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Family Planning for Sexual Minority Women

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Abstract

The family planning needs of sexual minority women (SMW) are an understudied but growing area of research. SMW have family planning needs, both similar to and distinct from their exclusively heterosexual peers. Specifically, SMW experience unintended pregnancies at higher rates than their exclusively heterosexual peers, but factors that increase this risk are not well understood. Contraception use is not uncommon among SMW, but lesbian women are less likely to use contraception than bisexual or exclusively heterosexual women. High rates of unintended pregnancy suggest contraception is underused among SMW. Contraception counseling guidelines specific to SMW do not yet exist, but greater adoption of current best practices is likely to meet the needs of SMW. SMW may have unique needs for their planned pregnancies as well, for which obstetrics and gynecology (Ob/Gyn) providers should provide care and referrals. In general, understandings of the distinct family planning needs for SMW are limited and further research is needed, with particular attention to issues of over-lapping health disparities related to status as a SMW and other factors such as race/ethnicity that may add additional layers of stigma and discrimination. Clinical resources are needed to help Ob/Gyns make their practice more welcoming to the needs of SMW.

Keywords

family planning; contraception; sexual minority women

Compared with heterosexual women, sexual minority women (SMW) in the United States receive fewer preventive reproductive health care services such as pap smears[1–6] and

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mammograms.[4,5] For the purposes of this review, SMW are defined as people assigned female at birth who either identify as something other than heterosexual or who at least sometimes have sexual relationships with other women[7] (see ►Table 1).[a] SMW have also been reported to have higher rates of STIs and higher rates of unintended pregnancy than their exclusively heterosexual peers.[8–13] Reasons for differences in reproductive health care and outcomes are not fully understood. However, these disparities are likely due not only to differences in behavior[14] but also to other factors, including differences in how providers offer care to these patients.[15,16]

Whether helping patients plan for a healthy pregnancy or prevent undesired pregnancy, providers should take the overall reproductive health of their patient into consideration regardless of their sexual identity or behaviors. However, in recognition of the barriers faced by SMW accessing care, the American College of Obstetricians and Gynecologists (ACOG) has specifically called for obstetrician and gynecologists (Ob/Gyns) to be prepared to competently and compassionately care for lesbian and bisexual women and decrease barriers, discrimination, and stigma associated with health care.[17]

In this article, we first discuss the best national estimates of the number of SMW in the United States, then transition to reviewing the research that has shaped our understanding of unintended pregnancy, contraception use, and desired fertility issues specific to SMW. This review highlights differences for young women as well as adult SMW. We close by discussing the current gaps in research and the clinical implications and available guidelines for the Ob/Gyn provider.

Estimates of SMW in the United States

Precise estimates of the number of U.S. women who identify as a sexual minority are lacking due to several factors. First, the U.S. Census Bureau and American Community Survey do not collect data on sexual identity and only recently has the National Health Interview Survey included such data.[18] Stigma against sexual minorities may also result in underreporting and underestimates during surveys. Finally, sexual identity is both multidimensional and changes over time,[19–21] leading to difficulty with obtaining a true estimate. The most conservative estimates to date suggest that approximately 3.4% (4,007,834) of adult women in the United States identify as a sexual minority, with 1.1 to 1.5% identifying as lesbian or gay and 0.9 to 2.2% identifying as bisexual.[22,23] Furthermore, women are more likely to identify as bisexual than men, which is true both in the United States and in countries worldwide.[22,23]

Emerging data suggest that younger women are more likely to identify as a sexual minority than adult women. New data from the National Survey of Family Growth (NSFG) suggest that the proportion of young women who identify as bisexual is increasing among younger cohorts.[24] Using data from The National Longitudinal Study of Adolescent to Adult Health, a nationally representative survey of U.S. adolescents grades 7 to 12 found that 15% of

[a]While transgender men fit into this definition and are more than deserving of research and intervention efforts, this review focuses on cisgender people who identify as women and who could also get pregnant.

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females identified as a SMW.[25] Additionally, data from the 2015 Youth Risk Behavior Survey, a national school-based survey of 9th to 12th graders, found that 2.0% of females identified as gay/lesbian and 9.8% as bisexual.[26]

Sexual Identity versus Sexual Behavior

Sexual identity and sexual behavior are not always concordant. For example, a patient who identifies as a lesbian may have or have had past heterosexual sex that does not change how they identify. Past or present sexual activity may put individuals at risk of pregnancy, STIs, or other health care needs.[27,28] Studies that have examined sexual behaviors among SMW have documented high rates of heterosexual sex among women who identify as bisexual and gay/lesbian.[9,14,29,30] Furthermore, multiple studies have demonstrated that different reproductive health outcomes exist depending on whether sexual identity or sexual behavior is measured.[14,31–33] Assessing both sexual identity and behavior at patient intake may therefore optimize communication and care surrounding individual family planning needs.

