

# Reproductive health-related experiences of LGBTIQA+ communities



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## Background

Jean Hailes for Women's Health is a national not-for-profit organisation dedicated to improving women's health across Australia through every life stage. They conduct their National Women's Health Survey (NWHS) annually to explore the health issues that affect women in Australia, their health-related attitudes, behaviours and experiences, and the health information and policy changes needed to improve their health and wellbeing.

As the NWHS was not designed to comprehensively explore the experiences of LGBTIQ+ communities, Jean Hailes commissioned Trezona Consulting Group to undertake qualitative consultations with lesbian, bisexual and queer (LBQ) women, and trans, gender diverse and non-binary (TGDNB) people presumed female at birth, to better understand their experiences and perspectives regarding sexual and reproductive health.

The project aimed to explore:

- experiences accessing healthcare and health information
- preferences for accessing healthcare
- attitudes towards reproductive leave.

The findings of this research will inform Jean Hailes advocacy strategy related to reproductive leave and other health-related issues, as well as their approach to developing health information for LGBTIQ+ communities, in partnership with other organisations.

# Methods

## Recruitment and participants

Jean Hailes partnered with Thorne Harbour Health (THH) to undertake a targeted recruitment of participants for the project. THH promoted the project via their LinkedIn and Facebook social media pages and their regular subscriber newsletter, and the lead researcher (Trezona Consulting Group) also promoted the project via their professional and personal networks. Participants were also encouraged to share information about the project with their peers and networks, including the recruitment and registration process.

To be eligible to participate in the project, participants had to be aged 18 years or over, a resident of Australia and presumed/assigned female at birth, and identify as lesbian, bisexual, pansexual, queer, trans, gender diverse or non-binary.

Participants were also required to provide informed consent to take part in an interview and for their de-identified information to be included in a report on the findings of the consultations. A copy of the participant information and consent form is provided in Appendix A.

A total of 18 people participated in the project, including 12 participants who identified as lesbian, bisexual or queer, 5 who identified as trans and one who identified as gender diverse / non-binary. The majority of participants were based in Victoria, with 2 participants from New South Wales, one from South Australia, and one from Tasmania.

While age data was not formally collected as part of the recruitment process, information shared by participants during consultations indicated that participants ranged between 30 and 58 years, with the majority aged in their early to mid 40s.

## Data collection

Semi-structured interviews were used for this project, which were conducted online (using Zoom) between May and June 2024.

A semi-structured interview guide was developed and used to guide a consistent approach to the consultations. The guide was divided into two sections:

1. experiences accessing reproductive health care and information; and
2. perspectives on reproductive leave policies (menstruation and menopause).

A copy of the interview questions is provided in the interview guide at Appendix B.

## Data analysis

The interviews were audio recorded, transcribed using an automated program and then cleaned for accuracy. The transcripts were then analysed using thematic analysis to identify key themes relating to the key project topics, which were:

- experiences accessing reproductive health care
- challenges and barriers to care
- access to information
- health professional preferences
- perspectives on reproductive health leave policies.

# Findings

## Experiences accessing reproductive health care

Participants were asked to broadly describe their experiences accessing reproductive health care. Responses from participants highlighted that some experiences are likely universal to all people accessing and navigating reproductive health care, some are common to LGBTIQ+ communities, and others are specific to people's sexuality and gender identity.

While a small number of participants reported positive experiences regarding their reproductive health care, people more commonly reported negative experiences, with some reporting harmful and traumatic experiences.

The key themes relating to experiences accessing reproductive health care included:

- Invisibility and erasure;
- Navigating disclosure of sexuality;
- Assumptions about health care needs;
- Poor or inadequate care; and
- Exclusion of trans people.

### Invisibility and erasure

Almost all participants described experiencing invisibility and/or the erasure of their queer identity when engaging with health professionals, which means their specific health care needs and experiences are generally not considered or addressed as part of their overall health care. Most participants noted that they are rarely asked about their sexuality, with some reporting they have never been asked about their sexuality by a health care provider.

