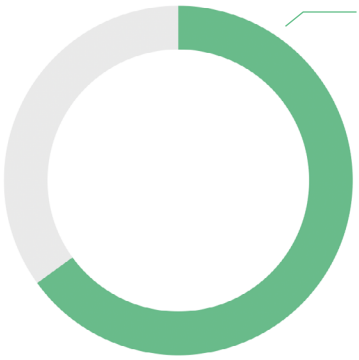
- (Roundtable participant)

And while there may be challenges to relationships with multiple people experiencing menopause, there may also be positives — feeling understood and going through something potentially challenging with a teammate:

"I don't feel scared of it as much [as a queer person] because I know I'll have partners that are going through it too or that will entirely understand my experience. I think a lot about sensuality and sexuality through the menopause and how there's such a misogynistic idea around women's sexuality as they get older. But sensuality and sexuality exist so far beyond what stupid sexist jokes say about menopausal women."

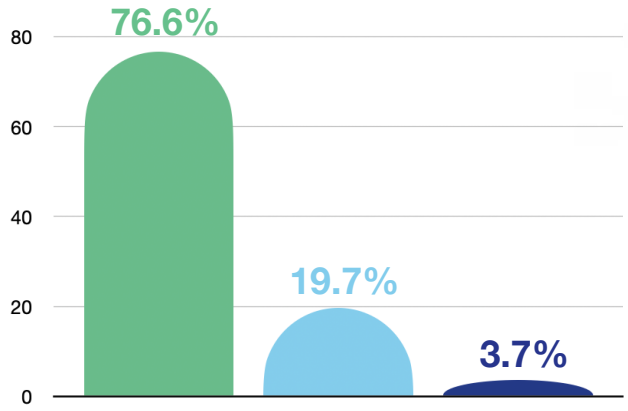
- (Roundtable participant)

Relationships



65% of survey participants were currently in a monogamous relationship.

For 76.6% of these participants, the relationship was romantic and sexual



in nature; for 19.7%, the relationship was purely romantic and not sexual and for **3.7%**, the relationship was sexual but not romantic.

56.3%

of participants in a monogamous relationship were with a partner of the same gender as themselves.

20.3% of survey participants were currently in a polyamorous relationship, or seeing multiple people.

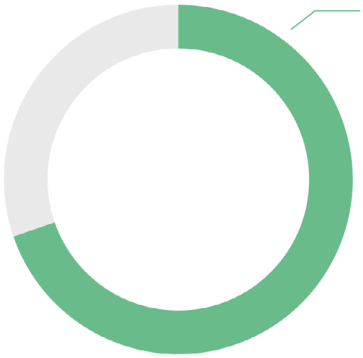
For **46.8%** of these participants, most of their relationships were romantic and sexual in nature, for

31.2%

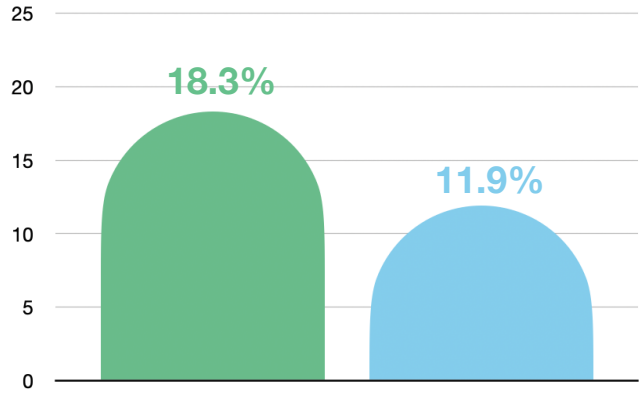
most of their relationships were purely romantic and not sexual and for

22%

most of the relationships were sexual but not romantic.

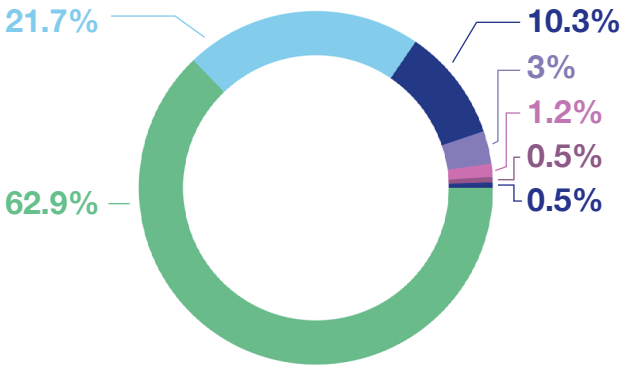


The majority (69.7%) of participants in polyamorous relationships had some partners of the same gender as themselves and some of different genders.



For 18.3%, all of their partners were the same gender as them, and 11.9% only had partners of different genders.

74.4% of survey participants had been sexually active in the past year. Of those:



- 62.9% had been sexually active with 1 person
- 21.7% had been sexually active with 2-4 people
- **10.3%** had been sexually active with 5-9 people
- 3% had been sexually active with 10-14 people
- 1.2% had been sexually active with 15-19 people
- 0.5% had been sexually active with 20+ people
- **0.5%** didn't know how many people they had been sexually active with

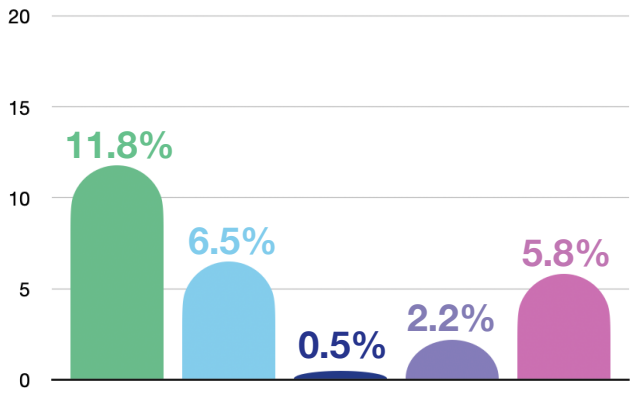
Prejudice & Discrimination

Many LGBTQIA+ people experience additional discrimination when they are openly in a queer relationship. Some people may receive backlash from queerphobic family members:

> "I have been disowned by all but one member of my family because of being LGBTQIA+."
>
> *- (Survey participant)*

> "For 30+ years, my mother did not recognise my lesbian partner. We also had three children through alternative insemination with anonymous donors. The men donated sperm for free. The sperm donors are still anonymous, 30+ years later. My mother did not acknowledge that I was in a long-term relationship with a woman."
>
> *- (Survey participant)*

Fear of being rejected by friends or family may impact someone's decision to tell their loved ones about their relationships. Less than three-quarters (**73.3%**) of LBT+ women and femmes said that their friends and family were aware of their partner(s).



- 11.8% said that only their friends were aware of their partner(s)

- **6.5%** said that their friends were aware of their primary partner but not other partners
- **0.5%** said that only their family were aware of their partner(s)
- **2.2%** said that their family were aware of their primary partner but not other partners
- **5.8%** said that none of their friends or family knew about their partner(s)

Being in a queer relationship in a heteronormative society can make you feel like your relationship isn't accepted, seen, or understood. Some LBT+ participants reported heteronormative assumptions being made about their partner(s):

> "[I'm] constantly worrying about how to talk about my partner and feeling upset/ frustrated whenever I've used gender-neutral language and people have assumed my partner was a guy."
>
> *- (Survey participant)*

> "It is hard to have to "come out" again and again to new people, as most people assume that I am a straight woman. It sometimes takes a while to work out whether it is safe to be out to someone new or not, or it feels embarrassing to have to correct them because of the awkwardness that often comes afterwards."
>
> *- (Survey participant)*

And beyond feelings of awkwardness or not fitting the mould, some people experience threats to their physical and emotional safety by openly existing in a LGBTQIA+ relationship. Between 2021 and 2022, there was a **26%** increase in hate crime in England and Wales[29]. LBT+ women and femmes from our survey reported feeling the effects of queerphobic abuse:

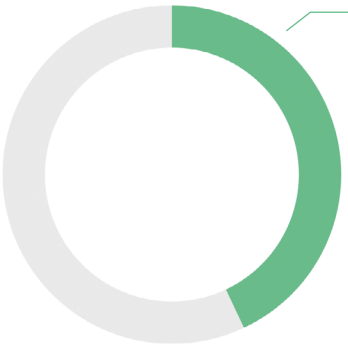
> "Homophobia is still very real; we got tormented by a homophobic neighbour for a year."
>
> *- (Survey participant)*

> "It's still kind of scary. We're looking at wedding venues right now, and my name is gender neutral; we weren't sure how to signify that we're two women looking. We live in a somewhat rural area. There have been two hate crimes in the past few weeks."
>
> *- (Survey participant)*

Abuse is even happening in spaces dedicated to LGBTQIA+ people:

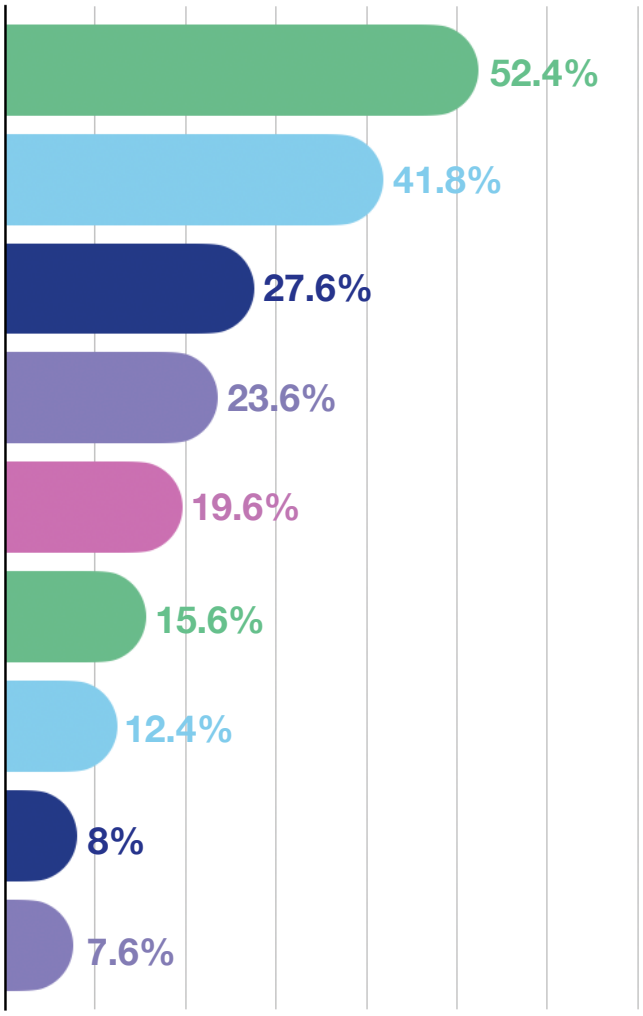
> "Dating websites skewed towards WLW are largely open to abuse and trolling, and the real WLW therefore tend to be wary of each other. We need some way of keeping a) trolls b) cis men and c) "gender criticals" away."
>
> *- (Survey participant)*

Meeting people and initiating relationships is hard for a lot of people, but queer people face additional risks due to queerphobia. It can be nerve-wracking to stick your head above the parapet and let somebody know that you're LGBTQIA+ without knowing if they'll also be interested in you or if they may abuse or attack you for being queer. LGBTQIA+ people need to navigate which spaces are safe to initiate relationships in.



43% of participants had met someone new in the past 12 months, with whom a sexual or romantic relationship had developed.

Of those who had met a new partner, the most common places to meet them were non-LGBTQIA+ dating apps or websites (52.4%),



LGBTQIA+ dating apps or websites (41.8%), and nightlife such as clubs or bars (**27.6%**). Other meeting places included:

- Other online platforms (Facebook, Instagram, etc.) - **23.6%**
- LGBTQIA+ social events - **19.6%**
- Work - **15.6%**
- School, college, or university - **12.4%**
- Non-LGBTQIA+ groups (such as a sports team, life drawing class, etc.) - **8%**
- Other - **7.6%** — open-text responses included:
  "Through friends"
  "Gym"
  "Travelling"
  "Beaches and sex clubs"
  "Kink events"
  "Escorting"

LBT+ women in relationships with other women may be more prone to sexual harassment due to the fetishisation of lesbians in the porn industry, which caters to a male gaze:

> "Harassment is still a huge issue, fetishisation by heterosexual strangers."
>
> *- (Survey participant)*

> "It's hard to openly be in a relationship in public with my partner (e.g. to kiss, hold hands, or show affection in public) because of a fear of violence or being sexualised, or just being generally stared at by people."
>
> *- (Survey participant)*

The hypersexualisation of queer relationships is what contributes to the idea that they are "taboo" or "sinful".

Queerness and Religion

While not all religious people condemn LGBTQIA+ people, there are many religious institutions that deem same-sex relationships to be "unnatural", and many religious people who interpret religious texts to mean that queer people are "against God".

