SEXUAL AND REPRODUCTIVE HEALTH CARE ACCESS FOR AFRICAN AMERICAN SEXUAL MINORITY WOMEN

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Jade Danielle Coley

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This thesis was presented

by

Jade Danielle Coley

It was defended on

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and approved by

Thesis Advisor:
Ronald Stall, PhD, MPH, Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Members:

Nina Markovic, PhD, Associate Professor
Dental Public Health and Epidemiology
School of Dental Medicine
Graduate School of Public Health
University of Pittsburgh

Amy Herrick, PhD, Assistant Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Ron Stall, PhD

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ABSTRACT

Background: African American sexual minority women (AA SMW) face several layers of discrimination when seeking healthcare. Chronic stress and existing health disparities slow access to health care. Discrimination is most clearly shown in obtaining timely preventative screenings and having pertinent sexual and reproductive health care information. This review investigated the current state of, as well as the barriers and facilitators to, sexual and reproductive health care quality and access for AA SMW.

Methods: A review of the literature was conducted using nine Boolean search terms in the PubMed database. Studies were included if they contained results related to the population and health outcomes described above.

Results: AA SMW are about a third less likely than heterosexual African Americans to have health insurance. A substantial portion of AA SMW do not disclose their sexual behaviors/orientation to their health care provider. To date, there is no existing literature on HPV vaccination specific to AA SMW. Mammogram uptake was higher than expected, indicating a need to investigate resiliency factors for AA SMW. The public health significance of this thesis is presented in the discussion of the results, which suggest the most promising intervention strategies for increasing health care access for AA SMW.

Conclusions: Interventions should aim to improve the patient-provider relationship for AA SMW, while also empowering AA SMW to disclose their sexual behaviors and request screenings. Further, accessible, culturally relevant sexual and reproductive health care information is needed for AA SMW. Future research should inquire about sexual behavior as well as identity. Future interventions should be adapted interventions that have proven to be successful with African American heterosexual women.

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PREFACE

Several acronyms are used in this literature review, which will be defined here for clarity.

HCA- health care access

SRH- sexual and reproductive health

SRHCA- sexual and reproductive health care access

AA- African American

SMW- sexual minority women

HCP- health care provider, (includes physician, nurse practitioner, or physician assistant)

ACA- Affordable Care Act

LGBT- lesbian, bisexual, gay, and transgender.

1.0 INTRODUCTION

African American and sexual minority women are marginalized groups that have endured historical mistreatment, generally regarding race and sexual orientation as exclusive groups. Women with multiple minority identities experience great disparities in health outcomes. The health disparities of African American Sexual Minority Women (AA SMW) mainly stem from access to health care. This literature review uses the Minority Stress Theory to describe the impact of chronic stress due to sociostructural discrimination and disparate health risks on health care access. The goal of health equity for AA SMW is reflected in Healthy People 2020, which states, "to achieve health equity, eliminate disparities, and improve the health of all groups". The primary aim of this literature review is to understand current strengths and weaknesses of health care access for AA SMW and determine the best potential intervention strategies based on these findings.

1.1 ACCESS TO CARE

Generally speaking, access to care refers to the ease with which an individual can obtain needed personal health services in a timely matter. According to Healthy People 2020, there are three distinct steps of health care access: gaining entry into the health care system, access to the location where health care services are offered, and finding a health care provider with whom the patient can communicate and trust. Access to care includes four components that include coverage,

services, timeliness, and workforce. Three of the four components will be explored in this review to determine the current state of coverage, services, and timeliness with which African American sexual minority women are accessing sexual and reproductive health care.

Poor health care access or quality can lead to unmet health needs, delays in receiving appropriate care, inability to get preventative services, loss of productivity, reduced quality of life, and hospitalizations that could have been prevented. On the other hand, excellent health care access can lead to improved health, increased health literacy, effective primary and secondary disease prevention, decreased spread of disease, greater patient trust in the health provider, and good patient-provider communication.

1.2 SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health plays a great role in overall quality of health. The definition of sexual and reproductive health using the World Health Organization as a guide would be the state of physical, emotional, mental, and social well-being in relation to sexuality and reproduction, not just the absence or disease or dysfunction. Diseases of sexual and reproductive nature, such as cervical or breast cancer, can go undetected for months or years, making it important for individuals to get the appropriate early detection screenings rather than relying on tertiary prevention methods for the best health outcomes and lowest costs. This literature review focuses on the prevention of sexual and reproductive cancers because of the on-going visits with a HCP needed to effectively screen for them. Prevention and care of sexually transmitted infections are also important for AA SMW, but are not covered in this literature review since they can generally be solved in one visit to a HCP.

1.3 AFRICAN AMERICAN WOMEN

African American (AA) refers to women whose ancestors originated in Africa. In this instance African American does not include recent African immigrants, but would include their children born in the United States. African American women are at risk for a plethora of negative health conditions, many of which are chronic (Office of Women's Health, 2012). The Office of Women's Health highlights lack of health care access to one of the major causes of poor health outcomes such as breast and cervical cancer, which are discovered at later stages, making it more difficult to treat (Office of Women's Health, 2012). Breast cancer is the most common cancer among African American women (American Cancer Society, 2013). The incidence of cervical cancer is higher for African American women than for European American women; and African American women are more than twice as likely to die from cervical cancer (Office of Women's Health, 2013). Many of the afflictions that disproportionately affect African American women could be resolved with increased access to care (Agency for Healthcare Research and Quality, 2013).

1.4 LESBIAN AND BISEXUAL WOMEN

Sexual Minority Women (SMW) will be used throughout this paper as an umbrella term to refer to women whose behavior, attraction, or identity could be described as lesbian, bisexual, or otherwise not heterosexual. SMW experience a large degree of invisibility in health care settings (Daley, 1998; San Francisco Human Rights Commission, 2011). Although several health disparities between SMW and heterosexual women have been observed, a full picture of SMW health and well-being is still developing. Low health care access for SMW has been documented

for over 30 years (Stevens, 1992), and similarly to LGBT health overall very few interventions have been funded by the National Institutes of Health (Coulter et al. 2014).

The health inequities that AA SMW face may stem from the historical and modern structure of racism, sexism, misogynoir (hatred of Black women), and homoantagonism (active hostility or opposition to homosexual people). These inequities are difficult to record because many SMW research studies are comprised of European American samples and many AA-specific studies do not include SMW. Population-based samples tend to have few AA SMW participants, and lack statistical power to analyze for both race and sexual orientation disparities.

2.0 BACKGROUND

Here the measures for sexual and reproductive health care access for AA SMW will be described as well as justification for their inclusion. The framework that connects existing health disparities to decreased health care access will also be provided.

