

The National



LGBT Partnership

VCSE

health &
wellbeing
alliance ■



Hard Done Bi: An Exploration of Bi+ Health Inequalities in England

March 2024

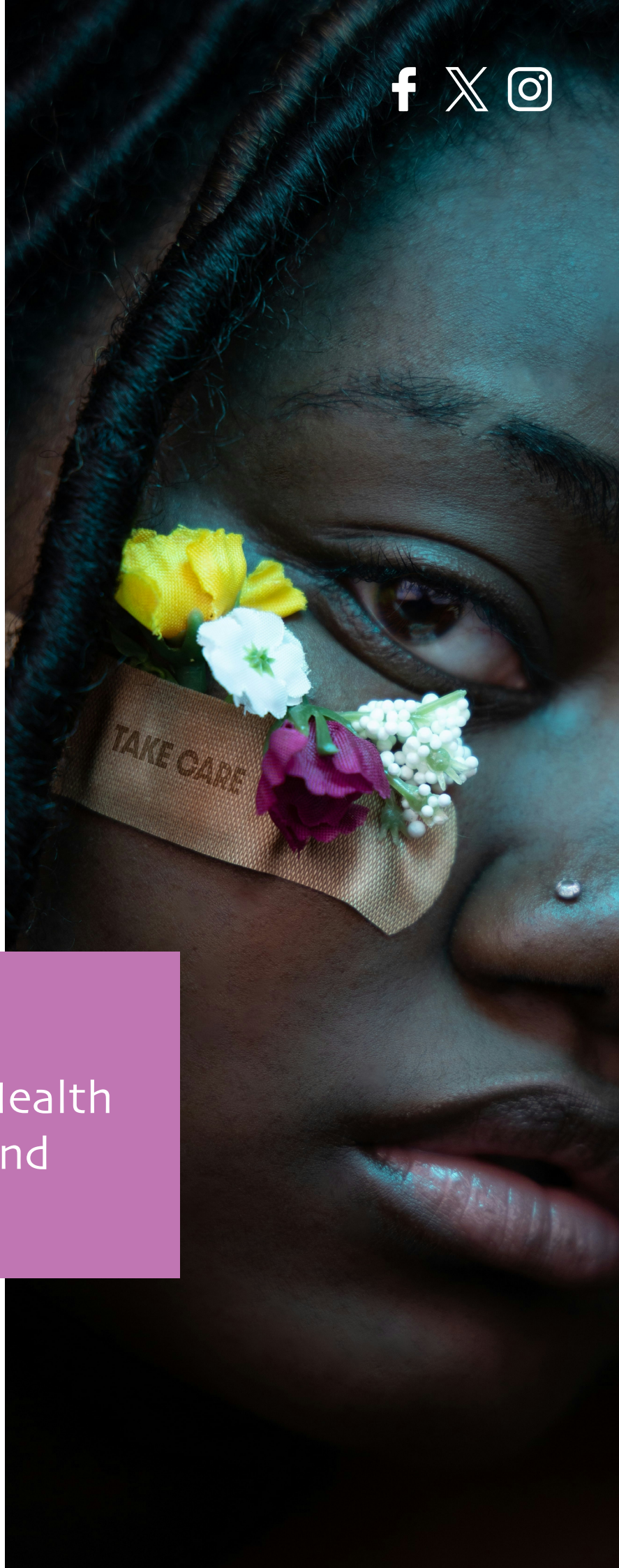


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Foreword

Within the bisexual, pansexual, and multi-gender (bi+) community, particularly among those of who involved in organising within the community, there has long been discussions based on anecdotal evidence that bi+ people were more likely to be disabled, chronically ill, or dealing with mental health issues than the general population. Many community organisers ourselves are disabled, chronically and/or mentally ill also, meaning community building has to be done around this.

There has been some research already to support this notion. For example, a study released last year found that bisexual women were four times more likely to be living with a long-term health condition than the general population.¹ There have also been a few studies from both the US² and UK^{3,4} showing that bisexual people, particularly women, are more likely to be struggling with mental health issues, including suicidality, self-harm, and eating disorders. In many ways, it comes as no surprise that these new findings shore up that data.

What is particularly interesting from this study is the insight in BPD/EUPD and bisexuality. Again, there has long been discussion within the bisexual community that bi+ women in particular are more likely to be diagnosed with a personality disorder. Perhaps in part because of the conflation with bisexuality and hypersexuality with the diagnosis criteria, as well as bi+ people's increased likelihood to be survivors of trauma, as also reflected in the findings of this study.

As such, it's vital that we know more about bi+ peoples experiences with accessing healthcare, and this study lays critical groundwork. As some studies in America suggest, and this one builds upon, bi+ people may be reluctant to seek medical health due to anxiety of experiencing microaggressions, a lack of understanding, or even due to hostility from healthcare practitioners. This may mean that bi+ people are not receiving early intervention or adequate care, which could be contributing to the rates of long-term illness we are seeing.

Other studies, including the one from Brighton and Sussex, suggests that the minority stress from the double discrimination bisexual people face could also be playing a role. Further research into the underlying causes of ill-health among bisexuals is necessary and this study is a positive step in this direction.

Lois Shearing (any pronouns)
Bi+ Activist & Author



Introduction

Who We Are

The National LGBT Partnership connects a group of thirty-nine LGBTQIA+ organisations across England committed to reducing health inequalities and challenging homophobia, biphobia, and transphobia within public services, improving access to health and social care for LGBTQIA+ people. The Partnership is led by [LGBT Foundation](#) and [Consortium](#). To view a full list of the thirty-nine partners, visit <https://www.consortium.lgbt/nationallgbtpartnership/about-the-partners/>

The Partnership is a Sector Strategic Partner of the Department of Health, Public Health England, and NHS England, collaborating with a wide range of organisations as part of the Health and Wellbeing Alliance, influencing policy, practice, and actions of Government and statutory bodies.

✕: [@LGBTPartnership](#)

Dr Rosie Nelson (they/them) contributed to the desk research and writing of this report. Rosie is an expert in bisexuality, gender, queer theory, and feminism.

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Laura Clarke (she/they) acted as the project lead for this report and contributed to the qualitative research. Laura is the Partnership Coordinator for the National LGBT Partnership and an LGBTQIA+ specialist as well as an accredited sex and relationships educator.

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Background

“The experiences of bisexual people are often invisible due to inadequate data collection. A high percentage of research into the experiences of LGBT people fails to identify that the experiences of bisexual people may be different to those of lesbian and gay people. Where data exists, this has been integrated in this report, but most notably, bisexual people in particular feel unable to be open about their identities with friends and family and face a worryingly high level of discrimination from within LGBT communities.”⁵

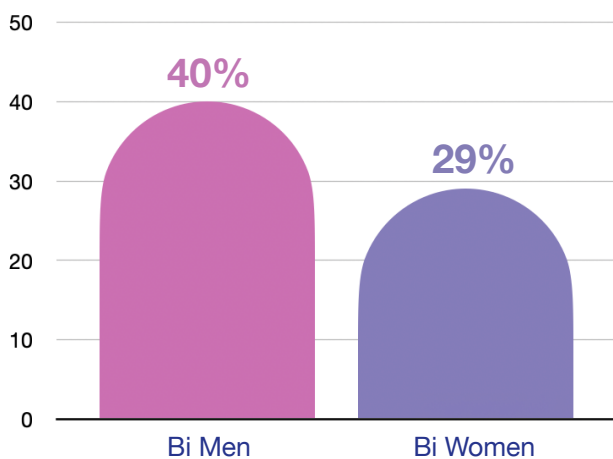
Bi+ people experience complex barriers related to biphobia and monosexism in their everyday lives. Examples of these barriers include being stigmatised as hypersexual, being underrepresented in the media, being mistaken for heterosexual or gay/lesbian, and being excluded from both heterosexual and

LGBTQIA+ spaces.⁶⁻¹¹ As a result, bi+ people experience unique forms of discrimination and oppression based on their attempts to navigate a monosexist society.¹²

Although we do know that bi+ people experience unique forms of discrimination and oppression in their day-to-day lives, bi+ people are still regularly under researched.¹³ What this means in practice is that we are not able to understand the full lived reality of bi+ people due to significant gaps in academic and research knowledge around bi+ lives. This is firstly because there is very little funding for bi-specific research as it is seen as niche, and secondly because bi+ people are regularly incorporated into wider studies of LGBTQIA+ communities, where their experiences are not specified or understood singularly. This latter issue is significant, as some researchers have suggested that the inclusion of bi+ people in broader LGB studies⁶ may actually negatively skew results and findings due to the complex discrimination bi+ people navigate.¹⁴

Although there are significant gaps in the knowledge surrounding bi+ people, there are some important findings that a small body of research has discovered that are relevant to health and wellbeing. In short, bi+ people are more likely than heterosexual people to experience complex health inequalities. In some cases, research has highlighted that bi+ people experience more significant levels of health problems when compared to lesbian and gay individuals. We can extrapolate from this data that we need to take the issue of health and bi+ people seriously. Bi+ people demonstrating poorer health is indicative of a human rights issue where bi+ people are not being afforded the dignity and resources needed to live an equitable life. In fact, in discussing young people, Költő et al. wrote that “young people attracted to both genders or identifying as bisexual are disproportionately affected by stigma, discrimination, social exclusion, and their negative health consequences than their exclusive same- or opposite-gender attracted (lesbian, gay, or heterosexual) peers. Interventions and policies should tackle [...] monosexism and biphobia”.¹⁵ This is complicated to tackle when we consider reports that:

sector research outputs. It is crucial to understand that there is not enough data and information here. To fully understand this issue, it is critical to fund larger-scale research to explore health inequalities amongst bi+ people, paying particular attention to intersectional issues of class, gender, race, age, ethnicity, and disability. Further, it is crucial to explore the experiences of those who demonstrate a multigendered attraction without specifically adopting a bi+ sexual identity.