For many participants, when sexuality has been raised by health professionals, it has generally been in relation to intimate and sexual partners, and often due to them having assumed they were heterosexual. Some participants described the awkwardness and discomfort they experience due to frequent assumptions about their sexuality (default assumptions of heterosexuality), and the emotional burden of having to support health professionals through their own reactions and responses to these false assumptions.

A number of participants described 'masking' their queer identity due to the heteronormativity of health care environments, and reported feeling like they are not able to bring their whole selves to their relationships with health professionals, which ultimately influences the quality and outcomes of their health care.

Bisexual women described the impact of biphobia on the invisibility and erasure of their sexuality, and reported this to be significantly more likely and challenging when they were partnered with men, due to heteronormative assumptions about their intimate relationships, life circumstances and related health and wellbeing needs.

Trans participants also described the invisibility and erasure they experience in accessing reproductive health care, noting that it occurs not only in relation to their gender identity and sexuality, but that reproductive health information and services are targeted to and tailored specifically for cis-women, therefore completely erasing and silencing the reproductive health experiences and needs of trans people at every life stage.

### **Navigating disclosure of sexuality**

As a result of the invisibility and erasure queer people experience within the health system, participants also widely reported that having to carefully navigate decisions about disclosing their queer identity was a routine part of their engagement with health care providers, particularly in relation to their reproductive health needs.

Participants noted that they frequently have to weigh up the benefits and consequences of disclosing their identity, and that it is very common for them not to disclose – particularly if they perceive that it is not directly relevant to the health issue or care they are seeking at the time. Some participants described masking or actively withholding information about their identity in order to get through appointments without the added challenges associated with disclosing.

Some also described the emotional burden of engaging with health professionals and navigating disclosure, knowing they have to anticipate the range of possible reactions to them disclosing their identity, but then also having to guide professionals to appropriately respond.

### **Assumptions about health care needs**

Lesbian and queer women reported that health care providers frequently make assumptions about their reproductive health care needs based on the gender of their sexual partners, including, for example, their contraception needs and preferences, STI risks and pregnancy intentions. Some participants noted that in some instances they have been provided with inaccurate and/or inappropriate advice based on these assumptions. Bisexual women described similar assumptions about their reproductive health care needs, but noted that different assumptions were made depending on the gender of their partner, particularly about their contraception needs, STI risks and pregnancy intentions.

A number of participants emphasised the particular challenges of navigating reproductive and maternal health care services, due to the way they reinforce cisheteronormative ideas and expectations about relationships, parenting and the health care needs of sexual and intimate partners.

Some participants also reported having experienced inappropriate and judgemental questions relating to their sexual relationships and sexual health practices, based on negative and harmful stereotypes about queer people.



## **Poor or inadequate care**

Most participants reported that the general standard of reproductive health care is poor or inadequate, noting the particularly negative experiences of people with serious reproductive health issues such as endometriosis and premenstrual dysphoric disorder (PMDD), but also inadequate care for people experiencing menopause and painful or debilitating periods.

It was widely reported that health care for menopause is inadequate, and that general practitioners do not proactively engage with people about healthy ageing, menopause symptoms and treatment options. A number of participants also reported that health professionals often lack compassion and empathy, and frequently dismiss severe symptoms of menstruation and menopause as 'normal' or 'common'.

Another common issue raised was the lack of contraception options available, and the expectation that people live with horrible side effects or other risks to their health. For some people, concerns about the safety of contraception are a deterrent to taking up contraception or using it for extended periods of time. There were a small number of participants who also described extremely painful and traumatic experiences with intrauterine devices (IUDs), and being refused appropriate pain management options in these instances.

Most participants, but particularly those living with endometriosis and PMDD, emphasised the challenges of seeking a formal diagnosis, the lack of treatment options available and the general lack of knowledge and understanding of health professionals about these health conditions. Some participants also reported having to rely on self-diagnosis, and proactively seek out possible treatment options for themselves.

