“This is what the real experience is like…”

The views of same sex attracted women in the ACT about their health; their health needs; their access to services, supports, and information; and the barriers to maintaining their health

Amber Hutchison

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women's centre for health matters

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About Women's Centre for Health Matters Inc.
The Women's Centre for Health Matters Inc. (WCHM) is a community based organisation which works in the ACT and surrounding region to improve women's health and wellbeing. WCHM believes that the environment and life circumstances which each woman experiences affects her health outcomes. WCHM focuses on areas of possible disadvantage and undertakes social research, advocacy, community development and health promotion to influence systems change with the aim to improve women's health and wellbeing outcomes.

About the AIDS Action Council
The AIDS Action Council (the Council) is Canberra's leading LGBTIQ and HIV+ community organisation. We work with and for people who are HIV+ as well as people in LGBTIQ+ communities, including their friends, families, colleagues, and allies. The Council has a proud history of working with and representing diverse groups of people. This includes gay and bisexual men, transgender and gender diverse people, sex workers, drug users, and people in custodial settings. Over this time, we have learnt to be dynamic, intersectional, and progressive with our approach to tackling complex social health issues such as HIV/AIDS and the health and wellbeing of sexuality, sex and gender diverse people.

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Introduction

Previous research by Women's Centre for Health Matters (WCHM) has explored the views of ACT women about their health and wellbeing and the barriers they faced in maintaining their health and accessing health services. This is due to binary gendered differences in social and economic circumstances, and differing health needs which the health system and services do not always acknowledge and accommodate.[1]

The ACT Women's Plan 2016-26 recognises that "health issues, and manifestations of health issues, are impacted by gender", and that:

> *"A gender lens must therefore be applied to health care services in the ACT to differentiate between requirements for health-related matters for males, females and those of diverse gender identities, and to ensure that affordable and accessible gender and culturally-sensitive health services are provided across the ACT."*[2]

Sexual orientation can also be a social determinant of health,[3] and there is a growing body of evidence that lesbian, gay, bisexual and queer women's needs are distinct from the general population, and each other.

Lesbian, gay, bisexual and queer women face multiple barriers to good health due to their individual experiences of discrimination and stigma, as well as the structural forces of heternormative bias.

Therefore it is important to know about the health needs and experiences of health services of lesbian, gay, bisexual and queer (LGBQ) women, including cis and transgender women in order to be able to develop appropriate health and wellbeing policies, community initiatives and other service responses.

Usually LGBQ women's health needs are included either in general women's health research or in studies about lesbian, gay, bisexual, trans, intersex, and queer (LGBTIQ) people where the findings for the diverse groups become amalgamated at a higher level.

There have been surveys in other states and territories in Australia exploring the specific health needs and barriers to health services and supports that LGBQ women, may face.[4] [5] [6] [7] [8] Locally the Canberra Gay Community Periodic Survey has surveyed gay, bisexual, and trans men 18 years and older every year since 2006[9] but there has been limited local ACT data on the needs of the LGBQ women's communities, and their health needs and barriers.

This is why WCHM and the AIDS Action Council decided to work together to investigate and highlight the specific local issues for same sex attracted women in the ACT. While we acknowledge the differences in lived experience and health needs for non-binary people and trans

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[1] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre of Health Matters, Canberra, 2018.
[2] The Legislative Assembly for Australian Capital Territory, *The ACT Women's Plan, Canberra 2016*, retrieved on the 4th of June 2019: https://www.communityservices.act.gov.au/__data/assets/pdf_file/0019/1108306/ACT-Womens-Plan_Report_2016_2026.pdf
[3] ACON, *Turning point. ACON lesbian health strategy, 2008-2011,* Sydney, 2008, retrieved on the 13th of September 2018: https://issuu.com/aconhealth/docs/lesbian-health-strategy-a5-web
[4] D Drew et al, *Exploring the health and wellbeing of lesbian, bisexual, queer and same sex attracted women living in the Illawarra and Shoalhaven regions*, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.
[5] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[6] R McNair, L A Szalacha, T L Hughes, 'Health status, health service use, and satisfaction according to sexual identity of young Australian women', *Women's Health Issues*, vol. 21, no. 1, 2011, pp. 40-47.
[7] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[8] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTIQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018,* The University of Sydney, ACON, Sydney, 2019.
[9] E Lee et al, *Gay Community Periodic Survey: Canberra 2017*, Centre for Social Research in Health, AIDS Action council, ACT Health, The Kirby Institute, Sydney, 2018, retrieved on the 4th of July 2019, http://unsworks.unsw.edu.au/fapi/datastream/unsworks:50098/bin5800aee4-afd8-480d-9a02-26b12b959ebf?view=true.

men, this research project only focused on the experiences and health needs of LGBQ women, regardless of the sex they were identified as at birth.

We asked women to use their own language to describe their sexuality. The wide range of terms they used included lesbian, gay, bisexual, and queer. For this reason, we use the term LGBQ women within this report. While we asked women to identify their sex assigned at birth, only a small fraction of the women surveyed indicated that they were identified as male. Regrettably, this research cannot be taken as representative of trans women generally in the ACT. But it did provide some insight into whether their experiences are different to those of LGBQ women who were identified as female at birth. Of the women that were identified as male at birth, many had experienced violence, discrimination and poor mental health indicators. This shows that the experiences of trans women in Canberra should be explored further in future research.

WCHM and the AIDS Action Council conducted this research to obtain the views of ACT LGBQ women because understanding how they use services and knowing about their health issues at different stages can help to inform the provision of better health responses for them in the ACT, and inform better access to appropriate health information provision.

The following report summarises the results of the research and provides the findings and narratives of the 359 ACT women who responded to the survey, and who completed all the survey questions.

This report is comprised of several parts. The first part describes the methodology used and is followed by a brief review of the literature about LGBQ women's health needs, their use of health services and information, their barriers and other relevant themes from similar national and international research.

We then present the survey findings, including the demographic characteristics of the survey respondents, and the responses for each of the main sections of the survey: their understanding of what good health means; their self-rated health; barriers to addressing their health issues; health service use and information seeking; and their experiences.

The discussion section explores the major themes from the consultation and looks more closely at the health issues, barriers and experiences facing LGBQ women in the ACT.

The conclusion outlines the overall key findings from the feedback from both the survey and focus group respondents.

Executive Summary

When women have good quality information and services that are available, affordable, accessible and appropriate, they are equipped to maintain their own health and wellbeing, as well as that of their children, partners and other family members.

WCHM's previous research has shown that women in the ACT have difficulty finding available, affordable, accessible, and appropriate healthcare services. Barriers to accessing health services includes the availability of appointments, long wait times, affordability of services, and services that have understanding and empathy for women's lives and health needs.

These same barriers are experienced by lesbian, gay, bisexual, and queer (LGBQ) women, whether assigned female at birth or transgender, but they are further compounded by discrimination and unconscious bias, and a lack of understanding by health services about how their sexuality and gender affects their health or lifestyle.

The views from LGBQ women are important to understand so that the ACT health care system can respond appropriately to their specific needs and issues.

Canberra aspires to be an inclusive city and has demonstrated great progress in celebrating diversity; however, research shows that LGBQ women continue to have trouble accessing health information and services that meet their needs.

One of the barriers for respondents within this report is that the LGBTIQ community cannot see themselves reflected in the operations of a service. Many local services have been designed based on the needs of cisgender heterosexual people[10], and health information, especially sexual and reproductive health information, is often heteronormative. Health information is harder to find for LGBQ women and does not provide adequate information for LGBQ women about ways to manage their health risks or to understand the health screening that they need. As a result women in our research had difficulty finding information that was inclusive of their sexual practices, and had experienced health service providers who did not have the knowledge to respond to their specific health-care needs – including not understanding that LGBQ women still need access to STI testing and cervical cancer screening.

Affordability, appointment availability and long wait times were the biggest barriers to accessing services for ACT women generally[11] and these were also the biggest barriers for LGBQ women in this study. However, LGBQ women also told us that they worry about stigma when seeking health services.

Our research shows that LGBQ women in the ACT have an increased need for some health services. For example, 58% of LGBQ women in this study reported having access mental health services, compared to 18% of women in WCHM's 2018 research into the health needs of ACT women generally.[12] Sixty six per cent of women in our study listed mental health as one of their top three health issues, higher than the 52% of women in the general population of women in the ACT.[13] Of the 19 trans women who participated in our research, 17 listed mental health as one of their top three issues.

Our research also showed a higher rate of smoking in LGBQ women, and a higher proportion of LGBQ women who drank more than four drinks per occasion than the general population of women.

[10] ACT Government, *The Capital of Equality*. Canberra, 2019. retrieved on the 6th of July, 2019. https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0005/1378184/Capital-of-Equality-An-ACT-Government-strategy.pdf
[11] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[12] Ibid,
[13] Ibid

Most women who participated in our research had experienced violence, with only 38% saying they had not experienced domestic, family, or sexual violence. Our study confirms existing research demonstrating an intersection between violence and mental health, and mental health was one of the top three health issues for 75% of women who reported having experienced violence.

The need for trauma-informed and LGBTIQ inclusive health services was seen as important and described by one of the women who participated in our study:

> *"I've never felt safe to disclose my experiences of childhood and adult sexual abuse, and domestic violence, or my sexual orientation. No health professional has ever seemed even remotely aware that either could be a factor, or what long term physical and mental health implications can follow. No awareness at all of the differing general or sex specific health needs of queer/lesbian/bi women…. not even my female gynaecologist is that sensitive. They never say or ask anything that gives you a hint that it would be ok to disclose to them without being more traumatised by their response. That combined with heteronormative at best or homophobic at worst makes the whole thing a tightrope."*

Despite experiencing these barriers to accessing health information and services that meet their needs, LGBQ women in the ACT did have a holistic understanding of health, which encompasses body and mind, and focuses on balance. Most of the women understood the importance of routine cervical cancer and breast screening and overcame the barriers to accessing these services.

The findings demonstrate the importance of health services which display inclusivity and have an understanding of LGBQ women's lives, as well as the need for health promotion and health information that is representative of the diversity of women's lives, including LGBQ women. This is needed to ensure that LGBQ women maintain a good understanding of health and wellbeing, and for the Canberra community to become more inclusive and understanding of the needs and experiences of LGBQ women.

This research adds a local context to national and international evidence but brings the specific voices of ACT's LGBQ women voices to the discussion. It also reinforces that many of the findings from previous research in the ACT are still relevant today.

