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An Exploration of the Health Care Experiences Encountered by Lesbian and Sexual Minority Women in Guyana

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ABSTRACT

This qualitative study explored the experiences of Guyanese lesbian and other sexual minority women when encountering health care. Sixteen Guyanese, cisgender, adult women self-identifying as non-heterosexual participated in semi-structured interviews which were then thematically analyzed. Identified themes included infrequent health care usage attributable to varied influences, such as tentative sexuality disclosure, feeling vulnerable and disrespected in the health care system, absent discussions on sexual health and general female preventive care, and the pathologizing of sexual minority identities. Deficits in comprehensive health care delivery for sexual minority women will require interventions addressing barriers at the health care, societal, and governmental levels.

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Women with sexual identities or practices that are not exclusively heterosexual are referred to as sexual minority women (Math & Seshadri, 2013). The healthcare needs of these women generally mirror that of exclusively heterosexual women, but with certain unique aspects, such as the increased risk of breast and ovarian cancers, increased risk of obesity and increased risk of mental health disorders and substance misuse (Mravcak, 2006). These risk factors are further compounded by avoidance of routine healthcare (Harrison & Silenzio, 1996), occurring partially because sexual minority women perceive healthcare workers as heteronormative, homophobic, or unaware of, and insensitive toward their sexual orientation and healthcare needs (Mravcak, 2006). A study from the Netherlands Antilles showed that the majority of homosexual patients (including women), would not disclose their sexual orientation to doctors whom they perceived as being homophobic, and 67% of Caribbean-born physicians exhibited intolerant attitudes towards sexual minority patients, compared to 14% of non-Caribbean born doctors (Radix, Buncamper, &Van Osch, 2004).

Guyana, the sole English-speaking country on the South American continent, shares a strong cultural, historical, and political heritage and continued ties with other English-speaking territories in the Caribbean. Along with most of the English-speaking Caribbean, the country retains laws criminalizing same-sex intimacy that originated under British colonial rule; there is no constitutional protection against discrimination on the grounds of sexual orientation or gender identity. Sections 351 to 353 of the Criminal Law (Offences) Act, Chapter 8:01 criminalize acts of same-sex intimacy between men ("The Unnatural Connexion," 2010). Even though these laws do not criminalize sexual intimacy between women and have not been directly enforced for consensual same-sex sexual activities in decades, their continued presence perpetuates stigmatization of sexual minorities in general. Efforts to repeal these laws have been met with religious opposition and political indifference, with a recent survey showing a significant proportion of Guyanese society opposing repeal of these laws on religious grounds (Caribbean Development Research Services Inc., 2013).

Although there are no official statistics on the size of the community of sexual minority women in Guyana, a national survey by Caribbean Development Research Services Inc. (2013) suggested that between 6 and 20% of Guyanese women may be considered to be sexual minority. There is, however, a paucity of research on the health

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and well-being of sexual minority women in Guyana, as well as the wider English-speaking Caribbean. This gap in our understanding of the well-being and needs of sexual minority women is in part perpetuated by the focus of sexual health research on human immunodeficiency virus (HIV), a paradigm in which sexual minority women are considered to be at low risk, and therefore low priority. Most research in the Caribbean has been focused primarily on men who have sex with men (MSM) in the restricted context of HIV (AIDStar-One, 2012; Gosine, 2005). Recently, two regional studies looking at the well-being of lesbian, gay, bisexual, and transgender (LGBT) persons more generally, and beyond the context of HIV prevention, also included sexual minority women. One Jamaican study in which 11 sexual minority women participated, found that five women reported an Axis I psychiatric disorder (which includes major depression and substance use disorder) within the last month but did not state which type of Axis I disorder was most prevalent in these women (White, Barnaby, Swaby, & Sandfort, 2010). In a separate study conducted in Trinidad among youths (ages 15 to 24 years) who were recruited on the basis of their marginalized status, which included having sex with persons of the same sex (16 out of 57; 47%) of same-sex loving participants felt that they had been treated differently by healthcare workers, and fewer than 20% of participants had utilized health services in the preceding year (Hasbún et al., 2012). This study did not, however, disaggregate the results to show exactly how many of the 18 female same-sex loving participants reported this view. The current study was conducted to explore how Guyanese sexual minority women experience healthcare interactions and initiate a foundation for addressing the lack of knowledge and evidence base as it pertains to Caribbean sexual minority women's health in general. It deliberately included women who have varying labels (including no labels) for their sexual orientation, in order to capture a diversity of views. Our study included women who had same-sex sexual attraction or experiences, including women who may or may not self-identify as sexual minority or lesbian.