## **Exclusion of trans people**

Trans participants consistently reported experiencing ongoing exclusion and marginalisation in relation to their reproductive health, that the reproductive health needs and experiences of trans people are completely invisible, and that trans inclusive and affirming reproductive health care is virtually non-existent.

Trans participants described the uniqueness and complexity of their reproductive health needs and experiences, and the need to navigate the way reproductive health care and trans affirming health care intersect. They noted that there is even greater complexity for trans people using gender affirming hormones, given the influence of hormone levels on all aspects of reproductive health, including menstruation, ovulation, pregnancy and menopause.

Most trans participants noted that, due to the negative experiences they continue to have in the health care system, there is a general reluctance to seek care for their reproductive health needs, particularly for screening and physical examinations. For some trans participants, the potential to experience dysphoria when navigating services for reproductive health also contributes to a fear of and reluctance to seek care.

## Challenges and barriers to care

As part of discussions about accessing reproductive health care, participants were asked to describe any specific barriers or challenges they had experienced regarding their reproductive health. The findings overall indicated that some challenges and barriers are systemic and likely universally experienced by people seeking reproductive health care. However, the most commonly reported and significant barriers and challenges experienced by LGBTIQ+ communities related to their sexuality and gender identity.

The key themes relating to challenges and barriers to care were:

- Discrimination;
- Lack of cultural safety;
- Lack of available services;
- High demand and long waitlists;
- Health professional capabilities;
- Financial barriers; and
- Lack of evidence.

### Discrimination

All participants reported having experienced discrimination within the health care system, and noted that past experiences and/or fear of future experiences of discrimination is one of the most significant barriers to them accessing services and engaging in their reproductive health care. They also noted that they often do not report experiences of discrimination out of fear it may be detrimental to their safety and the ongoing care they receive.

Some participants reported experiencing discrimination, shaming and stigma in relation to their sexual partners and practices, while others noted the specific forms of discrimination experienced by queer couples, particularly in relationships where one partner is a trans person.

Bisexual women described the subtle but constant biphobia displayed by health professionals, and the way this can sometimes be internalised by some women as part of their health care experience.

## **Lack of cultural safety**

The lack of cultural safety for LGBTIQ+ communities in health care systems and services is evident and reflected in a number of themes described in this report, including experiences of invisibility, erasure, exclusion and discrimination.

In addition to these, participants widely reported that a lack of cultural safety was a specific barrier to accessing and engaging with reproductive health care, noting the following examples:

- Administration and data collection systems are not inclusive of queer/TGD people (i.e. recording sexuality and gender identity, partner and parent relationships, preferred language).
- Queer-specific needs and experiences are not recorded or considered by the health care provider.
- A lack of training and development for staff on culturally safe practices, and therefore lack of cultural competence.
- The misuse of queer flags, posters and badges to signal that a service is queer inclusive, when the service is culturally unsafe for queer people.
- The persistent use of cisheteronormative language and imagery on websites, in waiting rooms and on information and resources.
- A lack of safe spaces for trans people within women's health services, which results in frequent confrontations and sometimes abuse from staff and other patients.

## **Health professional capabilities**

Based on the experiences described by participants, the expertise and capability of GPs to support people's reproductive health needs varies widely, which influences the quality and reliability of the advice and information provided, as well as referral practices to professionals with specialist expertise. The majority of participants reported having to be proactive and self-direct their care relating to their sexual and reproductive health issues and needs.

Participants consistently reported that it is difficult to find GPs and other health professionals who provide good health care for queer people, and that they lack knowledge and understanding of the specific reproductive health experiences and needs of queer people.

Participants also reported having to access gynaecological specialists in order to obtain adequate and useful information on their reproductive health, with a number of people reporting very positive experiences with specialist care providers. However, some participants noted that GPs sometimes act as gatekeepers and are resistant to making referrals to specialist providers when requested.