The research also complements findings from a series of consultations undertaken by the LGBTIQ Community Consortium to identify unmet needs in the ACT's LGBTIQ community, barriers to services and good practice in delivering appropriate and accessible services to people who are part of LGBTIQ population groups. And it addresses a local data gap for LGBQ women which will complement the Canberra Gay Community Periodic Survey of gay, bisexual, and trans men 18 years and older.

WCHM and AIDS Action Council hope that this feedback from ACT LGBQ women will provide an up to date understanding about the differences for LGBQ women in the health status, health issues, experiences of health and wellbeing, health service use and barriers, and health information seeking.

And that the findings contribute to informing improvements to health programs and policies in the ACT, that enable LGBQ women to use and engage with the ACT health care system more effectively to improve their overall health and wellbeing.

Recommendations

1. The AIDS Action Council to work with the Capital Health Network to provide ongoing professional development for GPs on the health needs of same sex attracted women.
2. WCHM and the AIDS Action Council to ensure the local evidence of LGBQ women's needs is considered in the development of the 2nd Implementation Plan for the ACT Women's Plan.
3. WCHM and the AIDS Action Council to work with the ACT Office for Mental Health to ensure that the evidence about the mental health needs of LGBQ women and their barriers to services and information are understood.
4. WCHM and AIDS Action Council to explore with the Coordinator General for Family Safety how the Family Safety Hub might respond to the results of the research.
5. WCHM and AIDS Action Council to work with ACT Health to identify how ACT Health can make their facilities, funded programs, and policies responsive to the needs of same sex attracted women including alcohol, tobacco and other drug services.
6. The AIDS Action Council to partner with the Health Service Complaints Commissioner to improve information to LGBTIQ people on their rights when accessing health services and the complaints mechanism.
7. The AIDS Action Council to continue supporting research projects on same sex attracted women in Canberra to ensure there is continued availability of local data to support input to policy and services.
8. WCHM to use the research findings to shape the content and information in its upcoming sexual and reproductive health website for women so that it is inclusive of the identified health information needs for LGBQ women.
9. The AIDS Action Council to partner with A Gender Agenda to undertake a research project on the health needs and experiences of health services of Canberra's transgender and gender diverse population.
10. AIDS Action Council to work with ACT Government to advocate for a change to the MBS and PBS policies regarding access to artificial reproduction technologies including IVF for people who are infertile due to the configuration of their relationship.

Terminology

LGBQ women: Cis and trans women who are sexually and/ or romantically attracted to women. This includes women who identify as lesbian, bisexual, pansexual, gay, queer or asexual.

LGBTIQ: An acronym for people who identify as lesbian, gay, bisexual, transgender, intersex and queer.

Cis (gender) women: Women who were assigned the same sex at birth as the gender they identify with.

Trans (gender) women: Women who were assigned a different sex at birth than the gender they identify with.

Sex assigned at birth: The sex that was allocated to a person at birth. It is usually assigned by medical staff checking physical anatomy. It is not determined by genetics. This is usually the legal sex which is put on birth certificates and other legal documents.

Gender dysphoria: This is the experience of the incongruence between a person's gender assignment and the gender that they are. It is considered a mental health condition due to the distress and anguish a person feels as a result of this incongruence. Not all transgender people experience gender dysphoria.[14]

Heteronormativity: This is the societal norm that everyone should be and is assumed to be normatively heterosexual.[15] This way of structuring society is damaging to people who don't conform to heteronormative convention. Heteronormativity assumes that heterosexuality is the only normal or natural sexual expression, and so people who are not heterosexual can be seen as non-normal or non-natural.[16]

Cis-normativity: This is the societal norm that everyone should have their outward gender identity or gender expression match their gender identified at birth. This promotes the negative assumption that anything else is unnatural. It encourages stigma and discrimination against trans people.[17]

Hetero-sexism / cis-sexism: Hetero-sexism or cis-sexism is the oppression of LGBTQ people due to the idea that heterosexual or cisgender-people are superior. Hetero-sexism or cis-sexism produces homophobia and transphobia. It grants privileges and rights to those who are heterosexual or cis gender and denies the same rights to LGBTIQ people.[18]

Homophobia/ transphobia: The fear, discrimination and dislike of LGBTIQ people.[19] Discrimination can occur overtly such as not giving someone a promotion even though they are overperforming in the workplace, or not allowing someone's partner to be with them in a hospital. Implied discrimination includes the belief that lesbian sex is not real sex. Homophobia or transphobia can lead to violence, harassment, and abuse, which can cause severe mental and physical harm.[20]

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[14] P Strauss et al, *Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results*, Telethon Kids Institute, 2017, Perth, Australia.
[15] Oxford Dictionaries, *Heteronormativity*, Oxford University Press, 2019, retrieved on 4th of June 2019; https://en.oxforddictionaries.com/definition/heteronormative
[16] S Jeppesen, *Heteronormativity,* The SAGE Encyclopedia of LGBTQ Studies, SAGE Knowledge, retrieved on the 3rd of June 2019; https://sk.sagepub.com/reference/the-sage-encyclopedia-of-lgbtq-studies/i5699.xml
[17] J Russo, *Queer dictionary, Cis-normativity*, 2014, retrieved on 4th of June 2019; http://queerdictionary.blogspot.com/2014/09/definition-of-cisnormativity.html
[18] Oxford Dictionaries, *Heterosexism,* Oxford University Press, 2019, retrieved on 4th of June 2019; https://en.oxforddictionaries.com/definition/heterosexism
[19] Oxford Dictionaries, *Homophobia*, Oxford University Press, 2019, retrieved on 4th of June 2019; https://en.oxforddictionaries.com/definition/homophobia
[20] P Strauss et al, Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, 2017, Perth, Australia.

Methodology

This project used both quantitative and qualitative methods to collect and interpret information on the views and experiences of same sex attracted women's health needs and access to health services.

A survey was conducted from October to November 2018 to collect quantitative and qualitative data from same sex attracted women in the ACT

The survey sought to answer the following research questions:

- How do women understand and manage their health needs?
- Which health services, supports and information they use and whether they experienced barriers to that access?
- What barriers they experienced to maintaining good health and wellbeing.

There were two qualifying questions:

1. Are you aged 16 or older and live and/or work in the Australian Capital Territory (ACT) or surrounding areas?
2. This survey is designed to help us understand the health and healthcare needs of people who identify as women* and are, exclusively or otherwise, sexually or romantically attracted to women. Is this you?

The online survey provided all participants with information about the project and an indication that, by completing and submitting the form, they were consenting to their information being stored and used for the purposes of this research.

The online survey was available via a link on the WCHM website and distributed through WCHM and AIDS Action Council networks and through those of other community organisations, service providers, and the Community Development Network. It was promoted at the CBR Fair Day, Canberra's large annual celebration of LGBTIQ communities. Advertisements were placed on the WCHM and the AIDS Action Council website, Facebook, and Instagram, and an article was published in RiotACT.[21]

The survey was open for 45 days. A total of 359 valid and complete survey responses, were received from a total of 492 responses.

The online survey was also used to directly recruit participants for the focus groups. The final question asked women to indicate if they would like to participate, and if so to provide contact details. The focus groups aimed to explore in greater detail the findings identified in the analysis of the survey responses.

Six focus groups were held, one in business hours and five outside business hours, between December 2018 and February 2019. Thirty two women attended the focus groups, and three women were interviewed over the phone.

Analysis of the qualitative, open ended questions was coded and analysed using the qualitative data program NVivo. Quantitative data was analysed using Microsoft Excel.

This qualitative study does not aim to be representative of all ACT LGBQ women's views, but rather to capture themes from a sample of ACT LGBQ women.

[21] E Davidson, *Understanding health needs of same sex attracted women*, RiotACT, retrieved on the 17th of November 2018: https://the-riotact.com/understanding-health-needs-of-same-sex-attracted-women/273988

Literature review

The objectives of the literature review were to explore the available research about LGBQ women in relation to:

- their understanding of health and wellbeing, and their self-rated status of physical and mental health;
- their top health and wellbeing issues, and their experiences of managing these;
- their use and experiences of particular health and wellbeing services and supports and information sources; and
- what barriers were experienced to that access.

Understanding of what good health means

The World Health Organisation has a definition of what good health means: *"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."*[22]

WCHM's 2018 report found that ACT women have a diversity of opinions when it comes to defining the meaning of good health which can depend on life circumstances, societal factors and age.[23] Some women (of unknown sexuality) identified good health as a combination of physical and mental health, while other women believed good health was more holistic and include spirituality, social and emotional wellbeing. Being physically active, eating well or looking fit, having autonomy, the absence of illness, ability to fulfil life roles, having access to health care services, and maintaining social connection were all considered by women as important when defining what good health means.[24]

No studies were identified in relation to how LGBQ women defined the meaning of good health.

Self assessed ratings of health

For many years researchers have used the 'self-rated health tool' to find out how people rate their health. The Australian Bureau of Statistics acknowledges it as an effective tool to determine the current state of a person's health status and *"provides a broad picture of a population's overall health."*[25] Poor self-rated health has been shown to be a predictor of mortality, morbidity, and increased health service utilisation.[26] [27] [28] For women, poor health, as indicated by the self-rated

[22] World Health Organisation, *From Alma Ata to the year 2000, Reflections at the midpoint*, WHO, Geneva, 1988.
[23] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre of Health Matters, Canberra, 2018.
[24] Ibid
[25] Australian Bureau of Statistics, *National Health Survey: first results 2014-15*, ABS cat No. 4364.0.55.001. Canberra, 2015, retrieved on the 23rd of April 2019; http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Explanatory%20Notes12014-15?OpenDocument
[26] M Jylha, 'What is self-rated health and why does it predict mortality? Towards a unified conceptual model', *Social Science and Medicine*, no.69, 2009, pp. 307-316.
[27] M Bopp, J Braun, F Gutzwiller & D Faeh, 'Health risk or resource? Gradual and independent association between self-rated health and mortality persists over 30 years', *PLoS One*, vol. 7, issue 2, 2012, pp. 1-10.
[28] P M Smith, R H Glazier & L M Sibley, 'The predictors of self-rated health and the relationship between self-rated health and health service needs are similar across socioeconomic groups in Canada', *Journal of Clinical Epidemiology*, vol. 63, 2010, pp. 412-421.

health tool, is impacted by age and the social determinants of health; such as economic position, education, gender, and sexuality.[29]