2.1 MEASURES OF HEALTH CARE ACCESS

Three of Healthy People 2020's health care access components will be explored in this review: coverage, services, and timeliness. Six domains of health care access for AA SMW will be explored: having health insurance, having a primary care physician, HPV vaccination, preventative screenings, patient perception of provider, and patient sexual behavior disclosure to health provider. These domains will illustrate where AA SMW are accessing care and where possible intervention strategies can be applied to increase health care access.

2.2 SEXUAL AND REPRODUCTIVE HEALTH CARE ACCESS FOR AFRICAN AMERICAN SEXUAL MINORITY WOMEN

To understand the importance of SRHCA for AA SMW, one must understand the current state of known health disparities and risk factors for this population.

2.2.1 Health Insurance As An Access Domain

In the United States, health insurance helps to mitigate the costs of health care, but it can also be a financial hardship on its own. Many couples are covered under their spouse's health insurance, but people who are legally barred from marriage maybe unable to share their insurance coverage (depending local and state laws). Insurance coverage by the majority of the U.S. population is through benefits from one's employer (DeNavas-Walt et al. 2013). Due to gender-based differences in wages and full-time employment, 40% of heterosexual women are covered by their spouses (Office on Women's Health, 2013b). Considering gender-based wage and employment differences and the inability to share coverage, SMW are significantly less likely to have health insurance (Diamant et al. 2000). Since the Affordable Care Act (ACA) passed, health insurance is now available to more citizens of the United States including people with pre-existing conditions, adults 26 and younger if their parents have insurance, and people 150% above the poverty threshold if their state approved the expansion of Medicaid. If information about the ACA is properly disseminated, millions more Americans will be able to obtain health insurance through the healthcare marketplace. Having a HCP means that a patient has probably sought care in the past and will seek care from that provider in the future (Mainous et al. 2001; Starfield, 1998). Patients who report having a usual site of care and a usual provider are more likely to receive preventative services (Rose et al. 2006).

2.2.2 Vaccination And Early Detection As Health Access Domains

The HPV vaccine is still relatively new and has great potential to reduce the incidence of genital warts and cervical cancer. The HPV vaccine is an important preventative measure for

cervical cancer. HPV vaccination was chosen as a health care access domain because it is a series of three shots, spaced several months apart which requires AA SMW to return to their HCP to complete the vaccination coverage. Also, the HPV vaccine is intended for people who have not had sexual contact, under the age of 26. This limited age range is best for exploring the health care access of younger adult women as well as teenagers.

Early detection screenings for cervical and breast cancer were selected as health access domains because they require ongoing screening in order to be used effectively. This ongoing nature requires that AA SMW have a relationship with their HCP as well as the self-efficacy to obtain the screenings. Breast and cervical cancer screening is of interest due to the existing disparities in the number of AA and SMW women who get those cancers. Mammograms are used to screen women for breast cancer. Pap tests are used to detect abnormal cell growth in the cervix, as a way to screen women for cervical cancer. Pap tests are recommended at age 21 with suggested intervals of no more than three years apart. Mammograms are recommended beginning at age 40 (American Cancer Society, 2013) or if at high-risk of developing breast cancer, or age 50 (United States Preventative Services Task Force, 2009). HPV vaccination, Pap test, and mammograms are preventative or early detection measures that are recommended for sexual and reproductive health care for women, which make rates of women receiving these services easily compared across groups to assess access.

2.2.3 Patient Disclosure of Sexual Behaviors to Health Care Provider

Disclosure of sexual behaviors to provider requires a certain level of comfort in the case of self-disclosure or direct inquiry from provider for prompted-disclosure. Non-disclosure of patient sexual behaviors to provider is an indicator of distrust or perceived discrimination. Providers that

do not know the health risk behaviors of their patients cannot make appropriate decisions about their patient's health (Stein and Bonuck, 2001). Disclosure of sexual orientation can also make SMW fearful to the point that they delay seeking care from a HCP (van Dam et al. 2001). AA SMW are less likely to disclose their sexual orientation to a HCP, compared to other LGB individuals (Durso and Meyer, 2013). Patient perception of HCP and disclosure of sexual behaviors to HCP give insight to how the patient-provider relationship could be improved on an individual, facility, and community level.

2.3 HEALTH ISSUES AND RISK FACTORS THAT IMPACT AA SMW HEALTH CARE ACCESS

This literature uses Minority Stress Theory as a guide in understanding how the cyclic relationship of chronic stress and existing health risks result in poor sexual and reproductive health care access for SMW. The cause of chronic stress is being in an environment in which one has no control. The result of chronic stress is negative biological effects that occur in one's body.

2.3.1 Socioeconomic Status

Socioeconomic status is a powerful predictor of health care access and outcomes. Socioeconomic status affects the amount of time and resources that can be used toward improving or maintaining health. Low socioeconomic status is correlated with negative health risk factors such as poor education, toxic environment, sleep deprivation, and food insecurity (National Center

for Statistics, 2012). African American same-sex couples have more than twice the poverty rate of different-sex African American couples (Lee Badgett et al. 2013).

2.3.2 Experiences of Stress and Discrimination

Many health inequities faced by AA SMW are due to historical and structural discrimination on the basis of race and sexual orientation. While structural racism and homophobia exist, the extent to which AA SMW perceive them is not well known. An example would be a pattern of AA SMW who sought out the socially conservative African American community after being rejected by European American-dominated, homosexual communities (Mays et al. 1993). Experiences of stress and discrimination in a health care facility can dissuade African American women from obtaining annual checkups and delaying problem visits due to fear of mistreatment. Presumably heterosexual AA women perceived discrimination from their HCP when seeking family planning services regarding the quality of the care they received (Thorburn and Bogart, 2005). The experiences of these women reflected stereotypes about Black women, such as the HCP assuming the patient had multiple sex partners. SMW tend to face discrimination in the form of erasure by HCP, by assuming heterosexuality or displaying a lack of cultural sensitivity. Experiences of discrimination at the individual, interpersonal, community, organizational, and policy level can affect HCA and quality for AA SMW (Kates and Ushra, 2014). According to minority stress theory, chronic stress experienced by members of minority groups is multiplicative, not additive in detrimental effects on health (Hatzenbuehler, 2009). Chronic stress leads to poor mental and physical health, while also diminishing time and resources available to accessing health care. This chronic stress is exacerbated by other factors such as low socioeconomic status and violence victimization.