40% of bi men and **29%** of bi women have not disclosed their identities to any healthcare professional (compared to **20%** of LGBTQIA+ people generally).⁴

This report will chart the health inequalities emergent across various academic and third



Glossary

- AFAB** This is an acronym meaning “assigned female at birth”
- AMAB** This is an acronym meaning “assigned male at birth”
- Asexual** This is an expansive term which is unique to the individual, however, it broadly means someone who does not experience sexual desire
- Aromantic** This is an expansive term which is unique to the individual, however, it broadly means someone who does not experience romantic desire
- Bi+** Bi+ is an umbrella term used to refer to any multigender-attracted sexual identities. It is intended to be a more inclusive term than “bisexual” as it acknowledges the variety of identities that include a multigendered attraction, such as pansexual, queer, or biromantic identities
- Bigender** This denotes someone whose gender identity is inclusive of two genders
- Biphobia** Biphobia is a dislike or prejudice against bi+ people
- Bi+ erasure** Bi+ erasure is where the existence or legitimacy of bi+ identities is called into question
- Bi+ invisibility** Bi+ invisibility is where bi+ identities are ignored, removed, falsified, or reexplained in society
- Cisgender (Cis)** Describing someone whose gender identity matches their assigned gender at birth
- Gray-Ace** This is a deliberately vague term used as an identity for people who may experience sexual attraction, or may not, dependent on various other factors, but it is not strictly consistent
- Gray-Aro** This is a deliberately vague term used as an identity for people who may experience romantic attraction, or may not, dependent on various other factors, but it is not strictly consistent



- LGB** LGB is an acronym used to refer to only minoritized sexual identities, including lesbian, gay, and bisexual people.
- LGBTQIA+** LGBTQIA+ is an acronym to refer to the many minoritized sexualities and genders, including Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, Aromantic and other identities. Throughout the report we predominantly use “LGBTQIA+”, however “LGBTQ+”, “LGBTQ”, “LGBT+” and “LGBT” are also used to represent the queer community as a whole.
- Monosexism** Monosexism refers to the belief that monosexual identities (e.g. attraction to a single gender, such as gay, lesbian, or heterosexual identities) are more legitimate or superior than bi+ identities.
- Non-Binary** Describing someone whose gender identity is outside of the gender binary of man and woman
- Pansexual** Pansexuality is the sexual and romantic attraction to individuals regardless of their gender identity
- Polyamory (Poly)** The practice of engaging in multiple romantic and/or sexual relationships with the knowledge of all individuals involved
- Pre-exposure prophylaxis (PrEP)** Preventative medication taken by a HIV-negative person to reduce the risk of contracting HIV
- Quariwarmi** A pre-colonial Peruvian/Incan mixed-gender identity, meaning ‘man-woman’
- Queer** Queer is a very expansive word that attempts to encompass the departure from dominant heterosexual and cisgender identities. Queer can refer to same-gender interest, different sexual practices, different relationship formats, and different gender expressions. It can mean all of these, or none of these. This word is deliberately ambiguous to challenge the convention of choosing an identity category and thus reinscribing power dynamics through hierarchical identities.
- Transgender (Trans)** Describing someone whose gender does not match their assigned gender at birth



Methodology

It must be noted that this study is a limited early exploration of bi+ health inequalities. This methodology was intended to begin to explore the issues and consider whether this topic is an issue that warrants further study. Our limited methodology has found that this is an issue that would benefit from further study, with a significantly more robust and expansive methodology to strengthen and further contextualise the findings from this study.

This was a five-part exploration:

1. **Desk-based literature review:** the Desk-Based Researcher (non-binary, bisexual, white) conducted a brief adapted scoping review methodology to explore UK-based literature on bi+ health inequalities to inform the study.
2. **Survey:** a survey, designed by the Project Lead (cis woman, bisexual, white), was advertised online for bi+ individuals to record their experiences of healthcare and discrimination within healthcare. This survey gathered 258 responses.
3. **Roundtable events:** two roundtable events were conducted by the Project Lead, where participants were invited based on their experiences recorded in the survey. These participants were asked to discuss collaboratively the issues relevant to healthcare for bi+ people. The total number of participants across the two roundtables was 15; 7 at the first and 6 at the second.
4. **Interviews with bi+ group leaders:** five interviews were held with five leaders/founders of bi+ social and support groups across England — one from Nottingham, one from Cambridge, one from Southampton and two from London. Interviews were semi-structured along the lines of the themes found in our survey and roundtables. Interviewees were asked to share their observations of these themes within the bi+ community.
5. The Project Lead met with the NHS England LGBT Health Team, led by Dr Michael Brady, to discuss strategic recommendations for the NHS based on the findings of this report. These aims include suggestions for further research.

Importantly, the methodology was purposefully limited due to time, staff, and funding restrictions. This means that specifically, the desk-based literature review did not use a variety of different search terms and in our primary research we were unable to fully represent the diversity of the bi+ community. Our survey was only advertised online (social media, newsletter) which may have contributed to this research largely representing a younger demographic. The survey may have been less accessible to older people, who are possibly less likely to use the internet. Our roundtables also primarily featured white participants due to a lack of time and resources for targeted recruitment aimed at bi+ people of colour. Another impact of time restrictions was that we were unable to present our strategic recommendations to the bi+ community for feedback.

Despite the limitations of this methodology, this research has found novel issues that require further attention, exploration, and research to contribute to the wellbeing of bi+ people accessing healthcare. This research has found significant avenues that require further exploration.

This report is composed of desk-based research, a survey, and several roundtable events. Each methodology will be discussed in turn.

Desk-based research

The Desk-Based Researcher (non-binary, white, bisexual) explored both academic and grey literature from third sector organisations. Importantly, the academic literature searches were limited due to time constraints, a discussion of which will follow. This report was developed under time constraints, and it is recommended that a further report be commissioned that uses a systematic review methodology and expands on search terms, databases, and consultation with academic experts.

This report, though not comprehensive, is able to briefly indicate the scope of the research field in relation to bi+ health inequalities. The search process followed a systematic approach of identifying the research area and question, searching the academic and grey literature, including/excluding relevant research items, and synthesising the findings into a thematic discussion. The research question posed in developing the literature searches was **“What do we know about bi+ health inequalities in the United Kingdom?”**

Academic Database Search

Searches were made across PubMed, ProQuest, Web of Science, CINAHL and PsycInfo. These searches used the following string of terms:

Bisexual AND health AND inequalit* AND (UK or United Kingdom OR England OR Wales OR Scotland OR Northern Ireland)*

Due to a high level of results, the ProQuest search included an additional amendment of searching bisexual* within the abstract exclusively to narrow the results. Articles were subject to a title and abstract and then full text review, and were included based on the following criteria:

Inclusion criteria:

- Empirical research (qualitative, quantitative, or mixed methods) or systematic reviews
- Focused on health outcomes, treatment, incidences
- Bi-focused research or research where bi+ people were not conflated with LGBTQIA+ identities
- UK-focused work

Exclusion criteria:

- Clinic notes, magazine articles, poster presentations, etc.
- Items that conflated bi+ identities with LGBTQIA+ identities (e.g. through not specifically drawing out bi+ incidences in healthcare settings)
- Items not focused on health and wellbeing
- International work with no specific mention of the UK
- Inaccessible items (e.g. due to no library access)
- The bi+ sample inclusion was too small and did not contribute meaningfully to the study findings

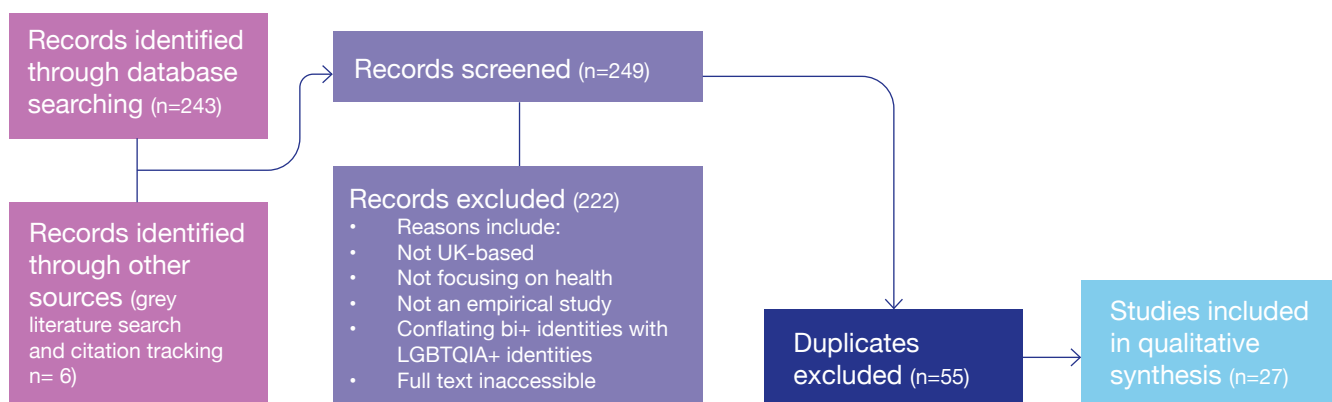
Grey Literature Search

Third sector organisations, NGOs, the NHS, and Government bodies have also contributed to this area of knowledge via surveys and studies. This has resulted in a strong body of grey literature. Grey literature was found for this study based on expert consultation with LGBT Consortium, searching relevant organisations websites, and Google searches.

The grey literature included further references to studies that had not been found via the academic database search, and these were incorporated to further bolster this report’s findings.

Search Process

The search was completed in May 2021. The list of all the included research can be found at the end of this report. The flowchart of the search process is as follows:



Identification

Screening and Eligibility

Duplication

Included

Search Limitations

The methodology used in this report has several important limitations that need to be recognised when contextualising the relevance and potential use of the findings. These limitations are largely due to the limited time available to construct this report.

Firstly, the academic search used only one string of terms across all databases. This has severely limited results, and further searches should consider including different terms and combinations (such as pansexual, wellbeing, queer, etc.)

Further, the current search reflects a very specific theoretical and academic approach to understanding bi+ health, specifically due to its incorporation of 'inequalit*' which has the impact of ensuring that any work found via academic database searching is going to adopt a theoretical understanding of health as being unequal for bi+ people. This limits the variety of research that can be found which may not presume inequality for bi+ people.

Additionally, this search did not approach academic and industry experts for further references and citations to bolster the findings of this report.

Future research should adopt a more diverse search strategy and consult with academic and industry experts to create a more consolidated report. It is also recommended that future research should adopt a more stringent search methodology, such as a systematic review or a scoping review, both of which are excellent methods of securing robust results that can indicate the scope of a field and the scope of findings.

Survey

To complement this research, a survey was developed to gain a direct insight into bi+ people's experiences of healthcare. This survey was titled "Bi Health Research Survey" and was available to any person over 18+ who lived in England and identified as bi+. The Project Lead (cisgender woman, white, bisexual) developed the survey using online survey website, Alchemer. All survey responses were gathered over 18 days, across May & June 2021, due to time restraints on the project.

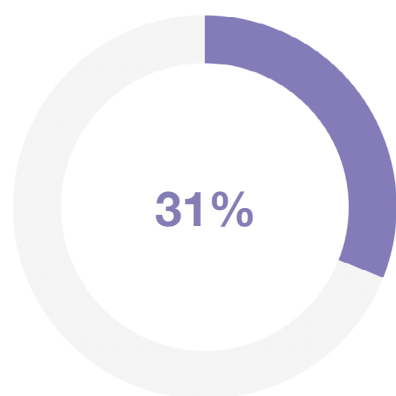
This survey recorded the participants demographic data in line with the data collection methods of LGBT Foundation.

Questions regarding the experiences of bi+ people were influenced by Stonewall's LGBT in Britain: Health Report (2018), the GP Patient Survey and the UK Census. Our aim was to ask similar questions so that we could easily compare findings such as the levels of the bi+ community living with mental health conditions compared to the general population, the percentage of bi+ people out to their healthcare professionals and satisfaction levels with healthcare providers. The survey included a number of tick-box multiple-choice questions along with open text boxes for questions that required more elaboration.

This survey was anonymous however participants could choose to leave their email address should they wish to speak at the roundtable events (see below). There was an incentive of a prize draw for a £50 Love2shop voucher for completing the survey.