Because so little is known about sexual minority women's health in Guyana, the researchers opted to use a grounded theory framework, which is a commonly employed strategy when engaging with qualitative data on a relatively unexplored subject (Stern, 1980). The aim of grounded theory, strictly speaking, is the generation of a plausible theory that arises naturally from the data itself (Braun & Clarke, 2006). However, in this study a more grounded theory "lite" approach is taken, whereby the overarching methodological framework uses the principles of grounded theory, but analysis is thematic in nature (Braun & Clarke, 2006). Thematic analysis is an analytic approach that seeks, analyzes, and reports patterns or themes that arise from the data. This allowed a flexible, inductive, detailed interaction with, and analysis of, the data without the need to provide a full-bodied theory of the phenomena contained in the data (Braun & Clarke, 2006).

Methods

Participants

Qualitative, semistructured interviews were conducted with 16 Guyanese sexual minority women over the course of 4 weeks in June 2014. Eligible participants were cisgender or transgender women over the age of 18 who identified as nonheterosexual. Recruitment was limited to women who had been resident in Region Four of Guyana for 2 or more years, because this region boasted the largest population density and was the most accessible under the given time, labor, and resource constraints of the study. Interviews were conducted until they no longer yielded any new themes, at which point the data was deemed saturated, and recruitment ended, hence determining the final number of participants. Participants were all cisgender, younger females, mostly without children and with equal numbers having attained secondary and tertiary level education. Socioeconomic status was not formally ascertained, but participants with varying types of employment status and salary earnings were recruited. Participants were allowed to self-identify their sexual orientation, without much emphasis being placed on the definitions of what they chose to identify as. However, the term *lesbian* broadly meant a woman who was attracted to other women; bisexual as a woman attracted to both women and men; and pansexual as a woman attracted to others without consideration of gender identity or sexual orientation. Participant demographics are further detailed in Table 1.

Procedures

Nonprobability purposive sampling was used, seeking to identify the range of female sexual minority experiences rather than having a statistically representative sample. This sampling technique further sought to

Table 1. Participant demographics.

Demographic	*n*
Age	
20-29	9
30-39	2
40 and over	5
Self-identified ethnicity	
Afro-Guyanese	6
Indo-Guyanese	3
Mixed	7
Self-identified sexual orientation	
Lesbian	5
Bisexual	6
Pansexual	2
Not heterosexual but unwilling to label	
Education	3
Secondary	8
Tertiary	8
Has children	
Yes	4
No	12

have broad representations in age, ethnicity, education level, and socioeconomic status amongst the recruited participants. A subtype of purposive sampling, snowball sampling, was also used due to its appropriateness for accessing highly stigmatized, hard-to-reach populations (Sadler, Lee, Lim, & Fullerton, 2010). Snowball sampling in this study entailed participants recommending individuals they thought would be eligible, as well as referrals originating from within the professional and personal networks of the researchers.

Participants were recruited via flyers distributed at the LGBT film festival hosted in June 2014 and by flyers placed in the offices of Society Against Sexual Orientation Discrimination (SASOD), which is a local LGBT human rights nongovernmental organization. Any potential participants who expressed an interest in becoming involved were verbally or electronically given a brief outline of what the interviews would entail and screened at that point to ensure they satisfied the eligibility criteria. More in-depth information detailing the purpose of the study, potential risks and the voluntary and confidential nature of the study was included in information sheets given to each participant prior to starting the interviews. Interviews were conducted at venues and times mutually agreed upon by research staff and study participants, and at the conclusion of each interview participants were given a stipend of US$10 to cover their traveling costs. They were also offered the opportunity to avail themselves of a list of online resources pertinent to sexual minority women's health along with a brief handout from the U.S. Gay and Lesbian Medical Association on health issues in sexual minority females.