Women were asked about their self-ratings of their health by WCHM in the 2018 ACT women's health study. Forty two per cent of respondents rated their health as fair, poor, or very poor, 48% rated their health as good, and 10% rated their health as excellent. More women in the older age groups (65+ years old) rated their health as good and excellent than those in the younger age groups.[30]

Bariola, Lyons & Leonard found that poorer self-rated health of lesbian women was not related to their sexual identity, but to their experiences of victimisation. Identity concealment was linked to poorer health.[31] Women who rated themselves as having poor health (in all sexual identity categories) experienced more violence and threats of violence then cis men in a large Swedish study. Poor self-rated health was related to older age, immigrants, low education, social isolation, reduced trust, and experience of abuse, threats of violence, and violence.[32] Poorer self-rated health is related to lower socioeconomic status in LGBQ people.[33]

Although some studies reported no differences in self-rated health between sexual identities,[34] [35] other research found that bisexuals (including pansexual) had poorer self-rated health.[36] [37] In a national survey on the health of LGBQ Australians, more lesbian women than bisexual women rated their wellbeing as excellent. And, more bisexual women compared to lesbian women rated their wellbeing as fair or poor.[38] Axelsson's et al study found that a higher percentage of bisexual women were exposed to low trust, violence, and threats of violence compared to lesbian women.[39] Other research suggests that the poorer self-rated health status of bisexual people may be due to their elevated economic, social, and behavioural disadvantages.[40]

For transgender women (unknown sexuality), poor self-rated health has been found to be related to having to change their gender, not being able to change their gender, and their negative experiences with health care professionals.[41] An Australian/New Zealand study that looked at trans people (all sexualities) found that 64% rated their health as good and very good. When participants were asked if they had improvements in their health from a year ago, most said that their health had improved or stayed the same.[42]

Self-rated mental health is a good predictor of overall health.[43] Few studies measure the differences in LGBQ women and self-rated mental health status. Veldhuis found correlations between older (55 years plus) LGBQ women and positive ratings of self-rated mental health.[44]

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[29] A Hosseinpoor et al, 'Social determinants of self-reported health in women and men: Understanding the role of gender in population health', *PLoS one*, vol. 7, no. 4, 2012, pp.1-10.
[30] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre of Health Matters, Canberra, 2018.
[31] E Bariola, A Lyons, W Leonard, 'Gender-specific health implications of minority stress among lesbians and gay men', *Australia and New Zealand Journal of Public Health*, vol. 40, no. 6, 2016, pp. 506-512.
[32] J Axelsson, B Moden, M Rosvall & M Lindstrom, 'Sexual orientation and self-rated health: the role of social capital, offence, threat of violence and violence', *Scandinavian Journal of Public Health*, vol. 41, 2013, pp. 508-515.
[33] M B Thomeer, 'Sexual minority status and self-rated health: The importance of socioeconomic status, age, and sex', *American Journal of Public Health*, vol. 103, no. 5, 2013, pp. 881-888.
[34] R McNair, L A Szalacha & T L Hughes, 'Health status, health service use, and satisfaction according to sexual identity of young Australian women', *Women's Health Issues*, vol. 21, no. 1, 2011, pp. 40-47.
[35] E Bariola, A Lyons, W Leonard, 'Gender-specific health implications of minority stress among lesbians and gay men', *Australia and New Zealand Journal of Public Health*, vol. 40, no. 6, 2016, pp. 506-512.
[36] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[37] L S Steele et al, 'Women's sexual orientation and health: results from a Canadian population-based survey', *Women & Health*, vol. 49, no. 5, 2009, pp. 353-367.
[38] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[39] J Axelsson et al, 'Sexual orientation and self-rated health: the role of social capital, offence, threat of violence and violence', *Scandinavian Journal of Public Health*, vol. 41, 2013, pp. 508-515.
[40] B K Gorman et al, 'A new piece of the puzzle: Sexual orientation, gender and physical health status', Demography, vol. 52, 2015, pp. 1357-1382.
[41] G Zaluf et al, 'Health, disability and quality of life among trans people in Sweden-a web -based survey', *BMC Public Health*, vol. 16, no. 903, 2016, pp. 1-16.
[42] M Couch et al, *Tranznation: A report on the health and wellbeing of transgendered people in Australia and New Zealand,* Gay and Lesbian Health Victoria, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, 2007.
[43] D Levinson & G Kaplan, 'What does self rated mental health represent', *Journal of Public Health Research*, vol. 3, no. 287, 2014, pp. 122-127.
[44] C B Veldhuis et al, 'Alcohol use, age, and self-rated mental and physical health in a community sample of lesbian and bisexual women', *LGBT Health*, vol. 4, no. 6, 2017, pp. 419-426.

Steele et al showed that bisexual women were more likely to rate their mental health as poor and fair compared to lesbian and non-LGBQ women.[45]

Top health issues

In the 2018 ACT women's health study respondents told WCHM that their top three health issues were chronic conditions (53%), mental health conditions (52%), and weight diet and fitness (49%).[46]

In 2018 the WCHM completed a report on chronic disease in younger women in the ACT. It was found that the top conditions were mental health conditions, autoimmune conditions, musculoskeletal disease, and endocrine conditions. Sixty one per cent had more than one chronic condition and many women had a multimorbidity of a mental health condition and a physical disease.[47]

In the 2016 SWASH study, 22% of women reported that they had chronic illness or disability,[48] and 24% of women in the 2018 SWASH study reported the same.[49] Twenty nine per cent of women in the Northern Rivers SWASH report had chronic illness or disability.[50]

Fifty four per cent of LGBQ women in the 2018 SWASH study were outside the healthy weight range[51] which was similar to the general population of women.[52] Qualitative research involving lesbian women with cardiovascular disease found that even though participants wanted to focus on reducing their weight to improve cardiovascular risk factors, this was not their main health priority. Minority stress, homophobia, anxiety, and depression impacted on their health behaviours and barriers to health behaviours.[53] Overweight and weight gain in lesbian women was found to be related to depression and alcohol intake in a study by Mason and Lewis.[54] A WCHM report on physical activity, healthy eating and health promotion in the ACT (unknown sexuality) found women experience stigma and shame when participating in healthy behaviours.[55]

Research showed the need for specific targeted health promotion and public health campaigns for LGBQ women, and to consult and sensitively engage with members of the LGBQ community to ensure effective healthy eating and physical activity campaigns.[56]

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[45] L S Steele et al, 'Women's sexual orientation and health: results from a Canadian population-based survey', *Women & Health*, vol. 49, no. 5, 2009, pp. 353-367.
[46] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre of Health Matters, Canberra, 2018.
[47] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, Women's Centre for Health Matters, Canberra, 2018.
[48] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[49] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.
[50] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTIQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018,* The University of Sydney, ACON, Sydney, 2019.
[51] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.
[52] Australian Bureau of Statistics, *National Health Survey: first results 2014-15*, ABS cat No. 4364.0.55.001. Canberra, 2015, retrieved on the 23rd of April 2019; http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Explanatory%20Notes12014-15?OpenDocument
[53] S J Roberts, E M Stuart-Shor & R A Oppenheimer, 'Lesbians' attitudes and beliefs regarding overweight and weight reduction', *Journal of Clinical Nursing*, vol. 19, no. 13-14, 2010, pp. 1986-1894.
[54] R B Mason & R J Lewis, 'Minority stress, depression, relationship quality, and alcohol use: associations with overweight and obesity among partnered young adult lesbians', *LGBT Health*, vol. 2, no. 4, 2015, pp. 333-340.
[55] A Hutchison, *Physical activity and healthy eating promotion to ACT women: A guide to getting it right*, Women's Centre for Health Matters, Canberra, 2018.
[56] J Mooney-Somers, R M Deacon & J Comfort, *Women in contact with the Perth gay and lesbian community: Report of the Women's Western Australian sexual health (WWASH) Survey 2010*, Western Australian Centre for Health Promotion Research, Curtin University, Perth, 2010.

Sexual and reproductive health

Health screening checks

LGBQ women have significant risk factors for some cancers such as cervical cancer and breast cancer.[57]

Breast cancer screening such as self-breast checks and mammograms are important detection methods.[58]

In the 2018 ACT women's sexual and reproductive health survey (unknown sexualities), 83% of women had been shown how to do a breast self-examination and 67% of women over 50 years were having regular mammograms. Women who were not getting regular mammograms were aware of the age that it was most effective and that they were below the age.[59] In comparison, rates of breast cancer screening in Australia for women over 50 years old are 54%, although national screening services aim for 70%.[60]

Breast screening rates for LGBQ women are the same, if not higher, as the rates for the general population.[61] [62] Seventy two per cent of LGBQ women had ever done a self-breast check. [63]

In the 2018 ACT women's sexual and reproductive health survey (unknown sexuality), 73% of women undertook regular cervical cancer screening.[64] Whereas, the most recent data out of the Australian Institute of Health and Welfare show that 58% of ACT women over the age of 20 years have had cervical cancer screening in the last 18 months.[65]

Even though LGBQ women are just as likely to develop cervical cancer than the general women population, some health practitioners and some LGBQ women think that they don't need cervical screening.[66] Women who identify as bisexual are more likely than all other sexual identities to have abnormal cervical cancer screens.[67] Screening for cervical cancer has been found to be a significant risk factor for invasive cervical cancer due to late diagnosis leading to poorer outcomes.[68]

Older reports show low cervical screening rates amongst LGBQ women.[69] [70] More recent research have shown improvements in LGBQ women's cervical screening rates and were comparative to the general population of women in NSW.[71] Qualitative research have shown that most LGBQ