The survey was promoted on the National LGBT Partnership’s Twitter & Instagram pages as well as in the newsletter. It was specified that we were looking for bi+ people, and explicitly mentioned that this included all non-monosexual identities. The survey was completed by 258 people. One limitation to this approach is that older people may have been less likely to encounter the survey as they may spend less time on the internet or find it less accessible. We also did not have time to specifically target bi+ minorities such as bi people of colour.

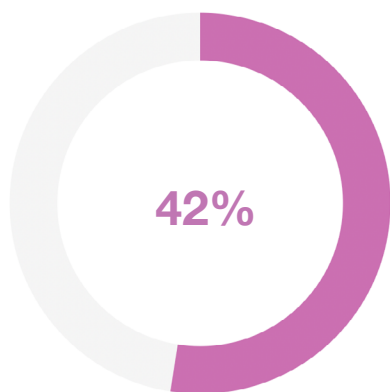
Our survey represented a diverse bi+ population in many ways.



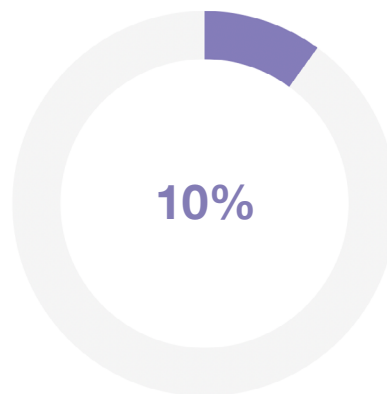
31% of people surveyed did not identify with the gender they were assigned at birth. One reason for this high number may be that a large percentage of the trans

community identify as bi+. Our survey also represented a large number of disabled people.

42% of those surveyed identified as having a disability or long-term physical or mental health condition that affected their daily life compared to the national average of **18%**.¹⁶



This may be explained by the fact that bi+ people are more likely to experience physical and mental health conditions.¹⁴



Only **10%** of those surveyed didn't identify as "White British", "White Irish" or "Other White Background". Within that **10%** we received responses from people identifying

as "Mixed White & Black African", "Mixed White & Asian", "Other Mixed Background", "Asian or British Asian Indian", "Asian or British Asian Bangladeshi", "Any Other Asian or Asian British Background", "Black or Black British African", "Any Other Black or Black British Background" and a small number who self-specified.

The Project Lead worked through the responses to the survey, identifying reoccurring themes and keywords. These were then sorted into seven key themes.

Roundtables

The Project Lead (cisgender woman, white, bisexual) conducted two roundtable events; one with 7 participants and one with 6 participants. The first of these events was organised during typical working hours, and the other outside of typical working hours. We hoped that this would reduce barriers to attendance. Participants were given the option of which to attend.

The roundtables were conducted via Zoom due to the COVID-19 pandemic and each lasted two hours.

The roundtables were predominately made up of white European cisgender women and non-binary people. Most attendees were between the ages of 18-45 and the majority identified as disabled.

Roundtable participants were chosen from the survey respondents. We selected people who had provided information that we wanted them to expand on, for example, those who had written about multiple experiences, those who had experiences outside of what we already knew through desk research and people who wrote at length about an experience relating to one of our key themes. During both roundtables the participants were presented with the themes we had identified from the survey, via a PowerPoint presentation. Each theme (e.g., mental health, LGBTQIA+ spaces, etc.) was backed up by anonymous quotes directly from the survey. We asked participants if they had experienced discrimination relating to the key themes, if they had any comments on the theme or the quotes presented or if they would like to expand on what they wrote in the survey. At the end of the roundtable participants were asked what healthcare providers could do to be more inclusive and understanding of bi+ people.

The roundtables were recorded with the consent of the participants and were transcribed at a later date. Quotes were taken from the transcription and sorted into the categories we had identified from the survey based on themes and keywords.

All roundtable participants were paid with a £25 Love2shop voucher for taking part in the 2-hour session.

Interviews with Bi Group Leaders

The Project Lead (cisgender woman, white, bisexual) reached out to bi+ social and support groups across England via email, inviting them to attend one-on-one interviews. These

interviews lasted roughly 45 minutes to an hour and were conducted on Zoom due to the COVID-19 pandemic. Interviews were held with five bi+ group leaders — one from Cambridge, one from Southampton, one from Nottingham and two from London.

The interviews were semi-structured, using the key themes from the desk research, survey and roundtables as conversation prompts. All interviews were recorded and transcribed with the interviewees consent.

Following the interviews, quotations were taken from the transcriptions and sorted into the seven key themes we'd previously identified.

Key Findings

- Bi+ people are often assumed to be promiscuous by healthcare professionals, which impacts the way services are delivered as well as service provision options
- Bi+ people who took part in this research have experienced therapists suggesting that their sexual identity was indicative of poor mental health, meaning that their mental health care has often centred around discussions of the individuals' sexuality
- Some healthcare providers assume that bi+ people are either heterosexual or gay/lesbian based on their partner
- Some LGBT-positive health care services still demonstrate biphobia and monosexism in their service provision
- Male sexual healthcare provision is often targeted towards gay men and is exclusionary towards bi+ men
- Healthcare experiences are complicated further by intersecting systems of oppression that impact people who possess multiple minoritised identities



Findings

The findings of this study indicate that bi+ health inequalities exist, which are different from the health inequalities that gay, lesbian, and heterosexual people experience.

This will be understood first from the presentation and analysis of quantitative results from our survey for bi+ people, then explored more deeply across seven themes which emerged via roundtable discussions with bi+ people, qualitative responses from the survey, and a literature review of pertinent UK-based literature.

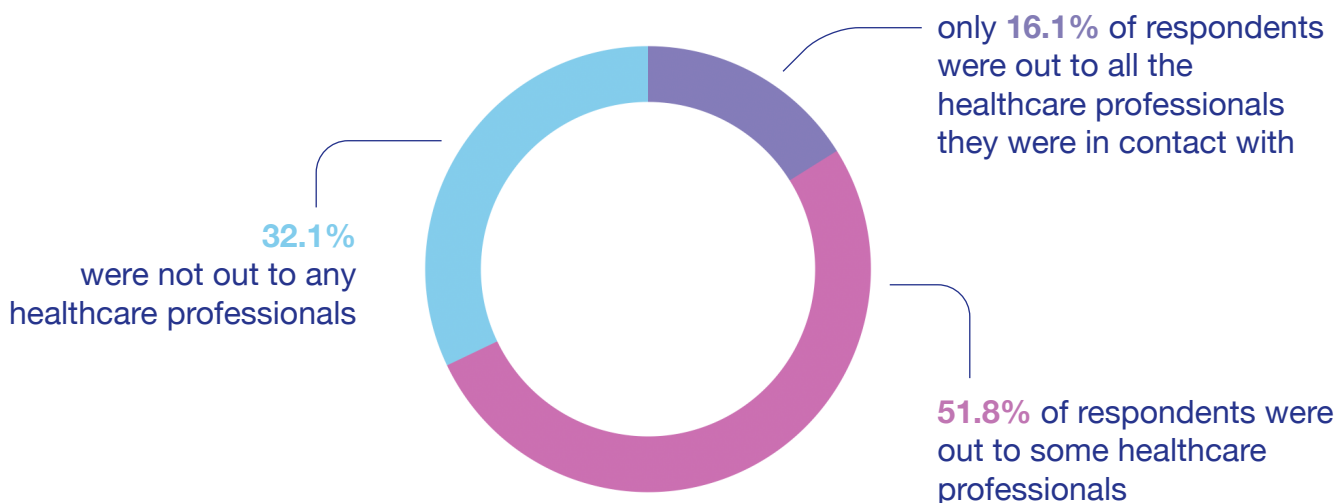
Quantitative Findings

We developed a survey to gain direct insight into bi+ people's experiences of healthcare; this included tick-box multiple-choice questions as well as open text boxes for questions that required more elaboration. Many of the written answers are embedded throughout the report, informing our analysis of key themes that we've identified in bi+ experiences.

The quantitative answers we received from

bi+ people revealed that respondents faced challenges with mental and physical long-term health conditions. We also understood that a significant number of respondents had negative experiences with health care professionals.

When we asked bi+ people whether they had disclosed their sexuality to healthcare professionals, we found that:

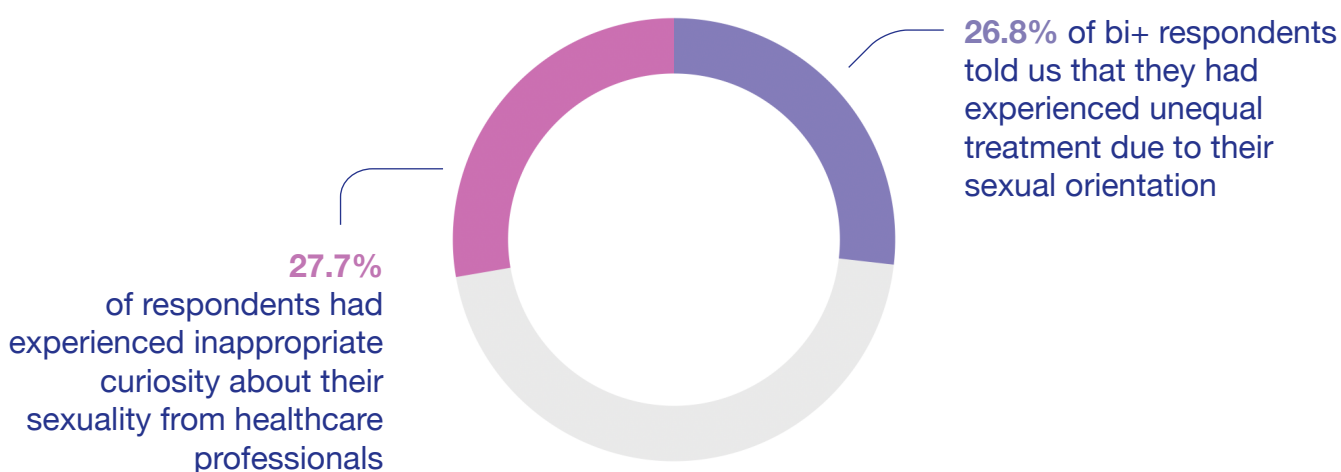


Respondents cited in written responses that they expected to receive scrutiny or a lack of understanding from healthcare professionals, or that they did not disclose because it did not seem relevant.