This study was approved by the Guyana Ministry of Health's Ethical Review Committee and written consent forms were signed by each participant prior to interviews. Confidentiality and anonymity were aided by conducting all interviews in a private, enclosed room and the assignment of a random pseudonym to each transcript, with no master list linking participant name to the assigned pseudonym.

Measures

Interviews were led by a semistructured interview guide that covered perceived healthcare providers' attitudes; disclosure of sexual orientation to providers; provider knowledge and recommendations; and perceived shortcomings of, and training recommendations for, healthcare providers. As an introduction to the questions in the guide, participants were first encouraged to recall their most recent healthcare encounter, and this then served as a launching point for the subsequent questions on that and less recent encounters. Questions were sometimes direct ("Is sexual orientation something you ever discuss with your healthcare provider?"), but most of them were open-ended and intended to prompt consideration of both the positive and negative aspects of the encounter ("What makes it easier or more difficult to discuss sexual health issues with a healthcare provider?"). Data collection was guided by a grounded theory framework, of which a defining tenet is the concurrent collection and analysis of data or "constant comparative analysis" (Cho & Lee, 2014). This process was followed, and means that although the specific topics in the guide were predetermined from a brief literature review on the healthcare experiences of sexual minority women, the guide was slightly modified with each successive interview. Another tenet of grounded theory directed that, as previously stated, recruitment continued until saturation in themes was evident (Kolb, 2012).

Data analysis

Interviews lasted on average 20 min each, were audiotaped and transcribed verbatim, then manually analyzed using thematic analysis. Thematic analysis involved seeking themes or 'repeated patterns of meaning' across the entire data set of interviews (Braun & Clarke, 2006), and proceeded through the phases as outlined by Braun and Clarke (2006) in an iterative fashion. The first phase was familiarization

and immersion into the data, which was accomplished mostly during transcription. This was followed by coding, or assigning words or phrases that captured the essence of a data section (Saldaña, 2009), and then collating these codes into potential themes which were then refined, defined and named. The analytic method in this study used an inductive approach with themes being allowed to emerge directly from the data, and with comparison between and within codes to allow the streamlining and definition of themes. During this process, the researcher endeavored to apply the appropriate reflexivity in analysis. Qualitative data software was not used. Instead, the developed coding scheme was exported into a spreadsheet (Microsoft Excel) to allow easier data manipulation. Color codes, as well as attached letters were used to mark and link different sections of text (from one or more interviews) relating to a particular theme. Data exploration and analysis involved manually color coding the themes and subthemes and cutting and pasting them together in the spreadsheet to create a typology and for ease of cross-referencing.

Results

Infrequent healthcare usage and the influences on use

Half of the participants (eight of 16) reported having visited healthcare providers within the last month. Only four of these women sought routine, preventative healthcare (without symptoms), whereas the remainder only visited for acute care or were being followed up for a previous complaint. The other participants last visited health services between 1 to 3 years prior. The majority of the women used a mix of private and public healthcare with a few who exclusively used private care, and only one participant exclusively used the public health system.

When asked whether they regularly visited health services, many women gave some variation of a response that indicated that they didn't feel it necessary because they were generally healthy, as illustrated by this participant: "I don't go to the doctor regularly. I'm not a sickly type of person" (Savi). A few others were less sure about their reasons for not visiting, even though they thought they should, for example, "I used to go routinely but now I don't. I'm scared … I don't know why, not that I do anything to endanger myself but I'm just scared" (Stella).

Responses varied as to whether there were any demographic preferences as it related to doctors. Some participants had no preferences, whereas others mentioned age, gender, ethnicity, sexuality, and nationality. Three women preferred older doctors, with one participant explicitly stating that age signaled greater experience, and one woman preferred younger doctors because "older folks are more traditional" (Valerie). The majority of participants who had a preference for the doctor's gender preferred male doctors. These women stated they felt more comfortable with male doctors because they perceived them as less judgmental, more patient, and friendlier. A few women felt their sexual orientation caused awkwardness in their encounters with female doctors and so preferred male ones: "I guess I feel a bit of guilt with females. I'm thinking what they're thinking if I identify myself, if the doctor might think 'I wonder if she's looking at me, I wonder if she want to hustle me'" (Lori). The small minority of participants with an ethnicity preference all preferred doctors who did not share their ethnicity; one Afro-Guyanese woman preferred doctors who were Indo-Guyanese because she thought they were better at keeping confidentiality, whilst an Indo-Guyanese participant preferred Afro-Guyanese doctors because she felt they were less homophobic. Two women indicated a preference for non-heterosexual doctors, and one participant mentioned a preference for foreign doctors:

> Foreigners, the Indian nationals, they I'm comfortable with … foreign people don't know who you are, don't make a mistake and go to a local. If it's for something like a twist arm or something yea, but if you're being abused or a venereal disease or infection don't go to local people (Lori).