2.3.3 Other Risk Factors that Contribute to Minority Stress and Decrease Ability to Access Health Care

Factors that affect general health access where there are known health disparities for AA and SMW are obesity, smoking, current tobacco user, cardiovascular disease, depression, substance abuse, risky sexual behavior, and violence victimization. AA SMW have higher rates of obesity compared to other ethnic minority SMW and the general population (Mays et al. 2002). Obesity puts AA SMW at heightened risk of high blood pressure and cardiovascular disease. AA SMW women were also more likely to be current tobacco users (Mays et al. 2002). Although the frequency of alcohol consumption was not significant for AA SMW, a significant proportion of AA SMW reported consuming 3 or more drinks per drinking day (Mays et al. 2002). Risky sexual behavior is another contributor to stress and poor health care access. A significant percentage of lesbian-identified women reported recently engaging in heterosexual sex (Cochran and Mays, 1988). This discordant behavior could easily be unknown to a HCP that does not properly inquire about a patient's sexual history, and making assumptions from disclosed identity or silence. AA SMW had differing percentages of transactional sex with 18.8% of bisexually behaving and 2% of lesbian behaving women in a study by Muzny et al. 2011. Transactional sex indicates a need for resources that AA SMW have difficulty fulfilling. One study found that, sexual minority girls who identified as Black or mixed race had four times the odds of having heterosexual intercourse with multiple male partners in the past 6 months compared to white sexual minority girls. (Thoma et al. 2013). A health care provider could also easily miss this risky behavior. Also, due to the age of the SMW, they may not be able to access health care on their own, causing a potential dilemma if they are not comfortable discussing their needs and behaviors with their caregivers. Although no AA SMW specific information on rape and sexual abuse was found, rates of sexual violence

against AA and SMW are high. Sexual assault of AA women ranges between 18% and 60% depending on age and definition of assault (Tillman et al. 2010). Tornello, et al. (2014) found that 29.8% of bisexual and 26.7% of lesbian young women reported being raped by a man. These health risks serve as obstacles for AA SMW to access health care.

3.0 METHODS

For the purpose of this literature review, one academic database was examined for research related to sexual and reproductive health care access for sexual minority women. In order to be included in this literature review, a study had to (1) be published in English; (2) be an academic journal article, book, thesis, or published report by research institutes, advocacy groups, and professional organizations, and either (3) identify or measure health access measures (health insurance, having a health care provider (HCP), disclosure of sexual orientation/behavior to HCP, HPV vaccination, mammogram, or pap test) for African American sexual minority women; or (4) make recommendations regarding health care access for this population. The fourth inclusion variable applies to articles that have some AA SMW, but were not sufficiently powered enough to conduct separate statistical analysis.

3.1 SOURCES

One academic database was consulted for this literature review. This database was chosen based on its relevancy to public health for this population. The academic database used for this literature review was PubMed. The majority of public health-related academic findings are shared in this database, making it the prime location to find relevant literature.

3.2 SEARCH TERMS

An initial search was conducted in the PubMed database (January 27-31, 2014), which yielded results suggesting medical subject headings terms and Subject Terms of interest. Based on the results of each search, the terms were modified, until the search was exhausted and relevant articles were duplicated in the results. In total, 9 Boolean terms were utilized in all the search engines and databases. Listed in the order searched, Table 1 (below) contains the list of search terms.

Table 1. Boolean Search Terms (in order searched)

Boolean terms used
(African American) AND (homosexuality, female) AND (access to care) AND (reproductive health) AND (sexual health)
(African American) AND (homosexuality, female) AND (access to care) AND (reproductive health)
(African American) AND (homosexuality, female) AND (access to care) AND (sexual health)
(African American) AND (homosexuality, female) AND (reproductive health)
(African American) AND (homosexuality, female) AND (access to care)
(African American) AND (homosexuality, female) AND (sexual health)
(homosexuality, female) AND (reproductive health)
(homosexuality, female) AND (access to care)
(homosexuality, female) AND (sexual health)

The PubMed search was conducted using Boolean terms that were more specific to the sexual and reproductive access to health care for African American sexual minority women then getting less specific as the search went one. The search was conducted in a narrow-to-broad fashion to ensure that no articles relevant to the subject were missed. Relevancy was examined by scanning all titles (774), then the abstracts if the titles were on topic (54), then the entire article was read if the title and abstract were relevant to the subject of this review (17). Of the 17 articles that were relevant to sexual and reproductive health care access for SMW, only 3 were specific to African

American women. Table 2 shows the results from the PubMed search. Figure 1 is a tree showing how the literature was selected.

Table 2. PubMed Search

Boolean Terms used	PubMed Search Results
(African American) AND (homosexuality, female) AND (access to care) AND (reproductive health) AND (sexual health)	0
(African American) AND (homosexuality, female) AND (access to care) AND (reproductive health)	0
(African American) AND (homosexuality, female) AND (access to care) AND (sexual health)	1
(African American) AND (homosexuality, female) AND (reproductive health)	0
(African American) AND (homosexuality, female) AND (access to care)	2
(African American) AND (homosexuality, female) AND (sexual health)	18
(homosexuality, female) AND (reproductive health)	69
(homosexuality, female) AND (access to care)	142
(homosexuality, female) AND (sexual health)	674

The goals of this study were multi-fold, including (a) to examine the current state of sexual and reproductive health care access for African American sexual minority women; (b) to identify barriers and facilitators to meeting the access needs of this populations; and to (c) identify gaps in the literature and determine the best intervention points to move the research forward. Therefore, considering the specificity of the population and health outcome, the search produced very few relevant findings. An article was deemed relevant if the title and/or abstract indicated that the literature measured the current status of, barriers, or facilitators in accessing sexual and reproductive health for African American sexual minority women. The articles were reviewed and revealed several themes in sexual and reproductive health access for this population.