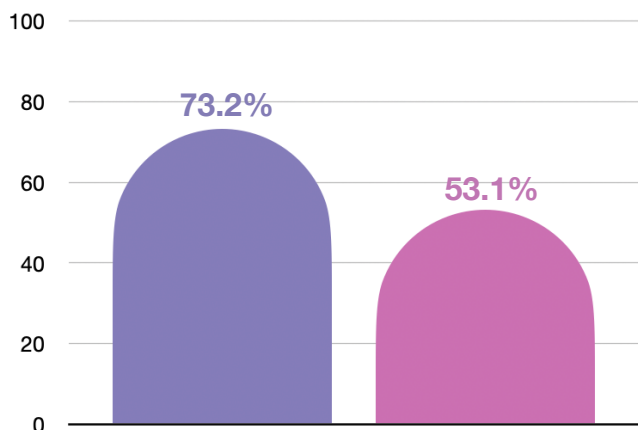
“I am not out to healthcare professionals. I am under the local mental health team and don't want them to scrutinise my sexual orientation as well as everything else in my life.”
- (Survey respondent)

“[...]so uncomfortable, did not disclose my sexuality because I knew he would not understand and it wasn't relevant in the first place.”
- (Survey respondent)

Respondents cited in written responses that they expected to receive scrutiny or a lack of understanding from healthcare professionals, or that they did not disclose because it did not seem relevant. Additionally,

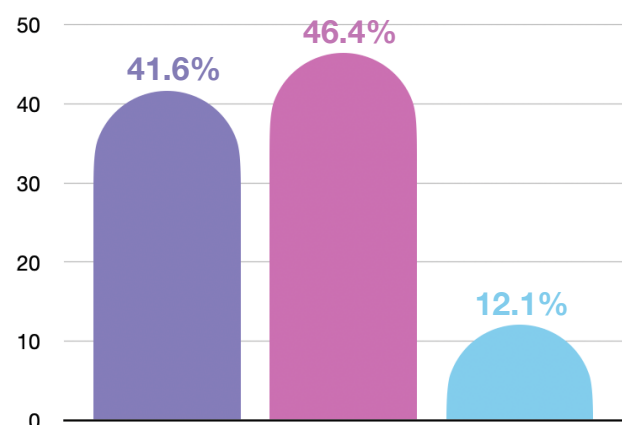


These instances of unequal treatment that bi+ people experience can be varied and are explored in more detail throughout the report. A wish to avoid unequal treatment and inappropriate questions may contribute to bi+ people's reluctance to come out to healthcare professionals.



Although 73.2% of bi+ respondents reported that they did not experience unequal treatment, over half of respondents (53.1%) told us that they experienced a lack of understanding about their sexual orientation from healthcare professionals. This lack of understanding is likely to be understood by some bi+ people as unequal treatment, but not all. For some respondents, a lack of understanding was felt to be an expected part of their experience.

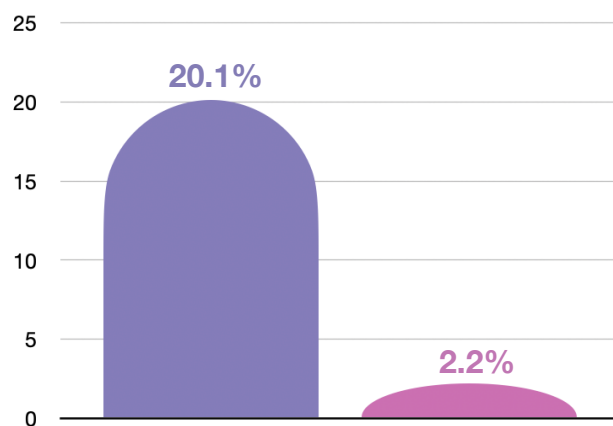
“Not necessarily unequal treatment, but just a complete lack of understanding.”
- (Survey respondent)



When asked how well they considered healthcare professionals to understand non-monosexuality; 41.6% thought that they had “no understanding” or “little understanding”, 46.4% thought that they had “some understanding”, and 12.1% thought that they had “decent understanding” or “full understanding”. This reflects the widespread non-monosexual experiences of bi+ erasure and invisibility. Many bi+ people told us that they would like to see more understanding of bi+ identities and experiences from healthcare professionals.

“Train staff to understand what bisexuality is and the biases and microaggressions faced by bisexual people.”
- (Survey respondent)

Many LGBTQIA+ people prefer to access services that indicate they are LGBTQIA+ inclusive or that are specifically designed for and delivered by LGBTQIA+ people. However,



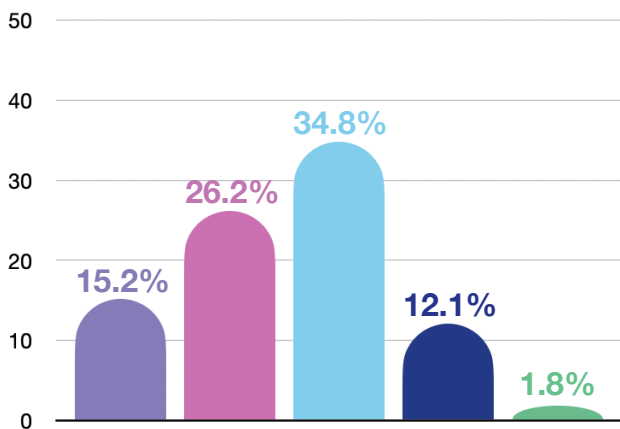
20.1% of bi+ survey respondents felt that there was no difference between how comfortable they felt accessing LGBTQIA+ inclusive services and general services, and 2.2% of people felt less comfortable.

6.7% of respondents felt that they had experienced unequal treatment due to their sexual orientation within LGBTQIA+ inclusive services.

“In terms of LGBTQ inclusive services, it’s very mixed. I have had some good and some bad. I experience bi erasure quite frequently.”

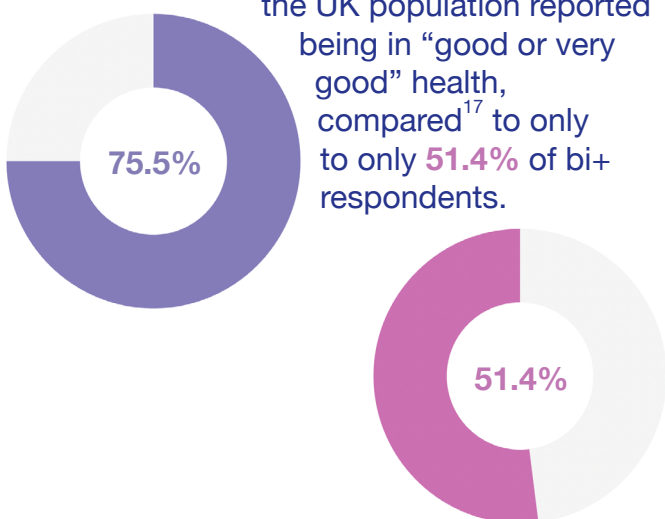
- (Survey respondent)

We asked bi+ people who responded to the survey to self-report how they perceived their general levels of health.

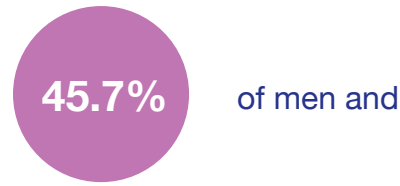


We asked bi+ people who responded to the survey to self-report how they perceived their general levels of health. **15.2%** of respondents told us their health was “very good”, **26.2%** of respondents told us their health was “good”, **34.8%** of respondents told us their health was “fair”, **12.1%** of respondents told us their health was “bad”, while **1.8%** of respondents told us their health was “very bad”.

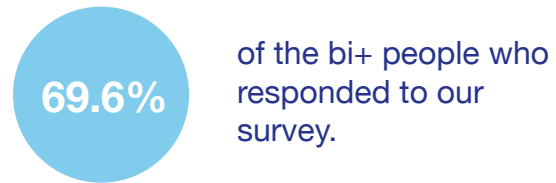
The 2021 UK Census found that **75.5%** of the UK population reported being in “good or very good” health, compared¹⁷ to only **51.4%** of bi+ respondents.



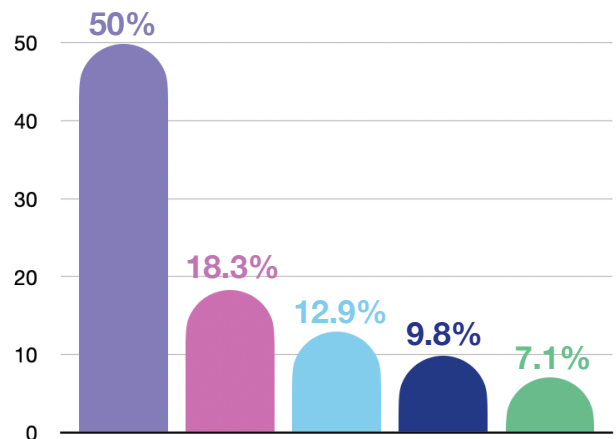
Additionally, according to the Office for National Statistics,



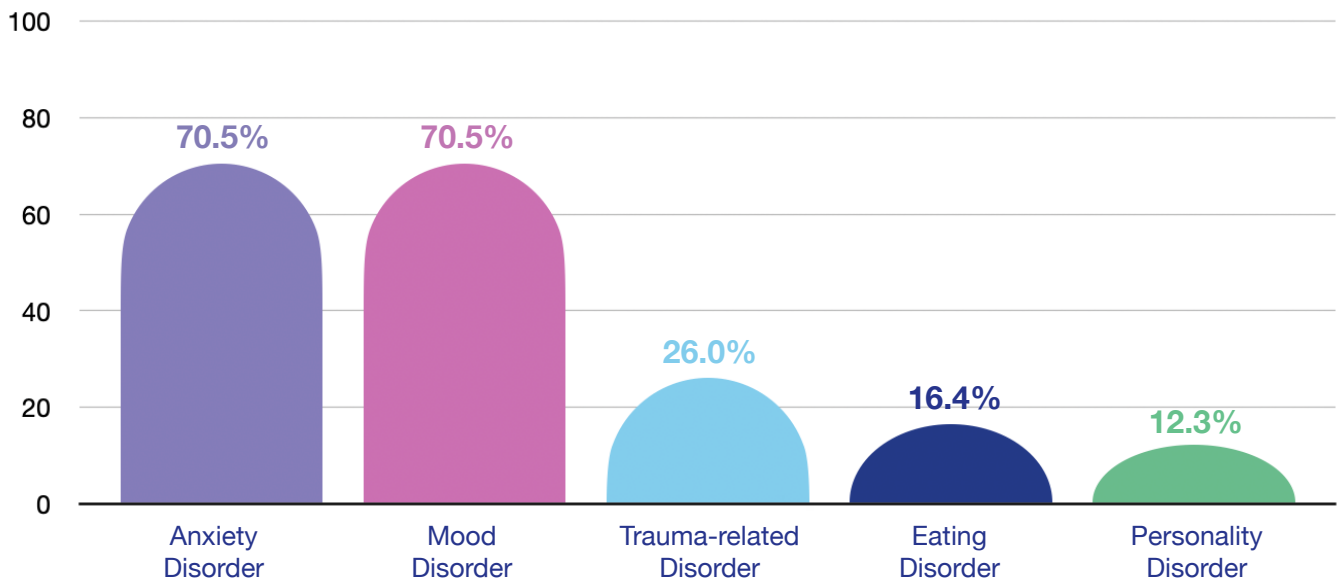
reported having a long-standing health condition¹⁷, compared with