## **Lack of available services**

Participants frequently raised the lack of service availability as a major barrier to accessing reproductive health care, including the lack of women's health services, queer-specific services, trans affirming health services and specialist reproductive health services. The lack of queer-specific and trans affirming services is a significant barrier to engagement in reproductive care, as they are more likely to provide culturally safe and responsive care for queer people.

A number of participants noted that service availability is significantly worse outside of major capital cities, and that in regional and rural areas, queer-specific and trans affirming services are virtually non-existent. They also described the challenge of maintaining an ongoing relationship with doctors in these areas, due to the transient nature of the workforce and high turnover in medical clinics.

Another issue commonly reported was the lack of services that specifically focus on perimenopause and menopause, which was seen as a gap overall, but in particular the lack of support specifically for queer women and trans and gender diverse people was a significant barrier to people accessing the information and care they need.

### **High demand and long waiting lists**

Participants consistently reported that it is becoming increasingly difficult to access GPs in general, due to workforce shortages, high demand and long waiting lists, and noted that demand and wait times are considerably higher for bulk billing services. Due to the lack of trans affirming health care providers, demand for these services is so high that many of them are unable to take new clients.

Participants also reported long waiting times and referral delays to specialists, including for initial diagnoses of reproductive health conditions and relevant treatments. They also noted that the few specialist reproductive health services available (such as Jean Hailes) are difficult to get in to due to high demand.

### **Financial barriers**

Participants consistently raised the cost of health care as a major barrier to accessing and engaging in reproductive health care, including the increasing cost of primary health care, the lack of bulk billing providers and the excessive cost of specialist gynaecological care. Participants noted that the high cost of specialist care means many people are not able to access specialists at all, and those who can often have to prioritise the treatment options they pursue based on what they can afford.

The financial barriers are compounded for trans people by the shortage of publicly funded gender clinics and the lack of trans affirming medical practices providing bulk billing options.

### **Lack of evidence**

A number of participants referred to the lack of evidence available on reproductive health issues and effective treatments, including on menopause, endometriosis and PMDD, and that there continues to be inadequate investment in research on reproductive health.

Trans participants emphasised the significant evidence gap on trans reproductive health care, particularly the impact of gender affirming hormone therapy on reproductive health at every life stage – from the onset of puberty through to perimenopause and menopause. The lack of evidence in this area has significant implications for the quality and safety of the care available to trans people, even for those with an ongoing relationship with GPs and specialists.

## Access to information

Participants were asked about the information they are provided by their GP or other regular health professionals. Depending on their responses, participants were also prompted to describe the accessibility of the health information, as well as their health information needs and information-seeking practices. Participant responses were synthesised according to the following themes:

- Role of GPs;
- LGBTIQ+ specific needs;
- Information gaps.

### Role of GPs

Participants consistently reported that in their experience, GPs do not generally proactively provide information, advice or support on reproductive health. As a result, people are generally required to do their own research in order to advocate with their GPs for the information, support and referrals for the care they need, including in relation to pregnancy, menstruation and menopause. Some participants reported recent encounters with GPs who were not aware of the introduction of the self-administered cervical screening test and other changes to cervical screening practices.

There was a common perception among participants that, as generalists, GPs lack expertise on reproductive health, with some participants reporting that they do not consider GPs to be the most appropriate professionals to provide reproductive health care – rather that it should be provided by appropriate specialists.

A small number of participants described having a positive, long-term relationship with their GP, and that as a result they had trust and confidence in their GPs ability to provide reproductive health information, and to make appropriate referrals to specialists.

### LGBTIQ+ specific needs

Participants widely reported that they are rarely asked about their sexuality and, therefore, their specific needs are not factored into the information and advice they are provided. In addition, written information and resources on reproductive health are generally targeted towards and tailored for cis-heterosexual women and are therefore often not relevant for or perceived as irrelevant by queer people.

Most participants noted that, in general, they do not see themselves or their experiences reflected in the information, resources and supports available on reproductive health, including in the way organisations present themselves through language and imagery. Some examples include the specification of women in the names of organisations or departments, the use of symbols and other gender signifiers (such as colours typically used to denote gender), and the absence of queer and TGD people in the images and testimonials on promotional material.

