Disparities in Use of Reproductive Care by Sexual Minority Women:

A Literature Review

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Research Question

What factors contribute to disparities in access to and quality of reproductive healthcare experienced by sexual minority women?

INTRODUCTION

Reproductive health refers to the condition of male and female reproductive systems during all life stages (National Institute of Environmental Health Sciences, 2025). These systems are made of organs and hormone-producing glands (National Institute of Environmental Health Sciences, 2025). Reproductive organs, also known as gonads, maintain the health of a person's reproductive system (National Institute of Environmental Health Sciences, 2025). The female reproductive organs are the ovaries, which are responsible for menstruation and reproduction, while other parts of the female reproductive system help a woman have sexual intercourse (Cleveland Clinic, 2022). Reproductive health care is a broad field that addresses all aspects of the female reproductive system and is comprised of contraceptive counseling, sexually transmitted disease (STD) prevention and testing, prenatal, maternal, and postpartum care, fertility, cancer screenings, and diseases of the reproductive tract. Reproductive care is typically accessed at a gynecologist, obstetrician, women's health center, or primary care provider.

Sexual minority is an umbrella term used to refer to anyone who is not heterosexual or straight (Assiciation for Behavioral and Cognitive Therapies, 2016). Sexual minorities are a group whose sexual identity, orientation, or practices differ from the majority of the surrounding society (Math & Seshadri, 2013). This can include lesbian, gay, bisexual, pansexual, and queer labels (Assiciation for Behavioral and Cognitive Therapies, 2016). It is estimated that over 11 million people in the United States identify as sexual minorities (Tabaac et al., 2021). That is

equal to just over 3.3% of the United States population (United States Census Bureau, 2025). Sexual minority women (SMW) are women who define themselves through sexual identity (lesbian, bisexual, pansexual, queer), behaviors (having sex with women, having sex with men and women), or relationship status (cohabitating with or being married to another woman) (Meads et al., 2019). In 2023 8.5% of women identified as LGBT (Statista, 2023).

Compared to Women who exclusively have sex with men, women who have sex with women (WSW) have lower engagement in health care and preventative screening, making them more susceptible to negative health outcomes (Rahman et al., 2023). Screening rates for cervical cancer are estimated to be between 43-70% for SMW compared to 73% for heterosexual women (Baptiste-Roberts et al., 2017). Research shows cisgender SMW have greater risks than cisgender heterosexual women for health problems such as cervical cancer, bacterial vaginosis, sexually transmitted infections (STIs), binge drinking, substance use, tobacco smoking, and mental health conditions (Rahman et al., 2023). SMW were significantly more likely to report frequent mental distress (OR 1.53 for lesbian women, OR 2.08 for bisexual women) and depression (OR 2.08 for lesbian women, OR 3.15 for bisexual women) than heterosexual women (Gonzales & Henning-Smith, 2017). SMW were more likely to report poor/fair health compared with heterosexual women (20.7% vs. 17.7% respectively, OR 1.21) (Gonzales & Ehrenfeld, 2018). This is true in states with comprehensive protections for sexual minorities (OR 1.26) and states with limited protections (OR 1.26) (Gonzales & Ehrenfeld, 2018)

Given the increased recognition of SMW in society and the changing political climate regarding reproductive health care, it is more important than ever to increase research on these topics to better understand the unique factors influencing the health of SMW. Past research has focused mostly on White, cisgender, educated SMW. There are many gaps in knowledge

regarding intersectionality, the framework that each person has different overlapping and intersecting social identities and can experience multiple systems of oppression and disadvantage. This literature review aims to identify factors that impact the access to and use of sexual and reproductive health care among SMW in the United States.

METHODS

A comprehensive search was performed using The University of Georgia's library multi-search tool. The UGA library is comprised of articles from 773 databases including Springer Link, The American Journal of Obstetrics and Gynecology, and Science Direct, spanning a wide range of topics. The multi-search tool makes it simple to filter articles by publication date, source type, language, database, and online availability. Access to the UGA libraries is granted to all students attending the university and is a very helpful resource to narrow broad searches. Because many searches were conducted to obtain data for this literature review, all searches conducted using the UGA libraries multi-search tool will be displayed in a table.