When asked more about their long-term conditions, we found that



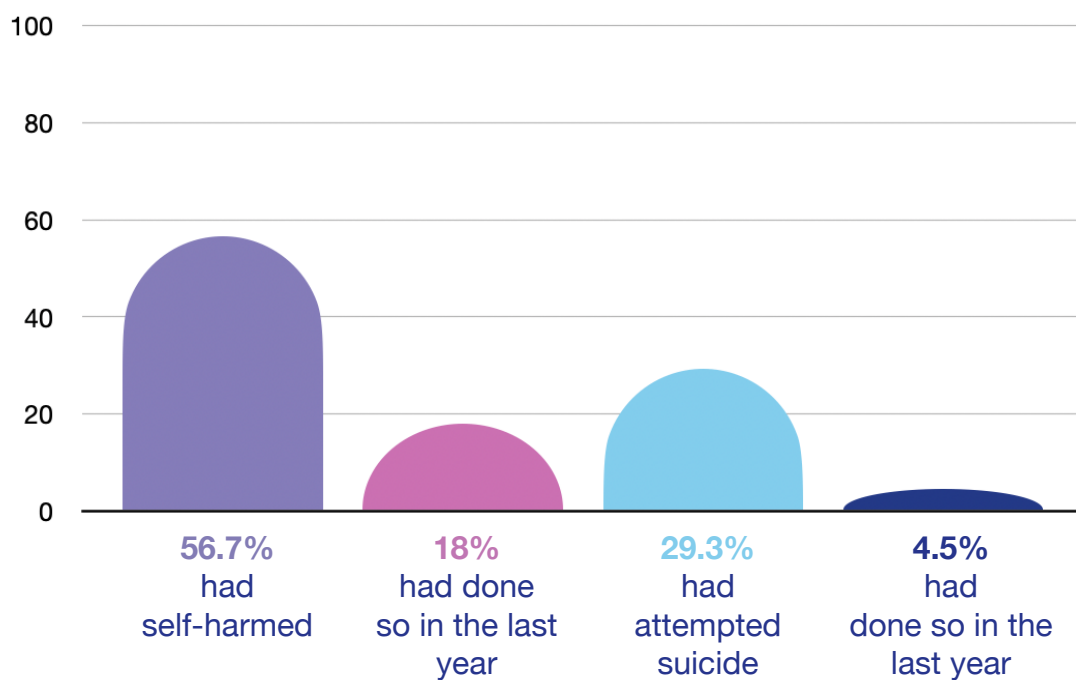
50% of bi+ respondents had a mental health condition; **18.3%** were autistic or had an autism spectrum condition; **12.9%** had a breathing condition such as Asthma or COPD; **9.8%** had an ongoing problem with their back or joints such as arthritis; and **7.1%** had a neurological condition such as epilepsy.



In terms of mental health, we found that **70.5%** of bi+ respondents had been diagnosed with an anxiety disorder, such as Generalised Anxiety Disorder or Panic Disorder; **70.5%** had been diagnosed with a mood disorder, such as Depression or Bipolar Disorder; **26.0%** had been diagnosed with a trauma-related disorder, such as Post-Traumatic Stress Disorder or Acute Stress Disorder; **16.4%** had been diagnosed with an eating disorder, such as Anorexia, Bulimia or Binge Eating Disorder; and **12.3%** had been diagnosed with a personality disorder, such as Borderline (otherwise known as EUPD) Personality Disorder or Antisocial Personality Disorder.

The percentage of bi+ respondents who were diagnosed with personality disorders (**12.3%**) is significant compared to a prevalence of **4.4%** among the general population¹⁸. Multiple survey respondents and roundtable attendees elaborated on this further, describing their experiences of diagnosis and perceived misdiagnosis of Borderline Personality Disorder.

In addition to this, of the bi+ respondents:



Qualitative Findings

The findings of this study indicate that bi+ health inequalities exist, which are different from the health inequalities that gay, lesbian, and heterosexual people experience. This will be understood first from the presentation and analysis of quantitative results from our survey for bi+ people, then explored more deeply across seven themes which emerged via roundtable discussions with bi+ people, qualitative responses from the survey, and a literature review of pertinent UK-based literature.

Assuming Promiscuity

Bi+ people who participated in the survey and the roundtables spoke about how healthcare professionals would often assume that they were promiscuous upon learning of their bi+ sexual identity:

“The nurse would just slut shame me after I came out to her as bi.”

(Non-Binary, Queer, 18-24, White British, Disabled, Survey Participant)

“Inappropriate suggestions of sexual promiscuity by multiple nurses.”

(Cis Woman, Bisexual, 25-34, White British, Disabled, Survey Participant)

“Comments about ‘anything goes’ when it comes to bisexuality. Assumptions made about level of sexual activity (e.g. assuming all bisexual people engage in group sex/multiple partners, non-monogamy)”

(Cis Woman, Pansexual, 35-44, White British, Disabled, Survey Participant)

The presumption that bi+ patients would be more sexually active, promiscuous, have multiple partners, take part in polyamory, or have sex with multiple partners was repeated across survey and roundtable participants. Bi+ people also connected disclosures of a bi+ sexual identity to a different treatment pathway as a result of their sexualities:

“I had a routine smear test, and my GP said “oh, there might be something a bit unusual, we’ll send you for a follow-up check-up”. As far as I remember, my GP doesn’t have my sexuality on file but they did ask me when I went to [the] hospital for the check-up. And then the immediate reaction was, “shall we do an STI panel as well?” and I said, “well I am in a long-term relationship with a cis man”. [They said] “oh, that’s alright then!” and I just thought, “hang on a second, what?” At the time, we were also in a non-monogamous relationship and they kind of just discounted that.”

(Non-Binary, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“They definitely pressured me very strongly to get HIV tested, when they hadn’t otherwise.”

(Agender, Bisexual, 35-44, Other White Background, Disabled, Roundtable Participant)

“When accessing sexual health services, the nurses seem to think that the fact that I sleep with women is completely irrelevant because women cannot possibly pass STIs onto each other. However, one time I told them that I had a crush on a bisexual man and they fell over themselves to offer me the Hepatitis B vaccine.”

(Bi Group Leader, Cambridge)

Participants noted that their experiences around sexual health were particularly marked due to presumptions around their sexual behaviour based on their sexual identities. Participants also noted that healthcare professionals directly acted biased towards service users after the disclosure of a bi+ identity.

“Especially during sexual health screenings or contraceptives talks — sort of condescending tones or facial expressions when talking about me being with female partners, or insinuating that I’m “greedy” for sleeping with multiple genders.”

(Cis Woman, Bisexual, 25-34, Other White Background, Disabled, Survey Participant)

“ [I’ve felt] judged for having sex with both AFAB and AMAB individuals, including being asked repeatedly about safe sex, despite the appointment having nothing to do with it.”

(Non-Binary, Bisexual, 25-34, Other White Background, Disabled, Survey Participant)

“I think particularly with bi men, they’re assumed to be in straight-passing relationships and also sleeping with gay men and there’s that inherent, kind of, dishonesty or untrustworthiness.”

(Agender, Bisexual, 35-44, Other White Background, Disabled, Roundtable Participant)

Apart from the clear stigma of bi+ identities, it was apparent that participants broadly felt that many healthcare staff that they interacted with did not understand what it meant to have a bi+ identity.

“ I am ethically non-monogamous but I’m also on the asexual spectrum so sex isn’t a big part of my relationships, so there’s the double, kind of, wrongness that goes with that [assumption of promiscuity]. So yes, I do have multiple partners but I’m not sleeping with lots of people and sex doesn’t play a big part.”

(Non-Binary, Queer, 35-44, White British, Disabled, Roundtable Participant)

“I think people have a fixed idea of what ‘bisexual behaviour’ is, or should be. And it doesn’t matter if their idea of sexual behaviour matches with my behaviour or it doesn’t, it’s still offensive.”

(Cis Man, Bisexual, 35-44, Mixed White and Asian, Disabled, Roundtable Participant)

“I sometimes query whether there is genuinely some level of misunderstanding among certain people about bi vs. poly. There shouldn’t be a stigma about poly to begin with, but just because you’re bi it doesn’t mean you’re poly.”

(Non-Binary, Bisexual, 25-34, White Irish, Disabled, Roundtable Participant)

“One person had been asked the question, “what’s it called when there are multiple people engaging in a sexual act?” I mean, that has no relevance. That’s just gratuitous nosiness that could have been satisfied by looking on the internet, not asking a patient in that setting and making them uncomfortable.”

(Bi Group Leader, Nottingham)

Participants’ experiences are clearly representative of bias, stigma, and a lack of understanding of bi+ identity that directly impacts the experience of receiving treatment, and even potential treatments or investigations that may be offered.

Mental Health

Bi+ people have significant risk indicators for poor mental health, which was echoed in bi group leader’s observations of the community:

“A lot of the people within my group have long-term, quite serious mental health issues. A lot of them have experienced quite a lot of trauma.”

(Bi Group Leader, Southampton)

“I never, until I came out as bi and began to engage with bi people, came across such high levels of social anxiety and insecurity.”

(Bi Group Leader, London)

“I’m friends with a performer who is bi and a person of colour and trans, and they basically say they don’t know any bi people who don’t have mental health conditions.”

(Bi Group Leader, London)

Bi+ people have been found to be less likely to report high family support, feeling comfortable with friends or feeling valued or respected.^{15,19} Young bi+ people also have higher rates of substance consumption, including cigarettes, alcohol, drunkenness, and cannabis when compared to lesbian and gay people.²⁰ Bi+ people are more likely to smoke tobacco and bi+ women have the highest alcohol intake when compared to other sexual identities.²¹

Bi+ people have also been shown to have poorer mental health than other sexual identities. Among men, multigendered sexual attraction is associated with higher odds of depression and of self-harm.^{19,22-24} Bi+ people have more significant rates of suicidality, eating problems, self-harm and addiction.²⁵ In fact, “bisexual people have elevated rates of depression and anxiety relative to heterosexual people, and [...] the magnitude of this disparity is as great as or greater than the disparities experienced by lesbian and gay people”.²⁶ This is reflected in the GP Patient Survey, where bi+ people were more likely to feel isolated and have mental health conditions than lesbian, gay, and heterosexual people.²⁷ In fact, “bi people are more likely to have thought about taking their own life than lesbian and gay people, 41 per cent compared to 28 per cent”.⁴

Among survey and roundtable participants, many bi+ people highlighted how some specific diagnoses were informed by their sexual identities:

“I feel strongly that my identity contributed heavily to being diagnosed with Borderline Personality Disorder.”

(Non-Binary, Queer, 35-44, White British, Disabled, Survey Participant)

“We know that LGBT people are disproportionately diagnosed with personality disorders when they’ve more commonly experienced trauma, and often that trauma is related to minority stress.”

