L-Health

THE L-WORLD IN HEALTH:

IMPROVING PRIMARY HEALTHCARE FOR LESBIANS

2026

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THE L-WORLD IN HEALTH

Research Report on LesBian* Health in Primary Care

Catalonia (Spain), 2024–2026 - Co-funded by the European Union - CERV-2023-EQUAL

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1. About L-Health

L-Health (*L-World in Health: Filling Knowledge Gaps and Promoting Competent Primary Care for LesBians**) is the **first scientific research project in Europe** designed specifically to study the health of lesbian, bisexual, pansexual and queer women, and women who have sex with women — collectively referred to in the project as **LesBians***. It is coordinated by the **Jordi Gol University Institute for Primary Care Research (IDIAPJGol)** and co-funded by the European Union through the **CERV-2023-EQUAL programme** (Grant Agreement n.º 101144766).

The project ran between 2024 and 2026 in Catalonia, Spain, and brought together five partner organisations: IDIAPJGol, the **Girona Biomedical Research Institute (IDIBGI)**, the **Barcelona Public Health Agency (ASPB)**, **Sida Studi**, and the **EuroCentralAsian Lesbian* Community (EL*C)**, responsible for communication and dissemination.

What makes L-Health unique?

- **It is the first research of its kind in Europe** — no comparable scientific study on LesBian* health in primary care had previously been conducted at a European level.

- **It is participatory**: LesBian* women and activists were involved in all stages of the research, not just as subjects but as advisors, co-designers and interpreters of results.

- **It is intersectional**: the research recognises that health inequalities are shaped by the intersection of multiple factors — sexual orientation, gender identity, racialisation, disability, age, migration background and rural or urban context.

- **It is solutions-oriented**: the research did not stop at identifying problems. It translated findings into concrete tools: a good practice guide, a policy brief, and a pilot training programme for healthcare professionals.

Our main goal

To promote clinical excellence in primary care for LesBians*, by identifying health inequalities, understanding the gaps in professionals' knowledge and attitudes, and designing and evaluating training to improve clinical practice.

Our perspective

L-Health is grounded in **feminist and intersectional research methodology**. We believe that lived experience is a source of knowledge, and that power structures affect health differently depending on who we are. That is why this project worked *with* LesBian* communities, not *on* them.

2. How We Conducted the Research

The L-Health research was structured in three interconnected studies, each addressing a different dimension of LesBian* health in primary care. A cross-cutting participatory body — the **Driving Group** — of LesBian* women and activists contributed to the design of the project, co-created recommendations, and participated in the interpretation of results throughout all studies.

Study 1 — Qualitative Study: Voices, Experiences and Needs

- 56 LesBian* participants in Catalonia
- Diverse profiles: cisgender and non-binary, urban and rural, with and without migration histories, with and without disabilities, across a wide age range (20–65)
- Methods: focus groups and in-depth interviews
- Focus: health needs, experiences with the healthcare system, barriers to care, and recommendations for improvement

Study 2 — e-Cohort Survey: Measuring Health Inequalities

- Over 850 LesBian* participants
- Chain-referral online survey linked to primary care clinical records (SIDIAP database)
- Participants: aged 18–74, born in Catalonia or from diverse migration backgrounds, including racialised people, people with functional diversity, different gender identities, and residents of urban and rural areas
- Focus: health inequalities, use of primary care services, disclosure of sexual orientation to healthcare providers

Study 3 — Assessment of Healthcare Professionals

- 45 primary care professionals (medical and nursing staff)
- Methods: focus groups
- Focus: knowledge, attitudes and clinical practice in relation to LesBian* health

3. Key Findings

3.1. What LesBians* Told Us: Voices and Experiences

LesBians* are invisible in the healthcare system. Health systems have historically ignored the specific needs of this group, treating them as part of a homogeneous population. This invisibility forces LesBians* to make enormous efforts to be recognised in clinical settings, generating emotional exhaustion and a profound loss of trust in healthcare services.