Participant-identified factors that guided their decision to visit health services can be categorized as doctor-related, situational, and history-related, with more women mentioning doctor-related factors than any of the others. The doctor-related factors that increased the likelihood of visiting health services included a referral from a friend; and a doctor who is perceived as trustworthy, caring, experienced, patient, and with whom they found a connection. The few situational factors that impacted the decision to visit health services included a decreased inclination to visit services if the participant was preoccupied with daily life, if the service was located a far distance from their place of residence, or if the service had lengthy wait times. Conversely, having an accompanying friend and being assured of

nonrecognition and confidentiality would increase the likelihood of a health service visit. Two history-related factors that would increase health service visits were mentioned—if the symptoms being experienced were deemed severe enough and if the healthcare providers avoided the topic of sexual health in their history taking. The avoidance of sexual health discussion decreased discomfort for these participants and encouraged them to seek continued interaction with the health service.

Tentative sexuality disclosures

Only two women regularly disclosed their sexual orientation when using healthcare, and they both did so because they felt it would enable the doctor to provide more tailored care. In addition, one of the routine disclosers saw it as an opportunity to educate healthcare workers, so they would better be able to learn about "people of my persuasion" (Rose). A few participants had disclosed their orientation to a single doctor in the past but did not make it a regular practice. In many of these cases the disclosure arose because of a complaint related to reproductive health, but in one instance the participant visited the health service with her partner, thus leading to disclosure. This left the majority of women having never discussed their sexual orientation with healthcare providers. When questioned on whether she discusses sexual orientation with healthcare providers, one participant said, "I don't dare because in conversation with them you can anticipate their reaction … Most doctors don't really discuss it, it's basically simple, your physical health" (Stella). This general avoidance of sexual orientation discussions was taken to the extreme by two participants who deliberately concealed their orientation when dealing with healthcare due to fear of stigmatization. Some women reported that even discussing their sexual identity in their everyday lives was only done after significant trust was gained, as one participant said, "I have friends who don't know really who I am; they just know one part of me … If somebody's a gay [they say] 'oh gosh how you could talk to them people' and in my mind I'm saying if they really know who I am they wouldn't talk to me either." (Anita).

Some participants could envision themselves revealing their orientation if they visited for a sexual health related issue, such as a sexually transmitted infection (STI), and others said they would reveal if they were simply asked. However, a quarter of the participants were doubtful they would ever reveal this information to the doctor. As one woman said, "you could be open to some people and some would throw it back in your face, so my suggestion is best you keep it to yourself and wait" (Nikki). Another participant who had previously disclosed her sexual orientation to one doctor was so disappointed by the reaction, she would not consider doing it again. In only two cases did revelation of sexual orientation then lead to a discussion of lesbian-specific sexual health issues, such as the use of dental dams to protect against HIV transmission.

Feeling vulnerable and disrespected in the healthcare system

Only a small minority of participants recalled negative healthcare interactions that were a direct result of their sexual minority status. Instead, the majority of negative experiences were due to healthcare workers' unfriendly attitudes toward clients in general and lack of respect for participants' person and privacy, combining to contribute to an overall feeling of insecurity when accessing healthcare services. Furthermore, two participants reported instances of outright sexual harassment by male doctors (with one doctor privy to the sexual orientation of the participant), and three other participants were subjected to perceived inappropriate sexual comments from male doctors.