Unintended Pregnancy

Surveys indicate that pregnancy during one's life is a relatively common experience for SMW. Approximately 37% of SMW report having had a child in their lifetime;[34] however, estimates vary by survey type and reported sexual identity. For example, the Women's Health Initiative found a stark difference in the reported rates of lesbians (35%) and bisexual women (81%) who have experienced at least one pregnancy.[35] Additional research by Marrazzo and Stine found that 25% of women who have sex with women surveyed reported a prior pregnancy.[31] However, these studies did not measure pregnancy intentions. Pregnancy intentions are likely nuanced for SMW as they are for all women; however, the current literature documents far less understanding of pregnancy intentions among SMW than other women. We recognize there are important limitations and critique of measures of pregnancy intentions;[36] however, it is important to understand the pregnancy intentions of SMW both from a public health and clinical perspective.

A growing body of research has documented increased risk of teen pregnancy among sexual minority adolescent girls compared with their heterosexual peers.[37–40] Data from the 1987 Minnesota Adolescent Health Survey showed that self-identified bisexual or lesbian adolescents reported significantly higher prevalence of pregnancies than their heterosexual peers.[41] Youth Risk Behavior Survey data from 2013 continue to support this trend: young SMW who were classified as either women who have sex with women or women who have sex with both women and men based on their responses to sexual behavior questions were significantly more likely to have been pregnant in the past 12 months than their peers who were women who have sex with men only.[42] More recently, Goldberg used The National Longitudinal Study of Adolescent to Adult Health data and found that when compared with heterosexual women, bisexual women were significantly more likely to experience teen pregnancy and lesbians were less likely to experience teen pregnancy.[38] Additional research using Youth Risk Behavior Survey data from New York City found that young SMW—using measures of both sexual identity and sexual behaviors—have higher odds of having experienced a pregnancy compared with heterosexual/WSM peers.[39] Tornello et al used 2006–2010 NSFG data and found that 8.4% of bisexual women aged 14 to 21 years

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surveyed had ever been pregnant, and they were almost three times as likely as their heterosexual peers to have ever terminated a pregnancy, suggesting pregnancy was not desired.[43] Additionally, young bisexual women were significantly more likely to report risks for unwanted pregnancy, such as younger age at sexual onset and ever having been forced to have sex.[43]

Less research has examined sexual orientation disparities in pregnancy intentions among adult SMW. However, extant research suggests that adult SMW experience increased risk for unintended pregnancy. Using NSFG data, Everett et al analyzed pregnancy intentions of SMW reporting pregnancies that were not terminated. The authors found that, compared with pregnancies reported by heterosexual women, the pregnancies reported by women who identified as heterosexual but who also engaged in sex with women were more likely to be reported as “mistimed.”[44] Additionally, pregnancies experienced by bisexual and gay/lesbian women were significantly more likely to be reported as “unwanted” compared with those of heterosexual women.[44] In an additional study, Everett et al found that among a diverse group of SMW in the Chicago Health and Live Experiences of Women study, 24% of the SMW reported at least one lifetime unintended pregnancy.[45] In another study, McCauley et al found that women who have sex with women had 1.45 times the odds of reporting an unwanted pregnancy as compared with women who have sex with men.[46] Marrazzo and Stine, using abortion rates as a proxy for unintended pregnancy, found in a sample of women aged 25 years or younger who have had sex with women in the past year that 60% of the pregnancies reported ended in abortion.[31] However, data on abortion rates among SMW are limited. Tornello et al found that bisexual women had the highest rates of pregnancy termination (12%) compared with heterosexual women (5%).[43] A systematic review found conflicting results when comparing abortion rates among SMW to rates among heterosexual women, with four of the reviewed studies reporting lower abortion rates among SMW and three reporting higher abortion rates as compared with heterosexual women.[47] Further research is needed, as abortion was a secondary outcome in all studies included in the systematic review rather than the primary focus of research.[47]

These studies suggest that the pregnancy intentions of SMW differ from their exclusively heterosexual peers. However, more research is needed to understand the reasons for these differences over the lifespan. To date, most explanations for this excess risk have focused on young SMW. These include increased engagement in heterosexual behaviors as a way to manage stigma,[33] lack of sexual education that is relevant to sexual minority youth,[48] and higher rates of behaviors traditionally associated with unintended pregnancy, including substance use[49] and history of sexual abuse.[50,51] Identifying as a sexual minority may predispose individuals to victimization, as it is documented that SMW experience high rates of sexual violence.[8,52–54] However, preliminary research has found that neither forced sex nor early sexual debut was able to explain increased rates of mistimed or unwanted pregnancies experienced by SMW compared with their heterosexual peers.[44]