For LBT+ women and femmes in religious communities, existing openly in a queer relationship can come as a challenge:

> "My in-laws struggled to accept our relationship initially because it conflicted with their religious beliefs, but things have improved a lot over time. It did mean that our civil partnership was not treated in at all the same way that it would've been had it been a heterosexual wedding."
>
> *- (Survey participant)*

"I have only recently started dating outside of my marriage. It is impossible to share with friends and family as we live in a conservative environment and my partner works in the church. It is frightening that people might find out, but I can't stay the way things were."

- (Survey participant)

"My immediate family knows about my partner, but my grandparents and extended family don't know that I am queer and living with my partner of four years. They are avid Christians, and I worry about what they will say about my sexuality and my partner's gender (they're non-binary)."

- (Survey participant)

There are organisations set up to aid religious LGBTQIA+ people, such as Hidayah, a charity that provides support to LGBTQIA+ Muslims.

Trans Relationships

Prejudice towards queer relationships doesn't stop at homophobia. For those who are trans and/or have a trans partner, transphobic family members may make relationships more difficult:

"My family do not respect my partner's identity as a nonbinary person and misgender him as 'she' constantly. I also get comments about when I will find a boyfriend or husband and have a family with him."

- (Survey participant)

"Being a trans and queer couple, I am not able to come out to my family because they are both transphobic and homophobic."

- (Survey participant)

"Some of my family members are a bit transphobic, which is not great with my partner, who is trans."

- (Survey participant)

Some people may feel that their trans identity is a barrier to developing romantic or sexual relationships, either due to external factors (like a lack of acceptance from the broader queer community) or personal factors:

"I still feel really uncomfortable being a gay trans woman. I'm really happy that I've figured out my sexual identity (finally!) but there's just so much negativity around trans lesbians. I feel like I'm an impostor in those spaces so much of the time."

- (Survey participant)

"I have never been in a sexual or romantic relationship, which causes me unhappiness, but at the same time I do not feel able to have a sexual or romantic relationship because of my trans status."

- (Survey participant)

"Currently, as I am early in my transition, it feels dishonest to engage in any kind of romantic or sexual relationship as I am subject to change both physically and emotionally. I am awaiting a more stable sense of self before I seek the company of others."

- (Survey participant)

For this reason, some trans people may seek relationships with other trans people, to ensure that their partner understands the nuances of their identity and can support them

accordingly. The hashtag #T4T (an abbreviation of "trans for trans") is used on social media not only to help trans people find one another for sexual or romantic relationships, but also to celebrate this kind of love and solidarity[30].

Bi+ Relationships

Bi+ people experience their own issues when it comes to dating and relationships. People who experience multi-gender attraction are scrutinised and disbelieved — bi+ women are often assumed to be straight and only partaking in same-sex relationships to get the attention of men, while bi+ men are presumed to actually be closeted gay men.

This is a form of monosexism that often means that bi+ people in relationships have their identity erased — assumed to be gay or straight, depending on the gender of their current partner:

> "I'm currently seeing a man (I'm a woman and bi) and it feels weird — although I've been told I'm still valid, I've also been told by friends that I can't consider myself bi any more. I don't think I agree with them, but it does feel like quite a big part of my identity has just been wiped out."
>
> *- (Survey participant)*

> "People assume that bisexual women are really just heterosexual and seeking attention — my sexuality is invalidated a lot, especially because my only public relationship has been with a male, and so people don't take me seriously when I affirm that I also like women."
>
> *- (Survey participant)*

> "I'm a bisexual woman in a long-term relationship with a man. I don't really feel seen by my friends and family as a bisexual woman. I'm not sure if that's even important to me (I haven't told some people in my life that I'm bisexual), but it is something I think about, as the version of me they know is missing a piece."
>
> *- (Survey participant)*

> "I have felt a lot of bi-erasure because my relationship visually presents as a cis-het couple. Even my partner seems to not always understand the importance of my queer identity to me."
>
> *- (Survey participant)*

Homophobia is experienced by most people who are attracted to the same gender as themselves but bi+ people face biphobia in addition to this. Biphobia is rife within the LGBTQIA+ community, among monosexual queer people as well as cis-het folks. This makes bi+ people feel that there's nowhere safe to turn, like they're being hit from both sides:

> "Biphobia is very real in the community. It's very much a double-edged sword where you're dismissed because of your lack of experience with women, but the reason you don't have more experience is because you're perceived as just a straight woman looking to experiment. Even making friends within the community, it can feel quite isolating sometimes, being dismissed because you're also attracted to men."
>
> *- (Survey participant)*

> "I find it especially difficult as being bisexual in queer spaces tends to be frowned upon, and many people won't date bisexuals. I find that recently some spaces have attempted to become ace inclusive by banning discussions of sex and frowning upon dating, and see

bisexuality as inherently more sexual than other orientations, and have made it clear bisexuals are not welcome. Straight spaces tend to be biphobic or fetishising and I find it difficult to get along with straight people en masse."

- (Survey participant)

"I used to identify as bi before fully identifying as asexual. My sexuality was fetishised by a lot of straight men, including saying how hot it was, bringing it up during sex, wanting me to have sex with women while they watched, wanting threesomes, etc."

- (Survey participant)

This can make dating hard — stereotypes that paint bi+ people as greedy, disloyal, promiscuous, undecided, or experimenting can cause monosexual queer people to avoid relationships with multi-gender attracted people. Bi+ women and femmes are especially hypersexualised, often not seen as worthy of a real relationship, only for casual sex or threesomes.

Bi+ people may prioritise bi-specific events to meet partners to avoid biphobia in the broader LGBTQIA+ community.

Poly Relationships

In a society where monogamy is the norm and upheld as the model of a perfect relationship, people in relationships with polyamorous dynamics can easily go unseen. As a society, we've begun to better understand that some people have multiple sexual partners, but the extension of this to romantic partners, formal polyamorous arrangements, and relationships where partners know about each other and/or live together are still swept under the rug. Because these people in relationships are not fully understood by many, they often become the subject of scrutiny and disrespect:

"The statutory/medical sector needs to skill up on consensual non-monogamy."

- (Survey participant)

"[I get] a lot of intrigue (and sometimes confusion) from monogamous, cis straight people when they find out I'm non-monogamous; they often like to challenge me about it."

- (Survey participant)

People in poly relationships may face prejudice or discrimination from family members who perhaps expect their lives to follow a more conventional path. Because sexual attraction to multiple people is better understood, and romantic attraction to more than one person is not, polyamorous relationships are hypersexualised — seen as dirty, risky, or taboo:

"I have two long-term partners, one of whom I currently live with, as well as sexual friendships with several other women and demiwomen. It is *extremely* difficult to be open about this beyond close friends, as the media portrayal of polyamorous life is sex-focused, usually involves at least one cis man, and often focuses on cheating. I doubt I will ever be able to be open about multiple partners with my parents, who are religious."

- (Survey participant)

"My parents have been extremely hurtful around me dating polyamorously, as they believe if I date bisexual men that I will get diseases."

- (Survey participant)

It's important to note that while lots of people in polyamorous relationships are LGBTQIA+, cisgender and heterosexual people may also partake in relationships with multiple people.

Queer Relationships for the Multiply Marginalised

For LBT+ women and femme-aligned people with other marginalised identities, relationships and dating may have additional, unique challenges.

In certain countries, cultures, and religions, being queer is punishable by death. From the fear of being disowned and exiled from a community to the threat of honour killings, there are many reasons why some queer people feel they can never come out to their families:

> "My friends and family are aware, but due to my girlfriend being a South Asian Muslim, she cannot ever let her family know due to the safety of her life and being disowned. There are some environments where we need to pretend to be just friends."
>
> *- (Survey participant)*

Disabled or neurodivergent LBT+ people may find initiating relationships more difficult. This may be due to physically accessing venues and events or the mental effort and vulnerability that are involved in meeting new people:

> "I struggle a bit with initiating new relationships — it's an area where my neurodiversity, especially RSD [Rejection Sensitive Dysphoria] can sometimes come to the fore."
>
> *- (Survey participant)*

And when racism, transphobia, ableism, fatphobia, and other prejudices are rife among more privileged LGBTQIA+ people, finding somebody who respects you and your identity can be a challenge in itself:

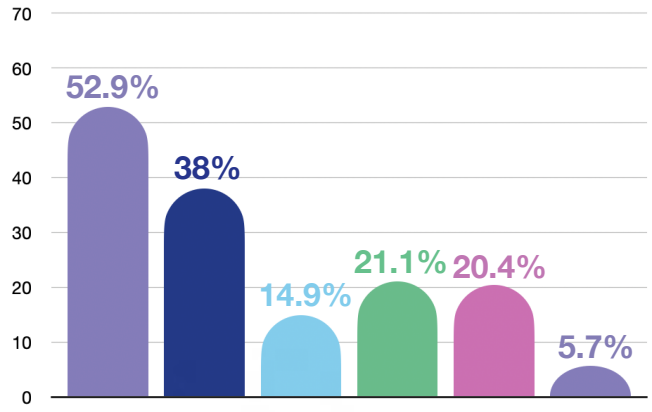
> "[I] can't find anyone to date [because] I'm multiply marginalised and everyone is an asshole in some capacity (bigoted and biased)."
>
> *- (Survey participant)*

Queer services, apps, and organisations need to do more to ensure that their spaces are safe for multiply marginalised queer people and have firm policies in place against any form of discrimination or prejudice.

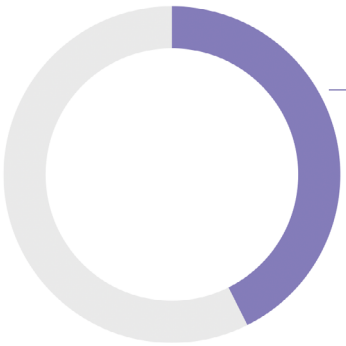
Pleasure

Pleasure is a huge part of sexual wellbeing, but one that is sadly deprioritised and stigmatised.

As seen in the section on Relationships & Sex education [page 25], only **0.8%** of people who received RSE were taught about pleasure.



Just over half of the LBT+ women and femmes surveyed (**52.9%**) said they were "Satisfied" (**38%**) or "Extremely Satisfied" (**14.9%**) with their sex life (or lack of) over the past 12 months. **21.1%** were "Neither Satisfied or Dissatisfied", **20.4%** were "Dissatisfied" and **5.7%** were "Extremely Dissatisfied".

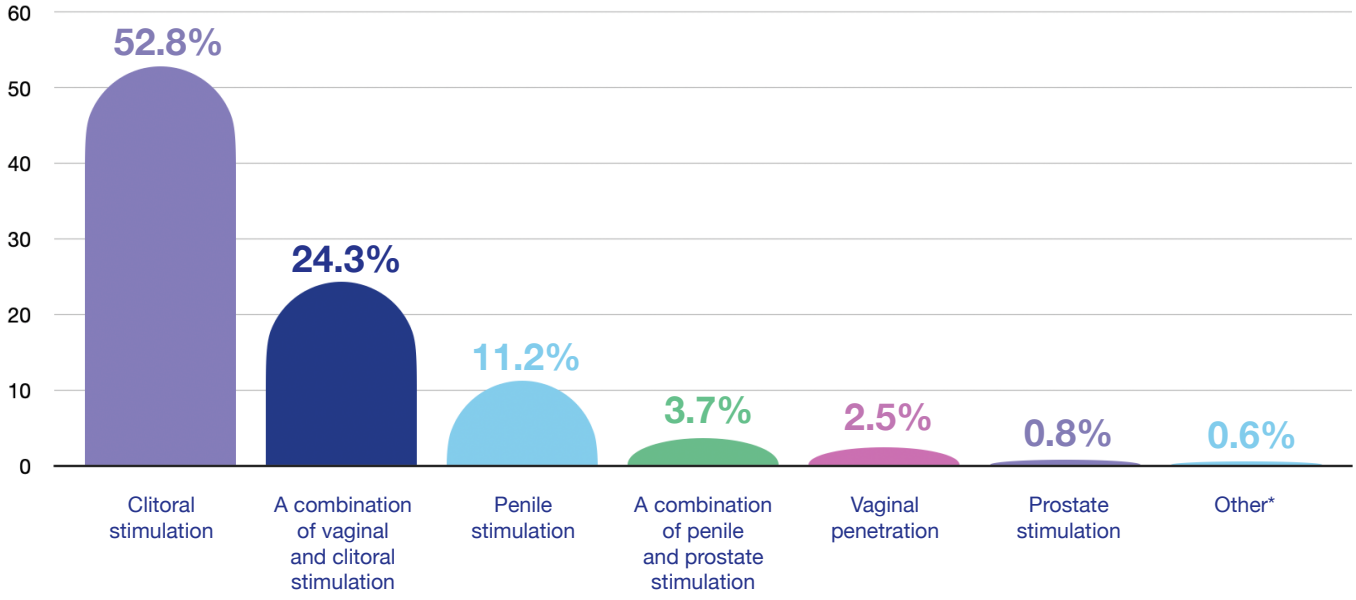


Of those who had engaged in sexual activity with another person in the past 12 months, **42.6%** said that they orgasmed over 80% of the time.