[57] ACON, *Turning point. ACON lesbian health strategy, 2008-2011,* Sydney, 2008, retrieved on the 13th of September, 2018: https://issuu.com/aconhealth/docs/lesbian-health-strategy-a5-web
[58] Breastcancer.org, *Breast Self-Exam*, Philadelphia, USA, 2019, retrieved on the 15th of May 2019; https://www.breastcancer.org/symptoms/testing/types/self_exam
[59] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.
[60] Cancer Control Indicators, *Breast screening rates*, Cancer Australia, Canberra, 2018, accessed on the 11th of January 2019, https://ncci.canceraustralia.gov.au/screening/breast-screening-rates/breast-screening-rates
[61] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[62] Z Hyde et al, *The health and wellbeing of lesbian and bisexual women in western Australia,* Western Australia Centre for Health Promotion Research, Perth, 2007, accessed on the 10th of January 2019: http://ceriph.curtin.edu.au/downloads/reports/51949LBWHWBSFinalReport.pdf
[63] D Drew et al, *Exploring the health and wellbeing of lesbian, bisexual, queer and same sex attracted women living in the Illawarra and Shoal haven regions*, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.
[64] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.
[65] Australian Institute of Health and Welfare, *Participation in the National Cervical Screening Program, by age, state and territory, Jan 2016–Jun 2017*, Canberra, 2019, retrieved on the 15th of May 2019; https://www.aihw.gov.au/reports/cancer-screening/national-cancer-screening-programs-participation/data
[66] Pap Screen Victoria and The Cancer Council Victoria, *Lesbians need pap tests too*, Victoria, 2006, retrieved on the 10th of January 2019: http://www.papscreen.org.au/downloads/resources/brochures/Lesbians_need_Pap_tests_too.pdf
[67] R McNair, L A Szalacha, T L Hughes, 'Health status, health service use, and satisfaction according to sexual identity of young Australian women', *Women's Health Issues*, vol. 21, no. 1, 2011, pp. 40-47.
[68] Henderson H, 'Why lesbians should be encouraged to have regular cervical screening', *Journal of Family Planning Reproductive Health Care, vol. 35,* 2009, pp. 49–52.
[69] D B Kerker, F Mostashari & L Thorpe, 'Health care access and utilization among women who have sex with women: sexual behaviour and identity', *Journal of Urban Health*, vol. 83, 2006, pp. 970-979.
[70] M Pitts et al, *Private lives, A report on the health and wellbeing of GLBTI Australians*, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2006.
[71] C Douglas, R Deacon and J Mooney-Somers, 'Pap smear rates among Australian community-attached lesbian and bisexual women: some good news but disparities persist', *Sexual Health*, 2015, vol. 12, pp. 249-256.

women view cervical screening as important.[72] However, other research found that women that had not had sex with a cis man felt they didn't need to be screened.[73] [74] Studies also show that lesbian women who don't have regular cervical screens tend to experience more discrimination and are less knowledgeable about guidelines of screening.[75] Women feared pain of penetration with cervical screening and experienced a lack of perceived need.[76] Sexual health promotion that is widely directed to heterosexual audiences are likely to miss LGBQ women.[77] Significant gaps exist in information provision about cervical cancer screening; at schools and in the public sphere generally.[78]

Screening rates are often lower in trans women.[79] Recommendations on breast screening of trans women often indicate screening over 50 years of age but some research is contradictory.[80] As trans women will retain a prostate, prostate screening is recommended at the same rate as cis men.[81] Additionally trans women with surgically made vaginas will need to consider cervical screening. 'Neovaginas' have been found to have similar cells as cervical tissue and which could lead to cancerous cell development.[82]

Transwomen rely on health providers for gender health but are often hesitant to access services due to fear of stigma and discrimination.[83] [84] Furthermore, many health professionals may not know the nuances of treating trans patients, particularly for health screening such as for breast and prostate cancer. Some procedures translate from cis women to trans women, but some do not.[85]

STIs, barrier protection and STI testing

Many LGBQ women feel that the risk of spreading STIs is minimal.[86] Sex between two women can be seen to be safe and low risk due to the assumption that because it is not with a cis man it is not considered as 'real sex'.[87] [88] Women who exclusively have sex with women are relatively

[72] S Munson & C Cook, 'Lesbian and bisexual women's sexual healthcare experiences', *Journal of Clinical Nursing*, vol. 25, no. 23-24, 2016, pp. 3497-3510.
[73] C Douglas, R Deacon and J Mooney-Somers, 'Pap smear rates among Australian community-attached lesbian and bisexual women: some good news but disparities persist', *Sexual Health*, 2015, vol. 12, pp. 249-256.
[74] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[75] J Tracy, A Lydecker & L Ireland, 'Barriers to cervical cancer screening among lesbians', *Journal of Women's Health,* vol. 19, 2010, pp. 229–37.
[76] C Currmi, K Peters & Y Salamonson, 'Barriers to cervical cancer screening experienced by lesbian women: a qualitative study', *Journal of Clinical Nursing*, vol. 25, 2015, pp. 3643-3651.
[77] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTIQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018,* The University of Sydney, ACON, Sydney, 2019.
[78] C Currmi, K Peters & Y Salamonson, 'Lesbian attitudes and practices of cervical cancer screening: qualitative study', *BMC Women's Health*, vol. 14, no. 153, 2014, pp. 1-9.
[79] A R Bazzi et al, 'Adherence to Mammography Screening Guidelines Among Transgender Persons and Sexual Minority Women,' *American journal of public health*, vol. 105, no. 11, 2015, pp. 2356-8.
[80] A R Bazzi et al, 'Adherence to Mammography Screening Guidelines Among Transgender Persons and Sexual Minority Women,' *American journal of public health*, vol. 105, no. 11, 2015, pp. 2356-8.
[81] M C McNamara, H Ng, 'Best practices in LGBT care: A guide for primary care physicians', *Cleveland Clinic Journal of Medicine*, vol. 83, no. 7, 2016, 531-541.
[82] A Grosse et al, 'Cytology of the neovagina in transgender women and individuals with congenital or acquired absence of a natural vagina', *Cytopathology*, vol. 28, no. 3, 2017, pp. 184-191.
[83] G R Bauer et al, 'Factors impacting transgender patients' discomfort with their family physicians: a respondent-driven sampling survey', *PLoS One*, vol. 10, 2015, pp. 1-16.
[84] G R Bauer, 'Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey', *Annals Emergency Medicine*, vol. 63, 2014, pp. 713–720.
[85] E B Sonnenblick, A D Shah, Z Goldstein & T Reisman, 'Breast Imaging of transgender individuals: A review,' *Current Radiology Reports*, vol. 6, no. 1, 2018, pp. 1-12.
[86] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[87] C Logie, '(Where) do queer women belong? Theorizing intersectional and compulsory heterosexism in HIV research,' *Critical Public Health, vol.* 25, no. 5, 2014, pp. 527–538.
[88] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health*, vol. 6, 2009, pp. 15-18.

rare which can mean that transmission of STIs from a cis man can occur.[89] [90] [91] Additionally LGBQ women have reported high rates of pressured or forced sex with a cis man.[92]

STIs can be transferred through blood, vaginal fluid (or semen), particularly if there are cuts or sores around mouth genitals or anus. Oral sex, which is one of the main sexual acts of LGBQ women,[93] can lead to transfers of chlamydia, herpes type 1 or 2, genital warts, gonorrhoea, hepatitis A, B, C, HIV or syphilis.[94] Bacterial vaginosis is more prevalent in the LGBQ women population due to uses of sex toys between women.[95]

Safe sex health promotion is mostly heteronormative and often centred around penetrative sex and therefore not directed toward LGBQ women.[96] LGBQ women have knowledge of heteronormative safe sex practices but not of safe practices that they can apply to the sex that they have.[97] In fact, heteronormative sex education at schools have been shown to erase LGBQ people, leading to inaccurate and heterosexist assumptions about risk,[98] and poorer knowledge of safe sex practices.[99]

Barrier protection among LGBQ women is often in the form of dental dams, gloves, and condoms. Rowen et al found that barrier protection was not used very frequently by LGBQ women even though there was a risk of bacterial vaginosis and STIs. Women in monogamous relationships were less likely to use barrier protection than those in non-monogamous relationships.[100] Richters et al found that only 10% of LGBQ women had used a dental dam and a small per cent had used them often.[101] Women think very poorly of dental dams.[102] They are too powdery and rubbery; not flavoured; poor tasting and feel; and too thick or dry. Condoms and gloves are more useful and are more likely to be used.[103] Cox and McNair found that promoting hygiene, communication, and visible signs of infection, can help women reduce their risk.[104] Richters and Clayton have stressed that there is little evidence for the promotion of dental dams.[105] Dental dams and other forms of barrier protection should be promoted to LGBQ women only if it is needed, for example, if one woman has a herpes outbreak.[106] [107]

[89] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016,* ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[90] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[91] D Drew et al, *Exploring the health and wellbeing of lesbian, bisexual, queer and LGBQ women living in the Illawarra and Shoal haven regions,* ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.
[92] R McNair, Lesbian and Bisexual Women's Sexual Health, *Australian Family Physician*, vol. 38, no. 8, 2009, pp. 388-393.
[93] M Pitts et al, *Private lives, A report on the health and wellbeing of GLBTI Australians*, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2006.
[94] National Health Service, *Sex activities and risk*, UK, 2018, retrieved on the 3rd of April 2019; https://www.nhs.uk/live-well/sexual-health/sex-activities-and-risk/
[95] L L Lindley, D B Friedman & C Struble, 'Becoming visible: Assessing the availability of online sexual health information for lesbians', *Health Promotion Practice*, vol. 13, no. 4, 2012, pp. 472-480.
[96] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[97] R Grant & M Nash, 'Navigating unintelligibility: Queer Australian young women's negotiations of safe sex and risk', *Journal of Health Psychology*, vol. 23, no. 2, 2018, pp. 306-319.
[98] Ibid
[99] Shannon B, 'Comprehensive for who? Neoliberal directives in Australian 'comprehensive' sexuality education and the erasure of GLBTIQ identity', Sex Education, vol. 16, no. 6, pp. 573-585.
[100] T S Rowen, 'Use of barrier protection for sexual activity among women who have sex with women', *International Journal Gynaecological Obstetrics*, vol. 120, no. 1, 2013, pp. 42-45.
[101] J Richters et al, 'Do women use dental dams? Safe sex practices of lesbians and other women who have sex with women,' *Sexual Health,* vol. 7, 2010, pp. 165-169.
[102] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health*, vol. 6, 2009, pp. 15-18.
[103] L Yap et al, 'Sexual practices and dental dam use among women prisoners- a mixed methods study', *Sexual Health*, vol. 7, 2010, pp. 170-176.
[104] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health*, vol. 6, 2009, pp. 15-18.
[105] J Richters & S Clayton, 'The practical and symbolic purpose of dental dams in lesbian safer sex promotion', *Sexual Health*, vol. 7, 2010, pp. 103-106.
[106] Ibid
[107] J M Marrazzo, P Coffey & A Bingham, 'Sexual practices, risk perception and knowledge or sexually transmitted disease risk among lesbian and bisexual women', *Perspectives in Sex and Reproductive Health*, vol. 37, no. 1, 2005, pp. 6–12.