Understanding pregnancy intention and the differences in pregnancy intention for SMW is important, as unintended pregnancies have been associated with poor maternal and neonatal outcomes such as preeclampsia,[55] low birth weight, premature rupture of membranes, and

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preterm birth.[56–58] Consistent contraception use has been shown to be the most effective way to prevent unintended pregnancy or to time desired pregnancies.[59]

Contraception

Similar to unintended pregnancy, the understanding of contraception use by SMW is limited. Marrazzo and Stine reported high rates of ever using contraception among self-identified lesbian (45%) and bisexual (68%) women.[31] Similarly, in the Women's Health Initiative, 40% of self-identified lesbians reported they have ever used oral contraception and 55% of bisexual women have used oral contraception.[35] Additional NSFG data further support the understanding that contraception use is not uncommon; however, these data also highlight important differences among SMW. The data show that 4 to 13% of women who had sex with women and 19 to 41% of women who had sex with both men and women had used contraception in the past year.[60] While these studies indicate that contraception use is not uncommon among SMW, the rates of lifetime contraceptive are nonetheless much lower than among the general population: it is estimated that almost all (99%) reproductive aged women (15–44) who have ever had sexual intercourse with a male have used any form of contraception, and 87.5% have used a form of hormonal contraception.[61]

Studies that have compared contraception use between SMW and heterosexual women have found notable differences, although the findings from various studies are at times inconsistent. An analysis of women enrolled in the Nurses' Health Study II and their children found that bisexual women were more likely than heterosexual peers to use hormonal contraception in both cohorts.[37] In contrast, a recent study of New York City Youth Risk Behavior Survey data found that young SMW who identified as gay/lesbian or bisexual were more likely to report using no contraception at last sex compared with their heterosexual peers.[42] Additional data indicate that young SMW report less frequent contraceptive use[62] and use of less effective contraceptive methods compared with their heterosexual peers.[41] NSFG data reported by Agénor et al found that contraception use among adult women of all races who have sex with only women was less common (4.1–13.6%) as compared with their peers who have sex with men only (31.6–38.7%).[60] Comparisons of contraception use between women who have sex with both men and women and their peers who have sex with men only varied by race with bisexual contraception use more common among black (33.1%) and white (41.7%) women who have sex with both men and women, but less common among Latina (19.0%) women who have sex with both men and women, as compared with their respective peers who have sex with men only (31.6,38.7, and 32.4%).[60]

Researchers have proposed various explanations for disparities in contraception use by sexual identity. Importantly, some SM W patients may not perceive themselves as at risk of pregnancy.[63] Also, dominant sexual education curricula typically equate risks with penetrative sex, and often exclude information on safe sex practices relevant to sexual minorities.[48,63] Similarly, health care providers may make assumptions based on an individual's sexual identity and not specifically assess sexual behaviors, and thus not counsel on or offer contraception.[15,16,64] Reasons for differing rates of contraception use are likely a combination of many factors, those described previously and those still not

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understood. Additionally, many people often use contraception for its noncontraceptive benefits. Thus, it is impossible to predict the reason patients are using contraception. Providers should avoid making assumptions about reasons for use based on an individual's sexual identity.

As previously mentioned, bisexual women report higher rates of contraception use than their lesbian/gay peers.[31,35,60] However, they also experience higher rates of unintended pregnancy.[38,43,44] There is evidence indicating that bisexual women are more at risk of experiencing a variety of health disparities both compared with heterosexual and gay/lesbian peers.[23] This may be in part due to the fact that bisexuals face discrimination and lack of acceptance both from society at- large and from the gay/lesbian community.[65] This double stigma likely influences the likelihood of being out, especially as compared with their lesbian/gay peers.[66,67]

Research also suggests that sexual identity-behavior discordance (i.e., lesbian-identified women who have sex with men or heterosexual women who have sex with women) is associated with increased reproductive health risks. Such discordant behavior and identity leads to unique needs and risks related to pregnancy, contraception use, and other reproductive health outcomes such as STIs, and preventative screenings.[5,14,38] One postulated reason is that these individuals experience a unique added stigma from two groups, both the heteronormative dominant culture and their lesbian and gay peers.[65]