(Non-Binary, Bisexual, 25-34, White Irish, Disabled, Roundtable Participant)

“ I wholeheartedly completely believe that [my diagnosis of Borderline Personality Disorder] was down to the fact that I discussed my bisexuality with the psychiatrist. I asked for my notes in the process and it did discuss my sexuality and my hypersexualisation [...] even though I am bi asexual [...] I was told that I was being sexually promiscuous because of my ethical non-monogamy. These were all used as symptoms that were then used to give me the diagnosis of Borderline Personality Disorder. ”

(Non-Binary, Queer, 35-44, White British, Disabled, Roundtable Participant)

“ This idea of promiscuity for me has led to me having trouble with people recognising my mental health. It led to a misdiagnosis of BPD because I was labelled as engaging with “dangerous sexual activity.” ”

(Bigender, Bisexual, 25- 34, Other White Background, Disabled, Roundtable Participant)

“ I had a friend who was diagnosed with Borderline Personality Disorder basically on the basis that she was bisexual. [...] They were like, “okay, well you’ve clearly got identity confusion because you don’t know if you’re gay or straight. And you’ve clearly got risky sexual behaviour in that you’ll just sleep with anyone.” ”

(Bi Group Leader, Cambridge)

Clearly, bi+ participants felt that healthcare professionals’ lack of training in sexual identities impacted their diagnosis of individuals. This was very specifically related to Borderline Personality Disorder in the experience of many participants, where some symptoms of BPD are also stereotypes of bisexuality (e.g. unstable identity, promiscuity). This extended to diagnoses outside of personality disorders, including anxiety and PTSD:

“ My identity was cite[d] as a reason for my mental health when I was actually suffering from PTSD. ”

(Cis Woman, Queer, 35-44, Black or Black British African, Non-Disabled, Survey Participant)

“ I saw an NHS professional for anxiety and, after the screening questions, she was like, “so how much do you think your anxiety has to do with your bisexuality or your queerness?” ”

(Non-Binary, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“One [female] member has quite bad mental health issues, which stem in part from PTSD caused by sexual violence but because the person that caused it was a woman, it wasn't taken seriously.”

(Bi Group Leader, Nottingham)

These comments are further reflected in the GP Patient Survey, where bi+ people were less likely to think that a professional recognised and/or understood the mental health needs that respondents had when compared with heterosexual, gay, and lesbian people.²⁷ In fact, in both the survey and the roundtable, participants who had previously been diagnosed with mental health disorders expressed firm beliefs that they had experienced misdiagnosis related to their bi+ identities.

Bi+ people do not demonstrate effective recovery rates from mental health treatment. One study demonstrated that “bisexual patients exhibited poorer treatment outcomes than heterosexual patients, in terms of symptom severity, reliable improvement, and reliable recovery after adjustment for baseline symptom severity and key treatment and sociodemographic variables”.²⁸ In this study, Rimes et al. found that, while bi+ men experienced worse outcomes than gay and heterosexual men, there was no significant difference between sexual minority women in terms of treatment efficacy.

Roundtable and survey respondents highlighted some poor experiences with mental health professionals which could elucidate the scholarly evidence. In particular, bi+ people gave numerous examples of a mental health professional considering their bi+ sexuality to be the core issue that needed to be resolved in talking therapies:

“[I've had] therapists telling me, “you need to pick one.””

(Cis Man, Bisexual, 35-44, Mixed White and Asian, Disabled, Survey Participant)

“The first time I tried counselling, after I first got signed off work, I ended up with a therapist who was unduly interested in my sexuality and my relationships, even though that was nothing to do with my struggles.”

(Agender, Bisexual, 35-44, Other White Background, Disabled, Survey Participant)

“In a counselling session it came up that I was bi and this had nothing to do with why I was there yet the practitioner spend almost half the session exploring how comfortable I am with that part of me even when I tried to move past it because I knew it wasn't relevant to my presenting problem.”

(Cis Woman, Bisexual, 25-34, White British, Non-Disabled, Survey Participant)

Beyond trying to “solve” participants bi+ identities, some service workers inappropriately assigned blame to participants sexual identities, thus limiting the potential treatment efficacy:

“After a suicide attempt at 15, the trainee CAMHS worker [decided] that my issues were down to my sexuality.”

(Cis Woman, Pansexual, 25-34, White British, Disabled, Survey Participant)

“Particularly when you’re dealing with mental health care, you’re going to people who are meant to make you better, health-wise. And if what you’re hearing from people is harming your mental health because you’re hearing offensive stereotypes, they’re not actually being doctors, they’re being harmful. And that is a really urgent priority for the NHS to fix — that when people go for healthcare, they should not reasonably expect to come out worse.”

(Cis Man, Bisexual, 35-44, White British, Disabled, Roundtable Participant)

“I was being screened by a psychiatrist. In the subsequent report was written, “she shows signs of unstable identity, including her sexual identity. She identifies as bisexual.””

(Non-Binary, Bisexual, 24-34, White Irish, Disabled, Survey Participant)

“When I was seeing a psychotherapist and mentioned marital problems, they assumed it was related to my bisexuality.”

(Non-Binary, Bisexual, 45-54, White British, Non-Disabled, Survey Participant)

Participants also referred to points at which mental health practitioners provided bad or inappropriate advice in relation to their sexual identities:

“When I was a teenager, a psychotherapist thought it appropriate to state their opinion that I would be better off being a lesbian, because penetrative sex would probably be difficult for me.”

(Non-Binary, Bisexual, 25-34, Other White Background, Disabled, Survey Participant)

“I used to have a therapist who believed that any non-straight sexualities were inferior. As such, I didn’t feel safe or encouraged to explore my sexuality in our sessions, and tried to follow her implied advice that I could only be “fully realised as a human” by pursuing a heterosexual relationship, and by trying to cultivate a culturally-typical feminine gender expression (which isn’t really my thing). She thought in strict binaries, so according to her, I could only be hetero or lesbian, so I didn’t even realise I could be bi+. This has set me back years in trying to understand myself and be myself.”

(Cis Woman, Gray-ace, Gray-aro, Bi, 35-44, Other White Background, Disabled, Survey Participant)

“I’ve had therapists literally tell me that I only think I’m bisexual, but I’m actually straight or actually gay because of something that happened in my childhood. [...] I’ve quit two therapies because every session was just over and over about trying to cure my bisexual behaviour.”

(Cis Woman, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

Distrust in the professionalism and level of understanding of healthcare workers can result in bi+ people feeling it’s a safe choice not to come out:

“I know one person that did manage to have quite a good therapeutic relationship with multiple healthcare professionals who decided not to disclose. Not to hide the bisexuality, but to hide the things associated with it in terms of non-monogamy and things like that. For fear of being judged.”

(Bi Group Leader, Nottingham)

Researchers have highlighted that mental health care provision and research needs to be conducted specifically to serve bi+ identities. This could be done by providing gender-specific care, recognising monosexism and biphobia in society and institutions, and providing bi-specific services.^{15,21,22,26,28}

Assuming a Monosexual Identity

It is common for bi+ people to not be recognised in public and private spaces.^{10,12} This is due to a combination of bi+ erasure and bi+ invisibility, which serves to conceal the possibility and validity of bi+ identities.²⁹ In the context of healthcare, it is common for healthcare practitioners to assume that bi+ people are lesbian, gay, or heterosexual.³⁰ The assumption of a monosexual identity has been noted as a potential problem in broader research, with Toze et al. saying that “the assumption that current partner status is synonymous with sexuality may also tend to obscure the identities of bisexual people and those not currently in a relationship”.³¹ This has clear implications in that little data is gathered surrounding bi+ people, healthcare

professionals are not confronted with bi+ issues, and bi+ people may be given inappropriate or insensitive health advice.

Bi+ participants in the survey and roundtable event highlighted that they were often assumed to be monosexual:

“ Unless you come out, you are assumed to be monosexual, one way or the other. The classic way when it comes to sexual health stuff is they ask about your most recent partner, and then they assume you’re monosexual of the sort that would fit whatever gender that is, without going, “are there any others?” or “what about before that?””

(Cis Man, Bisexual, 55-64, White British, Disabled, Roundtable Participant)

“ When I was 17, I went to therapy, and I told my therapist I was having a hard time coming out to my family, and she said, “oh, how long have you known you were a lesbian?””

(Bi Group Leader, Cambridge)

“ There’s a Facebook group that I’m a member of, and at least 50% of the posts on there are people complaining about [being assumed to be monosexual].”

(Bi Group Leader, London)

In fact, not only were participants assumed to be monosexual, but they were also often specifically assumed to be heterosexual:

“ The doctor had already ticked heterosexual on the form, and said, “oops, I’ll have to start from the beginning.””

(Non-Binary, Bisexual, 25-34, White British, Disabled, Survey Participant)

“ It is very, very common that I have to correct assumptions made that I’m either straight or, if I refer to my girlfriend (I am express as a woman), people, including health professionals, assume I’m a lesbian.”

(Cis Woman, Bisexual, 25-34, White British, Non-Disabled, Survey Participant)

“ When asked if I’m sexually active, it is always assumed that if I answer yes, that must be with a man.”

(Non-Binary, Queer, 25-34, Other White Background, Non-Disabled, Survey Participant)

“ I’d say that for a lot of people in my group, the assumption is that they’re heterosexual. Many of them have been in long-term relationships with opposite or different gender partners. ”

(Bi Group Leader, Southampton)

These experiences demonstrate that bi+ people have to be very active in engaging healthcare professionals to discuss and understand their sexual identities without them presuming a monosexual (or specifically heterosexual) identity. Given the increased risks for some bi+ people for various health concerns, as well as the evidence that bi+ people experience inequalities in accessing treatments, it is crucial for healthcare professionals to understand who they are working with.

In addition to the assumption of monosexuality, some participants also felt that the response of healthcare professionals to bi+ people confirming their bi+ identity could be negative, ill-informed, or judgmental:

“ Asked if I “really needed” birth control because “I was gay”. I’m not gay, I had just mentioned a previous girlfriend in a past appointment and was dating a bloke at the time! ”

(Cis Woman, Bisexual, 25-34, White British, Disabled, Survey Participant)

“ The nurse scoffed at me and said, “oh, I just thought you were a lesbian sorry” ”

(Non-Binary, Queer, 18-24, White British, Disabled, Survey Participant)

“ One of the things I get all the time — because I am very feminine and I dress very feminine as well — is the “oh, but you don’t look like you’d also be into women.” ”

(Cis Woman, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

Bi+ experiences of healthcare are mediated by the lack of healthcare openness to, or knowledge of, bi+ identities. It is perhaps unsurprising that the GP Patient Survey highlighted that bi+ people were more likely to have a stronger preference for which GP they see and were more likely to turn down appointments if they were not with their preferred GP.²⁷

LGBTQIA+ Spaces

Bi+ people are often excluded from both heterosexual and lesbian and gay spaces.^{8,32} This is due to a combination of monosexism, biphobia, and bi+ erasure, which impacts bi+ individuals differently, regardless of whether they are accessing a minoritized sexuality and gender space or not. In fact, Költő et al. have noted that “there is a growing acceptance to LGBT individuals and issues in Ireland [...] However, it seems that bisexual people do not benefit from this shift as much as their lesbian and gay peers”.¹⁵ Költő et al. point out that the consequences of this are that bi+ people are significantly more likely to feel that they are discriminated against based on their gender and age, and also experienced more discrimination than other groups.¹⁵