Inclusion and Exclusion Criteria

Specific inclusion and exclusion criteria were applied to searches to ensure the most relevant articles were analyzed. To be included, articles had to be published within the last 10 years to ensure data be as accurate and appropriate as possible. Full articles had to be accessible online and available in English to be included. Research had to be conducted in the United States to be included. Articles had to be peer reviewed to be included to ensure evaluation by other professionals in the field. All filters were applied concurrently, and article review was not conducted until after the filters were applied. Articles were excluded if they did not collect data about SMW or did not stratify data by sexual orientation. Articles were excluded if they did not

discuss access to or experiences receiving healthcare in any capacity (insurance, cost, stigma, discrimination, misinformation, health literacy). Articles were excluded if they did not mention reproductive care in some capacity. An exception was made for articles that focused on insurance status because insurance is helpful and often necessary to access any kind of healthcare.

Rationale for Chosen Articles

Once each search was completed and all filters were applied, articles were first reviewed based off title alone. Many articles presented from the UGA multi-search tool were irrelevant to the topic at hand. Eliminating these articles early was helpful in narrowing the pool of results. Articles were reviewed further if the title was relevant to SMW accessing reproductive/sexual/gynecologic/health care in the United States or their health insurance status. Once a title was identified as relevant, the abstract was reviewed to create an understanding of the research conducted. If the abstract included useful results and/or data, the article was then read in its entirety. Only the first five pages of results were reviewed for each search as articles became less relevant further on. The topics shifted from accessing reproductive care to mental health, other health conditions, gender minority individuals rather than sexual minority individuals, and studies from countries outside of the United States.

The final search was conducted using the search term "Agénor, Madina" because this person authored three of the first 19 articles found for this literature review. Their prevalence in research regarding SMW led to the discovery of another relevant article to include.

Table 1. UGA Multi-Search Search Terms and Yielded Results

Search Round	Search Terms	Yielded Results	Filters	Yielded Results	Articles Selected
1	(women or female or woman or females) AND (queer or lesbian or bisexual or WLW or SMW or sexual minority women) AND (gynecology*	3,060	Academic Journals English Past 10 years Online Only	1,171	4

	or reproductive care) AND (USA or united states or US or U.S. or America)		Peer Reviewed		
2	Women AND (queer OR lesbian OR bisexual) AND gynecology	1,356	English Past 10 years Online Only Peer Reviewed	611	3
3	Women AND queer OR lesbian OR bisexual AND gynecolo* care	1,242,196	English Past 10 years Online Only Peer Reviewed	100,338	1
4	(contraception) AND (women or female or woman or females) AND (queer or lesbian or bisexual or WLW or SMW or sexual minority women) AND (USA or united states or US or U.S. or America)	1,263	English Past 10 years Online Only Peer Reviewed	360	1
5	health insurance AND (women or female or woman or females) AND (bisexual or lesbian or SMW or sexual minority women or WLW or WSW)	2,231	English Past 10 years Online Only Peer Reviewed	625	6
6	sexual minority women and reproductive care	2,167	Past 10 years Online Only Peer Reviewed	794	1
7	(women or female or woman or females) AND (bisexual or lesbian or SMW or sexual minority women or WLW or WSW) AND (united states or us or USA or united states of America) AND (pregnancy or reproduction or IVF or in vitro fertilization or conception)	4,516	Past 10 years Online Only Peer Reviewed	1,401	2
Round 8	(women or female or woman or females) AND (queer or lesbian or bisexual or WLW or SMW or sexual minority women) AND (USA or united states or US or U.S. or America) AND (sex education or sexual education or sex ed)	3,749	Past 10 years Online Only Peer Reviewed Academic Journals	1,303	2
Round 9	Agénor, Madina	765	Past 10 years Online Only Peer Reviewed Academic Journals	463	1

RESULTS

SMW in the United States use reproductive healthcare services less than their heterosexual peers. Several factors contribute to this trend, but these factors can be grouped

under three primary themes: patient knowledge and comfortability, provider knowledge and comfortability, and insurance status/income. Combined, these are the main reasons that SMW use reproductive care at lower rates than heterosexual women.