Desired Fertility

While rates of unintended pregnancy are higher among SM W than among their heterosexual peers, not all SMW wish to avoid pregnancy and successful conception may require unique considerations of challenges for SMW. Helping patients plan for pregnancy and achieve conception is an integral part of the position of an Ob/Gyn provider. Specific needs unique to SMW may depend on their sexual identity, financial resources, and personal desires. Healthcare providers should be able to counsel and provide services or counsel and provide referral for any needed assistive fertility options, surrogacy, and adoption as indicated.[17,68] The ability to provide referrals for excellent colleagues is paramount, especially for SMW patients who face frequent stigma and discrimination in health care settings, and as SMW seek information online at high rates which often perpetuates misinformation.[69] Additional information can be found in this issue in the articles by Getrajdman, Kim, and Bushe and Romero.[70–72]

Future Research Needs

Our review suggests that the literature on the family planning needs of SMW is limited, but growing. Specific needs for future research include better national estimates of SMW and other sexual and gender minorities. Furthermore, continued efforts should be made to understand the factors associated with and the context within which SMW experience pregnancy.

Specific attention to inclusion of racial diversity in research populations of SMW is also imperative. A limitation highlighted in many research studies included in this review was

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that the populations were predominately white individuals.[14,31,35,37,38,41,43,46,63] Some exceptions exist with emerging data examining sexual orientation and race/ethnicity variations of pap testing,[60] STI and HIV risk factors,[73–75] and general reproductive health measures.[74] Agénor et al have specifically examined the reproductive health needs of African American SMW, and highlighted important similarities and differences between the rates of pregnancy, contraceptive use, HIV testing, pap test use, and sexual assault among African American SMW and previously published findings conducted among predominantly white populations.[76]

Considering the additional layers of stigma and oppression that SMW of color may face is critical for improving reproductive care for all SMW. Future research and clinical practice should incorporate theory of intersectionality, which posits that individuals' specific overlapping social identities lead to a systemic form of oppression that is unique to that combination of identifies.[77] These intersections likely impact health care needs.[78] Additional scholarship has examined the intersectional relationship between lesbians who are intravenous drug users and increased risk of HIV infection.[79] The findings from this large qualitative study supported the hypothesis that "multiple marginalization" influences SMW's increased HIV risk.[79] While current intersectional research is limited, it is an important area for future research, as the layers of oppression have clear impacts on health outcomes.

Clinical Importance

This review has highlighted clinical and research needs specific to SMW. According to the Code *of Professional Ethics* set forth by the ACOG, Ob/Gyn providers should not discriminate against their patients, including on the basis of sexual orientation or individual gender.[80] Furthermore, ACOG has specifically called for Ob/Gyns to be competent in their care for lesbian and bisexual women.[17] While clinical guidelines to inform best practice are still developing,[81] providers need to be proficient in providing quality care for SMW now. Stigma and prior negative experiences within a health care setting have been found to prevent future engagement with health care services, which likely contribute to reproductive health disparities.[5,64] Therefore, when SMW do present for care, it is imperative that providers are providing competent, compassionate care. ►Table 2 provides a list of resources for the clinician.

General approaches to making the patient care setting accessible and welcoming can be found in many resources. Specifically, the Joint Commission,[82] ACOG,[17] and the National Association of Community Health Centers[83] have detailed recommendations to guide creating LGBT-friendly clinics, which include training for all staff members, modifications for inclusion on clinic forms, use of inclusive language, and avoiding assumptions about sexual orientation and gender identity. Detailed recommendations are also described by Cook et al in this issue.[84]

As descried previously, in providing family planning care for SMW, clinicians should conduct a comprehensive sexual health history on all patients. As demonstrated through numerous studies, patients' sexual identity and sexual behaviors are not always one in the

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same, and thus individualized sexual health histories are warranted.[33] The National LGBT Health Education Center has published a guide for taking a routine sexual health history.[85] Importantly, the guidelines recommend normalizing the sexual health history and then asking the following three modified screening questions for all patients: (1) Have you been sexually active in the past year? (2) Do you have sex with anyone with a penis, a vagina? (3) How many people have you had sex with in the past year?[85] The responses to these three questions will lead the provider's discussion of further risk assessment and appropriate care. The Ob/Gyn provider can then provide appropriate care based on the identified needs elicited by the history.