Bi+ people highlighted how they felt that many people providing an LGBTQIA+ positive service

did not fully understand the health and wellbeing implications of bi+ specific identities and, particularly, the way in which LGBTQIA+ spaces could be harmful for bi+ people:

“ There’s a better understanding of homophobia, but I think what these spaces don’t understand is that with biphobia, the call often comes from within the house, within our own community. I don’t think they understand. It’s like missiles from both sides. There’s quite a lot of microaggressions in those spaces. ”

(Bigender, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“ I do think a lot of the time [bisexuals and pansexuals] are almost like the ugly stepsisters of LGBT. We’re often pushed to the side and ignored. ”

(Cis Woman, Pansexual, 35-44, White British, Disabled, Roundtable Participant)

“ I think there’s so much focus on making these spaces safe for LG people without understanding that half our unsafety can come from LG people themselves. So are these spaces ever actually inclusive of us? ”

(Bigender, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“ My therapist was shocked to learn about biphobia in LGBT+ spaces — [I] had to spend most of a session educating her. ”

(Cis Woman, Bisexual, 25-34, White British, Disabled, Survey Participant)

It is noted in broader research that bi+ people often experience discrimination or ignorance from lesbian and gay people due to biphobia, bi+ erasure, and bi+ invisibility.^{7,8} As a consequence, bi+ participants discussed feeling unsure as to whether or not they could participate in LGBTQIA+ positive healthcare settings:

“ Even if there is a space that identifies itself as LGBT-friendly, as a potential patient, you kind of wonder, “are you really?” Because we can respect the fact that you are accepting of lesbians and gays, no problem. But with actual bisexuals or even, to some extent, trans people, it’s very, very hit and miss sometimes. ”

(Cis Man, Bisexual, 25-34, White British, Non-Disabled, Roundtable Participant)

“ A lot of therapists will advertise that they’re LGBT-friendly, but as we know often that doesn’t necessarily mean they’re highly educated on bias issues or gender issues. There’s a difference between an ingrained knowledge and understanding of the complexities of the different letters of the alphabet and thinking of themselves as educated or perceiving themselves to be an ally.”

(Bi Group Leader, Southampton)

Clearly, previous negative experiences of biphobia within LGBTQIA+ positive spaces have impacted bi+ participants feelings towards accessing LGBTQIA+ positive health care services. Bi+ participants said that they were often excluded from services who promoted their LGBT-positive care.

“ I certainly never feel safe/welcome in an “LGBT” space unless it’s really specific about its bi inclusion.”

(Agender, Bisexual, 35-44, Other White Background, Disabled, Roundtable Participant)

Bi group leaders reported multiple instances of bi+ people only feeling welcomed in bi-specific spaces, or spaces that openly advertised themselves as bi-friendly:

“ We have people that come from [nearby city] and it takes a while to get here. And it’s because there’s nothing distinctly bi for them within their local community. And they feel they need a space that is bi-specific because they don’t feel welcomed within LGBT spaces necessarily.”

(Bi Group Leader, Southampton)

“ A lot of bi people are in relationships with someone of a different gender, and that will make them not feel like they belong in a certain space, whereas in a bi space, they immediately feel like they belong because everyone’s in the same boat as them, whatever their relationship status, no one is going to question them.”

(Bi Group Leader, Nottingham)

“ [In LGBTQ+ groups] when [bi people] come out as bisexual, they’re immediately seen as outsiders or untrustworthy in some way, not part of the group, not somebody that people want to get to know better and socialise with.”

(Bi Group Leader, London)

“Bi women have had difficult experiences when they’ve come out and often avoid coming out in [LGBTQ+] groups. They’re just perceived as lesbians, particularly if they have a female partner.”

(Bi Group Leader, London)

“I can quote somebody who comes to the [bi] group who said, “I come here to be nurtured. I come here because I don’t have to worry that there’s going to be some kind of fight at the door. I don’t have to be braced to be rejected.””

(Bi Group Leader, London)

Beyond concerns and a wariness of LGBTQIA+ spaces, there was evidence that bi+ participants had discriminatory experiences within these LGBTQIA+ services. Participants described examples of direct discrimination while attending LGBTQIA+ positive spaces on the basis of their bi+ identities:

“I was helping train someone at a queer charity and I mentioned my partner’s gender and he looked at me horrified and I said, “I’m bisexual” and he said, “oh, you’re one of the greedy ones are you?””

(Cis Man, Bisexual, 35-44, Mixed White and Asian, Disabled, Roundtable Participant)

“[When catering for an event, a lesbian nurse] said to me, “well, you’re bisexual so I guess you’ll eat anything!””

(Cis Woman, Pansexual, 35-44, White British, Disabled, Roundtable Participant)

These microaggressions are indicative of a bi+ exclusionary space, or a space where healthcare providers have not been adequately trained to understand the stigma and experiences of bi+ people in everyday life. As a consequence of bi+ erasure and invisibility within LGBTQIA+ positive healthcare settings, some bi+ participants’ treatment options were impacted:

“In terms of LGBTQ+ inclusive services, it’s very mixed. I have had some good and some bad. I experience bi-erasure quite frequently. On the worst occasion, a provider sought to turn me away from Men Who Have Sex With Men (MSM) services on account of my identity.”

(Cis Man, Bisexual, 25-34, White British, Disabled, Survey Participant)

Notably, bi+ participants felt that healthcare professionals providing LGBTQ+ positive health options were culturally competent in regards to lesbian and gay identities but lacked bi-specific knowledge:

“ You might meet a certain percent of professionals who are somewhat comfortable talking about lesbian and gay issues, and then there’s a reduction when it comes to awareness of being bi or having another orientation where there’s multiple attractions.”

(Non-Binary, Bisexual, 25-34, White Irish, Disabled, Roundtable Participant)

“Just because somebody is LGBT-accepting, [...], that doesn’t mean they understand the bi experience or would treat it with respect.”

(Bi Group Leader, London)

Clearly, participants had experienced significant barriers in accessing positive, informative, and appropriate healthcare within purportedly LGBT-positive spaces. This issue highlights the primacy of lesbian and gay identities within LGBTQIA+ health training and speaks to the need to offer bi-specific training to mediate the impact of ignorance, confusion, and discrimination for bi+ people.

HIV Treatment & PrEP

Research into HIV and pre-exposure prophylaxis (PrEP) often centres on “men who have sex with men” as a group under investigation, which has the unfortunate effect of not being able to draw out how bi+ and gay experiences may differ within the population.¹⁹ However, a small body of research has found that gay men typically possess greater knowledge about HIV than bisexual men.³³ Further, Jaspal et al. have highlighted that men with a higher level of “HIV knowledge and perceived HIV risk and who regularly test for HIV are most likely to endorse PrEP as a personally beneficial HIV prevention method”.³³ This means that bi+ men may be less likely to partake in preventative measures as above, leading the authors to recommend that “HIV awareness campaigns must target self-identified bisexual MSM”.³³ Other research has confirmed that factors associated with never testing for HIV include having a bisexual identity.³⁴

These issues were reflected in bi+ participants discussions of healthcare services. Bi+ participants discussed how materials were often advertised and targeted towards gay men. Consequently, some bi+ men were unaware of how HIV/PrEP could affect them, or what services they could be offered:

“PrEP materials are advertised very largely on the gay scene, usually with “gay men” printed all over it. So, if you don’t identify as gay you see it less. So, the knowledge of PrEP and even PEP — the post-exposure drugs — is much less among bisexual-identified men.”

(Cis Man, Bisexual, 55-64, White British, Disabled, Roundtable Participant)

“When it comes to support services, it’s always been that there is a gay men’s service and a straight group. So, if you are HIV positive and bisexual, you have to pick.”

(Cis Man, Bisexual, 55-64, White British, Disabled, Roundtable Participant)

“I see [HIV treatment] advertised a lot, and it does always feel like it’s advertised towards gay men, whether explicitly or not, that’s always the vibe I get whenever it’s mentioned.”

(Bi Group Leader, Nottingham)

Beyond a lack of bi+ services and information, bi+ participants discussed how their healthcare professionals could be unaware of PrEP and its usage, consequently impacting their potential healthcare options:

“ [My] GP had no idea what PrEP was and initially presumed I was HIV positive. When I attempted to help them understand what PrEP was, they remained entirely dismissive of PrEP and considered it an utter waste of (NHS) money.”

(Cis Man, Bisexual, 45-54, Other White Background, Non-Disabled, Survey Participant)

Bi+ participants also highlighted clear discrimination in accessing healthcare options or receiving treatment related to sexual health, HIV testing, and PrEP:

“ [During a HIV test] the healthcare professional who administered the test asked me about my sexuality and when I said I was bisexual, his previously friendly demeanor changed. He visibly tensed and, in a somewhat hostile way, asked, “what makes you think that?””

(Cis Man, Bisexual, 45-54, White British, Non-Disabled, Survey Participant)

“ A friend of mine was showing me quite a major provider of queer men’s sexual health services, and they have quite a fancy high-tech website that basically has a survey protocol to direct you to the right service. The number of clicks you needed as a gay man to get to PrEP was 2, and the number of clicks you needed as a bi man to get to PrEP was 6.”

(Cis Man, Bisexual, 35-44, White British, Disabled, Roundtable Participant)

There is a clear need for better sexual health provision for bi+ people in relation to HIV and PrEP. This research points to the lack of service provision for bi+ people, the inadequate inclusion of bi+ people, and the ignorance of healthcare providers in understanding the needs of bi+ people’s sexual health care.

Assumption of Confusion

Bi+ people regularly encounter ignorance and stigma relating to their sexual identities.^{7,8} Research has highlighted instances of this in healthcare, including in mental health care, where “[one woman describes feeling hurt when asked if she had “switched sides”, and a woman accessing counselling felt that the counsellor actively denied her bisexuality and wanted her to realise that she was really straight. If a woman had a woman partner at the time of the consultation, it was assumed that she was a lesbian and did not/had not had sex with men, an assumption that could be medically risky and denies the validity of bisexual identity”].³⁰

This was repeated by bi+ participants who felt that their identities were not taken seriously, were indicative of identity confusion, or could change in the future:

“ [The doctor] implied that I would “make a decision either way.””

(Non-Binary, Bisexual, 25-34, White British, Disabled, Survey Participant)

“ Staff asking, “are you sure?” and double checking my orientation after ticking bi on a form.””

(Cis Woman, Bisexual, 25-34, Other White Background, Non-Disabled, Survey Participant)

“ Little comments like “don’t forget to protect yourself if you change your mind again””

(Cis Woman, Bisexual, 35-44, White British, Non-Disabled, Survey Participant)

“ There have been times where healthcare professionals have tried to convince me that I was actually a “closeted gay man” instead of actually being bisexual.”

Cis Man, Bisexual, 25-34, White British, Non-Disabled, Survey Participant

“ I think coming out, it’s always presented as “now I know who I am, the world knows who I am, and now my life is okay.” But for bisexual people, it’s supposed to be a stepping stone.”

(Bi Group Leader, Cambridge)

These experiences are indicative of a lack of bi+ cultural competence on the part of healthcare staff.