The most frequent negative attitude of nurses was stated as being "rude." There were also a couple of instances where the nurses dismissed the validity of the participant's complaint, and one instance where the nurse exhibited behavior perceived as racist. Doctors' negative attitudes were, however, more often described as arrogant, impatient and dismissive. As one participant stated,

> I went to the doctor, he didn't examine me because he said 'Oh, I already have an idea what's wrong with you'. He wrote me a prescription for antibiotics and a bunch of painkillers so I'm like 'Aren't you going to check at least?"… He's like "No you're OK, you just need some antibiotics." (Mary)

Several women had experienced uncomfortable and distressing situations whilst on the examining table, with either little explanation of the procedure being undertaken or subjected to exhibition to other healthcare personnel without their consent.

> She [the gynecologist] was like "I don't have time for all of this, I'm sorry. Let's just get to the examination," so she was like "spread your legs please and she just went straight in…" I wasn't prepared. It hurt so much and she had the nurses restrain me on the table because I was telling her to remove herself from me and yea so that was really traumatizing. I've never gone back to a gynecologist. (Sophia)

Two accounts in particular encapsulate the feeling of vulnerability experienced by some of the participants: "I was lying on this bed and opened out and he's [the gynecologist] asking 'How is your mom doing, you've gotten so big' and I was like this is not ideally how I'll like my first gynecological experience to go, so I won't go back there ever" (Mary). A similar humiliating incident was experienced by Rose, who recounted,

> Here I am all sprawled out and then a set of people come in I'm like what the! I don't want my vagina up for public speculation. This is private. Nobody sees this unless they're getting some. It was embarrassing for me; it was embarrassing. If you could read my body you would've seen me cringing. (Rose)

Some reports by participants with negative interactions related to their sexuality and heterosexism (prejudice against persons who display non-heterosexual behaviors or identities, combined with the power to impose such prejudice [Green &Peterson, 2004]). This included one doctor's insistence on pregnancy testing even after the participant stated they only have female sexual partners, and two different instances where the doctor suggested that switching to heterosexual intercourse could alleviate the current medical symptoms, as one woman related "I've always had menstrual problems and I've been told maybe if I'm sexually active, and many times they mean sexually active between a man and a woman, so I've had to straighten up myself so that was awkward" (Valerie).

A significant contributor to the feeling of being exposed in healthcare situations was that of a lack of confidentiality. Some participants brought up this issue without being prompted; however, after prompting, three-quarters of the women revealed they felt that the healthcare system lacked confidentiality. Several participants had experienced healthcare workers breaching confidentiality by actually disclosing the identities of persons living with HIV: "She [a nurse] was like guess who has HIV? I'm like who? Oh xyz. I'm like OK … I don't think she's supposed to be telling me that" (Joan). Others had directly or indirectly noted a propensity for healthcare workers to discuss their patients in general and so concluded they themselves would be similarly discussed. This prevented them from either disclosing their sexuality or feeling comfortable enough to discuss sensitive information with the healthcare provider. Two participants mentioned that this lack of confidentiality coupled with them being well-known to the public acted as a disincentive to visiting health services.

Fortunately, almost all the participants were also able to recall positive interactions they had receiving healthcare services. The majority of these positive interactions were made notable by the personability of the healthcare worker, variably described as being kind, comforting, caring, or just generally "nice." Other positive interactions were characterized similarly, because the healthcare worker took the time to listen and explain. A few of the women commented that they had encountered at least one doctor who was supportive and nonjudgmental after they had disclosed their sexual orientation.

Many participants offered recommendations on how to decrease vulnerability and increase positive interactions in the healthcare system. These recommendations included training healthcare workers to be more professional, cultivating a neutral and less judgmental demeanor, along with sensitization on the existence of sexual minorities and how to be more tolerant of sexual minorities. Some participants thought that healthcare workers should endeavor to learn about sexual minorities in general and their health-specific issues and tailor the approach to each patient, whereas some other participants thought healthcare workers should instead strive to treat every patient equally. Several participants recommended that doctors especially should act in a friendlier and more patient manner, striving to put patients at ease and therefore increasing the chances of the patient opening up and engaging in more sensitive disclosures. As one participant said,

> Their interaction, how they speak with you, how they look at you, you know, their body language, that sort of thing; how welcoming they are, how open they are, basically how human they are, because they're people too and some of them hide behind the "Dr" like "I am a doctor; you're nobody." (Stella)

Three participants recommended that confidentiality in health services be improved, either by improved training or by penalizing persons found to be in breach of

confidentiality. However, an equal number of participants were of the view that improving confidentiality will be an extremely long, possibly unsuccessful process: "I don't think improving confidentiality is possible, sad to say, because people are always gonna talk … They're going to tell that person even if they tell that person in confidence that person will tell someone else so I don't think it's possible" (Indy). As one participant remarked, improving confidentiality might entail an entire shift in culture, "The nature of people is simply to gossip and bring people down—crabs in a barrel. So the culture has to change; I know to change culture is a very tall order" (Stella).