Of those who had masturbated/engaged in solo sex in the past 12 months, **64.5%** said that they orgasmed over 80% of the time.

Orgasm Frequency	Sex with partner(s)	Solo sex
81-100% of the time	41.6%	64.5%
61-80% of the time	16.4%	11.9%
41-60% of the time	10.4%	6.6%
21-40% of the time	10.2%	4.5%
1-20% of the time	13%	7.8%
0% of the time	7.4%	4.7%

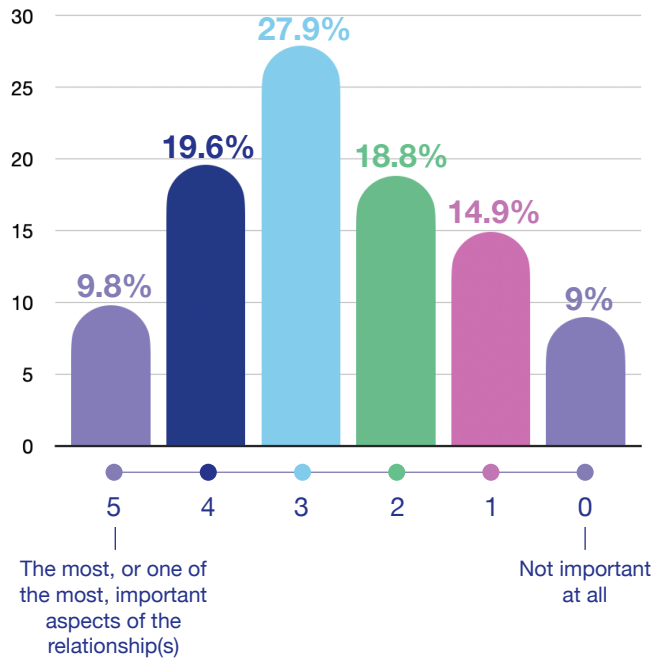
For the LBT+ women and femmes who had engaged in sexual activity in the past 12 months (either with themselves or with a partner), the most common way to achieve orgasm was through clitoral stimulation (52.8%). Other methods included:



*open-text responses included: “Nipple stimulation” and “Exercise, activating my ab muscles”

4.2% said that they seldom achieve orgasm during any kind of sexual activity.

Sex plays a different role in everyone's relationships. When we asked those who had been in a relationship in the past 12 months to rate (on a scale of 0-5) how important sex was to the relationship(s), their responses were as follows:



Orgasm Difficulty

As seen above, LBT+ women and femmes were more likely to experience orgasm during solo sex compared to sex with a partner. Solo sex may more reliably result in orgasm due to familiarity with one's own body and preferences and a lack of pressure to perform. However, sometimes there is a gendered element at play.

Vaginal penetration is upheld as the most common or valid type of sex, yet (as seen above), vulva-owners are far more likely to orgasm from clitoral stimulation than penetration. It can be hard to communicate this with a cis male partner who may have a different body and has likely seen vaginal penetration prioritised in pornography:

> "I don't feel able to ask my partner to support me in having more orgasms caused by him rather than me playing with myself. There's a real orgasm gap."
>
> *- (Survey participant)*

> "I have often struggled to climax during sex and require clitoral stimulation specifically for this, which my partners do not always wish to do."
>
> *- (Survey participant)*

And while an orgasm gap may exist for penis-in-vagina sex, sex for two vulva-owners comes with its own challenges. Stereotypes about WLW sex aren't helpful, either exaggerating pleasure and stamina or perpetuating a feeling of hopelessness:

> "I find it difficult to get help with a lack of orgasm in my relationship, dwindling sexual desire, or a lack of sex in the relationship. There is this idea that lesbians are always having multiple orgasms together, which means that when that's not happening in my relationship, I feel like something is going wrong. I can't find information about any other LBT couples that have this problem, so I feel very isolated about it and don't know how to solve it. I love my partner, but our sex life could do with a boost. I see lots of stories about lesbian bed death and feel like this is seen as a joke or an accepted part of what it means to be a queer woman, but I don't think it is and I don't know how to change our sex life together. I feel like I'm alone in this, as I can't find information anywhere that isn't either the inevitable bed death doom or everyone having orgasms all the time and hours and hours of sex. This is not my experience, and I feel lonely, like a failure, and isolated."
>
> *- (Survey participant)*

Sexual pleasure can also be difficult to achieve for those with mental health difficulties, either as a direct result of stress/anxiety/depression or as a side effect of antidepressants:

> "This past year has been a high-stress period, and I know this severely impacts my libido and ability to orgasm."
>
> *- (Survey participant)*

> "I am on antidepressants, which reduce my sex drive."
>
> *- (Survey participant)*

> "Sertraline has made it harder to achieve orgasm."
>
> *- (Survey participant)*

> "Last year I was prescribed SSRIs to manage anxiety, and these have significantly affected my ability to orgasm, although not my desire."
>
> *- (Survey participant)*

While poor mental health can affect anyone, LGBTQIA+ people are more likely to be affected[31], which may mean that queer people are disproportionately experiencing problems with arousal and pleasure due to mental health and antidepressants. Women are also more likely to experience mental health issues, with women twice as likely to be diagnosed with anxiety as men[32]. This may put LBT+ women at further risk of sexual dissatisfaction.

Trans Pleasure & Dysphoria

People who identify as trans or non-binary were roughly twice as likely to report feeling "Dissatisfied" or "Extremely Dissatisfied" with their sex life in the last 12 months (**40%**), compared to cisgender people **21%**

Trans people may experience difficulties getting information about sex that is specific to them:

> "Finding tips on how to have sex when trans is very difficult. I ended up looking at lots of guides to anal sex for gay men, even though I'm non-binary and using a strap-on, on another non-binary person."
>
> *- (Survey participant)*

Some trans people who go through transition, or come out, during a relationship may notice differences in their partner's attraction towards them, which can be extremely difficult to deal with:

> "I wish I had a partner who loved me and my body, but as I was getting closer to realising that I am non-binary and always have been, he started saying that he was never actually attracted to me in the first place."
>
> *- (Survey participant)*

Trans and non-binary people who medically transition (e.g. by taking hormones, receiving gender-affirming surgery, etc.) may notice that their levels of arousal and pleasure change as their bodies do. Transition is often referred to as a "second puberty", meaning that hormones and body image are chaotic, which could definitely interfere with sexual interest:

> "I'm still not sure what my body wants; having started hormonal therapy as a trans woman, it is a process of relearning, although I haven't been especially experimental."
>
> *- (Survey participant)*

"I'm four months post-reassignment surgery, so I'm still waiting for my neoclitoris to be comfortable and to wake up!"

- (Survey participant)

"Going on feminising HRT has drastically reduced my libido in line with how I feel, and I generally only rarely get aroused now as compared to before."

- (Survey participant)

And for some trans people, dysphoria gets in the way. Living in a body that doesn't feel 100% comfortable can make vulnerable moments like sex more difficult, especially as sex often involves body parts that are traditionally more gendered or most commonly trigger dysphoria:

"Genital dysphoria makes it difficult for me to have a good time with my own body when I'm with a partner. I get awful feelings I don't get when I'm alone, and it's sometimes a roadblock for me if I feel like my partner enjoys the manlier parts of my body. I'm working hard to love the whole of the woman I am, but it can be difficult to find ways to feel sexy."

- (Survey participant)

"I'm always initiating. It takes time for my body to become aroused; "wanna f*ck?" works for them but doesn't for me. They struggle to initiate in a way that helps me get aroused despite conversations, prompts, and help. My dysphoria can get in the way, and they're very good at navigating that."

- (Survey participant)

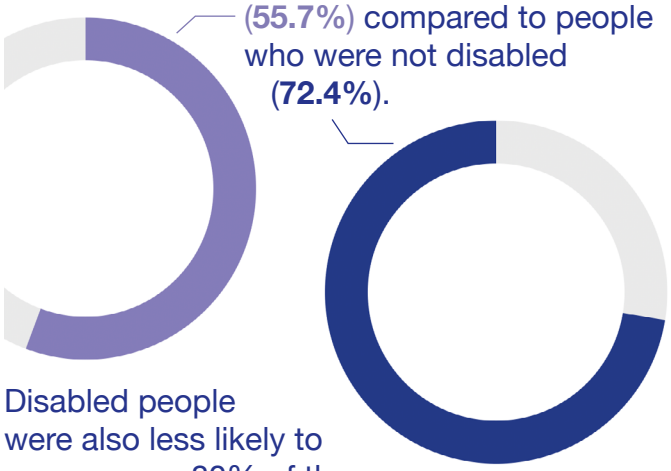
"Potential sexual trauma OR gender dysphoria makes me hate my boobs, so that's annoying during sex."

- (Survey participant)

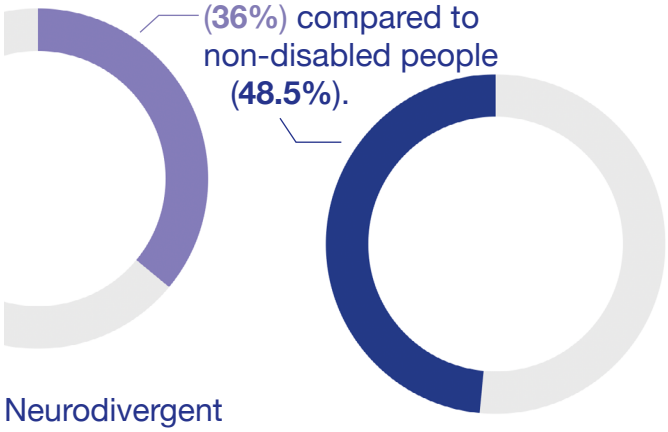
Trauma & Health Issues

People with physical or mental health issues, including those who have experienced trauma, may also find it difficult to enjoy sex or masturbation due to disability or emotional barriers.

Disabled people were less likely to orgasm over 80% of the time during masturbation (55.7%) compared to people who were not disabled (**72.4%**).



Disabled people were also less likely to orgasm over 80% of the time with a partner (36%) compared to non-disabled people (**48.5%**).



Neurodivergent people were less likely to orgasm over 80% of the time with a partner (**37.2%**) compared to those who were neurotypical (**48.3%**).

Previous sexual trauma can result in sex and masturbation feeling triggering, unenjoyable,

or unsafe:

> "Sex has been impacted by sexual assault and abuse in relationships. I find I'm no longer able to trust anyone, so it's difficult to get to a stage where sex is a possibility."
>
> *- (Survey participant)*

> "I have a lot of trauma from childhood sexual assault that has had a big impact on my sex drive and what I am comfortable doing."
>
> *- (Survey participant)*

> "I prefer to watch bisexual/lesbian porn/sexual content as it makes me feel uncomfortable watching men, and sometimes my partner/others I tell find this weird. Men/penetrative sex reminds me too much of sexual assault and seems too aggressive, whereas female-on-female pleasure or any situation where the female is more empowered is more enjoyable for me."
>
> *- (Survey participant)*

As mentioned in the section on Health Screenings [page 43] LBT+ women are disproportionately affected by rape and sexual assault.

37% of trans women have experienced sexual assault at some point in their lifetime[17]

and nearly half of bisexual women **46%** have been raped

compared to **17%** of heterosexual women.[9] Therefore, sexual trauma is likely to be higher in LBT+ women, and sex harder to navigate.

For some people, physical and mental health conditions can act as a barrier to enjoying sex, whether this is due to pain, mobility, or a lack of arousal:

> "I have a chronic illness that causes widespread pain and chronic fatigue. This impacts my sex life."
>
> *- (Survey participant)*

> "Reproductive health problems and contraceptives have interfered with my sex life/pleasure."
>
> *- (Survey participant)*

> "I have had trouble suffering from anxiety around sex and therefore struggle to relax and find pleasure in it. Whether that is due to my PCOS, suffering from anxiety, or coming to terms with the fact that sex isn't that important to me, I am not sure. But it has definitely had an effect on my mental health. To my knowledge, there is no support out there for me."
>
> *- (Survey participant)*

Sexual problems aren't something that most people feel confident seeking support for. For marginalised LBT+ women and femmes this is likely exacerbated. More information needs to be made available on where queer women can go for support without fear of shame, embarrassment, or misunderstanding.

Sexual Violence

When asked if they'd felt at risk of harm or violation while engaging in a sexual encounter in the past 12 months,

12.8% of LBT+ women and femmes surveyed said yes.

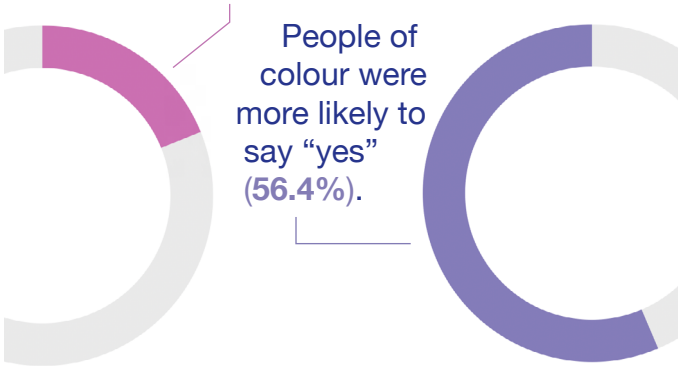
This number rose to

23.3% for those who identified as asexual and/or aromantic and

31.9% for people of colour.