Intersectional Identities

Intersecting systems of oppression affect bi+ people differently in different spaces. Research has highlighted that race and gender are two elements that can impact bi+ experiences in healthcare.^{21,28} However, research in this area is limited and we do not know a significant amount about how intersecting systems of oppression impact bi+ people in a healthcare setting. Bi+ roundtable and survey respondents did speak about their experiences of navigating these systems. A key comment that bi+ people discussed was how if they were disabled, they were often seen as sexless and unable to be queer:

“Being a disabled person as well, you’re inherently seen as an asexual thing, that you are not a person, that you are an asexual, desexualised being. [...] You’re either hypersexualised or desexualised. It’s like I’m wearing camo and high-vis at the same time.”

(Bigender, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“You can’t be more than one thing. They think if you’re disabled, you can’t be queer.”

(Agender, Bisexual, 35-44, Other White Background, Disabled, Roundtable Participant)

Some participants also highlighted how their gender impacted their experience of health:

“Part of the reason I’m kind of hesitant about seeking gender-related care is that I’m already so cynical about healthcare from being disabled and from being bi, and I know how tough a time my trans friends have had. It really puts me off even bothering.”

(Agender, Bisexual, 35-44, Other White Background, Disabled, Roundtable Participant)

“Very few of my experiences are changed by the fact I am bisexual that are not also changed (and to a far greater and more serious extent) than the fact I am transgender.”

(Trans Man, Bisexual, 18-24, Other White Background, Disabled, Survey Participant)

“I think a lot of the biphobia I get is because I’m female and female-presenting. [...] “All girls are a little bit bi” is such a common saying.”

(Cis Woman, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“There’s a lot of transphobia in general, and people feel more emboldened to be transphobic than they were in the past, with the gender critical movement. And that hurts bi people, partly because a lot of trans people are bi, and it also hurts them because it feels almost like an attack on our community. A lot of people that are in my group, even people who aren’t trans, feel a strong connection with the trans community, they feel sort of like a sibling community that we care strongly about.”

(Bi Group Leader, Nottingham)

Some participants also highlighted how their gender impacted their experience of health:

“I’m a non-binary and disabled person. Being a disabled person, I have a lot of contact with the NHS, and I’m dependent on them for treatment. As such, I’m very cautious about what I disclose about the people I see because I feel unsafe, even just in my gender presentation I feel unsafe.”

(Non-Binary, Bisexual 25-34, White Irish, Disabled, Roundtable Participant)

“Medical professionals’ responses to my sexuality (and therefore the ways that I am treated) are also influenced by the fact that I’m a wheelchair user, so sometimes it’s difficult to separate out what is ableism and what is biphobia!”

(Non-Binary, Bisexual, 25-34, Other White Background, Disabled, Survey Participant)

“I’m disabled and have constant contact with three different consultants, and I’ve noticed a huge difference between how I’m treated from when I was bringing a girlfriend I had previously to appointments versus how they treat me when I’m with my husband. When I have a man with me, I’m treated with much more respect.”

(Cis Woman, Bisexual, 25-34, White British, Disabled, Roundtable Participant)

“Intersectionality is such a huge thing in the bi community. People are like, “okay, well, I had this experience, and I don’t know if it was homophobia, ableism, racism or biphobia.””

(Bi Group Leader, Cambridge)

Clearly, intersecting systems of oppression impact bi+ people’s experiences of navigating healthcare – most research is needed in this field.



Conclusion

Bi+ people regularly encounter misunderstanding, stigma, and discrimination in everyday life.

This research has concluded that these experiences can be replicated in accessing health care and that healthcare services must expand on bi-specific training, bi+ services, and recognition of particular mental health concerns for bi+ people.

It is clear that bi+ people experience health inequalities when engaging with healthcare provision, services, and in the incidence of particular health concerns. A literature review of the subject matter has highlighted that bi+ people have worse mental health when compared to other sexual identities. Simultaneously, testimonies from roundtable and survey bi+ participants have highlighted

that accessing mental health care can mean that their sexual identities are brought into conversation as needing to be ‘resolved’ before true mental healing can begin. Similarly, bi+ participants highlighted that they experienced significant stigma and assumptions of promiscuity at points in accessing healthcare, while research and testimonies alike also highlight that bi+ people are not receiving adequate sexual health advice or information around HIV/PrEP.

This report has highlighted other issues relevant to bi+ people’s access to healthcare, including assumptions of promiscuity, mental health, assuming a monosexual identity, LGBTQIA+ spaces, HIV treatment and PrEP, assumptions of confusion, and intersectional-based issues. The bi+ people who took part in this research have made key highlights around what can be done to improve healthcare and access for bi+ people, specifically noting that healthcare provision should focus on:

1. Believing and listening to bi+ people

“Just to be more accepting that we know our sexuality and not to unnecessarily question aspects of this where it isn’t related to care.”

(Cis Woman, Pansexual, 25-34, White British, Non-Disabled, Survey Participant)

“Practice active listening. Believe us and listen to us. When we say something, believe that it comes from a place of experience and that our lived experiences are valid, it’s true, it’s real.”

(Non-Binary, Bisexual, 24-34, Other White Background, Disabled, Roundtable Participant)

“Stop thinking of bisexuality as “half” of something, or “in between” somewhere. It’s its own individual thing, we’re not just undecided.”

(Cis Woman, Bisexual, 25-34, Other White Background, Disabled, Roundtable Participant)

“If I say I am bisexual to a mental health practitioner, it’s as simple as that — I am bisexual. If I tell a sexual health worker or an x-ray technician that I can’t be pregnant as I haven’t had the sexual activity that could lead to it — just listen!”

(Non-Binary, Bisexual, 24-34, Other White Background, Disabled, Roundtable Participant)

2. Not making assumptions around sexuality, gender, and sexual behaviour

“Don’t assume someone is straight and cis just because they and their partner seem to present in a way that’s consistent with that assumption. Even in a “straight” relationship, one or both people might be bi.”

(Non-Binary, Pansexual, 25-34, White British, Non-Disabled, Survey Participant)

“We’re not all sexual people, and we may be bi but not have sexual experiences with other genders. The assumption that sex is the pinnacle of our identities is harmful.”

(Quariwarmi, Queer, 25-34, Other Mixed Background, Disabled, Survey Participant)

“Ask everyone (including straight people) how they’re having sex. Make no assumptions about anyone’s gender, sexuality or genitals.”

(Cis Woman, Queer, 18-24, White British, Non-Disabled, Survey Participant)

“Not assume that we are just promiscuous. Understand that just because we are attracted to all sexes and genders, we are not more likely to pick up STDs.”

(Non-Binary, Queer, 18-24, White British, Disabled, Survey Participant)

“Ask about sexuality (if relevant) rather than assuming that the gender of your current partner defines whether you’re gay or straight.”

(Non-Binary, Pansexual, 25-34, White British, Non-Disabled, Survey Participant)

3. Engaging with LGBTQIA+ training and educating healthcare providers around bi+ identities

“ I think the healthcare system should have an education course once a year at least to update their staff on appropriate language and give them a better understanding of LGBTQ+ people and their struggles.”

(Cis Woman, Pansexual, 18-24, White British, Non-Disabled, Survey Participant)

“ It’s more than having a rainbow pin on your lanyard. You have to actually change the culture, and that will come with education.”

(Cis Woman, Pansexual, White British, Disabled, Roundtable Participant)

“ Information on what makes bisexuality different to being gay and the separate struggles bi people face.”

(Cis Woman, Bisexual, 18-24, White British, Disabled, Survey Participant)

“ Have an awareness of the existence of non-monosexual identity rather than defaulting to hetero/homosexual considerations.”

(Cis Man, Bisexual, 25-34, White British, Non-Disabled, Survey Participant)

“ For me, as a biromantic asexual person, it’s really important for me that health providers have a better understanding of the split romantic and sexual attraction model, rather than disregarding or ignoring my asexuality altogether.”

(Cis Woman, Biromantic, 25-34, Other White Background, Non-Disabled, Survey Participant)

4. Providing an inclusive service which uses inclusive and clear language

“De-gender language around partners and instead focus on behaviours — e.g. when evaluating risk of sexual activity, pregnancy etc.”

(Cis Woman, Bisexual, 25-34, White British, Disabled, Survey Participant)

“ [Healthcare providers should] promote more that they are inclusive. This could be by putting up pride flags, using pronouns when you meet and asking your pronouns so you know they’re inclusive and can feel comfortable disclosing information. ”

(Cis Woman, Biromantic, 18-24, White British, Disabled, Survey Participant)

“Ask more specific questions about sexual activity and give time frames (e.g. not “are you sexually active?” when they mean “could you be pregnant?”)”

(Non-Binary, Bisexual, 25-34, White British, Disabled, Survey Participant)

“Show visible support for non-monosexual identities, include information and links to support on their website.”

(Cis Woman, Bisexual, 25-34, White British, Disabled, Survey Participant)

“Include sexual health information for sex with people of all genders, and explain the differences in risk. I’ve only experienced this once, and it was so useful.”

(Cis Woman, Bisexual, 25-34, Other Mixed Background, Non-Disabled, Survey Participant)

This report has various limitations, which must be acknowledged. Firstly, the literature review was necessarily limited in scope. The clear implications of this mean that there could be more literature that would be significantly relevant to understanding bi+ health inequalities. Secondly, the participants who took part in this research mainly identified as white. This biased sample therefore does not represent the experiences of people who have to negotiate intersecting systems of oppression, particularly race and ethnicity. It is known that BAME individuals have a worse experience of healthcare services when compared to white individuals, and so this absence in this research is significant. Consequently, future research in this area could look to expand on these areas.

The policy and practice implications for this research are clear; bi+ identities must be taken seriously within healthcare institutions. There is a clear and marked health inequality which must be addressed and accounted for to ensure a fair provision of health care services, equal access, and equal treatment.





Key Recommendations

Improving bi+ health outcomes is everyone's responsibility, which is why these key recommendations target a variety of decision-makers, including policy leads, healthcare services, researchers and charities.

All NHS trusts should implement sexual orientation and trans status monitoring of patients in line with the best practice guidance provided by LGBT Foundation (If We're Not Counted, We Don't Count: Good practice guide to monitoring sexual orientation and trans status, 2021)

All NHS trusts should arrange, or support their staff to attend, LGBTQIA+ training that specifically references bi+ identities and biphobia

All diversity and equity policies for patients and staff should directly reference biphobia as an act of discrimination and detail appropriate procedures to support the bi+ worker in the instance that this occurs

We recommend that further research should be undertaken to explore the health inequalities specifically experienced by minorities within the bi+ community, namely bi people of colour, disabled bi people and trans and non-binary bi people

More research should be undertaken to explore how a bisexual identity and a diagnosis of Borderline Personality Disorder relate to one another, that acknowledges the stigma surrounding both

Services that advertise themselves as LGBTQIA+ inclusive should evaluate how they make bi+ people feel welcome in these spaces and tackle instances of biphobia from within the LGBTQIA+ community

More effort should be taken to research and provide for the specific experiences of bi+ women, instead of only ever combining them with lesbian women, and similarly for bi+ men

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