The medical machine: A lack of sexual health and preventative care discussions

Half of the participants had never discussed any sexual health issues with a doctor, and the majority of the half that had only ever discussed whether they were sexually active and using protection from STIs. The majority of the women had been tested for HIV, often making the decision to get tested of their own volition rather than having it recommended by a healthcare worker. Similarly, half of the participants had undergone cervical cancer screening (either via Pap smear or visual inspection with acetic acid), but many did so, not on the recommendation of a healthcare worker, but rather by the prompting from public health messages or friends and family. A few women had received mammograms, with a couple on the recommendation of a doctor. Thus, although many participants had undertaken self-screening, half of them had never been screened for cervical cancer and almost a similar proportion had never checked their HIV status. Some women mentioned that screening had never come up in their healthcare interactions, but a few also reported that while they knew of the screening being available, they did not think it applicable to them. As one participant said when asked about cervical cancer screening: "No, they say you have to be 25. You have to have a certain amount of sexual partners, so I don't qualify for one of those" (Indy).

Mental health was not mentioned by most participants and most did not think it a particular issue amongst sexual minority women. At least one participant viewed seeking help for mental health as a weakness: "I have no problem with anything. I don't like being weak, so I wouldn't go and ask for therapists for this or whatever or anything at all because I try to deal with everything on my own" (Andrea). Only one woman had ever accessed mental health services, and she reported that she experienced significant difficulty opening up to the service providers. The majority of women were of the view that overall, sexual minority women's healthcare needs were not any different from heterosexual women, except for, as a few participants mentioned, contraception and child-bearing issues.

Framing this atmosphere of scant discussions when accessing healthcare services, was the feeling, likely shared by nonsexual minority women, of being disconnected from the healthcare provider and being rushed through the process of seeking healthcare. Terms used included *manufacturing plant, a business*, and, as one participant said, "Sometimes some doctors may be focused on something else or they're just trying to get rid of you so that they can move on to something else" (Indy). Some women felt that on occasion doctors were merely interested in profit-making—maximizing patients, minimizing interpersonal time, and ordering unnecessary tests.

Pathologizing versus patronizing sexual identities

A few participants discussed how being a sexual minority was pathologized by the medical community. One participant related how her sexuality was seen as something to be fixed by doctors, when it was noted she acted too masculine: "My mom noticed it and people tell her that she must carry me to the doctor. I can remember having injections … I think that was to suppress me [her masculinity]" (Anita). A few participants reported healthcare workers' attitudes changed to be more negative or unwelcoming once they revealed their sexual orientation. For example, "Other women that I talk to, they had similar experiences where they would say 'I'm seeing a woman' and the tone of the conversation changes and the doctors' faces fall and they look at you as if you're sick or something" (Sophia).

Because some women had heard their sexuality termed "nasty" (Anita), or a "stain" (Cindy), along with other derogatory terms in the community, they self-pathologized to some degree when dealing with healthcare. As one participant said when questioned as to whether she would discuss sexual orientation with healthcare providers, "I would never let [the doctor] know that I'm not normal at all because that's

strange for him" (Andrea). Conversely, some participants reported that their sexualities, instead of being treated with negativity, were merely dismissed or humored: "A lot of lesbians and stuff they get off on the healthcare system because it's kinda common that it's pretty okay to be a lesbian. They think you're going to be straight at some point in time" (Judith). One participant had her sexuality dismissed by healthcare providers because she was considered to be too pretty to be a lesbian. Another woman reported that the healthcare provider only seemed interested in her sexual orientation because of the stereotype of bisexual women always being interested in a threesome with both male and female sex partners.

Discussion

This study identified themes of infrequent healthcare use, tentative disclosures of sexuality, and feelings of vulnerability and disrespect encountered by sexual minority women using the healthcare system in Guyana. The infrequence of sexual and preventative health discussions, along with the pathologizing and patronizing of sexual identities during healthcare interactions, were also identified as significant themes.