The healthcare system defaults to heterosexuality. The assumption that all patients are heterosexual means that LesBians* must "come out" at every consultation — not once, but every single time. This produces pressure, emotional exhaustion and erodes the therapeutic relationship.

> *"The failure to examine heterosexuality as an institution is like failing to admit that the economic system called capitalism or the caste system of racism is maintained by a variety of forces, including both physical violence and false consciousness."* ***Adrienne Rich, Compulsory Heterosexuality and Lesbian Existence, Signs, vol. 5, nº 4, 1980, p. 637***

Sexual health needs are distorted by stereotypes. Lesbians are told they have no sexual health risk — the *"virgin lesbian myth"*, rooted in the assumption that they do not have penetrative sex with a cisgender penis. Meanwhile, bisexual and non-monogamous people are labelled "high risk" — the *"hypersexual bisexual myth"*. Both stereotypes result in unequal, inadequate and moralistic care. Racialised and disabled LesBians* face additional layers of hypersexualisation or asexualisation.

Discrimination has a direct impact on care-seeking behaviour. Minor comments, microaggressions, and lack of knowledge from healthcare staff create persistent discomfort and exclusion. Participants reported experiences including highly invasive treatment proposals, infantilisation, and dismissal of health concerns based on assumptions of "no risk". As a result, many LesBians* conceal their symptoms and identity, avoid appointments, or resort to private or community-based services.

Structural barriers limit access to quality care. Long waiting lists, lack of continuity with the same professional, and poor service coordination reduce the quality of care. These barriers are compounded in rural settings and for people with migration backgrounds.

"Queer joy" matters for health. Discrimination in clinical settings has driven LesBian* communities to build alternative care spaces: safe environments that facilitate access to health information and foster a sense of belonging and chosen family. This "queer joy" — the celebration of authenticity and community as a form of resistance — plays a protective role in health. However, a lack of dedicated spaces, especially in rural areas, limits access to these networks.

Participants proposed clear solutions: specific professional training that avoids assumptions; inclusive communication; the creation of non-heteronormative protocols; and health systems that recognise the diversity of identities and family configurations.

> *"Most of all I think of how important it is for us to share with each other the powers buried within the breaking of silence about our bodies and our health, even though we have been schooled to be secret and stoical about pain and disease. But that stoicism and silence does not serve us nor our communities."* ***Audre Lorde, A Burst of Light, 1988***

3.2. What the Data Shows: Health Inequalities

The e-cohort survey of over 850 LesBians* across Catalonia produced the first population-level data on health inequalities in this community. The findings are clear:

1 in 3	LesBians* reports having experienced discrimination based on sexual orientation in primary care. The rate increases to 36% among lesbians and to 43% among people with non-cisgender identities.
47%	of bisexual women have never shared their sexual orientation with any healthcare professional at their primary care centre, compared with 30% of lesbians.
4 in 10	*LesBians* do not feel free to be open about their sexual orientation at work. Among racialised LesBians** people, this rises to 6 in 10.
43%	of LesBians* under 30 have never accessed an ASSIR (Sexual and Reproductive Health Care Unit), compared with 35% of those aged 30 to 40. It falls to 15% among those aged 40–50, and to just 6% among those over 50.
1 in 4	LesBians* have never shared their sexual orientation with any healthcare professional at their *ASSIR* (*Sexual and Reproductive Health Care Unit*). Among bisexual and pansexual women, the figure rises to 31%.
57%	of LesBians* feel comfortable disclosing their orientation to biological family members. Almost all participants report feeling safe disclosing their orientation to friends.

> *LesBians* who had shared their sexual orientation with healthcare professionals reported significantly higher satisfaction with primary care services. Conversely, those who had experienced discrimination — particularly based on sexual orientation — reported significantly lower satisfaction.* **L-Health e-cohort survey, 850+ participants, Catalonia 2024–2026**

The survey also revealed the importance of community fabric: LesBians* who were connected to organisations, collectives and social networks showed greater engagement with the research — reflecting the vital role of community in sustaining health and wellbeing.