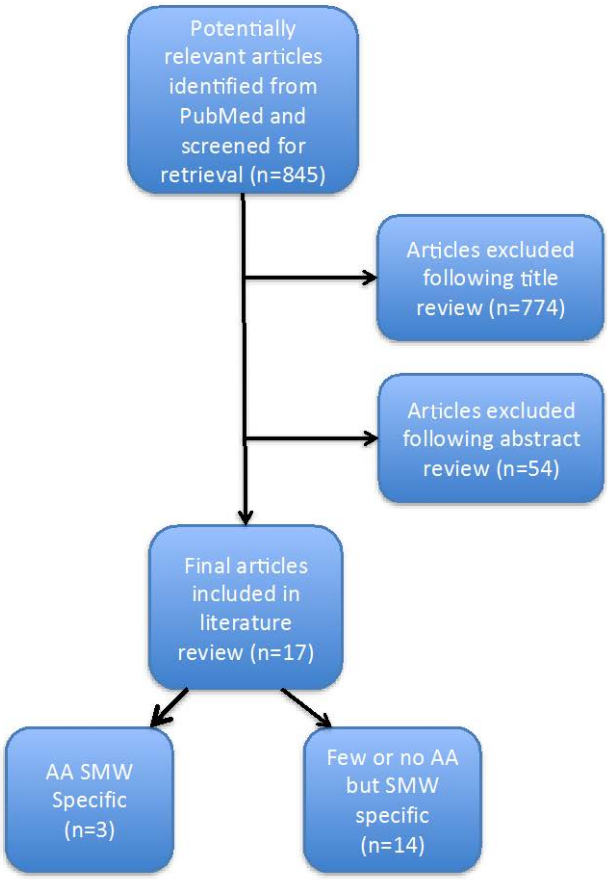

Figure 1. Tree of Literature Review

4.0 RESULTS

4.1 CURRENT STATE OF HEALTH CARE ACCESS FOR AA SMW

There were 3 studies relevant to AA SMW health care access that addressed five of the six domains being explored: health insurance, having a HCP, Pap testing, mammography, and disclosure of sexual identity or behavior to HCP. Another 14 articles were relevant to health care access for SMW, possessing information on the same domains being explored, but had few or no AA women. For more details, please see Table 3.

Each AA SMW-specific study expressed the need for more research on the health care access of AA SMW. Use of preventative screenings by AA varied between the studies. In one study that compared AA SMW to heterosexual African American women, AA SMW were more likely to have had a pap test in the past two years (Mays et al. 2002). A more recent study found that 60% of women in the sample reported having a pap test within the past year (Dibble et al. 2012). For AA SMW who were eligible, 85% reported having obtained a mammogram in the past two years (Dibble et al. 2012), which is higher than the percentage of AA or EA women who obtain timely mammograms (66% and 67%, respectively) (CDC, 2012). The percentage of AA SMW who did not have health insurance was 12% (Dibble et al. 2012), which was about one third less than the general population of African Americans that lack health insurance (18%, Centers for Disease Control and Prevention, 2008). Only one of the three studies asked whether participants had a health provider and found that fewer than 4% of the sample lacked a HCP (Mays et al. 2002). Finally, disclosure of sexual identity and behavior to HCP ranged from 30-56% of lesbian participants (Cochran and Mays, 1988 and Dibble et al. 2012), and a lower rate of disclosure (18%)

for bisexual participants (Cochran and Mays, 1988). The 24-year difference between those two studies may indicate that AA SMW disclosure of identity and behavior to HCP is on the rise.

4.2 HEALTH CARE ACCESS FOR SMW IN GENERAL

4.2.1 Health Insurance and HCP

Health insurance for SMW ranged from 72-86.4% in studies where lesbian and bisexual women were treated as one group (Cochran et al. 2001; Stevens, 1995; Mattocks et al. 2013). Each of those studies were vastly different from the others in terms of sampling method and study design. Health insurance in studies that separated SMW into two groups had larger ranges for lesbian (63-93%) and bisexual women (42-87.1%) (Diamante et al. 2000; Valanis et al. 2000;Fredriksen-Goldsen et al. 2010; Conron et al. 2010). Two of the studies were population-based and set 10 years apart; they show an increase for rates health insurance for SMW (Diamante et al. 2000; Fredriksen-Goldsen et al. 2010). The percentages of SMW who had a HCP were higher than the reported percentages in studies where lesbian and bisexual women were separated. Over 65% of SMW in all studies reported having an HCP or regular source of care (Tracey et al. 2013; Diamante et al. 2000, Valanis et al. 2000; Mattocks et al. 2013; Fredriksen-Goldsen et al. 2010).

4.2.2 Disclosure of Sexual Identity and Behavior

Four studies asked SMW about disclosure of sexual orientation to their HCP. Each of these studies used convenience sampling, and three of those four recruited less than 100 participants.

Disclosure of sexual identity appeared to increase when the three similar studies were ordered chronologically, from 31% to 73% (Lehmann et al. 1998; Polek et al. 2008; Polek and Hardie, 2010). The study that recruited nearly 500 participants had a higher percentage of reported disclosure (84.2%) than the other three studies (Steele and Tinmouth, 2006). Women who did not disclose their sexual orientation were about 80% less likely to have a regular source of care (Steele and Tinmouth, 2006).

4.2.3 Early Detection Screening

Seven studies included information on reported Pap tests or mammograms obtained by SMW, with conflicting results. A trend of Pap test screening showed bisexual women having 30% lower odds of having one in the past year, and lesbian women having 25% lower odds of having had a test in their lifetime compared to heterosexual women (Charlton et al. 2011). One study examined the differences within groups of women who had sex with women (WSW) in the past year and found that WSW who identified as lesbians had higher likelihood of receiving timely pap tests (97 vs 48%) and mammograms (86 vs 42%) than WSW that identified at heterosexual (Kerker et al. 2006). In the same study, SMW were found to be 10 and 4 times less likely to report timely pap tests and mammograms (Kerker et al. 2006). In a sample of SMW, 62% reported routinely obtaining Pap tests to screen for cervical cancer (Tracy et al. 2013). Cochran et al. 2001 examined seven studies of SMW preventative screening behaviors and found that SMW between the ages of 30 and 75 were significantly less likely to have ever obtained a mammogram. Three studies separated SMW into bisexual and lesbian women and had conflicting results. Two studies showed that both lesbian and bisexual women obtained Pap tests at lower rates than heterosexual women (Diamante et al. 2000; Valanis et al. 2000). For mammograms the rate for bisexual women was

slightly lower and slightly higher for lesbian women compared to heterosexual women (Valanis et al. 2000). Conron, 2010 did not find a significant difference in the rates of lesbian or bisexual women's screening for cervical or breast cancer. The last three studies mentioned were conducted ten years apart, so the differences in findings may be a reflection of the decade that passed between them.

4.3 SUGGESTED RESEARCH OR INTERVENTION POINTS

Most of the articles reviewed contained suggestions for future research or potential intervention points. The majority of articles that gave suggestions for future research were focused on disparities or sampling methods. The need for racial and ethnic diversity in SMW research was expressed in all three of the results relevant to AA SMW. In order to increase the sample sizes of AA SMW, suggestions were made to include SMW when racial/ethnic minorities are the priority population of a study or to make an effort to recruit racial ethnic minorities when SMW are the priority population (Mays et al. 2002). Due to the high quality of life reported by the AA SMW in the sample, Dibble et al. 2012 recommended future research based on resiliency and coping. Future research needs to include AA SMW in order to develop appropriate interventions for this population.