Nearly half (**42.4%**) of women and femmes surveyed said they'd experienced sexual harassment in the past 12 months, with a further **8.9%** saying they didn't know if they had (this is likely due to not knowing what constitutes sexual harrassment).

Those who identified as asexual and/or aromantic were far more likely to say that they didn't know (18.9%).



5.1% of women and femmes surveyed said they'd experienced sexual abuse in the past 12 months,

with a further **5.8%** saying they didn't know if they had.

This rose to

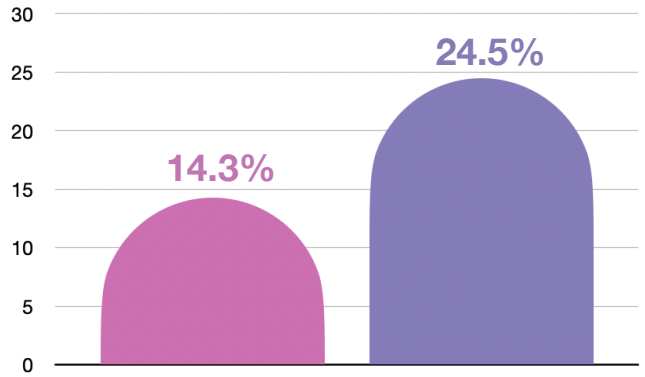
9.9% of asexual and/or aromantic people who said “yes” and

14.3% of asexual and/or aromantic people who said “I don’t know”.

People of colour were also more likely to say “I don’t know” (**14.9%**).

9.7% of women and femmes surveyed said they'd experienced sexual assault in the past 12 months,

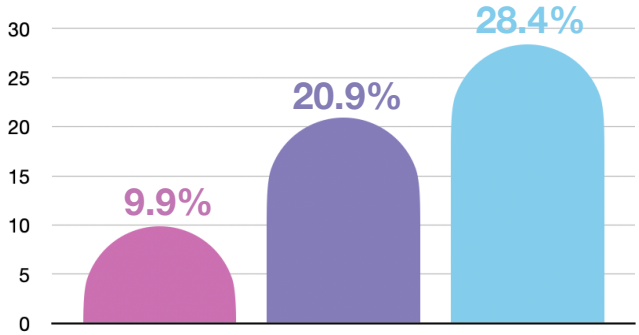
with a further **2.2%** saying they didn’t know if they had.



14.3% of asexual and/or aromantic people and 24.5% of people of colour said “yes”.

2.8% of women and femmes surveyed said they'd experienced rape in the past 12 months,

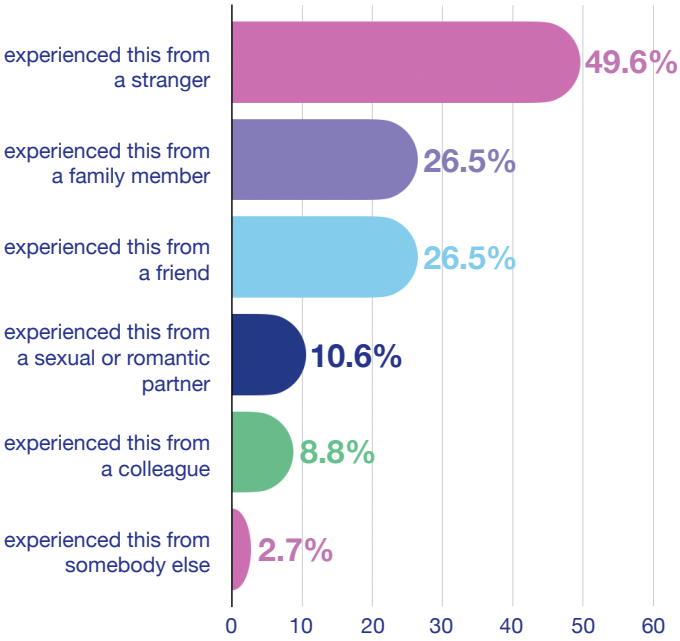
with a further **5.9%** saying they didn’t know if they had. This rose drastically for asexual and/or aromantic people —



9.9% of whom said “yes” and 20.9% said “I don’t know”. People of colour were also far more likely to say “I don’t know”, at 28.4%.

Figures for trans and non-binary people, people who experience multi-gender attraction, and disabled people were largely similar to the overall statistics. The biggest disparities were between allosexual/alloromantic people and asexual/aromantic people, and white people and people of colour.

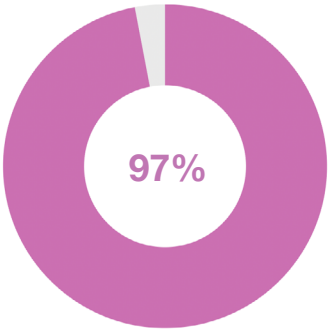
Of those who had experienced sexual violence in the past 12 months:



Sexual Harassment

Sexual harassment is legally defined in England and Wales as “when someone carries out unwanted sexual behaviour towards another person that makes them feel upset, scared, offended or humiliated”.[33] Less than half (48.7%) of our research participants were able to confidently say that they hadn’t been sexually harassed in the past 12 months.

Sexual harassment affects most women — recent research found that



of women aged 18-24 have experienced sexual harassment at some point in their lives[34].

However, LBT+ women and femmes may be even more likely to experience sexual harassment due to the hypersexualisation and fetishisation of women having sex with women. Several participants reported this in the free-text responses:

> "I was holding my partner's hand the other day, and someone (an adult male) shouted "lesbians" extremely loudly at us both in the street and ran away laughing."
>
> *- (Survey participant)*

> "I have often felt quite harassed and unsafe in sex club scenarios; as a bi polyam[orous] woman, I have had single men follow me around and call me "easy"."
>
> *- (Survey participant)*

> "[I am] catcalled or approached by men when I am with my partner, who want to use us as their fetish. Sometimes, if approached by men in public who are wanting to chat me up, I feel afraid to say I am not interested in them because I'm gay, in case it results in a backlash."
>
> *- (Survey participant)*

Sexual harassment may also be used as a tool to degrade and humiliate LGBTQIA+ people in public due to homophobia, biphobia, and transphobia.

While sexual harassment is serious in and of itself, any environment that allows sexual harassment to continue (sometimes called rape culture) can also allow more severe forms of sexual violence (such as sexual assault and rape) to occur:

> "Many of my friends, especially my LGBT friends, have experienced sexual violence; "fortunately" I have only been harassed, but I feel like it's only a matter of time until something worse happens. Casual sexual assault in nightclubs is endemic."
>
> *- (Survey participant)*

Rape culture thrives on enforced gender roles — the idea that women should be submissive and passive and men should be dominant and assertive. Which is why sexual violence is usually talked about as a gendered issue.

Men

Within the survey's free-text responses for the sexual violence section, an overwhelming number of women and femmes named men specifically as the problem:

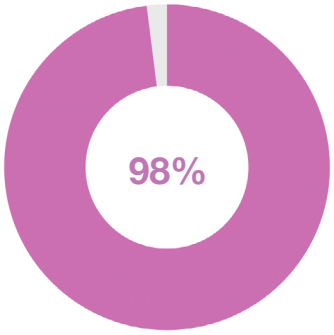
[When asked to comment on sexual violence]

> "Many times before, 99% by men."
>
> *- (Survey participant)*

> "In a long-term relationship, I have never felt at risk of partnered sexual violence, but as a woman, I am very wary of men I don't know very well when on nights out or at parties because I don't know them but I know they could overpower me, and in that way I do fear sexual violence."
>
> *- (Survey participant)*

It's important to stress that not all sexual violence is committed by men, and lots of men are also victims of sexual violence themselves.

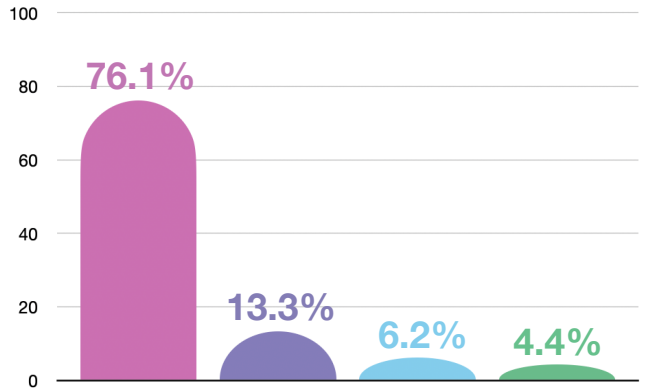
However, statistics show that women are significantly more likely to be victims of sexual violence[35], while



of all perpetrators are men[36].

Non-binary people are, sadly, often neglected in the data.

Of those who had experienced sexual violence in the past 12 months:



- **76.1%** said that the perpetrator(s) were of a different gender than themselves
- **13.3%** said that the perpetrator(s) were a mix of genders
- **6.2%** said that they didn't know the gender of the perpetrator(s)
- **4.4%** said that the perpetrator(s) were of the same gender as themselves

Due to the large percentage of cisgender women in this study, it wouldn't be unreasonable to assume that "of a different gender to myself" mostly refers to men and that men were the most common perpetrators of sexual violence for women and femmes in this study. That being said, this could also refer to non-binary people and/or women (in the case of non-binary people answering this question).

Bi+ respondents, who may have sex with people of multiple genders, noted a difference in treatment from men compared to people of other genders:

> "I've found any sex with men (as a bisexual woman) to be rougher/less focused on female orgasm/finishing with the male orgasm. I'm not sure if I'd count it as harassment, but I definitely feel like I've been coerced into sex in many relationships with men."
>
> *- (Survey participant)*

> "When I have experienced sexual violence in my past pre-my current relationship, it has always been from men and often has a lot to do with my bisexuality and the preconceptions surrounding it."
>
> *- (Survey participant)*

And several trans and non-binary people made reference to the fact that the perpetrators of their harassment were mostly men:

> "I have experienced standard transphobic harassment since being more open about my trans status, thankfully non-physical, largely consisting of men questioning my body and making vague threats."
>
> *- (Survey participant)*

> "Since I accepted being nonbinary and explored my queer identity more, I have stopped seeing cis men, which has improved my experiences of sex and dating."
>
> *- (Survey participant)*

From our research findings, a significant number of LBT+ women and femmes fear men and perceive them to be a huge part of the problem when it comes to sexual violence and rape:

> "In my life I have been raped twice

and sexually assaulted three times. I'm disgusted by the (lack of) response and the invisibility. It's a f*cking scandal that almost every woman in the country will be assaulted during her lifetime. A disgrace. I find cis men harder and harder to deal with."

- (Survey participant)

"I have felt degraded by men's comments as both a teenager and adult, with men verbally weaponising oral sex against me by way of belittling me, making me feel small, and attempting to silence me. I have felt sexually exploited by men and, on one occasion, felt sexually violated by a male partner who continued to have sex with me in a certain position after I said no, which took me a few years to realise was rape, yet I still can't quite accept it was. I have felt like my body was being used for sex rather than being an active participant where mutual pleasure was the aim."

- (Survey participant)

"I have been sexually assaulted by four men and raped by one. I have never felt unsafe around a woman (including trans women), but unfortunately, I cannot even trust my male friends now because they have made unwanted sexual jokes and drunkenly admitted they would have sex with me against my will."

- (Survey participant)

Asexuality

A few people in our survey mentioned sexual violence in relation to their asexuality. As seen on page 100, asexual people were far more likely to experience all kinds of sexual violence.

This is likely due to our allo-centric society, which assumes that all people want sex and that relationships need sex to function.

Ace people may feel less confident expressing their lack of desire to have sex or feel pressure to do so to satisfy a partner or conform to society's standards:

"I am now seeking trauma therapy for sexual abuse in my previous relationship. I'm asexual, and they were allo, and the compromise involved having sex when I didn't want to, but they did."

- (Survey participant)

"In the past, I have had sex that I really didn't want to have with a partner before I was aware of asexuality and thought that it wasn't valid for me to get companionship from a relationship without engaging in sex."

- (Survey participant)

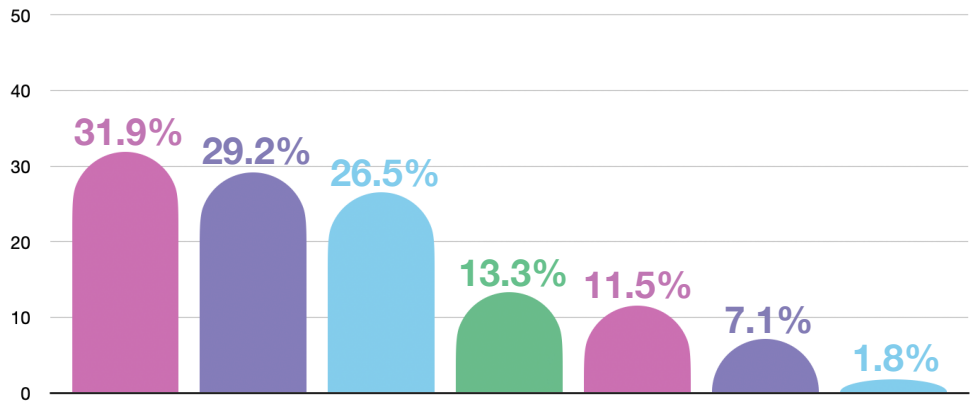
Asexual people may also be more likely to experience forms of so-called "corrective" rape[37] — partners who believe they can make someone enjoy sex by "showing them a good time".