> *“Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated. Thus, for feminist theory and antiracist policy discourse to embrace the experiences and concerns of Black women, the entire framework that has been used as a basis for translating ‘women’s experience’ or ‘the Black experience’ into concrete policy demands must be rethought and recast.”* ***Kimberlé Crenshaw, Demarginalizing the Intersection of Race and Sex, University of Chicago Legal Forum, vol. 1989, art. 8, p. 140***

3.3. What Healthcare Professionals Told Us

The study of 45 primary care professionals (medical and nursing staff) revealed a complex picture: genuine goodwill coexisting with significant structural and attitudinal barriers.

LesBians* remain invisible in health systems. Professionals tend to group LGBTQ+ people as a homogeneous collective, overlooking the specific needs of lesbian and bisexual women. Bisexual women are the most invisible group. The absence of sexual orientation data in health records conceals health inequalities and prevents evidence-based improvement of care.

Most professionals do not apply a social determinants of health lens. Many believe sexual orientation is only relevant to health in very specific areas (mental health, sexual and reproductive health). This narrow biomedical focus creates blind spots, failing to account for the structural conditions that shape LesBian* health — discrimination, exclusion, housing, employment and more.

Belonging to the LesBian* community does not automatically translate into clinical knowledge. Some lesbian and bisexual professionals reported feeling pressure to “represent” their community in clinical settings, without the specific training needed to do so. There was a visible gap between inclusive values and actual clinical practice.

> *“I fear that if we don’t take seriously the ways in which racism is embedded in structures of institutions, if we assume that there must be an identifiable racist […] who is the perpetrator, then we won’t ever succeed in eradicating racism.”* ***Angela Davis, Freedom Is a Constant Struggle, Haymarket Books, 2016, p. 24***

Heteronormative stereotypes continue to shape clinical decisions. Clinical questions and practices assume heterosexuality as the norm. The persistent “virgin lesbian myth” leads to under-testing, misinformation and delayed diagnoses. Existing protocols also fail to accommodate diverse family configurations.

There is ambivalence about recording sexual orientation. Some professionals highlight the risk of data being used against patients; others recognise that the absence of data perpetuates ignorance about LesBian* health needs. Current protocols do not include spaces to record diverse sexual orientations or family structures.

The will to provide inclusive care exists — but the tools and training do not. Many professionals want to improve their practice but do not know how to ask about sexual orientation without it feeling intrusive. Training on LGBTQ+ health has typically been non-existent, optional or superficial — and rarely addresses the specific needs of lesbian and bisexual women.

Better care requires both individual training and systemic transformation. Professionals emphasised the importance of long-term patient relationships, inclusive structures and organisational cultures, not just better individual practice.

4. Voices from the Final Conference

On **11 June 2026**, the L-Health team presented the project's results at its Final Conference at the Centre Corporatiu of the Institut Català de la Salut in Barcelona. Here is what the project's partners said:

> *"If the L-Health training programme were implemented across all primary care centres, Catalonia could become an international benchmark for healthcare for lesbians and bisexual women."* Dr **Anna Ponjoan, L-Health Research Coordinator — IDIAPJGol / IDIBGI**
>
> *"It is essential to understand how healthcare professionals conceptualise health and illness, as our research shows that the social factors influencing health are often not given sufficient consideration. These factors include discrimination, social exclusion, and other forms of inequality that can affect people's well-being."* **Dr Constanza Jacques, L-Health Research Coordinator — IDIAPJGol**
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> *"One of the key features of this project is that we involved lesbian and bisexual women throughout all stages of the research, serving as advisors in both the study design and the interpretation of the findings. Additionally, we presented the project in various activist spaces, as it was important to build trust within the community and create the conditions for participants to share their experiences while feeling safe, supported, and cared for."* **Dr Vanessa Puig, L-Health Researcher — Barcelona Public Health Agency (ASPB)**
>
> *"EL*C believes that knowledge should not remain confined to universities, reports or conferences. It should empower communities, strengthen advocacy, and contribute to improving the lives of lesbians across Europe and Central Asia."* **Silvia Casalino, Executive Director — EuroCentralAsian Lesbian* Community (EL*C)**