Due to the lack of LGBTIQ+ specific information available, participants frequently reported relying on peers for information, and advice and considered them to be the most reliable and trusted information source, particularly for recommendations about safe and inclusive health professionals. Trans participants emphasised the importance of peer networks and supports in particular, as they are often the only source of reliable information that they can access about their reproductive health needs.

## Information gaps

Participants were asked whether the reproductive health information they need is available to them, and if not, what they saw as the current information gaps. The following gaps were described by participants:

- Premenstrual dysphoric disorder (PMDD, including symptoms and treatment/ management options).
- Perimenopause and menopause, including symptoms and treatment/ management options.
- Long-term use of contraception and its impact on hormonal imbalances at every life stage (particularly in relation to pregnancy and menopause).
- Trans-specific reproductive health information, including the relationship between gender affirming hormone therapy (GAHT) and menstruation, ovulation, pregnancy and menopause.

Participants also noted that, in general, they were unsure where to seek information on reproductive health and health care (particularly for menopause), and that it is not routinely provided by GPs or through women's health or queer health services.

## Health professional preferences

In order to explore people's preferences when finding and accessing a health professional, participants were initially asked whether the gender of their GP was important to them, and whether there are any specific health issues they would be unlikely to raise with them based on their gender. Depending on their responses, participants were also prompted to describe other factors that influence their decisions about health care providers.

Queer women commonly reported a preference for women doctors for their reproductive health care needs, particularly for screening, physical examinations and other invasive procedures. Some queer women indicated that they would only ever engage with women doctors, whereas others indicated they would seek care from male doctors but that there were topics that they likely would not discuss with them. They also noted that they would likely delay care for certain health issues or examinations until they could access a woman doctor.

However, most participants reported that they have had negative experiences with both men and women doctors (noting they had not received care from gender diverse/non-binary doctors), and that for queer people, engaging with both straight women and straight men was just as uncomfortable, as they often lack the knowledge and skills to provide culturally safe care. Some participants reported that the sexuality of their doctor was more important to them than their gender, and that, in their experience, queer-specific doctors provide safer and higher quality care.

The majority of participants reported that the most important factor in choosing doctors and specialists is their cultural competence, and capability to provide safe, inclusive and affirming health care. This was particularly important for trans participants, who face significant barriers to accessing safe health care, and frequently experience harm and discrimination from health and medical professionals. Some trans participants reported a reluctance to seek reproductive health care in general, and indicated they would only engage with a trans affirming medical clinic for this purpose.

## Experiences with family planning and fertility services

While it was not a specific focus of the consultations, a number of participants shared their experiences accessing and engaging with family planning and fertility services. Most of these participants reported a negative overall experience, with some describing aspects of their engagement with these services as traumatic and distressing.

Most participants reported poor quality care from doctors in specialist and tertiary services, poor follow-up care after fertility procedures, and a lack of support in general from GPs and other health professionals over the course of their engagement with fertility services. A number of participants expressed concern that their poor care experiences may have contributed to their inability to conceive, and that they had chosen not to continue planning a family due to the barriers and distress they experienced navigating and engaging with fertility services.

Many of the experiences and barriers described in relation to family planning and fertility services were consistent with the experiences participants described in relation to health care more broadly, particularly the invisibility and erasure of their queer identity, discrimination and lack of cultural safety. However, these issues presented and impacted them more specifically in relation to their family and parenting decisions and preferences. Both queer and trans participants described the following as examples of these issues:

- Paperwork and administration processes not accounting for the gender identity and/or sexuality of the birthing or non-birthing parent.
- The non-birthing parent's role and identity is not considered as part of the pregnancy, and they are excluded from decision-making processes.
- Non-birthing parents not being able to attend appointments.
- Prejudice and discrimination during mandatory counselling, particularly regarding expectations around informing the child about how they were conceived.
- Counselling staff lacking the knowledge or skills to support people in queer relationships through fertility planning (i.e. they are made to feel 'othered' or different).