In relation to STI testing, the 2018 ACT women's sexual and reproductive health survey (unknown sexuality), 74% of women had ever been tested for an STI. Most women in the study reported that they felt comfortable talking to a healthcare provider about STIs and/or asking for a STI check. [108]

Historically, STI testing rates have appeared to be quite low for LGBQ women with only 25% of women participating in testing.[109] Higher rates have been recorded of late, multiple studies show that 50-70% of women have ever accessed an STI test.[110] [111] [112] Higher amounts of testing have been found in women who had ever had sex with a cis man (72%).[113] Disclosure of sexual identity does not indicate that LGBQ women will gain access to STI testing. A few LGBQ women in the 2018 ACT women's sexual and reproductive health survey advised that health providers incorrectly believed that they did not need regular STI testing unless they were working in the sex industry.[114] Power, McNair & Carr found that GPs assumed that some LGBQ women weren't sexually active, if they said no, when asked if they had a male partner.[115]

Mental health

LGBQ women have higher rates of mental health conditions and report significantly poorer mental health than non-LGBQ women.[116] They have higher levels of anxiety, depression,[117] suicide ideation,[118] and self-harm.[119] Minority stress also has a significant impact on LGBTIQ people. It can occur from stigma arising from discrimination or victimisation, and from own self-beliefs such as internalised homophobia or concealment of identity due to worry about stigma.[120]

McNair and Bush surveyed over one thousand Australian LGBQ women, trans women, and gender diverse and found that 80% had reported experiencing some mental health issue in the last 12 months. Trans women and gender diverse were significantly more likely to be stressed, distressed, or depressed.[121]

In the latest SWASH study, 41% of women overall and 62% of young women (16-24 years old) reported high psychological distress. The study also found that 41% of women had received a mental health diagnosis and 68% had accessed psychological services in the past five years. In the past 12 months, 31% had felt their life was not worth living and 14% had self-harmed.[122] In

[108] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.
[109] M Pitts et al, *Private lives, A report on the health and wellbeing of GLBTI Australians*, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2006.
[110] D Drew et al, Exploring the health and wellbeing of lesbian, bisexual, queer and LGBQ women living in the Illawarra and Shoal haven regions, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.
[111] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.
[112] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTIQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018*, The University of Sydney, ACON, Sydney, 2019.
[113] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.
[114] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.
[115] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[116] R McNair, L A Szalacha, T L Hughes, 'Health status, health service use, and satisfaction according to sexual identity of young Australian women', *Women's Health Issues*, vol. 21, no. 1, 2011, pp. 40-47.
[117] M Pitts et al, *Private lives, A report on the health and wellbeing of GLBTI Australians,* Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2006.
[118] M D Skerrett & M Mars, 'Addressing the social determinants of suicidal behaviors and poor mental health in LGBTI populations in Australia', *LGBT Health*, vol. 1, no. 3, 2014, pp. 212-217.
[119] M Pitts et al, Private lives, *A report on the health and wellbeing of GLBTI Australians,* Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2006.
[120] I H Meyer, 'Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence', *Psychological Bulletin*, vol. 129, no. 5, 2003, pp. 674-697.
[121] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[122] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018,* The University of Sydney, ACON, Sydney, 2018.

the 2016 SWASH study only 14% of women and 35% of young women (16-24 years old) had experienced high levels of psychological stress.[123]

Young LGBQ women have poorer mental health than women in older age groups.[124] [125] They have a higher risk of anxiety, depression, suicidality and substance abuse than the general population.[126] Experiences of discrimination, stigma, and homophobic physical abuse were associated with psychological distress and suicidal thoughts.[127] Family rejection is a significant risk factor for poorer health outcomes, depression, attempted suicide, drug use, and increased sexual risk (unprotected sex).[128] Seventy three per cent of lesbian youths have considered taking their own lives.[129]

Bisexual women have significantly poorer mental health than lesbian women.[130] Studies show that bisexual women were diagnosed with anxiety, had psychological stress, and mental health conditions more than lesbian women.[131] [132] Bostwick et al found that bisexuals had higher rates of mood and anxiety disorders when compared to lesbian women.[133] Steele et al show that bisexuals were more likely to have higher life time suicidality.[134] Poorer mental health in bisexual women may be from internalised biphobia, being in a heterosexual relationship, and having an un-supporting partner.[135] While other studies conclude that it may be linked to previous child abuse, risky sexual behaviour, and not disclosing sexual orientation.[136]

Trans people have higher rates of mental health conditions than cis gendered people in the LGBTIQ community.[137] Fifty seven per cent of trans women in the Private Lives 2 study have been treated or diagnosed with a mental health condition in the past three years.[138] An Australian study of 859 young trans people (14-25 years), found that many have experienced mental health issues such as depression, anxiety, post-traumatic stress disorder, body dysmorphia, autism spectrum disorder, self-harm, suicide ideation, and gender dysphoria. Seventy two per cent of young trans people have considered taking their own lives, while 48% have tried.[139] Trans women show reductions in psychological stress as they age.[140]

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[123] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[124] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[125] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[126] T Lea, J de Wit & R Reynolds, 'Minority stress in lesbian, gay, and bisexual young adults in Australia: Associations with psychological distress, suicidality, and substance use', *The Lancet*, vol. 43, no. 8, 2014, pp. 1571-1578.
[127] Ibid
[128] C Ryan et al, 'Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults, *Pediatrics*, vol. 123, 2009, pp. 346-352.
[129] Y C Padilla, C Crisp & D L Rew, 'Parental acceptance and illegal drug use among gay, lesbian and bisexual adolescents: results from a national survey', *Social Work*, vol. 55, no. 3, 2010, pp. 265-275.
[130] B Loi, T Lea & J Howard, 'Substance use, mental health, and service access among bisexual adults in Australia,' *Journal of Bisexuality*, vol. 17, no. 4, 2017, pp. 400–17.
[131] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[132] B Loi, T Lea & J Howard, 'Substance use, mental health, and service access among bisexual adults in Australia,' *Journal of Bisexuality*, vol. 17, no. 4, 2017, pp. 400–17.
[133] W B Bostwick et al, 'Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States', *American Journal of Public Health*, vol. 100, 2010, pp. 468-475.
[134] L S Steele et al, 'Women's sexual orientation and health: results from a Canadian population-based survey', *Women & Health*, vol. 49, no. 5, 2009, pp. 353-367.
[135] J Taylor et al, 'Bisexual mental health: Findings form the 'Who I am' study', *Australian Journal of General Practice*, vol. 48, no. 3, 2019, pp. 138-144.
[136] T J Persson et al, 'Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure?' *Social science medicine*, vol. 128, 2015, pp.366–73.
[137] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[138] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[139] P Strauss et al, *Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results*. Telethon Kids Institute, 2017, Perth, Australia.
[140] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.

A resistance among some women to include trans women in women spaces has marked a strong negative 'us and them' mentality that discriminates and facilitates stigma.[141] Level of outness had been found to have a positive influence on psychological wellbeing in a study with trans women.[142]

Many trans people experience gender dysphoria which is a mental health condition due to the incongruence between their sex assigned at birth and the gender that they identify with.[143] Although some trans people don't experience gender dysphoria, the condition is used by medical professionals as a necessary step to getting specialised transitional medication or surgery.[144] However, having a mental health condition which only applies to trans people increases stigma and prejudices.[145] It is important to have programs aimed at supporting young trans people in schools and health care settings to ensure that they have the support that they need to keep them out of harm.[146]

Verelli et al found that LGBQ people in Australia had experienced higher psychological stress in the time of the Australian marriage equality vote due to negative and hurtful media. Having a supportive network of friends and family had a protective effect, they experienced less psychological stress even if they were exposed to negative media. Whereas, people that didn't have supportive friends and family benefited from seeing positive and supportive media.[147] Gaining marriage equality however improves social inclusion[148] and mental health in LGBQ people.[149] [150]

Tobacco, drugs, and alcohol

Experiences of marginalisation, social exclusion, minority stress, discrimination, and violence, in combination with contact with smoking, drugs, and alcohol encourages further use.[151] [152] Poorer mental health has been correlated with smoking, drug and alcohol use.[153] [154]

Tobacco use

Research shows that historically LGBQ women smoking rates are double the rates of the general women's population.[155]

[141] G Beemyn & M Eliason, '"The intersections of trans women and lesbian identities, communities, and movements": An introduction', *Journal of Lesbian Studies*, vol. 20, no. 1, 2016, pp. 1-7.
[142] Strain J D & Shuff M I, 'Psychological Well-Being and Level of Outness in a Population of Male-to-Female Transsexual Women Attending a National Transgender Conference', *International Journal of Transgenderism*, vol. 12, no. 4, 2010, pp. 230-240
[143] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[144] C Moleiro & N Pinto, 'Sexual orientation and gender identity: review of concepts, controversies an their relation to psychopathology classification systems', *Frontiers in Psychology*, vol. 6, article. 1511, 2015, pp. 1-6.
[145] S Winter et al, 'Transpeople, Transprejudice and Pathologization: A Seven-Country Factor Analytic Study', *International Journal of Sexual Health*, vol. 21, no. 2, 2009, pp. 96-118.
[146] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[147] S Verrelli et al, 'Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian marriage law postal survey', *Australian psychologist*, 2019, pp. 1-11
[148] M V L Badgett, 'Social inclusion and the value of marriage equality in Massachusetts and the Netherlands', *Journal of Social Issues*, vol. 67, no. 2, 2011, pp. 316-34
[149] E Bariola, A Lyons, W Leonard, 'The mental health benefits of relationship formalisation among lesbians and gay men in same-sex relationships', *Australian and New Zealand Journal of Public Health*, vol. 39, no. 6, 2015, pp. 530-535.
[150] ML Hatzenbuehler et al, 'The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study', *American Journal of Public Health*, vol 100, no.3, 2010, pp. 452-459.
[151] T Hughes et al, 'Sexual victimization and hazardous drinking among heterosexual and sexual minority women', *Addictive Behaviors*, vol. 35, 2010, pp. 1152-1156.
[152] T Hughes, L A Szalacha, R McNair, 'Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women', *Social Science & Medicine*, vol. 71, no. 4, 2010, pp. 824–831.
[153] L A Drabble et al, 'Comparing substance use and mental health outcomes among sexual minority and heterosexual women in probability and non-probability samples', *Drug and Alcohol Dependence*, vol. 185, 2018, pp. 285-292.
[154] J A Comfort, *Understanding the Higher Rates of Smoking Among Lesbian and Bisexual Women*, Curtin University 2012, retrieved on the 9th April 2019: https://espace.curtin.edu.au/bitstream/handle/20.500.11937/2370/186679_Comfort2012.pdf?sequence=2
[155] J Mooney-Somers et al, *Lesbian, bisexual and queer (LBQ) Women's tobacco reduction projection project community report online survey findings*, ACON and VELiM, University of Sydney, Sydney, 2016.