5. What We Built: Tools for Change

The L-Health research did not end with data. It produced three concrete, publicly available tools designed to transform clinical practice and health policy:

I. A Good Practice Guide for Primary Care

"A Practical Guide for the Care of Lesbians, Bisexuals and Other Sexual Dissidents in the Consultation: A Reflective Approach from Primary Care"

This guide is structured around three moments of the clinical encounter:

Before the consultation

- Reflecting on how health and illness are understood, including the social determinants of health
- Questioning what professionals know (and do not know) about sexual diversity in their patient population
- Examining their own beliefs and assumptions about what it means to be LesBian*

During the consultation

- Avoiding assumptions: replacing "Do you have a boyfriend/husband?" with "Do you have a partner or partners?"

- Reviewing stereotypes that generate discrimination in clinical practice
- Recognising that there is no single valid way to ask about sexual orientation — context, purpose and how responses are received all matter
- Acknowledging the limits of one's own knowledge: "I don't know" combined with a commitment to find out can strengthen, not undermine, the therapeutic relationship

After the consultation

- A self-reflection process: What surprised me? What worked? What could I approach differently?
- Recognising that continuity of care allows for repair, clarification and deepening of the relationship
- Understanding that care extends beyond the consultation: community resources and networks are part of the care ecosystem

II. A Policy Brief

The L-Health policy brief addresses decision-makers and health planners, setting out priority actions organised across three strategic areas:

Training and professional competence

- Implement the L-Health training programme across all primary care centres
- Guarantee access to the Good Practice Guide for all primary care staff
- Develop advanced training in sexual and reproductive health for LesBians*

Data, records and protocols

- Train staff in the collection, recording and clinical use of sexual orientation and gender identity data
- Update administrative forms and procedures to eliminate heteronormative approaches and incorporate inclusive options

Health promotion and prevention

- Guarantee access to adequate prevention in sexual and reproductive health for LesBians*

III. A Pilot Training Programme for Healthcare Professionals

Developed and delivered by **Sida Studi**, in collaboration with the full research team, the pilot training consisted of:

- **8 hours across 2 in-person sessions** for 21 primary care professionals
- **4-hour workshops** for researchers and students (1 online, 1 in-person), reaching 37 people

The training was grounded in a feminist evaluation framework and used methods including personal journeys, stereotype deconstruction, power mapping and role-playing exercises.

Training evaluation results

The training produced measurable improvements across all participant groups:

- **Knowledge**: +0.34 improvement for heterosexual professionals; +0.14 for LBT+ professionals — greatest gains in understanding sexual practices and the fluidity of sexual preferences
- **Myths and prejudices**: +0.83 for heterosexual professionals; +0.43 for LBT+ professionals
- **Skills and self-efficacy**: +0.94 for heterosexual professionals; +0.86 for LBT+ professionals — improvement in approaches to sexual diversity across all groups
- **Satisfaction**: maximum satisfaction ratings from all participants

> *"Dismantling the cisnormative and heteronormative framework requires personal work. That is why the training starts from each participant's own knowledge, experience and position."* **Sida Studi training team, L-Health Final Conference, Barcelona, June 2026**

The main challenge identified was reaching professionals who are not already sensitised to LGBTQ+ issues. Recommendations include combining the training with broader awareness-raising strategies, increasing the hours dedicated to structural determinants and racism, and evaluating long-term impact.

6. What Comes Next

L-Health has produced the most comprehensive evidence base on LesBian* health in primary care in Europe. But the work does not end here. The tools created by the project are designed to travel — to be adapted, replicated and implemented in other territories, health systems and countries.

The next steps depend on political will, institutional commitment, and continued community engagement. Based on the evidence and the tools produced, the L-Health consortium calls on health authorities to:

1. **Implement the L-Health training programme** systematically in primary care centres, not as an optional add-on but as a structural component of professional development.
2. **Make the Good Practice Guide universally available** to all primary care professionals as a standard clinical reference.
3. **Reform health records and administrative systems** to eliminate heteronormative assumptions and enable the ethical, consensual collection of sexual orientation and gender identity data.
4. **Invest in long-term research** that measures the impact of these interventions over time and continues to centre LesBian* communities as co-producers of knowledge.
5. **Extend this approach across Europe**, working with LGBTQ+ organisations, research institutions and health authorities to build comparable evidence in other national contexts.