Another issue regarding future research was the lack of prevalence data for SMW health. Ongoing surveillance of SMW health is needed and can be done by including SMW in large populations studies (Diamante et al. 2000). Health disparities within SMW groups have been observed, making it difficult to develop interventions for SMW as a group. When possible, lesbian

and bisexual women within SMW samples should be analyzed separately since they have different health risks (Fredriksen-Goldsen et al. 2010).

A frequently echoed intervention strategy was at the level of the health care provider or health care facility, where disclosure of patient behavior could be enhanced by requiring HCPs to improve their cultural sensitivity, take comprehensive sexual histories of patients, and to create a space that is welcoming for all patients (Cochran and Mays, 1998; Lehmann et al. 1998; Polek et a. 2008; Diamante et al. 2000; Valanis et al. 2000; Cochran et al. 2001; Polek and Hardie, 2010; Tracy et al. 2013). Research aimed at discovering additional barriers that HCP face in inquiring about their patient's sexual orientation/history in also needed (Steele and Tinmouth, 2006).

Lesbian women perceived fewer benefits to cervical cancer screening, even after controlling for age, education, and insurance status (Tracy et al. 2013), showing a need for interventions that increase the knowledge and self-efficacy of SMW who perceive cancer screening to be of little importance. Kerker et al. 2006 emphasized the same intervention as Tracy et al. 2013, while stressing the need to include SMW that do not identify as lesbian or bisexual. Educating SMW about the importance of preventative care was also echoed by Diamante et al. 2000. Similarly, the impact of location (outside of a hospital or clinic setting) in improving SMW screening behaviors should be explored according to Charlton et al. 2011.

Table 3. Results of Literature Review

Authors and year	Title	Sample strategy	Sample Size	How SMW defined	Comparison Group	Calculated disparities estimates	Suggested future research/intervention points	Domains
Mays et al. 2002	Heterogeneity of Health Disparities Among African American, Hispanic, and Asian American Women: Unrecognized Influences of Sexual Orientation	Random Digit Dial (RDD) interviews	4255 (Ages 18-64, 462 AA)	self-identified as not heterosexual	Heterosexual AA women	Just as likely to have had a Pap test in the past 2 years (94.1%). AA SMW reported no regular source of health care (3.6%).	Suggested researchers include SMW when racial/ethnic minorities are the priority population	Pap Test, Health Care Provider
Dibble et al. 2012	Correlates of wellbeing among African American lesbians	convenience questionnaire	123 (Age 22-79, all AA)	self-identified as lesbian	N/A	88% of sample had health insurance. 56% reported being out to their health care provider. 85% of participants reported having a mammogram in the past 2 years. 60% of sample had pap test within the past year.	Resiliency and coping data are needed based on the high quality of life reported by the sample.	Health Insurance, Disclosure, Mammography, Pap Test
Cochran and Mays 1988	Disclosure of sexual preference to physicians by Black lesbian and bisexual women.	convenience mail-in survey	594 (Ages not specified mean 32 years, all AA)	self-identified as lesbian or bisexual	N/A	84% of lesbian and 87% of bisexual women had a HCP. 33% of lesbian and 18% of bisexual women disclosed their sexual preferences to HCP.	Further research is needed in this population because this sample was biased toward women who were open with their sexuality, were educated, and middle-class.HCP should take comprehensive sexual histories of patients and not assume exclusive heterosexual or homosexual involvement.	Disclosure
Tracy et al. 2013	Understanding cervical cancer screening among lesbians: a national survey	Random sample from Harris Group	1006 (ages 20+, 78 AA SMW)	self-identified as lesbian or bisexual	Routine and non-routine screeners within the sample	62% routinely screened for cervical cancer, 17.3% lacked a physician, other women who didn't get screened gave the reasons of cost and not feeling at risk.	Public health interventions focused on increasing cervical cancer screening in lesbians should therefore be designed to educate this population about the risks of cervical cancer and the benefits of screening, suggest strategies to overcome barriers, and improve relationships between lesbians and their HCPs.	Pap Test, Health Care Provider
Charlton et al. 2011	Reproductive health screening disparities and sexual orientation in a cohort study of U.S. adolescent and young adult females	one time survey from prospective cohort	4224(Ages 17-25, <18 AA SMW)	self-identified as lesbian or bisexual	compared to heterosexual women	Bisexual women 30% less odds of having a pap test in the past year. Lesbian women had 25% lower odds of having a pap test in their lifetime compared to the heterosexual group.	These barriers should be explored risky sexual behavior, fear of disclosure to HCP, and site-access (location) for services.	Pap Test
Lehmann et al. 1998	Development and health care needs of lesbians.	convenience questionnaire	53 (Ages 18+, race not specified)	self-identified as lesbian or bisexual	N/A	31% of lesbian-identified women in the sample disclosed their sexual orientation to their health provider.	N/A	Disclosure

Table 3 continued

Authors and year	Title	Sample strategy	Sample Size	How SMW defined	Comparison Group	Calculated disparities estimates	Suggested future research/intervention points	Domains
Kerker et al. 2006	Health care access and utilization among women who have sex with women: sexual behavior and identity.	computer-assisted RDD surveys	19,349(Ages 18-64, 16 AA SMW)	sexual behavior of last 12 months	women who didn't have sex with a woman in prior 12 months	After controlling for health insurance, WSW were 10 and 4 times more likely (than non-WSW) to not have had a timely pap test or mammogram. For example, WSW who identified as lesbians were more likely to have received timely Pap tests (97 vs. 48%, p<0.0001) and mammograms (86 vs. 42%, p=0.0007) than those who identified as heterosexual.	Increased information and training for HCP to improve women's use of primary health care. Similar education for risk awareness for women who have sex with women (especially women who do not identify as bisexual or lesbian).	Mammography, Pap Test
Steele and Tinmouth, 2006	Regular health care use by lesbians: a path analysis of predictive factors.	convenience paper survey	489(age mean of 36, no AA SMW)	self-identified as lesbian or bisexual	N/A	Of the smw who disclosed their SO 84.2% had regular health service use compared to 66.4% of smw who did not disclose their SO	Research that addresses barriers to provider inquiry about sexual orientation could provide an important next step to improving service delivery to this vulnerable population.	Health Care Provider, Disclosure
Cochran et al. 2001	Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women	National and regional surveys (some snowball, some convenience)	11878 (18 to 75 years, less than 2375 AA)	self-identified as lesbian	compared to US Women	SMW were 86.4% likely to have health insurance compared to 92.6% of all women. 72.9% of SMW compared to 87.4% of all women reported having a pelvic exam in the past two years. Of three age ranges (30-39, 40-49, and 50-75) SMW were significantly less likely to have ever had a mammogram 32.2%, 73.1%, and 82.9% respectively, versus 39.6%, 86.7%, and 90.2% for all women.	There is a strong need for culturally competent interventions for SMW especially with HCP and in health care settings.	Health Insurance, Mammography
Diamante et al. 2000	Health behaviors, health status, and access to and use of health care: a population-based study of lesbian, bisexual, and heterosexual women	RDD, Los Angeles County Health Survey	4610(ages 18+, 51 lesbian, 36 bisexual, 6% AA)	self-identified as lesbian or bisexual	compared to heterosexual women	63% of lesbian and 42% of bisexual women had health insurance compared to 70% of heterosexual women. 75% of les and 67% of bi women had a regular health care source compared to 76% of hetero women. 61% of les women (significant) reported having a pap test in the past 2 years compared to 74% of het and 72% of bi women.	Train health care professionals to provide sensitive and non-judgmental care, include les/bi health in large population studies. Educational outreach to community lesbians about the importance of preventative care.	Health Insurance, Health Care Provider, Pap Test
Valanis et al. 2000	Sexual orientation and health: comparisons in the women's health initiative sample	Survey, interested participants contacted the clinical center to express interest	93311 (50 to 79 years,1313 SMW, 7% AA)	By reported behavior, lifetime and after age 45	compared to heterosexual women	Pap in last 2 years: Hetero 89.8%, Bi 86.3%, Les 83.5%, and adultles 86.9%. Mammogram in past 2 years: Hetero 83.8%, Bi 81.8%, Les 84.2%, Adultles 86.9%. No health insurance het 6.8%, Bi 12.0%, Les 10.4%, Ales 9.7%. Over 90% of participants had a HCP regardless of sexual orientation.	HCP should ask nonjudgmental questions when asking about sex behaviors. Patients deserve individualized care.	Pap Test, Mammography, Health Insurance, Health Care Provider