People with lesser-understood orientations, like asexuality, may feel less able to seek support because they fear being misunderstood.

Seeking Support

> "The sexual assault I experienced as a child has had a huge impact on me now. I didn't want help with it as a child because I was embarrassed that it had happened. As an adult I have tried to access help and support with very little success."
>
> *- (Survey participant)*

Sadly, many people who experience sexual violence do not seek support out of fear of being disbelieved, humiliated, or exposed. Of those who had experienced sexual violence in the past 12 months:



- **31.9%** didn't seek support from anybody
- **29.2%** sought support from an LGBTQIA+ service or charity
- **26.5%** sought support from family or friends
- **13.3%** sought support from a service that isn't solely for LGBTQIA+ people
- **11.5%** sought support from a therapist or counsellor
- **7.1%** sought support from a doctor or medical professional
- **1.8%** sought support from the police or other legal services

One reason that people may not seek support is the fear of victim-blaming, which is where responsibility for sexual violence or abuse is assigned to the victim or survivor and not the perpetrator:

> "The police blamed me for my rape."
>
> *- (Survey participant)*

> "I was harassed (physically) at work and tried to report it to my employer, who then sent me an email about how upset I made the person who assaulted me."
>
> *- (Survey participant)*

> “People made comments that it wasn't that bad, that I must have done something to get their attention, or that I should just avoid the people in the future. The onus has and is placed on women and femme-aligned people to not get assaulted instead of assaulters and rapists to be held accountable.”
>
> *- (Survey participant)*

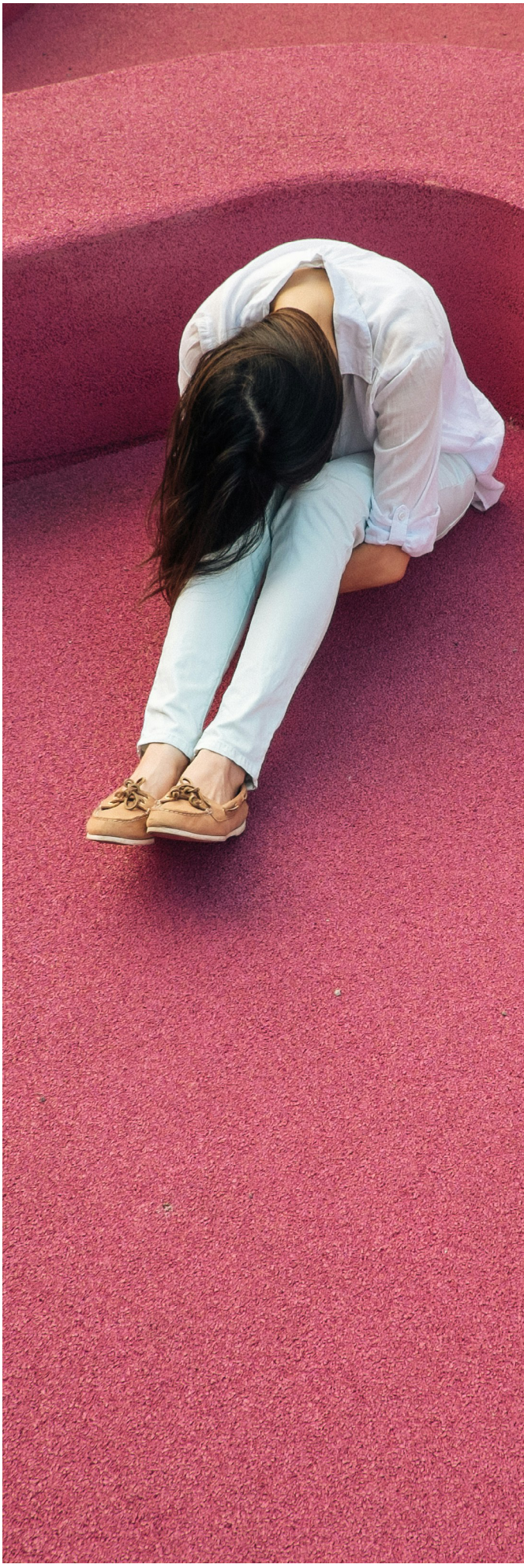
LBT+ women and femmes may be more likely to experience victim-blaming due to the hypersexualiation of queer people — LGBTQIA+ people are assumed to always want sex or be sexually deviant in some way, leading to the disbelief that they can experience sexual violence.

Trans and non-binary people who experience sexual violence and opt to seek support from a women-specific service may face additional barriers to getting the support they need due to their gender identity or trans status:

> “Second-guessing transphobic attitudes when accessing support services for a rape I suffered three years ago. It's stressful accessing women's services and worrying that they won't see me as a woman.”
>
> *- (Survey participant)*

> “I worry that certain services wouldn't cater towards me as I no longer identify as a cis woman.”
>
> *- (Survey participant)*

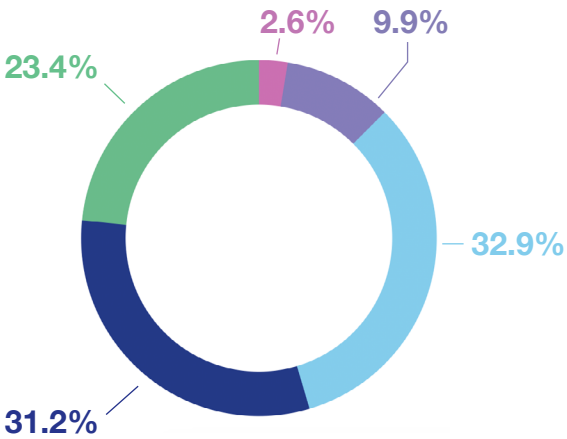
More support and guidance are needed for LBT+ survivors of sexual violence, and services need to receive adequate training on how to support queer people.



Substance Use

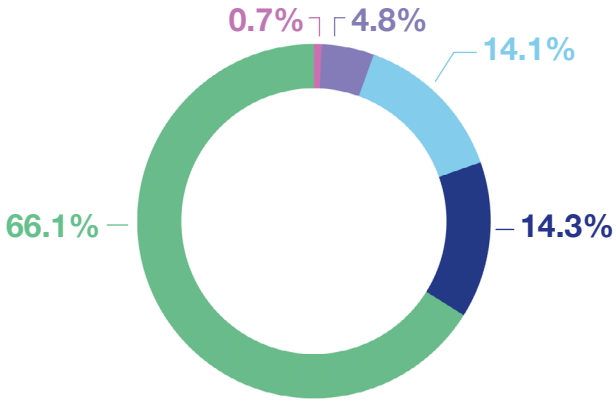
We chose to include substance use in our survey as we recognise that drugs and alcohol have a large impact on sex and dating for many LGBTQIA+ people. Research by Stonewall has found that smoking, alcohol, and drug use are higher among LGBTQIA+ people compared to the general population[12].

Our survey found that of those who had engaged in sexual activity with another person in the past 12 months:



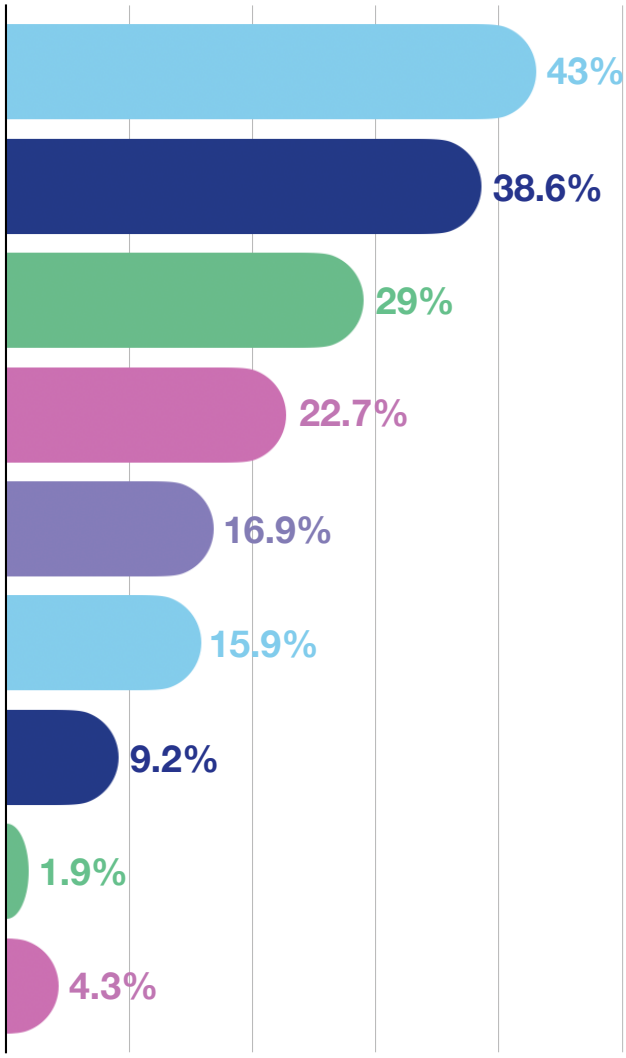
- **2.6%** said that they always consumed alcohol before sex
- **9.9%** said that they consumed alcohol before sex most of the time
- **32.9%** said that they consumed alcohol before sex some of the time
- **31.2%** said that they rarely consumed alcohol before sex
- **23.4%** said that they never consumed alcohol before sex

When asked about drug use:



- 0.7% said that they always used drugs before sex
- 4.8% said that they used drugs before sex most of the time
- 14.1% said that they used drugs before sex some of the time
- **14.3%** said that they rarely used drugs before sex
- 66.1% said that they never used drugs before sex

Those who consume drugs or alcohol before sex do so for a number of different reasons. For survey participants who regularly took drugs or drank alcohol prior to sex, the most common reasons were confidence (43%), relaxation (**38.6%**), and sex following an activity that involves drugs or alcohol, like clubbing (29%). Other reasons included:



- Help with arousal (22.7%)
- To feel less shame (16.9%)
- To make the sex more pleasurable (15.9%)
- Using drugs or alcohol most days, regardless of intent to have sex (**9.2%**)
- Pressure from a partner (1.9%)
- Other reasons (4.3%) — open-text responses included:
  "Dysphoria"
  "I had to get drunk to psych myself up to do it"
  "Regular sex regardless of evening activities"

A large percentage of people reported using drugs or alcohol to improve sex in some way.

Sexual Improvement

With **43%** of LBT+ women and femmes using drugs or alcohol to boost confidence, **38.6%** using them to relax, and **22.7%** using them to help with arousal, it's clear that substances are perceived as assisting pleasurable sex by many:

> "Alcohol can amplify the sensory sensations, and sex will be more harmonious under the catalysis of alcohol."
>
> *- (Survey participant)*

> "I find that when I'm high on marijuana, I find myself being more verbal and open with my partner (this is all consensual)."
>
> *- (Survey participant)*

> "Poppers really help me relax and enjoy sex. Why isn't it talked about how helpful poppers are for women?"
>
> *- (Survey participant)*

Some people may turn to alcohol or drugs to "fix" sexual problems such as lack of arousal or issues with stamina:

"I find alcohol tends to boost my libido."

- (Survey participant)

"Only ever alcohol, although I am tempted to use drugs to make our sex life more active."

- (Survey participant)

Some LBT+ women and femmes may use alcohol and drugs to suppress their sexual orientation or allow them to have sex with somebody when they otherwise wouldn't want to:

"As an asexual person, I tend to only be interested in sex when drunk."

- (Survey participant)

"I used to only be able to find men attractive when I was drunk or high."

- (Survey participant)

16.9% of LBT+ women and femmes reported using substances to reduce their feelings of shame during sex. When society perpetuates the idea that queer sex is sinful or wrong, these notions can come to the forefront during sex and create a mental or physical block to pleasure. Sometimes, drugs and alcohol can "turn off" those feelings of shame and decrease inhibitions:

"They help with suppressing religious trauma, which can affect [my] ability to engage in sex properly."

- (Survey participant)

"I don't regularly have sex with alcohol, but I'd say my best sexual experience was a one night stand I had where we were both really drunk, because I felt no shame and it helped with arousal. It just allowed me to do more and feel less bad about it."

- (Survey participant)

But when inhibitions are lowered, the door is also opened to higher risks and the potential for not feeling in control of your actions.

Risks

Several people within our study felt that consuming drugs or alcohol can leave you more vulnerable and more prone to dangerous or risky situations:

"Prior to abstaining from alcohol altogether about 14 months ago, I would frequently engage in chemsex. It definitely led me into risky situations, including my HIV infection — however, I recognised the damage it was doing to me and that I needed to stop, which has actually been really successful."