> *Caring for our bodies, naming our discrimination, and demanding that science include us is still a political struggle. And we will not stop until our bodies are at the centre of health training and research.* **Silvia Casalino, Executive Director of the EL*C — EuroCentralAsian Lesbian* Community**

7. Project Partners

IDIAPJGol — Jordi Gol University Institute for Primary Care Research

Project coordinator. IDIAPJGol is a reference centre in primary care research in Catalonia, with a strong commitment to research oriented towards health equity and community wellbeing.

IDIBGI — Girona Biomedical Research Institute

IDIBGI contributes biomedical research expertise and co-led the design and analysis of the e-cohort study.

ASPB — Agència de Salut Pública de Barcelona (Barcelona Public Health Agency)

ASPB led community engagement and participatory elements of the research, ensuring that LesBian* communities were meaningfully involved in all phases of the project.

Sida Studi

Sida Studi designed and delivered the pilot training programme for primary care professionals, and led its feminist evaluation.

EL*C — EuroCentralAsian Lesbian* Community

EL*C is the international NGO responsible for the visibility, communication and dissemination of the project and its results. EL*C ensures that knowledge produced by L-Health reaches lesbian communities, policymakers and health systems across Europe and Central Asia.

8. A Word from EL*C: Knowledge Is a Political Act

The L-Health project has produced something unprecedented: the first scientific evidence base on LesBian* health in primary care in Europe. But evidence alone does not change systems. That requires political will, community pressure, and organisations willing to take that knowledge and turn it into action.

At EL*C — the EuroCentralAsian Lesbian* Community — we believe that lesbian health is not a niche issue. It is a feminist issue, a human rights issue, and a public health issue. When healthcare systems fail to see us, they are not just making a clinical error. They are reproducing the same structures of exclusion that have always made our lives harder, shorter and less visible.

> *“Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare.”*
> ***Audre Lorde, A Burst of Light, 1988, p. 131***

Lorde wrote those words in 1988 while battling cancer. She wrote them for Black women. She wrote them for all of us. They remain as true today as they were then — and the findings of L-Health are the data that prove it.

The heteronormativity that Adrienne Rich named in 1980 is not a relic of the past. It is alive in every consultation room where a doctor assumes their patient has a husband. It is alive in every gynaecological check-up that was never offered because “lesbians don’t need it”. It is alive in every health record that has no space for who we actually are.

The intersectional framework that Kimberlé Crenshaw gave us in 1989 is not abstract theory. It is the reason why a racialised lesbian with a disability in a rural area faces not one, not two, but multiple compounding barriers every time she tries to access care. L-Health has now measured those barriers. They are real, they are systemic, and they are our responsibility to dismantle.

EL*C was founded on the conviction that lesbian communities deserve visibility, dignity and power — not as a footnote to broader LGBTQ+ agendas, but as a political subject in our own right. Our participation in L-Health has been guided by that same conviction: that research which centres our lives is not a luxury. It is a necessity. And that knowledge which stays in academic reports does nothing for the woman who goes to her doctor next week and is told, again, that she has no risk.

This report is our commitment to making sure that does not happen. The science exists. The tools exist. The political will is what we are demanding — from health authorities, from training institutions, from European institutions, and from every system that has for too long looked at us and seen nothing.

> *Caring for our bodies, naming our discrimination, and demanding that science include us is still a political struggle. And we will not stop until our bodies are at the centre of health training and research.* **EuroCentralAsian Lesbian* Community (EL*C), 2026**

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(*) The L-Health project uses the term LesBians as an inclusive concept encompassing lesbians, bisexual and pansexual women (both cisgender women and other gender-diverse people) and heterosexual women who have affective-sexual relationships with other women.*