In addition to these factors, trans participants described experiencing exclusion and marginalisation and a lack of safety in regard to family planning and fertility care, citing the use of cisheteronormative frameworks and practices, and the need to access women's specific services as key factors. Trans participants who had accessed these services described frequent misgendering and misidentification of birthing and non-birthing parents, with one participant describing the aggression and abuse they experienced from staff. Trans participants also emphasised the lack of information available about the relationship between gender affirming hormone therapy and fertility, as well as the lack of guidance and support for them regarding decisions about future pregnancy decisions as part of their gender affirmation (i.e. egg freezing or pausing hormones).

It is worth noting that it was common for participants to assume that the focus on reproductive health meant that the consultations were primarily interested in people's experiences with pregnancy and fertility, and that this was a strong motivation for participating among those who had had negative experiences with family planning and fertility services. Some participants described the ongoing stigma of infertility and shame associated with using fertility services and, therefore, the silencing and lack of support available to people going through it or having been through it, including peer and professional supports following miscarriage.

## Perspectives on reproductive health leave policies

To explore perceptions of and perspectives on reproductive health leave policies, participants were asked a series of questions on the topic, including whether they had heard about the policy, their perspectives on the potential benefits and challenges of these policies, and how they would feel personally about accessing this type of leave. Participant responses were synthesised according to the following themes:

- Policy intent;
- Equity and discrimination concerns;
- Potential barriers; and
- Potential benefits.

### Policy intent

Overall, participants acknowledged that a significant proportion of people are impacted by painful and debilitating periods and other serious reproductive health issues, and are supportive in principle of policies that seek to promote wellbeing and more flexible and accommodating workplaces, including additional leave.

Some participants were supportive of the introduction of a specific reproductive leave policy, particularly those who had experienced endometriosis, PMDD and/or other reproductive health issues in the past, noting that it would have had significantly improved their ability to participate in work whilst also managing their health.

However, most participants agreed that the intent of the policy could be achieved by introducing additional leave without the need to categorise it specifically as 'reproductive leave'. Some participants felt that there are other more important policy issues facing women and TGD people in the workplace, including in relation to parental leave, family violence leave and trans inclusive/affirming environments.

### Equity and discrimination concerns

When asked about the potential challenges of implementing reproductive leave, the majority of participants discussed the influence of social and cultural norms, and acknowledged there would need to be a significant cultural shift – both at a societal and organisational/institutional level – for it to be feasible. They also expressed concern that, without strong political leadership to drive the culture change, this type of policy could reinforce sexist ideas about women and increase the stigma and discrimination they already face in the workplace.



Some participants reported that employees who already experience marginalisation would face significant barriers to accessing this leave, and that it would further exacerbate inequalities for some women. Of critical concern for some participants was the likelihood of this type of leave completely excluding and potentially harming trans people, noting that people who are not 'out' in their workplace would not be able to access it, and that it may compromise the psychological safety of trans people in the workplace. Some trans participants reported that they would be deterred from seeking employment at organisations with this type of leave policy in place, which suggests it could create a further barrier to employment for trans people.

### **Potential barriers to uptake**

In addition to the equity and discrimination concerns described above, participants reported a broad range of potential barriers to implementation and uptake of reproductive leave, including:

- increased administrative burden for managers and employees
- willingness to access it depending on approving manager
- concerns over how it would be awarded, including evidence required and discretion of managers
- concerns about having to disclose personal information
- concerns about confidentiality
- increased risk of and fear of discrimination
- fear of being further stigmatised and pathologised
- fear of having health issues weaponised against them
- concerns about negative impacts on employment and promotion opportunities
- concerns about being perceived as less employable, less capable, less reliable and therefore less valued
- potential for backlash from those not eligible
- risk of being 'outed' (trans people)
- fear of experiencing dysphoria (trans people).