Patient Knowledge and Comfortability

Human papillomavirus (HPV) is the most common STD in the United States, and in some cases can lead to cancer (Agénor et al., 2019). Many SMW incorrectly believe that having sex with other women puts you at a low or negligible risk of contracting HPV because of minimal bodily fluid exchange in female-to-female sex, showing a misunderstanding of how HPV can be spread from skin-to-skin contact or the use of sex toys (Agénor et al., 2019). These misconceptions extended to other STI's and generally SMW in the study reported believing that STI risk reduction behavior is primarily relevant for heterosexual women (Agénor et al., 2019). The impact of this misconception is reflected in the elevated prevalence of HPV among bisexual women aged 20-59, of whom 58% report having HPV (Agénor et al., 2019). This rate is higher than the prevalence among both lesbian (36%) and heterosexual women (41%) (Agénor et al., 2019). 84% of participants studied reported engaging in unprotected sexual activity with women (Emetu et al., 2023). 9.7% of participants reported using a dental dam at least once in the past six months while only 2% reported using them often (Emetu et al., 2023). This high rate of unprotected sex helps explain higher rates of STDs among SMW. 74% of women who have sex with women (WSW) have reported using vibrators, 56% have used strap-ons, and 56% have used dildos in their lifetime (Emetu et al., 2023). These devices require extensive and specialized cleaning beyond soap and water to prevent the spread of bacterial and viral infections and can create small genital tears that increase susceptibility to infection if used roughly (Emetu et al.,

2023). High rates of sex toy use, and difficulty cleaning could further explain high STI rates in this population.

Similar to the fact that SMW generally experience low risk perceptions of contracting STDs, they have the lowest usage rate of STD testing (Makrides et al., 2023). Women who have sex with women only (WSWO) have the lowest rates of STD (6.9%) and HIV (2.6%) testing, contraceptive counseling (13.7%) and distribution (10.3%), and emergency contraceptive counseling (3.3%) (Makrides et al., 2023). Women who have sex with women and men (WSWM) have the highest rate of STD (45.8%) and HIV (25.0%) testing, and emergency contraceptive counseling (8.2%) and method distribution (11.0%) (Makrides et al., 2023). Women who have sex with men only (WSMO) and WSWM have similar rates of contraceptive counseling (29.2% vs. 29.0%) and method distribution (51.7% vs. 48.3%) respectively (Makrides et al., 2023). This data shows differences in the use of sexual health care between groups of SMW. There are different risk perceptions for WSWO and WSWM.

Additionally, there are many emotional and societal reasons that SMW use sexual and reproductive care the least. 38.4% of Black women surveyed reported being treated poorly or unfairly by health care providers because she is a Black woman (Gray & Fisher, 2024). 24.4% reported being treated poorly or unfairly by health care providers because she is a woman who is sexually attracted to women (Gray & Fisher, 2024). Black and other non-White women experience a compounding effect of discrimination for being women, people of color, and a sexual minority (Gray & Fisher, 2024). Half of participants were afraid their provider held negative feelings towards SMW (Gray & Fisher, 2024). Of study participants, 80% said they had not discussed their sexuality with their provider, or their provider assumed them to be heterosexual (Gray & Fisher, 2024). This study found that bisexual women were more likely to

have received care in the past six months compared to lesbian or queer women (Gray & Fisher, 2024). These findings are consistent with previous research findings that bisexual women utilize sexual and reproductive healthcare more frequently than other SMW (Gray & Fisher, 2024).

Acquiring comprehensive, LGBTQ informed care is harder for some SMW than others (Carpenter, 2021). Those who live in rural areas with limited physicians or conservative areas with conservative physicians wish they had the resources to access queer friendly providers (Carpenter, 2021). These SMW often avoid gender identity and sexual orientation disclosure because of a fear of discrimination or bias, emotional self-projection, and the desire to get the health care they need (Carpenter, 2021). SMW often allow providers to make incorrect assumptions about their sexual and gender identities because it is easier and less emotionally taxing than explaining their identity (Carpenter, 2021). SMW often must become experts in their own care because of a profound lack of queer specific reproductive health information (Carpenter, 2021). Through their own research, SMW often gain community in other queer people seeking similar care (Carpenter, 2021).

Provider Knowledge and Comfortability

SMW face barriers to equitable healthcare, including discrimination and stigma in medical settings and providers who are not trained to meet their needs (Leonard et al., 2022). These barriers can be exacerbated during pregnancy since it is typically viewed as a heteronormative experience (Leonard et al., 2022). SMW in this study are defined as mothers giving birth with mother partners (Leonard et al., 2022). Mothers with mother partners experienced the highest rates of multifetal gestation (8%), hypertensive disorders of pregnancy (16.2%), labor induction (18.7%), cesarean delivery (40.4%), postpartum hemorrhage (8.6%), severe morbidity (1.7%), and preterm birth (11.8%) compared to mothers giving birth with father