Table 3 continued

Authors and year	Title	Sample strategy	Sample Size	How SMW defined	Comparison Group	Calculated disparities estimates	Suggested future research/intervention points	Domains
Stevens, 1995	Structural and interpersonal impact of heterosexual assumptions on lesbian health care clients	Snowball, interviews, focus groups	45(Age21+, 9 AA)	self-identified as lesbian	N/A	16% of sample didn't have health insurance. 18% of sample had children. Heterosexism and heteronormativity displayed by their HCP discouraged the participants from obstaining accurate information	HCP should focus on what the patient needs, not just issues around heterosexual reproduction. Every health facility that serves women needs to be aware that they serve lesbians and should strive to be inclusive	Health Insurance
Mattocks et al. 2013	Sexual victimization, health status, and VA healthcare utilization among lesbian and bisexual OEF/OIF veterans	Prospective cohort, mail surveys to female veterans	35	self-identified as lesbian or bisexual	compared to heterosexual veterans	72% of LBvets had health insurance compared to 92% of hetvets. Significant numbers: 31% LB vets reported only using VA healthcare services in the past year compared to 14% of HetVets. 100% of LBVets plan on using VA healthcare as primary or secondary source of care compared to 88% of HetVets.	VA HCP should create an environment free of assumed heterosexuality.	Health Insurance, Health Care Provider
Fredriksen-Goldsen et al. 2010	Disparities in health-related quality of life: a comparison of lesbians and bisexual women	Random, telephone, WA-BRFSS	1496 (Age 18+, <18% AA)	self-identified as lesbian	Lesbian health compared to bisexual health	Health insurance: Lesbian 83.5% Bisexual 75.1%. HCP Lesbian78.5% 62.9% Bisexual	Lesbian and bisexual women should be analyzed separately in studies because they are not the same/face different risks	Health Insurance, Health Care Provider
Conron et al. 2010	A population-based study of sexual orientation identity and gender differences in adult health	Massachusetts Behavioral Risk Factor Surveillance surveys	1151 (Ages 18-64, 4.5% AA)	self-identified as lesbian or bisexual	compared to heterosexual women	NoHI: L 7.0%, Bi 12.9%, Het 7.1%. NoHCP L11.3%, Bi16.1%, Het 9.0%. (Mam and Pap not sig) Mammogram: L65.4%, Bi 56.4%, Het 58.9%. PAP (prior 3 years): L 89.9, Bi 86.7%, Het 90.1%.	SMW are less likely to have HCP and Insurance, no observed differences in mam and pap uptake	Health Insurance, Mammography, Pap Test
Polek and Hardie, 2010	Lesbian women and knowledge about human papillomavirus	convenience paper survey	96 (Age 18-64, 7 AA)	self-identified as lesbian	N/A	73% of SMW disclosed their sexual preference to their HCP. 30% ofSMW did not believe HPV could be transmitted between women. 30% ofSMW did not identify HPV as a cancer risk. 50% of SMW volunteered their sexual orientation with their HCP, 6% shared after being asked by their HCP, 26% would share if asked, the remaining 16% did not respond or would not share their orientation.	Perceived homophobia or heterosexism prevents some SMW from obtaining care until health has gotten worse.	Disclosure
Polek et al. 2008	Lesbians' disclosure of sexual orientation and satisfaction with care	convenience questionnaire	69 (Ages 18-64, race not specified)	self-identified as lesbian or bisexual	N/A	A woman's self-identified sexual orientation was significant (p =0.004) in predicting whether a woman had shared her sexual orientation with her HCP. As a woman's satisfaction with her HCP increases, she is more likely (46%) to share her orientation.	Disclosing one's sexual orientation leads to increased use of heath care services and greater satisfaction with care. Suggestions to imprve the health of lesbian/bisexual patients include creating nonjudgemental office environments, advocating for inclusive language in all paperwork, asking rather than making assumptions about sexual behavior and identity, posting nondiscriminatory policy in offices and waiting areas, training all staff in cultural sensitivity, inquiring about sexual behavior instead of sexual orientation, and using gender-neutral language.	Disclosure

5.0 DISCUSSION

Sexual and reproductive health care access for AA SMW was lower than the general population, with the exception of mammogram obtainment, which was much higher than expected. AA SMW were about a third less likely to heave health insurance compared to the general AA population which suggests that their sexual minority status has negatively influenced their ability to access health care. Low rates of AA SMW patient disclosure of sexual orientation/behavior to their health care provider prompt investigators to explore the underlying reasons behind nondisclosure. Several articles suggested improving disclosure by implementing interventions at patient-provider level and facility level.