### **Potential benefits**

Despite the concerns raised about reproductive leave, participants acknowledged that this type of policy may have important benefits, namely that it would generate open conversations about reproductive health and health issues, which may not only normalise/validate people's experiences, but also influence a shift in attitudes and positive social and culture change.

In addition, the policy may raise awareness about the seriousness of reproductive health issues, the impact these issues can have on people in the workplace, and the importance of more supportive, flexible and wellbeing-focused workplaces.

Some participants reported that it would enable people to better manage their reproductive health conditions and needs, including through planned time off for pain management and treatment.

## **Intentions to access leave**

When asked how they would feel personally about accessing reproductive leave, 8 participants indicated they would take up this type of leave, 6 participants indicated they would not take it up, and 4 were unsure. People who had experienced severe and debilitating periods or reproductive health issues at any stage in their life were more likely to report they would take up this leave than other participants.

Participants who reported being unsure about whether they would take up this leave noted that it would depend on the workplace and organisational culture, the level of disclosure required to access it, the complexity of the process involved, and whether they perceived there would be negative consequences for accessing the leave.

The majority of trans participants reported that they would not access this type of leave, noting the significant risks of disclosing their reproductive health needs, including the potential for further stigma, discrimination and marginalisation.

# Appendix A: Information and consent form

## Health related attitudes, experiences and preferences of LGBTIQ+ communities

### About this project

This project is being undertaken by Jean Hailes in partnership with Thorne Harbour Health to better understand the experiences and perspectives of lesbian, bisexual, and queer (LBQ) women and trans, gender diverse and non-binary (TGDNB) people presumed female at birth, regarding sexual and reproductive health care (for example, menstruation and menopause).

The project will involve a series of consultations that explore topics that expand on the findings of the recent National Women's Health Survey (NWHS), which aims to understand:

- The health issues that affect women in Australia
- Their health-related attitudes, behaviours and experiences
- The health information and policy changes that will help improve their health and wellbeing.

### Who can take part in the project?

Anyone presumed female at birth, over the age of 18, is a resident of Australia and who identifies with one or more of the following sexual and gender identities can participate in this project:

- Lesbian
- Bisexual
- Pansexual
- Queer
- Trans/transgender
- Gender diverse
- Non-binary

### What does the project involve?

Taking part in this project will involve participating in a 30-minute interview with an experienced researcher from Trezona Consulting Group.

You have the option to participate in the interview online (via zoom), or face-to-face at Thorne Harbour Health's Abbotsford location.

## **Risks and benefits of being involved**

There are no expected risks involved in taking part in this project. You may experience some discomfort or when talking about sexual and reproductive health, but you don't need to share personal information and or anything you don't feel comfortable sharing.

If you participate in an interview, you will receive a \$50 VISA cash card for your time and feedback.

There are no other direct benefits of taking part in the project, but the information you share will help improve health information and resources, health care and health related policies.

## **How we will protect your privacy and confidentiality**

We will not share your name or other personal information with anyone, or in any reports about the project. Your feedback will be combined with feedback from other community members to protect your identity.

## **Exiting the project**

Taking part in this project is voluntary. You do not have to take part, and you can decide not to go ahead with an interview. Once you do take part in an interview, the information you provide will be included in the results, but we will not include any specific comments from you in the report.

If you decide not to take part, or you choose to leave the project, it will not affect your relationship with Jean Hailes, Thorne Harbour Health, Trezona Consulting Group or any other organisation connected with the project.

## **How your data will be stored**

Data will be collected using an online or face-to-face interview. The interview will be audio recorded and then transcribed. Once the interview has been transcribed, the audio recording will be destroyed. The transcript will be de-identified and securely stored on a password-protected computer system at Trezona Consulting Group. Only authorised staff at Trezona Consulting Group will have access to this data.

## **How will your feedback be used**

Your feedback will be included in a report on the findings of the research, which may be shared with people who work at Jean Hailes, Thorne Harbour Health, and other organisations and individuals interested in the findings from this project.