partners and fathers giving birth(transgender men) with any partner (Leonard et al., 2022). Full-term infants born to mothers giving birth with mother partners also experienced the highest rates of low birthweight (3.4%) and low APGAR score (1.7%) (Leonard et al., 2022). Mothers giving birth with mother partners experienced multifetal gestation over 5 times as often as mothers giving birth with father partners (Leonard et al., 2022). This could be due to higher rates of medically assisted reproduction (MAR) use among SMW compared to heterosexual women (Januwalla et al., 2019). SMW are more likely to use certain MAR than heterosexual women (Soled et al., 2024). There are two categories of MAR, assisted reproductive technology (ART) and non-ART MAR. ART includes invitro fertilization (IVF), which is the process of fertilizing an egg before implanting it into the uterus (Soled et al., 2024). Non-ART MAR includes things like intrauterine insemination (IUI), intracervical insemination (ICI), and intravaginal insemination (IVI), all forms of injecting sperm for the purpose of conception (Soled et al., 2024). These various types of insemination are often paired with ovarian stimulation and tracking ovulation to promote the end goal of pregnancy (Soled et al., 2024). Non-ART MAR is more commonly used by SMW because of a lack of sperm in their relationship (Soled et al., 2024). Participants with same-sex partners compared to different-sex partners were almost five times as likely to use MAR (Soled et al., 2024). Multifetal gestations are higher risk pregnancies than singletons, putting SMW at a higher risk of complications. SMW are significantly more likely to experience pregnancy complications (27.4% vs. 8.8%) (Januwalla et al., 2019). Increased rates of multifetal gestation may be correlated with significantly higher rates of pregnancy complications among SMW.

Cancer screening disparities exist among sexual minorities (Stenzel et al., 2025). Individuals who identify as LGBTQ+ have lower uptake of screening for cervical, colorectal,

and breast cancer (Stenzel et al., 2025). 53-66% of heterosexual women, 54.7-62.9% of bisexual women, and 34.2-53.9% of lesbian women interviewed had received a pap test (cervical cancer screening) in the past 12 months (Agénor et al., 2021). Lesbians were the least likely to have received a pap test across all racial groups included in the study (Agénor et al., 2021). Opinions on pap testing varied widely in this sample of SMW and there was found to be variation in recommendations given by providers (Agénor et al., 2021). These findings have implications for providers, who should provide evidence based recommendations to their SMW patients (Agénor et al., 2021). On top of low uptake of certain cancer screenings, SMW may be more likely to develop breast cancer than their heterosexual counterparts (Clavelle et al., 2015). This is because SMW are more likely to be nulliparas since they may choose alternative ways to make a family or only one of the female partners caries a baby (Clavelle et al., 2015). The mean lifetime Gail score for SMW was significantly higher than for heterosexual women (10.7% vs. 8.9%) (Clavelle et al., 2015). A Gail score is the estimation of your risk of getting breast cancer and is typically reported as 5-year risk and lifetime risk (Clavelle et al., 2015).

50% of obstetrician gynecologists felt underprepared to care for lesbian and bisexual patients (Guerrero-Hall et al., 2021). Feeling prepared to care for lesbian and bisexual patients was correlated with attending a university based program (Guerrero-Hall et al., 2021). 62% of participants stated their program only spent 1-5 hours per year on programs dedicated to lesbian and bisexual healthcare (Guerrero-Hall et al., 2021). 92% of participants desired additional training to better care for LGBTQ+ patients (Guerrero-Hall et al., 2021).

Healthcare providers carry their own assumptions about STI transmission among WSW. These perceptions can be wrong because of the systemic issue of poor sexual education and lack of LGBTQ+ specific training in medical schools. A majority of participants in this study did not

mention having conversations about STI prevention for WSW (Jahn et al., 2019). Some participants were explicitly told that their risk of STI transmission was low and to therefore seek less healthcare (Jahn et al., 2019). Some providers went as far as saying "since you're not having sex with men, your risks are really low, so you don't actually need to get a regular pap smear" and "because you're not having sex with men you never need to see a gynecologist" (Jahn et al., 2019). These misconceptions have the potential to be very harmful for SMW. Most people are trusting of healthcare providers and will take their word as the truth. One 26 year old participant detailed how she was still so confused about the protection options for WSW because STI prevention is often centered around penis in vagina sex and her provider never discussed other options with her (Jahn et al., 2019).

Women of any sexuality can use contraception, however SMW are counseled and receive contraceptives less often than heterosexual women (Agénor et al., 2021). Black and Latina women also had the lowest rates compared to their White counterparts, demonstrating the intersectionality of sexuality and race (Agénor et al., 2021). In the past year 37% of White heterosexual women versus 6.2% of lesbian Latina women had received contraception from a health care provider (Agénor et al., 2021). It is suggested that socioeconomic and health care factors can help explain this discrepancy (Agénor et al., 2021).