The latest data from the National Health Survey shows that the number of ACT women who currently smoke is 11% (7% of 15-24 year olds). Ten per cent of ACT women smoke daily.[156]

The 2018 SWASH report found that 22% of the LGBQ women surveyed smoked regularly (24% of 16-24 year olds).[157] This is just under double the rate of the rest of the women's population where 13% reported that they smoked (11% daily).[158]

Correlations exist between smoking and stigma, discrimination, wanting to fit in, mental health, [159] experience of homophobic behaviour, and '*fewer economic, social and psychological resources'.*[160] To address this it has been found that smoking cessation and prevention initiatives for LGBTIQ young people need to be LGBTIQ specific, affordable, accessible, inclusive, relatable, empowering, incorporate peer and integrate other activities beyond smoking. [161]

Alcohol use

The most recent results from the National Health Survey show that an average of 29% of women in the ACT exceed the four standard drink NHMRC recommended limit per occasion. Fifty four per cent of 18-24 year old women exceed the limit.[162]

LGBQ women have higher rates of alcohol use than non-LGBQ women.[163] LGBQ women who experienced childhood sexual assault and adult sexual assault revictimisation were more likely to misuse alcohol. [164] Bisexual women were found to have the highest use of alcohol.[165]

The latest SWASH study found that 17% drank 5 or more drinks in one occasion in the last 6 months. Researchers in Western Australia found that 28% of women drank more than four standard drinks per day, once a week or more.[166] Private Lives 2 found that 5% of lesbian women and 4% of bisexual women drank on a daily basis.[167]

Drug use

The 2016 SWASH study found that 45% of survey respondents had used one or more drugs in the past 6 months. Cannabis was used by 29% of LGBQ women, ecstasy was used by 19%, and cocaine by 16%. The women in the study were asked where they used certain drugs. Cannabis and benzodiazepines were mostly used at home. Methamphetamine, ecstasy, cocaine, amyl, special K, GHB, and LSD were more likely used at parties.[168] Forty nine per cent of LGBQ women in Western Australian said that they had used illicit drugs in the last 6 months.[169]

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[156] Australian Bureau of Statistics, *National Health Survey: First Results, 2017-2018,* Canberra, 2018, retrieved on the 23rd of April 2019; http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001?OpenDocument

[157] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.

[158] Australian Institute of Health and Wealth, *National drug strategy household survey 2016: Detailed findings,* Canberra, 2016, retrieved on the 29th of May 2019; https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true

[159] J A Comfort, *Understanding the Higher Rates of Smoking Among Lesbian and Bisexual Women*, Curtin University 2012, retrieved on the 9th April 2019: https://espace.curtin.edu.au/bitstream/handle/20.500.11937/2370/186679_Comfort2012.pdf?sequence=2

[160] R M Deacon & J Mooney-Somers, 'Smoking prevalence among lesbian, bisexual and queer women in Sydney remains high: Analysis of trends and correlates," *Drug and Alcohol Review*, vol. 36, 2017, pp. 546-554.

[161] N B Baskerville et al, 'A qualitative study of tobacco interventions for LGBTIQ+ youth and young adults: overarching themes and key learnings', *BMC Public Health*, no. 18, vol. 155, 2018, pp. 1-14.

[162] Australian Bureau of Statistics, *National Health Survey: First Results, 2017-2018,* Canberra, 2018, retrieved on the 23rd of April 2019; http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001?OpenDocument

[163] D Kerr et al, 'An alcohol, tobacco, other drug use comparison of lesbian, bisexual, and heterosexual undergraduate women', *Substance Use & Misuse*, vol. 50, 2015, pp. 340-349.

[164] T Hughes et al, 'Sexual victimization and hazardous drinking among heterosexual and sexual minority women', *Addictive Behaviors*, vol. 35, 2010, pp. 1152-1156.

[165] D Kerr et al, 'An alcohol, tobacco, other drug use comparison of lesbian, bisexual, and heterosexual undergraduate women', *Substance Use & Misuse*, vol. 50, 2015, pp. 340-349.

[166] J Mooney-Somers, R M Deacon & J Comfort, *Women in contact with the Perth gay and lesbian community: Report of the Women's Western Australian sexual health (WWASH) Survey 2010,* Western Australian Centre for Health Promotion Research, Curtin University, Perth, 2010.

[167] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, Monograph Series Number 86, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.

[168] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.

[169] J Mooney-Somers, R M Deacon & J Comfort, *Women in contact with the Perth gay and lesbian community: Report of the Women's Western Australian sexual health (WWASH) Survey 2010*, Western Australian Centre for Health Promotion Research, Curtin University, Perth, 2010.

The need to fit in to a group or a scene where people accept your sexuality may lead to higher rates of alcohol, tobacco, and drug use if the group are using them.[170] Drug use has been linked to poor mental health, and the use of 'party drugs' was linked to psychological stress. Bisexual women were found to use cannabis far more than lesbian women.[171] Which may be due to feelings of not belonging to either LGBQ or non-LGBQ communities.[172] Exclusively, LGBQ women who experienced victimisation rated their health as poorer, and were also more likely to smoke, and use illicit drugs compared to those who hadn't experienced victimisation.[173]

Environmental influences such as family history of drug use and exposure to drug users, physiological, and genetic factors, and social norms of drug use may impact an LGBQ adolescents' risk for illegal drug use.[174] However, those that turn to illegal drug use may also be experiencing homophobic stigma, discrimination, and internalised feelings of homophobia.[175] Lack of family support is a very important protector for drug use.[176]

Violence

LGBQ women may experience social exclusion and discrimination and not being able to be their true selves. LGBQ women may experience abuse, high levels of stress, and discrimination during their lifetime.[177] Violence is perpetuated by stigma and discrimination due to societal heterosexist norms.[178]

Anti-LGBTIQ behaviour can include verbal abuse or harassment, unwanted disclosure about a person's sexuality or gender, bullying, physical threat or intimidation, being pushed or shoved or being bashed, refusal of services, or refusal of employment/ promotion. Forty per cent of the women in the SWASH report had experienced some form of anti-LGBTIQ behaviour, with the most reported being verbal abuse or harassment.[179] In the *Coming Forward* study 70% of harassment occurred by strangers and many incidents included multiple people. This study showed that many LGBQ people often alter their behaviour or the way they dress and hide their sexual identity for fear of harassment.[180]

The Australian marriage equality vote gave rise to anti-LGBTIQ propaganda in media and through other sources. Prior to the Australian marriage equality vote, studies warned about the potential trauma and psychological stress that can impact the LGBQ community during a volatile time. Verelli et al found that LGBQ people in Australia had experienced higher psychological stress in the time of the Australian marriage equality vote due to negative and hurtful media.[181]

One out of every six Australian women have experienced family, domestic or sexual violence. Perpetrators of violence can be from a stranger, from a family member, or from a current or ex-

[170] A Murnane, et al, *Beyond perceptions: a report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*. Melbourne: Centre for Youth Drug Studies, 2000.
[171] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians,* Monograph Series Number 86, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[172] D Kerr et al, 'An alcohol, tobacco, other drug use comparison of lesbian, bisexual, and heterosexual undergraduate women', *Substance Use & Misuse*, vol. 50, 2015, pp. 340-349.
[173] E Bariola, A Lyons, W Leonard, 'Gender-specific health implications of minority stress among lesbians and gay men', *Australia and New Zealand Journal of Public Health*, vol. 40, no. 6, 2016, pp. 506-512.
[174] Y C Padilla, C Crisp & D L Rew, 'Parental acceptance and illegal drug use among gay, lesbian and bisexual adolescents: results from a national survey', *Social Work*, vol. 55, no. 3, 2010, pp. 265-275.
[175] Y C Padilla, C Crisp & D L Rew, 'Parental acceptance and illegal drug use among gay, lesbian and bisexual adolescents: results from a national survey', *Social Work*, vol. 55, no. 3, 2010, pp. 265-275.
[176] Ibid
[177] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[178] B Fileborn, *Sexual violence and gay, lesbian, bisexual, trans, intersex, and queer communities*, Australian Institute of Family Studies, Canberra, 2012, retrieved on the 29th of May 2019; https://aifs.gov.au/publications/sexual-violence-and-gay-lesbian-bisexual-trans-intersex-and-queer-communiti
[179] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016,* ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[180] W Leonard et al, *Coming forward: The underreporting of heterosexist violence and same-sex partner abuse in Victoria,* Australia Research Centre in Sex, Health and Society, La Trobe University, Victoria Law Foundation, Gay and Lesbian Health Victoria, Melbourne, 2008.
[181] S Verrelli et al, 'Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian marriage law postal survey', *Australian psychologist*, 2019, pp. 1-11

partner.[182] LGBQ women have been found to experience violence at the same level or higher than the general population of women.[183] [184]

The 2018 SWASH report found that 48% of LGBQ women had experienced domestic violence and 32% were from a female partner.[185] Domestic violence can involve *'emotional, financial, psychological, physical, sexual, social isolation, and the use of power and control by one partner over another.'*[186] [187] LGBQ people often face additional barriers such as not being able to recognise abusive relationship dynamics, barriers to disclosure of violence to their peers for fear of being alienated, and not believed.[188] [189] LGBQ people may face heteronormative and homophobic discrimination from services that aren't set up in a way to help them.[190] [191]

Violence is perpetrated against trans women throughout their lives and has a substantial impact on their quality of life, health outcomes, and access to services.[192] Trans women are often victims of violence whose perpetrators target *'gender nonconformity, gender expression or identity, and perceived sexual orientation.'*[193] Often violence is perpetrated by family members who use coercive, verbal and physical abuse to control, deny autonomy, and reject the women's true gender.[194] Trans gender students experienced sexual assault as much as cis women students.[195]

Access to health information

One key component of looking after one's health is accessing information. Women are particularly concerned with getting information about their health.[196] LGBQ women face two issues when seeking information:

- health information mostly comes with a heteronormative perspective and not inclusive of lesbian sex or relationships; and
- health information from health professional sources may be stigmatising and discriminatory in nature.[197] [198] [199]