- (Survey participant)

"In the past, I have been taken advantage of because of my level of intoxication, and as a result, I don't really feel safe in clubs and more and will often only have 1-2 drinks on the rare occasions I do go out."

- (Survey participant)

"My girlfriend likes to use marijuana before sexual encounters, and it does make me anxious that someone will take advantage of her. She has had times where she is afraid that she isn't able to respond properly due to being incapacitated, but

she still likes to get high, and I worry for her safety."

- (Survey participant)

People under the influence of drugs or alcohol are not able to consent to sexual activity. And while sexual assault is never the fault of the victim (regardless of state of mind), some people do feel more vulnerable and susceptible to being "taken advantage of" when they are drunk or high. For this reason and many others, people may choose to abstain from drinking or taking drugs.

Several people in our study shared that they avoid substances, either all together or in circumstances involving sex. A key reason for this was the fear of being assaulted when not fully in control:

"I refrain from sexual relations when under the influence due to previous experiences of sexual assault as a teenager, and I find it triggering not to be in control."

- (Survey participant)

"I gave up drinking in 2014. Prior to then, I had a few bad experiences with alcohol and sex, including a sexual assault when I was too drunk to consent. I feel much better now that I don't drink."

- (Survey participant)

"I don't ever use substances before sex, mainly because of the fear of being taken advantage of as a female-adjacent person."

- (Survey participant)

But fear isn't the only reason that people may choose not to use drugs or alcohol before sex. While substances help some people to relax or feel more pleasure, for others the opposite is true, and a clear mind can make sex all the more enjoyable:

"I prefer being sober because I enjoy it more."

- (Survey participant)

More support needs to be provided for LBT+ women and femmes around substance use, especially as queer spaces (where dating and hookups are initiated) are focused largely on drugs and alcohol. Sober spaces should be more commonplace so that LBT+ people who abstain from alcohol, either due to addiction issues or simply personal taste, can initiate safer relationships.

Services & Helplines for LBT+ Women & Femmes

If you are an LGBTQIA+ person who has experienced any of the difficulties we've addressed throughout this report, it's important to remember that there are plenty of places you can seek help. We've compiled a number of LGBTQIA+ support services below that have helplines, websites, and resources to help people like you. If you're struggling, please reach out.

General Support

LGBT Foundation

The LGBT Foundation exists to support the needs of the diverse range of people who identify as lesbian, gay, bisexual, and trans. Throughout all of their work, they support LGBT people to increase their skills, knowledge, and self-confidence to improve and maintain their health and wellbeing.

: 0345 3 30 30 30
: https://lgbt.foundation
: @LGBTfdn

Gendered Intelligence

Gendered Intelligence is a registered charity that works to increase people's understanding of gender diversity and improve the lives of trans people. They are a trans-led and trans-involving grassroots organisation with a wealth of lived experience, community connections of many kinds, and a depth and breadth of trans community knowledge that is second to none.

: 0330 3559 678
: https://genderedintelligence.co.uk/index.html
: @Genderintell

Sexual Health

56 Dean Street

56 Dean Street is an expert sexual health clinic in London that focuses on the needs of the LGBTQI+ community. They run a dedicated space for trans and non-binary people called 56T.

: 020 3315 5656
: https://www.dean.st/
: @56deanstreet

CliniQ

CliniQ offers a holistic sexual health, mental health, and wellbeing service for all trans people, partners, and friends. They are a trans-led team that offers a safe, confidential space for those who may not feel comfortable accessing mainstream services.

: admin@cliniq.org.uk
: https://cliniq.org.uk/
: @Clini_Q

Clinic T

Clinic T is a trans and non-binary friendly sexual health and contraception service. They offer testing and treatment for STIs, help with bleeding control and contraception, cervical cytology, vaccination, social support, and signposting to local partner support organisations.

: 01273 523388
: https://brightonsexualhealth.com/service/clinic-t/
: @clinicTbrighton

Fertility & Pregnancy

LGBT Mummies

LGBT Mummies have created a global community that is a safe haven for like-minded women and people who are looking to start a family, extend their family, or meet other families like theirs. In a safe and positive space, they can ask for guidance, make friends, share journeys and their lived experiences, but also talk about the stigma, the trauma, and the difficult times within their journeys.

: contact@lgbtmummies.com
: https://lgbtmummies.com/
: @lgbt_mummies

The Queer Parenting Partnership

The Queer Parenting Partnership was launched in response to the shocking lack of birth and parenting support services for LGBTQ+ people in the UK. Its founders combined their knowledge of midwifery and childcare to create a complete antenatal and postnatal education programme for LGBTQ+ families.

: parentingqueer@gmail.com
: https://www.parentingqueer.co.uk/
: @ParentingQueer

Mental Health

MindOut

MindOut is a mental health service run by and for lesbians, gay, bisexual, trans, and queer people. MindOut's services are for LGBTQ people aged 18+ who are based in Brighton and Hove, with the exception of their online support service which is available globally.

: 01273 234839
: https://mindout.org.uk
: @MindOutLGBTQ

Mindline Trans+

Mindline Trans+ is an emotional and mental health support helpline for anyone identifying as transgender, non-binary, or otherwise gender-diverse. They also offer support to family members, friends, colleagues, and carers.

: 0300 330 5468
: http://mindlinetrans.org.uk
: @MindlineTrans

Abuse & Hate Crime

Galop

Galop works directly with thousands of LGBT+ people who have experienced abuse and violence every year. They specialise in supporting victims and survivors of domestic abuse, sexual violence, hate crime, and other forms of abuse, including honour-based abuse, forced marriage, and so-called conversion therapies.

: Domestic Abuse Helpline - 0800 999 5428

: LGBT+ Hate Crime Helpline - 020 7704 2040

: https://galop.org.uk/

: @GalopUK

Bi Survivors Network

Bi Survivors Network is a network of survivors who identify as bisexual. They offer support, solidarity, and community to one another through bi-weekly virtual chats. They also raise awareness for bisexual, pansexual, and other non-monosexual (bi+) survivors, working to ensure that voices are heard and needs are met.

: bisurvivorsnetwork@gmail.com

: http://bisurvivorsnetwork.org/

: @NetworkBi

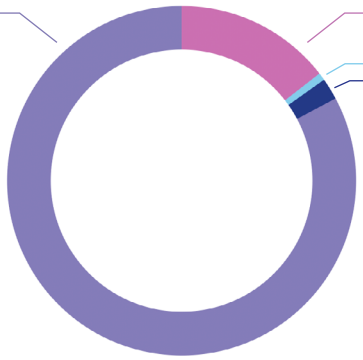
Appendices

Demographics

The report draws from a survey that we distributed between the 17th of August and the 31st of December, 2022. The survey received 551 responses from LBT+ women and femmes (16+) who were living in England. For the most part, we asked participants to reflect on the past 12 months at the time of taking the survey.

Of the 551 valid responses to the survey:

82.8% were women, including trans women (n=456)



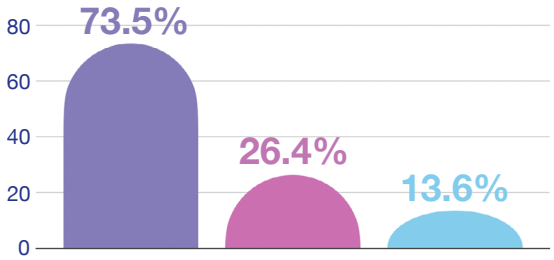
14.5% were non-binary, including identities that sit outside of the gender binary, such as genderqueer, agender, transmasculine, etc. (n=80)

0.7% were men, including trans men (n=4)

2% identified in another way (n=11)

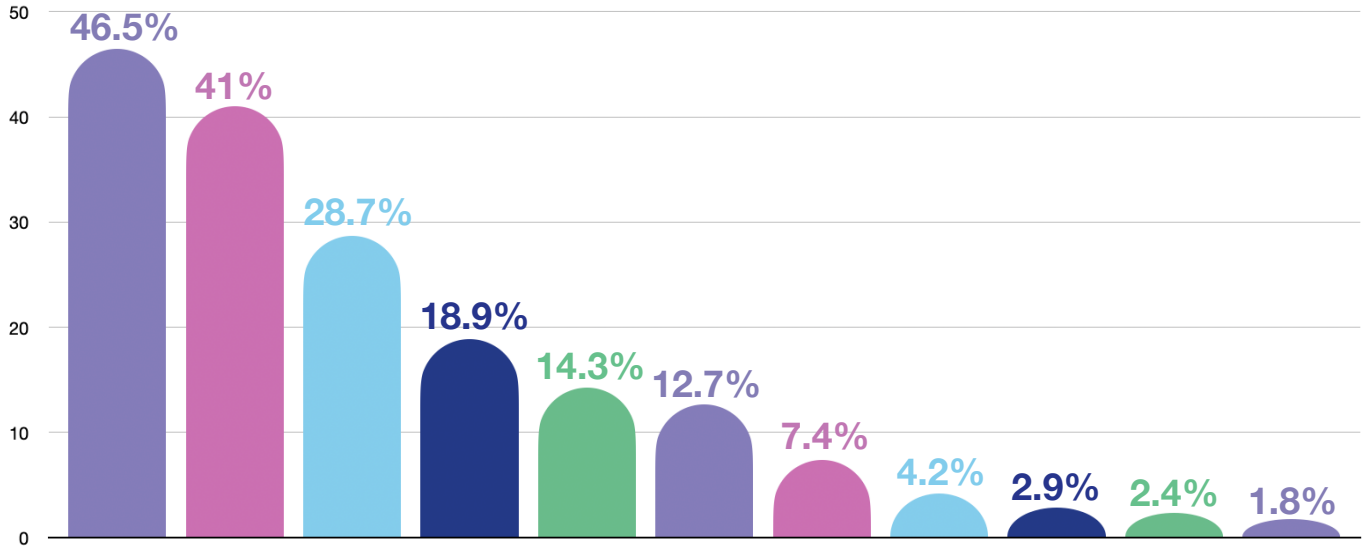
People who identified "in another way" included answers such as "demigirl", "genderqueer woman", "queer", "gender non-conforming" and answers from those who identified with multiple gender labels. Those who identify as men may be genderfluid or femme-leaning.

Within that,



- **73.5%** were cisgender (n=405)
- **26.4%** identified as trans or non-binary (n=146)
- **13.6%** would describe themselves as intersex (n=75)

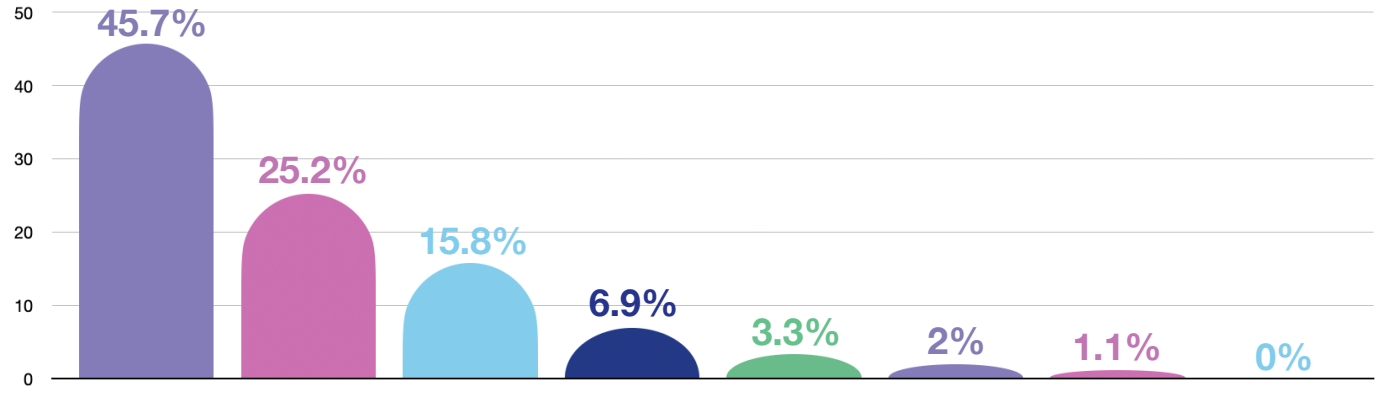
In terms of sexuality,



- **46.5%** identified as bisexual (n=256)
- **41%** identified as queer (n=226)
- **28.7%** identified as gay or lesbian (n=158)
- **18.9%** identified as pansexual (n=104)
- **14.3%** identified as asexual (n=79)
- **12.7%** identified as biromantic (n=70)
- **7.4%** identified as panromantic (n=41)
- **4.2%** identified as aromantic (n=23)
- **2.9%** did not know or were unsure (n=16)
- **2.4%** identified as heterosexual/straight (n=13)
- **1.8%** identified in another way (n=10)

People who identified in another way gave answers that included “demisexual”, “homoromantic”, “aspec” and those who identified with multiple sexuality labels. Those who responded with “heterosexual” may have trans, gender-diverse, or other non-cisgender identities.