Some disparities in care can be attributed to the gender of the healthcare professional being seen. The LGBT-Development of Clinical Skills Scale (LGBT-DOCSS) is used to measure a healthcare professionals clinical preparedness, attitudinal awareness, and basic knowledge regarding LGBT patients (Nowaskie & Najam, 2022). Female healthcare professionals reported significantly higher LGBT-DOCSS scores for attitudinal awareness and basic knowledge, while males reported significantly higher clinical preparedness scores (Nowaskie & Najam, 2022).

Healthcare professionals who identify as sexual or gender minorities reported significantly higher LGBT-DOCSS scores (Nowaskie & Najam, 2022). More diversity, intersectionality, and multiple minority identities appear to lead to higher competency (Nowaskie & Najam, 2022).

Insurance Status/Income

The expansion of Medicaid through the Affordable Care Act significantly increased health insurance coverage among women in same sex couples by 6.5% (Mann et al., 2023). 12 states still have not expanded Medicaid and have only had a slight increase in amount of SMW covered by Medicaid (Mann et al., 2023). The 2015 supreme court ruling on marriage equality also had the potential to improve access to health insurance for LGBT people (Bolibol et al., 2023). In 2013 sexual and gender minority adults were significantly less likely than non-LGBT adults to have insurance coverage and more likely to report difficulty obtaining care (Bolibol et al., 2023). Implementation of the Affordable Care Act in 2012 increased coverage and by 2019 coverage rates for LGBT adults were comparable to those of non-LGBT adults (Bolibol et al., 2023). Despite this increase, disparities in access to care still remain (Bolibol et al., 2023). One study found that SMW are more likely to use Medicaid (17.3% vs 11.0%) and be uninsured (13.1% vs. 8.6%) than heterosexual women (Nguyen et al., 2024). 54.1% of heterosexual women have insurance through an employer compared with 42.3% of SMW (Nguyen et al., 2024).

Data collected from 2013-2018 shows a statistically significant interaction between sexual orientation and race/ethnicity in relation to having health insurance among adult women (Agénor et al., 2023). 91.2% of White heterosexual women were insured and had significantly higher odds of having health insurance compared to all women studied accept for heterosexual Asian women (91.7%) and Asian SMW (91.1%) (Agénor et al., 2023). Latina heterosexual women (73.2%) and Latina SMW (77.8%) have the lowest rates of insurance coverage, followed

by Black SMW (83.4%) and Black heterosexual women (87.0%), and finally followed by White SMW (89.0%) (Agénor et al., 2023).

SMW were significantly more likely to be underinsured than heterosexual women during the COVID-19 pandemic (Nguyen et al., 2024). Early in the pandemic, more than 13% of sexual and gender minority individuals reported losing their health insurance, leading to one in eight sexual minority adults living in 34 states being uninsured (Nguyen et al., 2024). This widened existing inequities in having a personal doctor from 82.2% to 77.1% for SMW compared with 88.5% to 86.8% for heterosexual women and having a checkup in the past two years from 97.3% to 93.1% for SMW and 97.4% to 96.5% for heterosexual women (Nguyen et al., 2024). Lack of insurance increased lack of access to care (Nguyen et al., 2024). Sexual and gender minority adults experienced substantially higher rates of financial precarity (Nguyen et al., 2024). These findings suggest that insurance status is an important driver of access to care for sexual minority populations, with substantial disparities in access for those without insurance (Nguyen et al., 2024).

A study measuring the differences in access to and satisfaction with health care found that sexual minority status is significantly related to all categories being studied (Fish et al., 2021). Heterosexual participants reported better access to care (10-20% greater), medical tests (5-14% greater), and prescription drugs (4-14% greater) than sexual minority participants (gay, lesbian, bisexual) (Agénor et al., 2023). Lesbian women were found to have the lowest access to care overall (12.8% lower) (Agénor et al., 2023). Lesbian women were 20-30% more likely than men and heterosexual women to delay care and forego prescriptions and medical testing (Agénor et al., 2023). SMW appear to be the most susceptible to economic instability and might explain their likelihood to delay and forgo care (Agénor et al., 2023).

DISCUSSION

The factors contributing to decreased use of reproductive health services by SMW can be directly linked to stigmas, stereotypes, and a lack of comprehensive sexual education for both SMW and healthcare providers.