Contraception counseling is an important aspect of reproductive health care for SMW. Optimal contraception counseling conversations may need to differ for SMW, although research on this topic is lacking. However, increasing providers' use of best practices may likely to meet needs of all patients regardless of sexual orientation or gender identity. According to The Jaccard 10 Manual, a presentation of 10 best practices about contraception based on extensive review of the literature, there are three key attributes needed to facilitate a contraception counseling discussion: trustworthiness, expertise, and accessibility.[86] With this foundation, the provider can use the 10 best practices for contraception counseling detailed in the manual, which are evidence based and provide tools to guide the contraception counseling conversation with any patient.[86] Additional best practices publications have been published, with significant overlap in themes.[87]

Providers should not assume that a sexual or gender identity alone precludes the need for or necessitates contraception use. The need should be assessed individually based on the patient's distinct risk factors and personal needs, which may include unique noncontraceptive factors among this population. Specifically, providers may need to discuss methods that are easy to conceal use (i.e., long-acting reversible contraception methods or medroxyprogesterone acetate) for individuals whose contraceptive use may "out" their sexual behaviors to other groups.

Additionally, providers should not assume that one's sexual or gender identity indicates a desire or lack of desire for biological children. Plans for pregnancy and parenting should be assessed with each patient, and appropriate care provided. Ob/Gyn providers are likely to be involved in pregnancy care of SMW at various stages, including preconception, prenatal, or intrapartum care. The Ob/Gyn provider should have an understanding of the available options for becoming a parent, and referrals for those sources of care as needed (see Getrajdman, Kim, and Bushe and Romero articles in this issue).[70–72] Additional resources can be found from Fenway Heath Education and in ►Table 2.

Finally, it is important to remember that holistic care for this population is especially important. Every individual is at a different place in terms of their own coming out process, as well as the acceptance of their family and friends. As primary care providers, Ob/Gyns should pay attention to primary care concerns that may be facing SMW, which may influence their health outcomes and may be related to their social situations. Specifically, the Ob/Gyn should pay particular attention to screening for mental health concerns,

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interpersonal violence, and substance use issues to promote general wellness and support patients' reproductive health.[17]

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Table 1

LBGT terminology[a]

Term	Description
Sexual minority	Used to describe people whose sexual orientation is not heterosexual only
Gay/lesbian	People who are attracted to people of the same sex
Bisexual	People who are attracted to those of the same gender or to those of another gender
Heterosexual	People who are attracted to people of the opposite sex
Mostly heterosexual	An individual who identifies as straight/heterosexual, but may have sex with an individual of the same sex
Cisgender	People whose gender identity and gender expression align with their assigned sex at birth
Transgender	An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth
WSW	Women who have sex with women
WSMW	Women who have sex with men and women

[a]Adapted from Fenway Health at: http://www.lgbthealtheducation.org/wp-content/uploads/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms_fi.pdf.

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Table 2

Clinical resources

General LGBTQ friendly clinic practices resources	
The Joint Commission	The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Oak Brook, IL, 2011. http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf.[82]
American College of Obstetricians and Gynecologists	ACOG Committee on Health Care for Underserved Women. Committee opinion no. 525: Health care for lesbians and bisexual women. 2012;119 (5):1080–1088.[17]
National Association of Community Health Centers	Reaching Out to Other Special Populations: Providing Services to Gay, Lesbian, Bisexual, and Transgender Patients. NACHC. Special Population Series' Information Bulletin #11. http://www.nachc.org/wp-content/uploads/2015/06/LGBTInformationBulletinAugust20072.pdf. [3]
General LGBT health resources	
Centers for Disease Control and Prevention: Lesbian, Gay, Bisexual, and Transgender Health	https://www.cdc.gov/lgbthealth/
Gay and Lesbian Medical Association (GLMA): Health Professionals Advancing LGBT Equality	Provider, patient, and student resources available at: http://www.glma.org
The Fenway Institute	http://fenwayhealth.org/the-fenway-institute/
Essential Access Health	http://www.essentialaccess.org/sites/default/files/Providing-Inclusive-Care-for-LGBTQ-Patients.pdf
Out for Health: For Providers from Planned Parenthood	http://www.outforhealth.org/for-providers.html
Human Rights Campaign: Healthcare Equality Index for LGBTQ Patients	http://www.hrc.org/hei/for-lgbt-patients
Contraception counseling resources	
The Jaccard 10 Manual	Jaccard J, Levitz N, Kantor L, Levine D, Westohoff C, Morfesis J, Kohn J. The Jaccard 10 Manual: Ten evidence-based practices for contraceptive counseling. Planned Parenthood 2016.[86]
	Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. Clin Obstet Gynecol 2014;57(4):659–673.[87]
Conception/Parenthood resources	
National LGBT Health Education Center	https://www.lgbthealtheducation.org/wp-content/uploads/Pathways-to-Parenthood-for-LGBT-People.pdf