In terms of age,



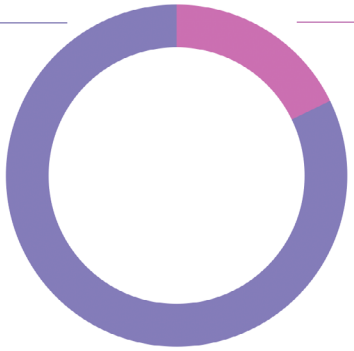
- **45.7%** were between the ages of 26-35 (n=252)
- **25.2%** were between the ages of 18-25 (n=139)
- **15.8%** were between the ages of 36-45 (n=87)
- **6.9%** were between the ages of 46-55 (n=38)
- **3.3%** were between the ages of 56-65 (n=18)
- **2%** were between the ages of 16-17 (n=11)
- **1.1%** were between the ages of 66-75 (n=6)
- **0%** were 76+ (n=0)

The majority of respondents were between 18 and 45 years old; this is likely due to the distribution of the survey being online, mostly via social media.

In terms of racial identity and background,

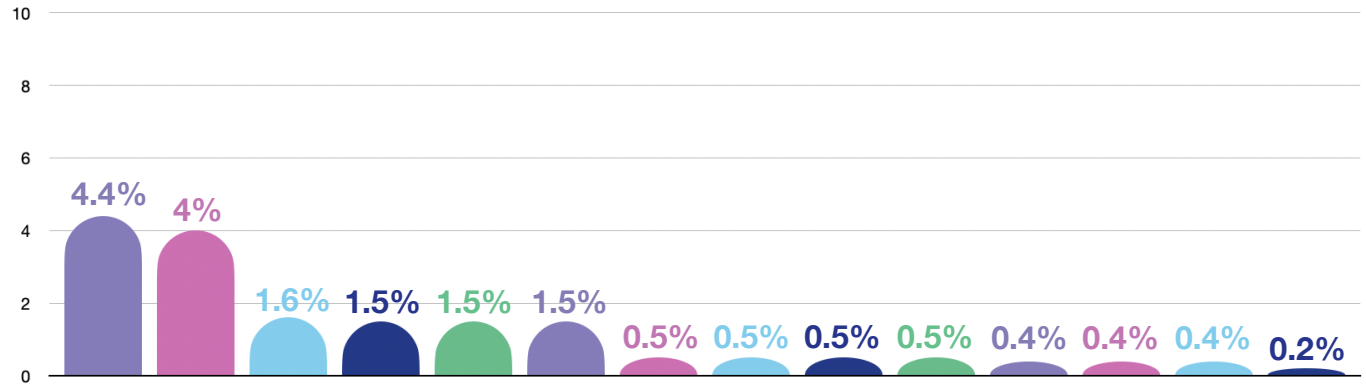
82.2%
had a white background (n=453).

This included "White British", "White Irish", "mixed White background" and "any other White background".



17.8%
were of a different ethnic background (n=98)

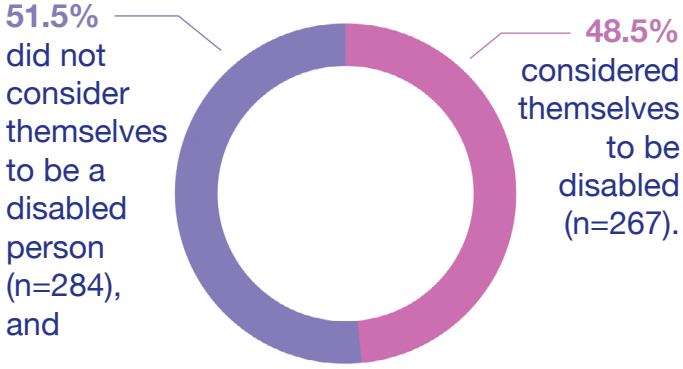
Of those who did not identify as "White British", "White Irish", "mixed White background" or "other White background",



- **4.4%** identified as "Asian or Asian British Chinese" (n=24)
- **4%** identified as "Asian or Asian British Indian" (n=22)
- **1.6%** were of "Any Other Ethnicity/Racial Background, including other mixed backgrounds" (n=9)
- **1.5%** identified as "Asian or Asian British Bangladeshi" (n=8)
- **1.5%** identified as "Black or Black British African" (n=8)
- **1.5%** identified as "Mixed White & Asian" (n=8)
- **0.5%** identified as "Asian or Asian British Pakistani" (n=3)
- **0.5%** identified as "Black or Black British Caribbean" (n=3)
- **0.5%** identified as "Mixed White & Black African" (n=3)
- **0.5%** identified as "Mixed White & Black Caribbean" (n=3)
- **0.4%** were of "Any other Asian or Asian British Background" (n=2)
- **0.4%** were of "Any other Black or Black British Background" (n=2)
- **0.4%** were of "Roma/Traveller Background" (n=2)
- **0.2%** were of "Arab Background" (n=1)

Some people who responded with “any other ethnicity/racial background” may not identify as people of colour, but have a heritage that they would not describe as “White British”, “White Irish”, “mixed White background” or “other White background”. These respondents may also face additional challenges around those identities or consider those identities to be racially minoritized. For simplicity, they are included in the group referred to as “people of colour”, but this diversity of heritage within the category should be kept in mind.

In terms of disability,

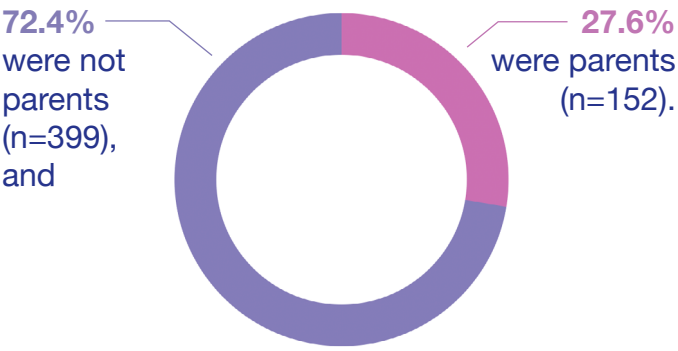


In our survey, we asked respondents, “Do you consider yourself to be a disabled person? (This may also include long-term medical conditions)”, and respondents who self-identified as disabled may do so for many different reasons. However, we did not give respondents the option to further describe their disability.

It’s important to remember that there are many different types of disabilities and disabled people all have different experiences. Respondents who identified themselves as disabled people may have many different circumstances, including (but not limited to) multiple disabilities, long-term medical conditions, invisible disabilities, limited mobility, autism, neurodiversity, learning disabilities, chronic health conditions, severe mental health conditions, blindness or partial sight, or be deaf or hard of hearing.

In terms of neurodiversity, **51.9%** did consider themselves to be neurodivergent (n=286), and **48.1%** did not consider themselves to be neurodivergent (n=265).

Of the 551 valid responses to the survey,



Of those who were parents,

- 106 people had a child or children over the age of one
- 40 people had a child or children under the age of one
- 18 people were pregnant

In terms of caring responsibilities,

- 16% were carers (someone who is looking after a family member, partner, or friend who needs help because of illness, frailty, or disability and is not paid for this) (n=88)
- 84% were not carers (n=463)

47 people were full-time carers, and 41 people were part-time carers.

While this data provides a much-needed insight into the sexual and reproductive health experiences of LBT+ women and femme-aligned people, the distribution of this survey through social media and various voluntary and community sector organisations means that the resulting research is vulnerable to self-selection bias. Therefore, it is less likely to represent the full spectrum of experiences across those who identify as LGBTQIA+. This includes:

- Limited responses from those experiencing digital poverty
- Limited responses from those not already engaged with social media, the LGBT
- Partnership, or our partner organisations
- Limited responses from those with high speech and language needs
- Limited responses from people over 56, even more limited responses from people over 66, and no responses from people over 76

Glossary

AFAB AFAB is an acronym for Assigned Female at Birth. This is most often used in contexts in which a person's gender identity contrasts with the female sex they were assigned at birth, for example, trans men or non-binary people.

Agender An agender person is a person who does not identify as any gender or consider themselves to have a gender identity. Some agender people identify as trans or non-binary, while others do not.

Alloromantic Someone who is alloromantic is someone who experiences romantic attraction to others — someone who is not aromantic.

Allosexual Someone who is allosexual is someone who experiences sexual attraction to others — someone who is not asexual.

AMAB AMAB is an acronym for Assigned Male at Birth. This is most often used in contexts in which a person's gender identity contrasts with the male sex they were assigned at birth, for example trans Women or non-binary people.

Aromantic (Aro) An aromantic (or aro) person is a person who experiences little-to-no romantic attraction. For some aromantic people, their experience of romantic attraction varies depending on their circumstances, and there are many different ways to be aromantic. Many aromantic people experience sexual attraction, and those who do might also identify as lesbian, gay, bisexual, straight, or queer as well as aromantic.

Asexual (Ace) An asexual (or ace) person is a person who experiences little-to-no sexual attraction. For some asexual people, their experience of sexual attraction varies depending on their circumstances, and there are many different ways to be asexual. Many asexual people experience romantic attraction, and those who do might also identify as lesbian, gay, bisexual, straight, or queer as well as asexual.

Bi+ Bi+ is an umbrella term used to describe those who experience romantic and/or sexual orientation towards more than one gender. “Bi” refers to bisexual and biromantic people, while the “+” represents other people who experience multi-gender attraction but may not use the term “bi”, such as pansexual, polysexual and queer people. There are many different ways to be bi+ and bi+ people may experience different types of attraction to different genders or be equally attracted to all genders.

Biphobia	Biphobia is any intolerance or prejudice directed towards people who are bisexual or perceived to be bisexual, based on negative perceptions and stereotypes about bisexuality.
Biromantic	People who are biromantic experience romantic attraction to more than one gender. Some biromantic people may also experience sexual attraction to more than one gender, while others may sexually identify as heterosexual, gay or lesbian, asexual or another sexual orientation.
Bisexual	People who are bisexual experience sexual attraction to more than one gender. Some bisexual people may also experience romantic attraction to more than one gender, while others may romantically identify as heteroromantic, gay or lesbian, aromantic or another romantic orientation.
Butch	Butch is an LGBTQIA+ identity that is most often associated with masculine-presenting lesbians, but can be used by people of many different genders and sexualities to describe their identity or their presentation. Sometimes butch is used to refer to a particular type of non-binary gender identity. Butch also sometimes refers to a person's style of presentation or expression as particularly masculine or masculine-aligned.
Chemsex	Chemsex refers to engaging in sexual activity while under the influence of stimulant drugs.
Cis(gender)	A cisgender (or cis) person is a person who identifies as the same gender that they were assigned at birth.
Cisnormativity	Cisnormativity is the assumption that everyone is, or should be, cisgender.
Coming Out	Coming out refers to the process of telling someone else about an LGBTQIA+ identity, whether it is a romantic or sexual orientation or a gender identity. Coming out can be different for everyone and is a continual process that may need to happen many times.
Conversion Therapy	Conversion therapy refers to the practice of attempting to change an individual's sexual orientation or gender identity to align with heterosexual and cisgender norms. It is often an attempt to "cure" someone of being LGBTQIA+ and is extremely emotionally damaging.
Dead Name	A "dead name" refers to the birth name of a trans or non-binary person who has changed their name as part of their transition. To "deadname" somebody is to use their birth name after they have changed it.
Demigender	Demigender is a gender identity that someone may hold if they identify partially with an aspect of the gender spectrum, but not completely. Similarly to non-binary identities, demigenders are an understanding of gender outside of the binary. A demiguy or demiman might identify with some aspects of masculinity or being a man, but not all of them, and a demigirl or demiwoman might identify with some aspects of femininity or being a woman, but not all of them.

Demisexual	A Demisexual person is a person who only experiences sexual attraction towards another person after an emotional bond has been formed. Some demisexual people experience romantic attraction, and those who do might also identify as lesbian, gay, bisexual, straight, or queer as well as demisexual.
Digital Poverty	Digital poverty is defined as the inability to interact with the online world when and how a person needs to. Digital poverty impacts people's abilities to access education, healthcare, social support, and employment and is experienced by many vulnerable people in the UK.
Discrimination	Discrimination is the act of unfair or unjust treatment of a person because of characteristics they may have, such as race, gender, class, age, religion, or LGBTQ+ identities. Discrimination includes direct and indirect discrimination as well as harassment and victimisation.
Endosex	An endosex person is someone whose sex characteristics fit normative medical or social ideas for female or male bodies — someone who is not intersex.
Female Genital Mutilation (FGM)	FGM describes a number of procedures that involves total or partial removal of external female genitalia for non-medical reasons. This practice is often cultural or religious and is illegal in the UK.
Femme-Aligned	This report defines femme-aligned as anyone who feels a connection to womanhood or femininity, even if they do not fully identify as a woman. This includes, but is not limited to, cisgender women, transgender women and some non-binary, genderfluid and genderqueer individuals.
Gay	Gay is a sexual orientation that is usually used to describe men who experience romantic or sexual attraction towards men. However, gay is also often used as a generic term by those who don't identify as men and who experience attraction towards people of the same gender or that is other than heterosexual.
Gender-Affirming Care	Gender-affirming care refers to a number of physical and mental treatments that trans and non-binary people may receive to assist their gender transition. Gender-affirming care can range from hormones to surgery to therapy and looks different for everyone.
Gender Dysphoria	Gender dysphoria describes a strong feeling of incongruence, unhappiness, discomfort, or distress in response to social or physical traits that are associated with a person's assigned gender. Gender dysphoria is not a mental illness or a mental health problem. Not all trans, non-binary or gender-diverse people experience gender dysphoria.
Genderfluid	Someone who is genderfluid is somebody who doesn't have a fixed gender identity. Their gender may change over a period of time or be flexible.
Gender Identity	A person's gender identity refers to their sense of themselves as being of a particular gender. Some people don't think of themselves as having any gender, and some people's perception of themselves as one gender may change over time to another gender.