5.1 LIMITATIONS OF RESULTS

One major weakness of the existing literature is the fact that this is an emerging literature. Existing knowledge of lesbian and bisexual women's health is severely limited, even more so when the priority population is not European-American women. Due to the specificity of race and sexual minority status for this population, the existing research used convenience and random digit dial sampling approaches. These sampling methods are not the gold standard, but this population requires creative sampling methods need to be used to get a large enough sample for a reasonable amount of funding. Using the most efficient sampling method could also be viewed as strength.

The information gained from convenience sampling is not generalizable, but it illustrates a possible scenario. Another weakness is the cross-sectional design of the majority of the studies, which only provide data for what was observed at that point in time. Access to data over time from a prospective or retrospective study might give insight into the health domains being explored for SMW.

Inconsistency in defining SMW makes the existing data difficult to interpret. Studies that put bisexual and lesbian-identified women into the same group, makes it impossible to understand the needs of each population. SMW can be defined by attraction, behavior, or identity, but each has its own strengths and weaknesses. The definition of SMW must support the research question being asked in order to be effective.

HPV vaccination was the one health domain was not covered in the literature review. While no AA SMW-specific data was found in this review, it is known that young Black women and young women without healthcare insurance were found to be less likely to initiate the HPV vaccine (Fisher et al. 2013). The current HPV vaccine protects individuals against two strains of HPV (16 and 18) that cause cervical cancer, but these two strains are not as prevalent in AA women (36%) as they are for European American women (65%) (Hoyo, 2013). Since the current HPV vaccine requires 3 separate visits to a HCP, interventions to increase preventative care would still be beneficiary in encouraging HPV vaccination.

5.2 STRENGTHS OF RESULTS

The strengths of the relevant literature lie mainly in the specificity of their subject matter. The results gave insight to five of the six health domains of interest for AA SMW and SMW in

general. All of the studies included in this literature review were aware of their limitations, and had ideas of where seeds for future research should be planted.

5.3 GAPS IN THE LITERATURE

Additional factors outside of results that may contribute to SRHCA and intervention, such as: defining sexual orientation, differences among subgroups of SMW, discordant behavior of SMW, and location change.

5.3.1 Sample Bias in the AA SMW Results

In each of the AA SMW specific results, the samples were bias toward highly educated, middle-class women. They represented a higher socioeconomic bracket than expected. The existing literature is lacking information on the health care access of AA SMW with lower socioeconomic levels. In addition to these women being more educated and financially stable, they also self-identified as lesbian or bisexual, which may be due to feeling safer to live authentically.

5.3.2 Defining Sexual Orientation in Research and Interventions

Sexual orientation was determined by self-identification in all, but two of the relevant studies. From a health risk perspective, sexual identity does not necessarily provide insight into sexual behavior, which is the information that HCP and researchers need to make informed decisions. Due to the stigmatized status of LGBT individuals, it is possible that women who did

not identify as, but exhibited bisexual or lesbian behaviors were not included in these results. Also, women who identify as bisexual or lesbian may not have exhibited any lesbian or bisexual behavior during the study periods. Sexuality and identification are fluid, so while identification may give a clue to what is presently happening, a detailed sexual history would be more beneficial to the HCP in the long run. Sexual identity is reflective of one's sense of self, their comfort, their support system, and other factors that might not be reflective of the AA SMW population as a whole. In the literature, sexual identity was used in many cases due to its affordability. Sexual identity requires fewer questions than sexual behaviors for questionnaires and surveys. Since each question on a survey is expensive, generally as few questions as necessary to answer the research question are asked. Also, asking about sexual identity is less intrusive than asking participants about their sexual behaviors. One issue about asking about sexual behavior only is considering the timeframe of the behavior of interest. Of the two studies that defined SMW by behavior, one was only interested in sexual behavior of the last 12 months (Kerker et al. 2006) and the other defined SMW by reported lifetime behavior (Valanis et al. 2000). Even though both studies defined SMW by similar information, the time frames used answer different questions.

5.3.3 Identity and Behavior Discordance

Some women behave sexually in a way that is inconsistent with their sexual identity. For example, one study saw that 52% of heterosexual identified AA women had sexual contact with another women in the prior 3 months (Ross et al. 2003). This type of sexual identity and behavior discordance should be further explored to examine a possible relationship between discordance and sexual health care access. Based on the perceived lower risks of homosexual intercourse, women may not feel as though they need to practice safe sex with other women, which could spread infectious disease. This perception of lowered risk is a contributor to SMW feeling as though they do not need to see a health provider, unless they observe disease symptoms.

5.3.4 Lesbian and Bisexual Women as Subgroups of SMW

Care must be taken to ensure that researchers do not design interventions for sexual minority women as a monolith due to intrinsic differences between the groups. Only one of the three studies specific to AA SMW examined the differences between lesbian and bisexual women, despite both groups having unique risk factors and needs. Health care access for SMW varies depending on how SMW are defined, and by the comparison groups. Only one AA SMW-specific study contained a comparison group. The better the population's needs and strengths are known, the better the proposed interventions will be.

5.3.5 Location

One study suggested offering sexual and reproductive health care in non-clinical settings (Charlton et al. 2011). The majority of women in the United States see HCP for hormonal birth control, but if women do not need (or do not perceive a need) for birth control, then it is unlikely for them to attend annual appointments where they would traditionally get screened. A family planning based lesbian health clinic was established in the United Kingdom in response to community requests for a lesbian-specific health service (Carr et al. 1999). This may be appropriate given the community demand for this resource, but other options should be considered for SMW who are not interested in family planning.

5.4 IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

Based on the literature and its gaps, there are several points for interventions or future research. The implications for future research and practice are presented below, by health domain.

5.4.1 Health Insurance

Since the ACA is still new and not well understood by the U.S. population, it is necessary to disseminate this information to AA and SMW communities so that they can obtain insurance. Information about the ACA must be provided in the form of human contact (e.g. forums, one-on-ones, or question-and-answer) informal settings in the communities where AA SMW reside. A respected member of that community or an outsider with established rapport should make the point

of contact. In addition to the forum, someone should be available at designated times in community computer labs to help individuals navigate the healthcare marketplace. If paper materials are used as a supplement to refresh the applicable ACA information, it should be tested by a small group of SMW to assess readability, cultural relevancy, and message.

Public health professionals should remain vigilant even when health insurance rates appear to be equal across all demographics. Access to health insurance alone does not imply access to quality health care, especially for vulnerable populations who have difficulty with meeting basic needs, poor health literacy, or low perceived power in the patient-HCP relationship. With this in mind, increased access to health insurance is connected to the next domain.