In the 2018 ACT women's health study, women (of unknown sexualities) sought health information on the internet as their first preference rather than going to their GP for general health issues. When separating for age, women older than 55 years sought health information from their GP as their first preference, and all age groups younger than 55 years of age sought health information

[182] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia,* 2018, Canberra 2018, retrieved on the 15th of May 2019; https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary
[183] M Campo & S Tayton, *Intimate partner violence in lesbian, gay, bisexual, trans, intersex and queer communities*, Australian Government, Australian Institute of Family Studies, retrieved on the 23rd of April 2019; https://aifs.gov.au/cfca/publications/intimate-partner-violence-lgbtiq-communities
[184] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[185] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.
[186] W Leonard et al, *Coming forward: The underreporting of heterosexist violence and same-sex partner abuse in Victoria*, Australia Research Centre in Sex, Health and Society, La Trobe University, Victoria Law Foundation, Gay and Lesbian Health Victoria, Melbourne, 2008.
[187] M Greenhalgh & A Roberts, *Transforming domestic violence support in the ACT: Improving accessibility for lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) clients*, Women's Centre for Health Matter, Canberra, 2015.
[188] Gay and Lesbian Health Victoria, *Submission to the Victorian Royal Commission into Family Violence,* Australian Research Centre in Sex, health & Society, La Trobe University, Melbourne, 2015.
[189] M Greenhalgh & A Roberts, *Transforming domestic violence support in the ACT: Improving accessibility for lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) clients*, Women's Centre for Health Matter, Canberra, 2015.
[190] Gay and Lesbian Health Victoria, *Submission to the Victorian Royal Commission into Family Violence,* Australian Research Centre in Sex, health & Society, La Trobe University, Melbourne, 2015.
[191] M Greenhalgh & A Roberts, *Transforming domestic violence support in the ACT: Improving accessibility for lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) clients*, Women's Centre for Health Matter, Canberra, 2015.
[192] M Lanham et al, '"We're Going to Leave You for Last, Because of How You Are": Transgender Women's Experiences of Gender-Based Violence in Healthcare, Education, and Police Encounters in Latin America and the Caribbean', *Violence and Gender*, vol. 6, no. 1, 2019, pp. 37-46.
[193] A L Wirtz et al, 'Gender-based violence against transgender people in the United States: A call for research and programming', *Trauma, Violence, & Abuse*, 2018, pp. 1-15.
[194] M Rogers, 'Transphobic 'honour'-based abuse: a conceptual tool', *Sociology*, vol. 51, no. 2, 2017, pp. 225-240.
[195] J C Hoxmeier, 'Sexual assault and relationship abuse victimization of transgender undergraduate students in a national sample', *Violence and Gender*, vol. 3, no. 4, 2016, pp.20-207.
[196] A Deeks et al, 'The effects of gender and age on health related behaviors', *BMC Public Health*, vol. 9, no. 213, 2009, pp. 1-8.
[197] Seaver MR, 'Healthcare preferences among lesbians: a focus group analysis', *Journal Women's Health*, vol. 17, no. 2, 2008, pp. 215-225.
[198] G Alencar Albuquerque et al, 'Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review', *BMC International Health and Human Rights*, vol. 16, no. 2, 2016, pp 1-10.
[199] Hillier et al, *Writing themselves in 3, The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people,* LaTrobe and Australian Research Centre In Sex, Health & Society, Melbourne, 2010.

on the internet for general health issues. When looking for health information for a specific issue, all women sought information from their GP as their first preference. [200]

Fifty seven per cent of women from the *2018 Jean Hailes for women's health survey* (unknown sexualities) sought health information on the internet before accessing a health professional. Some women preferred to receive health information via factsheets and face-to-face, whereas others, particularly younger women preferred to access health information via apps.[201]

In the *2017 Jean Hailes for women's health survey* (unknown sexuality), women were asked which sources of information they found contained trustworthy and reliable information. The top listed trustworthy and reliable information was 'health professionals' (e.g. Doctors, specialist) 'independent health organisations' (e.g. Jean Hailes), and 'Government health website's'. Women recognised that the internet, social media, television shows, and commercial organisations may not be trustworthy or reliable.[202]

Sexual health information is harder to find for LGBQ women,[203] due to the infrequency of sexual health information available and suitable for them.[204] LGBQ women in the 2018 ACT women's sexual and reproductive health survey found it difficult and complicated to find information about their sexual health. Sources of sexual health information such as credible websites and formal sexual health education only focused on non-LGBQ women and so they accessed less trustworthy forums and blogs.[205] Lindley, Friedman & Struble found that there were limited websites that were trustworthy and reliable. Out of the 25 unique functioning websites, 66% discuss STIs, however not many talked about how to protect LGBQ women against the spread of STIs.[206]

The health services that ACT LGBQ women use

Women can face challenges to health service access, and LGBQ women have unique health needs and experience access to services differently to the rest of the population.[207] To attempt to address the unmet health needs and barriers to health of the LGBTIQ Community in the ACT; AIDS Action Council, Northside Community Services, A Gender Agenda and Sexual Health and Family Planning ACT formed the Canberra Inclusive Partnership (formerly Canberra LGBTIQ Community Consortium).[208] The research highlighted the need for services to promote the use of respectful and inclusive language, without assuming biological sex or sexual orientation so that users can feel safe and accepted.[209]

Women access a wide variety of services, for themselves and their families.[210] Participants in the 2018 ACT women's health study were asked what health services they had accessed in the last 12 months. Ninety four per cent of respondents accessed GP services, 82% filled prescriptions, 64% accessed a dentist and 18% reported that they had accessed mental health services.[211]

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[200] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre of Health Matters, Canberra, 2018.
[201] Jean Hailes for Women's Health, *Women's Health Survey 2018: Understanding health information needs and health behaviour of women in Australia*, Melbourne, 2018.
[202] Jean Hailes for Women's Health, *Women's Health Survey 2017: Understanding health information needs and health behaviour of women in Australia*, Melbourne, 2017.
[203] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health*, vol. 6, 2009, pp. 15-18.
[204] J C Magee et al, 'Sexual health information seeking online: A mixed-methods study among lesbian, gay, bisexual and transgender young people', *Health Education & Behavior*, vol. 39, no. 3, pp. 276-289.
[205] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs,* Women's Centre for Health Matters, Canberra, 2018.
[206] L L Lindley, D B Friedman & C Struble, 'Becoming visible: Assessing the availability of online sexual health information for lesbians', *Health Promotion Practice*, vol. 13, no. 4, 2012, pp. 472-480.
[207] Mayer et al 'Sexual and gender minority health: What we know and what needs to be done', *American Journal of Public Health*, vol. 98, 2008, pp. 989-995.
[208] LGBTIQ Community Consortium, *CBR LGBTIQ Community Consortium consultation findings*, Canberra, 2016, retrieved on the 13th of September 2018: https://www.aidsaction.org.au/images/documents/LGBTIQ_Consortium_Report_2016_FINAL.pdf
[209] Ibid
[210] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health,* Women's Centre of Health Matters, Canberra, 2018.
[211] Ibid

In the 2018 ACT women's sexual and reproductive health survey, most women accessed their regular GP for a range of sexual and reproductive health services such as STI testing, cervical screening, mammograms, and contraception.[212]

Studies show that 60-75% of LGBQ women have a regular GP. Seventy to 85 per cent who report having a regular GP or practice said that they were satisfied or very satisfied. LGBQ women who had disclosed their sexuality were more likely to be very satisfied, compared to those who had not disclosed. [213] [214] [215] [216] In the Private Lives 2 report, cis women accessed GPs double the amount of trans women, and bisexual women accessed GPs more than lesbian women. [217] McNair, Szalcha and Hughes found that LGBQ women attended GPs more than non-LGBTQ women but had a poorer continuity of care and lower satisfaction of that care. Thirty one per cent of lesbian women reported that they preferred a female doctor always, as opposed to 18% of bisexual women. [218]

Sixty eight to seventy five per cent of LGBQ women were found to have accessed psychological services in the last five years.[219] [220] McNair and Bush measured help seeking behaviours for mental health services. Seventy four per cent of LGBQ young women sought help for mental health issues from a GP and 44% accessed psychologists or counsellor services in the last 12 months.[221] Trans women reported using mental health services more than cis women, and bisexual women used mental health services more than lesbian women.[222]

Eleven per cent of women sought help for drug and alcohol abuse. Seventy one per cent accessed a psychologist or counsellor (79% in the 2016 SWASH)[223] [224] and 54% accessed specialist drug and alcohol services for drug and alcohol abuse. [225]

Barriers to accessing services

LGBQ women attempt to determine the attitude of the GP before attending an appointment, as it is necessary for their care that GPs to be women-centred, empathetic and accepting. And to have an understanding about women's health and a wholistic approach.[226] It is important that the health care provider ensures that women are heard, and a proper investigation is done particularly when there are medically difficult to diagnose symptoms.[227]

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[212] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs,* Women's Centre for Health Matters, Canberra, 2018.
[213] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[214] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018,* The University of Sydney, ACON, Sydney, 2018.
[215] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTIQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018,* The University of Sydney, ACON, Sydney, 2019.
[216] D Drew et al, Exploring the health and wellbeing of lesbian, bisexual, queer and LGBQ women living in the Illawarra and Shoal haven regions, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.
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[220] J Mooney-Somers et al, *Women in contact with the Sydney LGBTIQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018,* The University of Sydney, ACON, Sydney, 2018.
[221] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian LGBQ women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[222] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[223] Ibid
[224] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[225] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTIQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018,* The University of Sydney, ACON, Sydney, 2019.
[226] J Edwards & H van Roekel, 'Gender, sexuality and embodiment: Access to and experience of healthcare by same-sex attracted women in Australia' *Current Sociology*, vol. 57, no. 2, 2009, pp. 193-210.
[227] B Sabo, M R Joffres & T Williams, 'How to deal with medically unknown symptoms', *Western Journal of Medicine*, vol. 172, 2000, pp. 128-130.

LGBQ women in other studies struggled to be listened to or believed, they often felt rejected, dismissed, [228] [229] [230] and disempowered when accessing health services.[231] Because they looked too well they had to justify why they were seeking healthcare.[232] [233] And as GPs are often the gatekeepers for provision of medical services such as, prescriptive medicines and referrals to other health professionals,[234] women may not get the health care they need.