Participants in this study did not often utilize health services for preventative care, but instead visited mainly for acute conditions. This parallels studies in the United States that show that lesbians and other sexual minority women access preventative healthcare less often than heterosexual women (Bonvicini & Perlin, 2003; Kerker, Mostashari, & Thorpe, 2006), with a study by White and Dull (1997) showing that only 22% of lesbians sought preventative healthcare. In some other studies (Scherzer, 2000; Stevens, 1996), women explicitly cited discrimination because of their sexual orientation as being the reason they chose not to visit healthcare services; however, most of the women in this study did not share that sentiment. They instead rationalized their low utilization of healthcare as a result of their illnesses not being severe enough, or were generally ambivalent about the need to seek healthcare in general and at all. Participants identified certain healthcare provider characteristics, such as trustworthiness, patience and a kind and caring attitude as factors which facilitate a positive healthcare experience, as did the women in a similar U.S. study (Seaver, Freund, Wright, Tjia, & Frayne, 2008). Interestingly, studies from the United States (Seaver et al., 2008), Australia (Mulligan & Heath, 2007), and Canada (Geddes, 1994) show sexual minority women in those countries either having no gender preference or mostly preferring female doctors, the opposite of the preference expressed by participants in this study. This finding could possibly reflect more patriarchal attitudes present in Guyanese society, where men are seen as more competent professionals or might stem from a simple discomfort on interacting with other women in such personal circumstances; either way, a finding worthy of further exploration.

Within the theme of tentative sexuality disclosures, an overwhelming majority of participants did not regularly disclose their sexual orientation to healthcare providers, a feature they have in common with women in other parts of the world, as rates of disclosure vary from 18% to 90% (Bjorkman & Malterud, 2007). The reasons for nondisclosure, which include fear of stigmatization, perceived irrelevance to the interaction, and simply not being asked, echo the reasons given by women in other studies (Bjorkman & Malterud, 2007; Boehmer & Case, 2004).

Sexual minority women experiencing dissatisfaction with the healthcare encounter, as explored in the themes of feeling vulnerable and disrespected, along with the pathologizing and patronizing of sexual identities, is a frequently occurring subject in the global literature on this topic. The heterosexist comments, pathologizing and unprofessional healthcare provider attitudes, and dismissiveness and traumatizing encounters the women in this study recounted have similarly been recorded elsewhere (Bjorkman & Malterud, 2009; Saulnier, 2002; Scherzer, 2000). Although sexual minority women in developed countries have stated a desire for confidentiality in medical record-keeping (Hunt & Fish, 2008; Seaver et al., 2008), they do not appear to share the perception of the women in this study—that of a healthcare system largely lacking confidentiality in general. The issue of healthcare workers providing substandard levels of confidentiality has however been mentioned in other Caribbean studies (Hariharan, Jonnalagadda, &Gora, 2006; Rutledge, Abell, Padmore, & McCann, 2009), and may be a reflection of cultural norms, whereby Caribbean folk are noted to "like to talk a lot" (Rutledge et al., 2009).

One theme concerned the rarity with which sexual health and preventative care discussions occurred, including discussion on mental health, even though

data from the United States suggest that sexual minority women may have higher rates of depression and suicidal ideation than heterosexual women (Institute of Medicine, 2011). However, in this study, even though the topic of mental health needs was specifically probed for in each participant, the issue did not figure prominently and only one participant had accessed mental health services. Rather than this finding demonstrating the mental health wellness of the participants, it may actually represent the significant stigma surrounding mental illness in Guyana, which is the country with the highest suicide rate in the world (World Health Organization, 2014), and mostly inaccessible or unavailable mental health services (World Health Organization, 2008). The short duration of interviews might have also precluded in-depth discussion of this stigmatized and sensitive topic.