Implications for Practice

Patients and providers alike lack specific education about the unique reproductive needs of SMW. Sexual education in the United States has been a controversial topic leading to limited implementation. Only 33 states require HIV information, 18 states require contraception information, 13 states require medically accurate information, and only eight require inclusivity of sexual orientation (Hall et al., 2016). It is seen through these numbers that sexual education is not comprehensive in most states. This disproportionately affects SMW who typically need a wider range of education to participate in safe sex, and results in greater sexual risk taking among sexual minority youth compared to nonsexual minority youth (Lowry et al., 2017). To combat this in the future it is crucial that comprehensive sexual education be taught across the United States. When looking at three decades worth of research there is clear evidence that abstinence only sexual education is ineffective at delaying sexual activity or preventing risky behavior (World Health Organization, 2023). Consistent data shows that high quality sexual education leads to positive health outcomes and lifelong skills (World Health Organization, 2023). Young people who receive high quality sexual education are more likely to delay the onset of sexual activity and when they do engage they are more likely to do so safely (World Health Organization, 2023). Sexual education should start before it is believed that children are engaging in sexual activity. This will ensure that they know how to protect themselves when that time comes. An age-appropriate form of sexual education should be taught as young as

elementary school. The United Nations global guidance indicates starting comprehensive sexual education at the age of five (World Health Organization, 2023). This will teach children the basics of consent and anatomy. In middle and high school this education will increase to include safe sex strategies that are encompassing of LGBTQ+ people. For example, many people believe that those engaging in same-sex sexual activities do not need to use barrier methods like condoms. However, this is a misconception because same-sex partners can still spread STDs.

In addition, there needs to be an increase in LGBTQ+ specific content and training in medical schools so that providers can deliver the most competent care possible to their patients. If providers know how to discuss sexuality and understand the effects it can have on a person's health, sexual minorities will experience less discrimination when accessing healthcare. This can be done through inviting sexuality disclosure and offering sexual and reproductive services to SMW at a variety of health care encounters (Madelyne Z. Greene, 2018).

When asked about what factors contribute to positive healthcare experiences, SMW responded with LGBTQ friendly and knowledgeable providers who affirmed their identities (Rahman et al., 2023). SMW of color expressed the importance of having a provider of the same color or race as them, having LGBTQ status and being a woman (Rahman et al., 2023). SMW who saw queer providers felt more comfortable disclosing their sexual identity (Huang et al., 2024). SMW of different races, ethnicities, sexual orientations, and gender identities seek validating healthcare experiences that affirm their identities (Rahman et al., 2023). The lack of sexual and racial representation in the medical field may be to blame for some of the underutilization of reproductive care by SMW. Factors that contributed to negative healthcare experiences were providers perceived heteronormativity, lack of awareness of SMWs healthcare needs, and poor provider interactions (Rahman et al., 2023).

Limitations

The main limitation of this literature review is the small number of articles analyzed. This literature review only analyzed 20 articles, which is not enough to encompass the entire body of research. Many studies analyzed did not breakdown sexual minority status into lesbian women, bisexual women, queer women, etc. They were only classified as SMW or LGBT. This makes it difficult to assess the exact impacts of being bisexual versus lesbian. Some studies analyzed had very small sample sizes because they performed in depth interviews with participants. Studies that had small sample sizes were often concentrated in a specific geographic location. Therefore, these studies are not very generalizable to the entire population. Almost all studies included are subject to self-report bias. Studies are made of surveys or interviews where participants report what they remember about specific situations. There is no way to confirm that the data reported is accurate. Many studies included did not contain quantifiable data and only reported figures like “majority” or “more likely to”. This lack of numerical data emphasizes the need for further research in this field.

Irrelevant to the data presented in each study is the current political climate of the United States. The Trump administration has been making it difficult to access reproductive health information online, chiefly by removing information detailing reproductive rights, contraceptive use guidelines, research into HIV and other STI’s, as well as through the removal of references to LGBTQ+ health issues from government websites (National Women’s Law Center, 2025)

Conclusion

Reproductive health care is currently in a precarious condition in the United States. Some progress has been made in recent years regarding the insurance status of SMW and acceptance of LGBT people. The current administration is dismantling reproductive rights and increasing

discrimination against women and LGBT people. Regardless, increases in comprehensive sexual health education is crucial to the health of SMW. This way they can have agency over their bodies. Similarly, it is necessary to implement more LGBT specific education and training into Obstetrician Gynecology programs. Increasing this education across all medical specialties would help SMW feel safe and receive the best care possible wherever they are. The current political climate will make these goals difficult, but none the less it is crucial to push forward.

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