5.4.2 HCP, Patient-Provider Relationship, Disclosure

All healthcare facilities and HCP that serve women will serve SMW, so they should be adequately prepared to create a safe space for SMW. It is the responsibility of the healthcare facilities and HCPs to ensure that they are serving SMW effectively. Despite medical providers receiving little training on interacting with LGBT patients, the onus is on them to increase their knowledge of LGBT health issues on an ongoing basis in order to properly serve these populations. For providers who wish to understand how they are serving LGBT patients, there are several ways to evaluate patient satisfaction with healthcare facilities and HCP. One way to evaluate HCPs is to have pre and post-questionnaires for patients to fill out about their expectations and outcomes with their HCP. A contact person to whom questions or inquiries about patient services should be accessible at all times so that comments and complaints can be passed on without fear of retaliation. Another way to evaluate providers is to have video elicitation interviews where the

provider and patient consent to being recorded and after the appointment, watch the video with a researcher to point out the ways in which the interaction could have been improved.

The relationship between patient and provider should be further explored to determine the barriers and facilitators for disclosure of sexual behavior or identity. For example, this relationship could be explored using a survey from an online sample of AA SMW, in order to understand how AA SMW perceive their providers and the level of trust in their HCP to serve their needs. On the provider side, and LGBT competency test could be used to examine where doctors stand in their LGBT-health issue competency and be offered workshops on improving their weaknesses. Once the variables are appropriately measured and weighted, an agent-based behavior model could be designed to identify the most effective intervention.

In addition to the HCP, the overall facilities in a health care setting should be examined to determine if it is a safe space for SMW. The staff, brochures, forms, restrooms, and even waiting room materials should be welcoming to SMW. Health care facilities should recruit a variety of women, including AA SMW, to assess the space, materials, and supporting staff.

HCP and their health care facilities will have to actively seek and recruit AA SMW. This recruiting process could be performed by appearing in the community, serving at a AA SMW supportive event, or attending AA SMW conferences. Exposure will help AA SMW find appropriate HCPs.

5.4.3 Vaccinations and Screenings

Vaccinations and screenings require an ongoing commitment by patients and providers to the health of SMW. Women who have a good relationship with their HCP are more likely to participate in preventative screening (Rose et al. 2006). More research is needed about women

who do not obtain preventative screenings, despite having health insurance and a HCP. Similarly, research focused on AA SMW who faithfully obtain preventative screenings may be beneficial in discovering protective factors. Understanding what drives AA SMW to uptake preventative screenings could lead to findings for self-efficacy-based intervention strategies.

For women who are uncomfortable with their local options for healthcare, it may be effective to establish cancer screening in locations that are important to the AA SMW community. A community-based approach to cancer screening would be received better than outsiders attempting to impose on AA SMW. If the AA SMW community is unable to host cancer screening, then they can establish a relationship with HCPs who are committed to improving the health of AA SMW and host events around preventative behaviors, dispelling myths about SMW risks, and ways to get involved with research that is specific to improving AA SMW health. Another community research approach would be to adapt interventions that have proven successful with African American to AA SMW needs. One example would be similar to The Girlfriends Project that Pittsburgh AIDS Task Force uses, where instead of sharing information about preventing the spread of HIV in a small party setting, AA SMW could bring their friends and discuss health risks, barriers, and facilitators to getting timely cancer screenings, discuss safer sex options, and receive vouchers or screening on location. Interventions to improve AA SMW health can be part of a larger effort to improve African American or SMW health.

Despite lack of AA SMW specific information on HPV vaccination uptake, people without insurance and young Black women are unlikely to initiate the vaccination making it likely that AA SMW need information on and access to HPV vaccination. The HPV vaccine should be marketed to young AA SMW as necessary regardless of the gender that they are attracted to. For younger

AA SMW, attraction may be a more useful definition of SMW than identity due to the possibility that AA SMW may be exploring their sexuality and identity.

5.4.4 Other Ways to Move the Field Forward

All of the studies in the review were disparities-focused, which means little is known about AA SMW who are successfully accessing healthcare. Future research on resiliency factors may shed some light on ways to increase healthcare access with SMW who are faring well. Another way to move the field forward is to include SMW-specific questions on all national or large-sample surveys, so that prevalence data can be established for the health needs of this population. One of the frustrating aspects of current research on SMW health is that researchers struggle to raise funds to collect data on prevalence for SMW, when other key demographic information is already included in major datasets. LGBT people are facing inequities on individual and community levels and the institutional level deals double damage when the people who are suffering the most are also told that they must foot the bill to determine the cause of their suffering.

Another suggestion to improve the depth of AA SMW research is include multiple levels of AA SMW life by including individual, household, and neighborhood questions. Simple demographic questions will not be enough to create and adapt interventions for AA SMW. The existing literature is based mainly on the individual level of SMW life, but researchers need to work toward understanding multiple levels of SMW life and how those levels interact. Multiple level analysis is needed to understand how social support networks or policy affects these women.

The health of AA SMW was the focus of this literature because there is an enormous lack of intersectionality in public health research. It is not as though the needs of AA SMW are so

foreign that they must me treated as an unknown group, the problem is that social science researchers need to incorporate intersectionality in our work. We continue to do a disservice to ourselves, as researchers, when we ignore the sociohistorical backgrounds of marginalized groups because it limits our ability to understand key factors in the origin of health inequities (Bowleg, 2008). We must remain cognizant that human beings are inherently different, no matter how we try to group them for analysis. AA SMW have been deliberately excluded from AA-specific and SMW-specific research which needs to end in order to collect data on AA SMW in a reasonable way. If money is the issue, then a grant (or additional funding) given to researchers who err on the side of inclusion would be an appropriate incentive. Women do not live single identity lives, so it is unreasonable to conduct research and practices as if they do.

6.0 SUMMARY

AA SMW have a lower likelihood of having health insurance compared to their heterosexual peers which could be improved by through dissemination of the Affordable Care Act's marketplace that expanded Medicaid coverage (in states that agreed) and new low-cost insurance options in the marketplace. HPV vaccination uptake for AA SMW should be explored in future research to determine trends and establish baseline data. Sexual identity as well as behavior should be explored in future research to monitor differences in concordant and discordant women. Similarly, HCP should obtain comprehensive sexual histories instead of assuming heterosexuality to best understand the health risk behavior of their patients. It is the responsibility of HCP and health care facilities to understand the unique health needs of AA SMW, and they should implement and welcome on-going evaluation of their work. More research is needed to understand the gap in early detection screening for AA SMW despite having health insurance and a health care provider, especially considering the low number of women who disclose their sexual orientation/behavior. Resiliency factors should be explored for future research and interventions, focusing on AA SMW who access health care in ways greater than expected. When possible, multi-level interventions should be used to create the most impact in improving AA SMW health care access. Finally, an intersectionality approach should be considered for AA SMW research in order to gain more data and keep costs reasonably low.

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