The findings of this study can be used to recommend policy and practice shifts in Guyana, regarding sexual minority women's healthcare. A common recommendation offered by participants and endorsed by the authors is the need for training of healthcare providers. Training content should be two-pronged: aimed at improving ethics, emphasizing the foremost importance of confidentiality in healthcare encounters, and including fostering more tolerant and personable attitudes; and aimed at improving knowledge of sexual minority women's health issues with the skills to tackle the sensitive issues of sexuality. Improvement in healthcare provider ethics and conduct will likely benefit all Guyanese women, and not just the sexual minority population. This is because many of the negative incidents described, particularly as related to vulnerability and disrespect, occurred not because of the participants' sexual orientation, but because the providers treated their patients that way in general. Training opportunities can be at two levels: continuing education for professionals already practicing and implementing curricular adjustments in training schools for doctors, nurses and other healthcare providers. A U.K. study suggests that the latter tactic of introducing sexual minority health in medical schools can improve interactions with the sexual minority population after medical students graduate (Dixon-Woods et al., 2002).

The theme of medicine operating as a "machine" that came up during this study is likely indicative of a larger issue being experienced at the health systems level by the general populace, and not just sexual minority women. Guyana has both a shortage and maldistribution of healthcare providers due to several factors, but largely owing to the emigration of trained healthcare workers (Goede, 2014). This has resulted in a ratio of 0.95 physician to 1,000 persons (Goede, 2014), and a health system that is stretched by time and labor constraints, likely contributing to the "assembly line" feeling experienced by some participants in this study. Efforts to change this situation will require governmental intervention in the form of incentives that discourage emigration, training a larger volume of healthcare workers and inculcating professionalism and empathy for patients in general, and sexual minorities in particular, in said healthcare workers.

To decrease pathologizing, intolerant attitudes and to make steps toward alleviating heterosexism in healthcare, a society-wide approach would be of benefit. Here, multiple governmental and nongovernmental players, including healthcare professional, human rights and health advocacy organizations, can contribute, by training their members as well as sensitizing the public to decrease stigmatization of sexual minorities. Further, as White et al. (2010) suggested, decriminalizing same-sex intimacy and legislating nondiscrimination on the basis of sexual orientation will promote an environment where healthcare providers, as members of society, recognize the need for improved interactions with sexual minorities in general.

This study can serve as a basis for other qualitative research on sexual minority women and healthcare providers, which can delve more in-depth into the issues that revealed they needed further elucidation and context, and utilizing a more geographically varied sample. This study also provides a base for further quantitative research on the subject of sexual minority women's healthcare experiences, but there were several limitations. Because of resource constraints, only the views of sexual minority women in Region Four were gathered, without exploring the experiences of healthcare workers in Guyana. Also most participants chose to mainly focus on their interactions with doctors and nurses, without mentioning other types of healthcare providers, such as medexes, community health workers, pharmacists and healthcare assistants (for example, nursing or dental assistants). These providers all contribute to the healthcare encounter at various points, and sometimes, as in the case of rural medexes, are the only healthcare providers available in the public system (World Health Organization, 2008). The sample leaned

more toward younger and women without children, but otherwise had a good range of educational background, ethnicity, and sexual identity. The qualitative nature of the study prevents generalization of the findings to all Guyanese sexual minority women, as the intention was not that of statistical generalization, but instead of a gathering of a range of experiences and views. Resource constraints prevented the triangulation of findings via other research methodology such as focus groups, as well as participant validation. Many participants had similar narratives of not experiencing negative interactions with healthcare services due to their sexual orientation, which might reflect the snowball sampling methodology, which tends to attract persons who share similar characteristics (Sadler et al., 2010). However, this could also simply be because many did not disclose their sexual orientation to healthcare thus avoiding overt judgment. Because the interviewer is a medical professional, it is possible that there was some response bias from participants seeking to provide answers deemed acceptable, but this was offset by the fact that many participants were not told of the interviewer's professional status until after the interview, coupled with the interviewer not residing in Guyana for nearly a decade.

Conclusion

This study suggests that sexual minority women in Guyana infrequently use healthcare for preventative means and rarely disclose their sexual orientation when accessing care. Discussions on sexual and mental health are also often lacking in these encounters. Participants reported both positive and negative experiences, with the latter mostly resulting from attitudes and behaviors of healthcare personnel that are unlikely to stem from sexual orientation discrimination per se, and more likely to result from cultural patterns and training deficits in relation to providing patient sensitive and friendly services for sexual minority women. To address these issues of culture and training, input from both the government and nonstate actors will be necessary.

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