You will not be identified in this report or any presentations about the project. You can access a copy of the report at the end of the project by contacting Jean Hailes at [rose.dupleix@jeanhailes.org.au](mailto:rose.dupleix@jeanhailes.org.au)

## **Contact details**

If you would like to take part in this project, or want more information about it, please contact the lead researcher:

Dr Anita Trezona

Email: [anita@trezonaconsultinggroup.com](mailto:anita@trezonaconsultinggroup.com)

Mobile: 0421 270 089

## **Making a complaint**

If you have any complaints or concerns about your participation in the study that the researcher has not been able to answer to your satisfaction, you may contact Louise Browne, Head, Public Health & Education at Jean Hailes at [louise.browne@jeanhailes.org.au](mailto:louise.browne@jeanhailes.org.au) or 03 9453 8999.

## **Support services**

The following services are available if any distress arises during or following your interview:

QLIFE: 1800 184 527

Thorne Harbour Health (Counselling): (03) 9865 6700

# Consent Form

I have read and understood the attached Participant Information Statement and freely agree to participate in this project as outlined in the Participant Information Statement.

I have had an opportunity to ask questions about the research and I am satisfied with the answers I have received.

I understand that I will be given a signed copy of this document to keep.

I agree to the interview being audio recorded, but understand that my identity will be protected in transcripts, typed notes and reporting.

Agree to recording

Do not agree to recording

The investigators have agreed not to reveal my identity in any report, publication, or presentation without my written permission.

I understand that my decision to participate or not to participate, or to withdraw, WILL NOT affect my relationship with Jean Hailes, Thorne Harbour Health or Trezona Consulting Group in any way.

I consent to participating in the project.

Agree to take part

Do not agree to take part

Name of Participant (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to:

Dr Anita Trezona

Email: [anita@trezonaconsultinggroup.com](mailto:anita@trezonaconsultinggroup.com)

Mobile: 0421 270 089

# Appendix B: Interview guide

## About this consultation

Jean Hailes, in partnership with Thorne Harbour Health, are undertaking a series of consultations with lesbian, bisexual and queer (LBQ) women, and trans and gender diverse (TGD) people presumed female at birth, to better understand their experiences and perspectives regarding sexual and reproductive health care (this includes menstruation and menopause).

These consultations aim to expand on the National Women's Health Survey (NWHS), which aims to understand:

- the health issues that affect women in Australia
- their health-related attitudes, behaviours and experiences
- the health information and policy changes that will help improve their health and wellbeing.

## Your safety and confidentiality

I know that our health and health care needs are deeply personal, and can be hard to talk about, especially for people who have had negative experiences with the health system.

You only have to share information you feel comfortable talking to me about, and we can pause or stop the interview at any time you like.

This interview is confidential, so any personal information you share will stay between us, and only general information will be included in the consultation findings.

Do you have any questions before we start?

## Confirming consent

Before we start the interview, can I confirm that you have read and understood the consent form?

Do you agree to participate in this interview?

Do you agree to this interview being recorded?

## Questions

### Accessing health care and information

The following questions relate to accessing health care and health information for sexual and reproductive health:

1. Have you experienced any challenges finding and accessing the health care you need relating to sexual and reproductive health? Tell me about your experiences.
2. Would you say your doctor / health professional provides you with information in ways that are easy to understand? Tell me about some examples.
3. When choosing a GP, is the gender of the doctor important to you?
  - a) Can you tell me more about this?
4. Are there any issues you would be unlikely to raise with your doctor based on their gender?
  - a) e.g. periods, itchy or sore genitals, sex, menopause etc.

### Workplace policies

The following questions relate to workplace sexual and reproductive leave (including menstrual/menopause leave):

5. A number of employers are introducing or considering paid sexual/reproductive leave in addition to sick leave for when people they have their periods. I am interested in your thoughts/perspectives on this.
6. What do you think might be some of the benefits and challenges of providing sexual/reproductive leave in the workplace?
7. How would you feel personally about accessing this type of leave?



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