Gender Marker	Gender markers are data points that show the gender of a person on a document or in a computer system, such as “F” for “female” or “M” for “male”.
Gender Non-Conforming	People may describe themselves as gender non-conforming if they don't present, dress, or behave in line with what society sees as the norm for their gender. People of any gender identity can be gender non-conforming.
Genderqueer	A genderqueer person is a person whose gender identity is outside the binary of “male” and “female”. A person who identifies as genderqueer might use the term to resist categorisation, or to acknowledge the fluidity of their gender identity. Some genderqueer people identify as trans, but others do not.
Hate Crime	A hate crime is a criminal offence that is motivated or perceived to be motivated by hostility or prejudice towards a person based on characteristics they possess, such as race, sexual orientation, transgender identity, religion, or disability. Hate crime includes physical assault, verbal abuse, and actions that incite hatred towards a particular person or group.
Heteronormativity	Heteronormativity is the assumption that everyone is, or should be, heterosexual.
Heterosexual	Heterosexual (or straight) refers to a man who has a romantic and/or sexual orientation towards women or a woman who has a romantic and/or sexual orientation towards men.
Homophobia	Homophobia is any intolerance or prejudice directed towards people who experience same-gender attraction.
Homosexual	Homosexual refers to somebody who experiences romantic and/or sexual orientation towards someone of the same gender. Some consider this term to be outdated or medical, and the term ‘gay’ is now more commonly used.
Honour Killing	An honour killing is the murder of an individual committed by somebody trying to preserve what they perceive as their family's dignity. Honour killings are often connected to religion or caste, or to sexuality.
Hormone Replacement Therapy (HRT)	HRT is hormonal therapy used to manage symptoms of menopause, and is also used as a form of gender-affirming care for transgender people.
Intersectionality	“Intersectionality” is a term coined by Kimberlé Crenshaw in 1989 and refers to overlapping or interconnecting social categorizations such as race, class, and gender. Those who hold multiple marginalised identities (e.g. queer women) may experience unique or additional barriers due to multiple forms of discrimination (e.g. queerphobia and misogyny).

Intersex	"Intersex" is a term that is used to describe a wide variety of natural variations in people's bodies that do not fit the typical understanding of "male" and "female" sexual characteristics. This can include variations in external genitalia, reproductive organs, chromosomes, or hormones. Intersex babies are assigned a gender at birth and may or may not continue to identify with their assigned gender.
Intrauterine Insemination (IUI)	IUI is a fertility treatment where sperm is placed directly into someone's uterus.
In Vitro Fertilisation (IVF)	IVF is a fertility treatment in which an egg is fertilised by sperm in a test tube or elsewhere outside of the body, and the resulting embryo is implanted in the uterus.
LBT+	In this report, the acronym LBT+ is used to collectively represent queer and trans women and femmes. Our decision to remove the "G" (for "gay") from this popular acronym is not intended to erase women who identify as gay (as many do), but to create a distinction between conversations about queer women and the LGBTQIA+ community more generally. The "+" includes all queer women who may not identify as lesbian, bisexual, or trans, but still hold non-heterosexual, non-cisgender identities, including gay women.
Lesbian	"Lesbian" is a sexual orientation used to describe women who experience romantic or sexual attraction towards women. Some non-binary people will also use the term lesbian to describe their sexual identity. It is also sometimes defined as "not-men attracted to not-men".
LGBTQIA+	LGBTQIA+ is used in this report to refer to people who identify as lesbian, gay, bisexual, transgender, queer, intersex, or asexual, as well as those who identify in other non-cisgender non-heterosexual ways such pansexual, questioning, genderqueer or agender, or those who choose to be unidentified in terms of their gender or sexuality. Other acronyms, such as LGBT, LGBT+ and LGBTQ+ are also used as umbrella terms for this group of identities.
Marginalised	When a group or community is marginalised, they face structural, social, financial, or political obstacles that mean they are excluded from society, face discrimination, and do not have the same opportunities as other groups or communities. Marginalisation means that the needs of these groups are not met by society. Marginalised groups include (but are not limited to) disabled people, asylum seekers and refugees, people in poverty, LGBTQIA+ people, and people of colour.
Medicalised Fatphobia	Medicalised fatphobia refers to weight discrimination within healthcare settings whereby people with larger bodies may receive a lower quality of care, a lack of thorough examination, or disbelief of symptoms due to their weight. One example of medicalised fatphobia is when ill health is blamed on fatness without a proper examination taking place.
Microaggression	Microaggressions are forms of indirect, subtle, or unintentional discrimination against members of a marginalised group.

Misgendering Misgendering is when a person intentionally or unintentionally mislabels a person's gender. This might be using a set of pronouns that the person does not use, or describing them with gendered words that do not fit their identity. The impact of misgendering is different for everyone, but can range from discomfort to distress. Misgendering is considered a microaggression — a subtle and often unintentional action that expresses prejudice towards a marginalised group.

Misogyny Prejudice or discrimination towards women, people assigned people at birth, or femininity.

Monogamous Someone who is in a monogamous relationship is in a sexual or romantic relationship with only one person at a time.

Monosexism Monosexism refers to a dislike, intolerance, or prejudice towards people who are attracted to multiple genders (e.g. bisexual, pansexual, etc.). Monosexism holds up monosexual identities as the societal ideal, and others people who are non-monosexual.

Monosexual A person who is monosexual is a person who is sexually attracted to only one gender (i.e. someone who is gay or straight). Non-monosexual people are attracted to more than one gender (i.e. bisexual or pansexual people).

Moral Panic A moral panic refers to public anxiety or alarm in response to an issue that is seen as threatening the moral standards of society.

MSM MSM is an acronym that stands for Men Who Have Sex With Men.

Neoclitoris A neoclitoris refers to an artificially created clitoris, constructed as part of a clitoroplasty which is a surgery that some trans women and non-binary people may receive as a part of their gender-affirming care.

Neurodivergent The term "neurodivergent" describes people whose brain differences affect how their brain works or whose mental or neurological function differs from what is considered typical or normal. Neurodivergency includes (but is not limited to) Autistic people.

Neurotypical "Neurotypical" is a term that's used to describe individuals with typical neurological development or functioning — people who are not neurodivergent.

Non-Binary Non-Binary is a term that refers to any gender identity that is outside the binary gender categories of 'male' or "female". Not everyone who identifies with a gender outside of the gender binary uses the term non-binary to describe their identity — other identities outside the binary might also include agender, genderqueer or genderfluid.

Orgasm Gap The orgasm gap is a social phenomenon referring to the general disparity typically between heterosexual men and women in terms of sexual satisfaction and frequency of orgasm during sex.

Othering	To “other” a person or a group of people is to view or treat them as intrinsically different from oneself or as different from the societal norm.
Panromantic	People who are panromantic experience romantic attraction to people of any gender. Some describe panromanticism as attraction without regard to gender. Panromantic is sometimes used as an alternative to the term biromantic. However, some people who identify as panromantic consider the term to be more deliberately inclusive of those who identify outside of the gender binary. Some panromantic people may also experience sexual attraction to more than one gender, while others may sexually identify as heterosexual, gay or lesbian, asexual or another sexual orientation.
Pansexual	People who are pansexual experience sexual attraction to people of any gender. Some describe pansexuality as attraction without regard to gender. Pansexual is sometimes used as an alternative to the term bisexual. However, some people who identify as pansexual consider the term to be more deliberately inclusive of those who identify outside of the gender binary. Some pansexual people may also experience romantic attraction to more than one gender, while others may sexually identify as heteroromantic, gay or lesbian, aromantic or another romantic orientation.
People of Colour	In this report, the term people of colour is used to refer to people who are Black (including Black African, Black Caribbean or another Black heritage), Asian (including Indian, Pakistani, Bangladeshi, East Asian, Pacific Island or another Asian heritage), Latinx, mixed heritage, or of another non-white heritage.
Polyamorous	Someone who is polyamorous is involved in the practice of engaging in multiple romantic or sexual relationships with the consent of all the people involved. This is also sometimes referred to as ethical non-monogamy.
Polysexual	People who are polysexual experience sexual attraction to multiple genders. Polysexual is sometimes used as an alternative to the term bisexual. However, some people who identify as polysexual consider the term to be more deliberately inclusive of those who identify outside of the gender binary. Some polysexual people may also experience romantic attraction to more than one gender, while others may sexually identify as heteroromantic, gay or lesbian, aromantic or another romantic orientation.
Pronouns	Pronouns are words that we use to refer to items or individuals rather than using their names. When referring to people, the pronouns used will often depend on the person’s gender — for example, he/his, she/her, they/theirs. Some people will also use newer pronouns, also called “neopronouns”, for example xe/xer, ve/vis, ey/em.
PSHE	PSHE is an acronym that stands for Personal, Social and Health Education. Relationships and Sex Education (RSE) usually sits within this category and is taught as part of this subject.

Queer	Queer is a term that some LGBTQIA+ people use to describe their identity without using specific or pre-existing labels. Some people use queer to mean that their sexuality or gender identity is other than the "norm", to convey a sense of fluidity, to embrace the diversity of their identities, or to connect themselves to wider LGBTQIA+ communities. Some LGBTQIA+ people consider queer to be a slur, but others have reclaimed the word and embrace its use.
Queerphobia	Queerphobia is any intolerance or prejudice directed towards people who are queer or perceived to be queer, based on negative perceptions about queerness and queer people.
Questioning	In the context of this report, questioning refers to any person who is unsure of their sexual identity or who is questioning whether or not they identify as LGBTQIA+.
Racial Profiling	Racial profiling involves making negative assumptions about particular people because of their ethnic background or race.
Rape Culture	Rape culture is a culture where sexual violence (harassment, abuse, assault, and rape) is normalised and not treated as seriously as it should be. Within rape culture, sexual violence is often accepted, reduced, excused, laughed off, or not challenged enough by society as a whole.
Sexually Transmitted Infection (STI)	An STI is an infection or disease passed on through unprotected sexual contact with another person. STIs are sometimes referred to as STDs (Sexually Transmitted Diseases), but some consider this outdated as not all STIs are diseases.
Sexual Orientation	A person's orientation describes their attraction or type of attraction to other people, which might be sexual or romantic. Examples of different sexual orientations might be heterosexual, gay, lesbian, or bisexual. These terms also refer to a person's identity based on how they experience attraction to others.
Transexual	Transexual is a more medical term (similar to homosexual) to refer to someone whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. This term is considered outdated and offensive by many, with most people opting to use "trans" or "transgender" instead. However, this term is still used by some people who have reclaimed it.
Transfeminine	Transfeminine is a term that covers various transgender identities that are related to femininity, including binary and non-binary transgender identities. Transfemininity can contain many different forms of expression and presentation. Transfeminine people might identify as trans women, non-binary, genderfluid, genderqueer, or in another way.
Trans(gender)	A transgender person is a person whose current gender identity is different from the gender that they were assigned at birth based on their body's characteristics. A transgender person might identify as a binary gender (as a man or a woman) or another gender outside the binary. Not all non-binary or gender diverse people identify as trans.

Transition	Transition (or gender transition) involves the physical and social steps that a person takes in order to be more aligned with their gender identity. Some people opt to medically transition, using hormones and/or surgery, while others may only transition socially (changing pronouns, name, clothing, etc.)
Transmasculine	Transmasculine is a term that covers various transgender identities that are related to masculinity, including binary and non-binary transgender identities. Transmasculinity can contain many different forms of expression and presentation. Transmasculine people might identify as trans men, non-binary, genderfluid, genderqueer, or in another way.
Transphobia	Transphobia is any intolerance or prejudice directed towards people who are transgender or perceived to be transgender based on negative perceptions of trans people.
Trans Status	Trans status is the current state of an individual being or not being transgender.
Triggering	If something is triggering for somebody, this means it has caused them emotional distress, usually as a result of arousing feelings or memories associated with past trauma.
Unidentified	Someone who is unidentified is somebody who has not yet labelled their sexual orientation or gender identity or does not wish to do so. This could be somebody who is still figuring out their identity or somebody whose identity is fluid.
WLW	WLW is an acronym that stands for Women Loving Women.
WSW	WSW is an acronym that stands for Women Who Have Sex With Women.

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