Research from the 2018 ACT women's health study found many women (unknown sexuality) had barriers to accessing health services in the ACT. Fifty per cent had affordability barriers, 49% had appointment availability barriers, and 42% reported that long wait times was a barrier. Some women in that study reported that affordability was such an issue that there were times that they skipped or delayed treatment, medical visits, tests and medications. ACT women need more affordable, accessible, and appropriate health support options.[235] [236]

The *"I don't have the spoons for that…"* report found that younger women with chronic disease experienced many barriers to accessing health services. Dissatisfaction with treatment by services (57%), limited services available (38%), affordability of services (37%) and time barriers (32%) were significant barriers to the health services for women with chronic disease.[237] This research from the WCHM along with other research shows the significant impact and cost that women with chronic diseases endure, such as ongoing medical costs of specialised food or equipment, medications, health providers and specialists.[238] [239] [240]

LGBQ women in a study by Drew et al, reported on what was important to them when choosing or staying with a health care professional. Seventy seven per cent of the women reported the service needed to be in their local community. They reported it needed to be LGBTIQ friendly (65%), bulk billed or free (65%), a women only service (39%), and recommended to them by someone trustworthy (38%). Forty one percent of the women delayed general health care in the last 2 years due to the cost and others had concerns about how they would be treated (31%), lack of time (29%), lack of services (28%), and access to timely appointments (21%). Women delayed their mental health care in the last 2 years due to lack of timely appointments (45%), lack of time (44%), the cost (35%), concerns about how they would be treated (27%), and lack of services (20%).[241]

LGBQ people value word of mouth recommendations from LGBTIQ peers and professionals' referrals when choosing a service to attend, and some are influenced by LGBTIQ specific

[228] A Werner & K Malterud, 'It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors', *Social Science & Medicine*, vol. 57, 2003, pp. 1409–1419.
[229] C Durif-Bruckert, P Roux & H Rousset, 'Medication and the patient-doctor relationship: a qualitative study with patients suffering from fibromyalgia', *Health Expectations*, vol. 18, pp. 2584-2594.
[230] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, Women's Centre for Health Matters, Canberra, 2018.
[231] M DiGiacomo et al, 'Developing a gender-based approach to chronic conditions and women's health: a qualitative investigation of community-dwelling women and service provider perspectives', *BMC Women's Health*, vol. 15, no. 105, 2015, pp. 1-11.
[232] A Werner & K Malterud, 'It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors', *Social Science & Medicine*, vol. 57, 2003, pp. 1409–1419.
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[234] Australian Medicine Association, *Gatekeeper role of GPs under scrutiny in MBS review*, Canberra, 2015, retrieved on the 31st of May 2019; https://ama.com.au/ausmed/gatekeeper-role-gps-under-scrutiny-mbs-review
[235] A Carnovale & E Carr, *It goes with the Territory! Act Women's views about health and wellbeing information,* Women's Centre for Health Matters, Canberra, 2010.
[236] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health,* Women's Centre of Health Matters, Canberra, 2018.
[237] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, Women's Centre for Health Matters, Canberra, 2018.
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[239] L M Hunt, M Kreiner, H Brody, 'The changing face of chronic illness management in primary care: a qualitative study of underlying influences and unintended outcomes', *Annals of Family Medicine*, vol. 10, no. 5, 2012, pp. 552-560.
[240] Y Jeon et al, 'Economic hardship associated with managing chronic illness: a qualitative inquiry', *BMC Health Services Research*, 2009, vol. 9, no. 182, pp. 1-11.
[241] D Drew et al, *Exploring the health and wellbeing of lesbian, bisexual, queer and LGBQ women living in the Illawarra and Shoal haven regions*, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.

advertising. They may be unlikely to attend a service if they hear another LGBQ person received poor service.[242]

Disclosure

Disclosure of sexual identity is important to addressing health needs and issues.[243] [244] But in an American study, 33% of bisexual women and 13% of lesbian women did not disclose their sexuality to a health care professional (18% of all LGBQ women).[245] Because disclosure can open the patient up to discrimination, stigma or homophobic behaviour, [246] women may weigh up the risk by assessing the attitudes of that health care professional. If they show heterosexist attitudes, then women may be unwilling to disclose.[247]

Steele, Tinmouth & Lu found that health service use was highest with health care providers that asked about sexuality and felt positively about LGBTIQ people.[248] Bjorkman & Malterud wrote that health professionals should ask about a women's sexuality status, have a good attitude by respecting and acknowledge lesbian orientation and be knowledgeable in lesbian health issues. Researchers found that asking or having an awareness of a women's sexuality and having a good attitude led to satisfactory health care.[249] [250]

Treatment by health professionals

The way a patient is treated by a health professional is an important aspect of their satisfaction with their care.

Health services are often heteronormative; they treat and presume the client to be heterosexual and communications and clinical environment reflects this.[251] Health services become a barrier to good health when the patient is presumed to be heterosexual.[252] Some health providers just don't have the training to see LGBTIQ health as an issue,[253] [254] and have doubts whether it is clinically relevant.[255] In Australia, GPs reported that they didn't realise being a LGBQ women had health inequalities and implications related to their sexuality.[256] Health providers who try to maintain a neutral position promote homosexual invisibility. Health providers need to acknowledge, understand and accommodate differences in sexuality, and gender without being judgmental.[257]

Homophobic behaviour from health providers is intertwined with the health provider's own personal views on homosexuality which may be influenced by society as a whole, passing

[242] LGBTIQ Community Consortium, *CBR LGBTIQ Community Consortium consultation findings*, Canberra, 2016, retrieved on the 13th of September 2018: https://www.aidsaction.org.au/images/documents/LGBTIQ_Consortium_Report_2016_FINAL.pdf
[243] L E Durso & I H Meyer, 'Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, bisexuals', *Sexuality Research and Social Policy*, vol. 10, 2013, pp. 35-42.
[244] M Bjorkman & K Malterud, 'Being lesbian – does the doctor need to know? A qualitative study about the significance of disclosure in general practice', *Scandinavian Journal of Primary Health Care*, vol. 25, 2007, pp. 58-62.
[245] L E Durso & I H Meyer, 'Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, bisexuals', *Sexuality Research and Social Policy*, vol. 10, 2013, pp. 35-42.
[246] G Alencar Albuquerque et al, Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review', *BMC International Health and Human Rights*, vol. 16, no. 2, 2016, pp 1-10.
[247] S Munson & C Cook, 'Lesbian and bisexual women's sexual healthcare experiences,' *Journal of Clinical Nursing,* vol. 25, no. 23-24, 2016, pp. 3497-3510.
[248] L S Steele, J M Tinmouth, A Lu, 'Regular health care use by lesbians: a path analysis of predictive factors', *Family Practice*, vol. 23, no. 6, 2006, pp. 631-636.
[249] M Bjorkman & K Malterud, 'Lesbian women's experiences with health care: A qualitative study', *Scandinavian Journal of Primary Health Care*, vol. 27, 2009, pp. 238-243.
[250] K E Mosack, A M Brouwer & A E Petroll, 'Sexual identity, identity disclosure, and health care experiences: Is there evidence for differential homophobia in primary care practice?', *Women's Health Issues*, vol. 23, no. 6, 2013, 341-346.
[251] Ibid
[252] LGBTIQ Community Consortium, *CBR LGBTIQ Community Consortium consultation findings*, Canberra, 2016, retrieved on the 13th of September 2018: https://www.aidsaction.org.au/images/documents/LGBTIQ_Consortium_Report_2016_FINAL.pdf
[253] G Alencar Albuquerque et al, Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review', *BMC International Health and Human Rights*, vol. 16, no. 2, 2016, pp 1-10.
[254] S Hinchliff, M Gott & E Galena, ''I daresay I might find it embarrassing': general practitioners' perspective on discussing sexual health issues with lesbian and gay patients', *Health and Social Care in the Community*, vol. 13, no. 4, 2005, pp 345-353.
[255] K H Mayer et al 'Sexual and gender minority health: What we know and what needs to be done', *American Journal of Public Health*, vol. 98, 2008, pp. 989-995.
[256] R P McNair, K Hegarty & A Taft, 'From silence to sensitivity: A new identity disclosure model to facilitate disclosure for same-sex attracted women in general practice consultations', *Social Science & Medicine*, vol. 75, 2012, pp, 208-216.
[257] K Baker & B Beagan, 'Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients', *Medical Anthropology Quarterly*, vol. 28, no. 4, 2014, pp. 578-598.

homophobia down through generations.[258] LGBQ women in a qualitative study acknowledged that homophobia can be implied or overt, and both can impact access to health care services. Implied homophobia can be health professionals viewing penetrative sex as the only true and relevant form of sex. And overt homophobia could be interpretation of hospital rules where 'only family' can visit patients but denying the patient's same sex partner visiting rights.[259]

Trans people often have barriers to accessing health care.[260] When accessing healthcare, they may be met with lack of respect and sensitivity, discrimination and stigma. Trans people report that when they access healthcare they faced discrimination such as refusal of care, demeaning language, refusal to examine specific body parts, lack of sensitivity, and discrimination.[261] [262] Delay of medical care due to fear of discrimination was found to be linked to poorer general health, depression suicidal ideation and attempted suicide in the past 12 months.[263] Witten found that many trans lesbian women worried about the type of care they were going to get as they aged. The research found that they felt anxious and fearful about mistreatment. They were concerned about lack of provision of gender confirming health care in older age. And they felt concerned that they may not be able to defend themselves and face abuse by health professionals and carers.[264]

Conclusion

Research discussed in this literature review highlights the primary issues for LGBQ women in accessing health services and health information, their experiences of health issues and the barriers that hey face in accessing appropriate health and wellbeing services, supports and information.

Given the potential impact of these issues on their health and wellbeing, it is important to understand the ACT context and to address these.

[258] G Alencar Albuquerque et al, Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review', *BMC International Health and Human Rights*, vol. 16, no. 2, 2016, pp 1-10.
[259] S Munson & C Cook, 'Lesbian and bisexual women's sexual healthcare experiences', *Journal of Clinical Nursing,* vol. 25, no. 23-24, 2016, pp. 3497-3510.
[260] K L Seeman et al, 'Transgender non-inclusive healthcare and delaying care because of fear: Connection to general health and mental health among transgender adults', *Transgender health*, vol. 2.1, 2017, pp. 17-28.
[261] G R Bauer et al, 'Factors impacting transgender patients' discomfort with their family physicians: A respondent-driven sampling survey', *PLOS One*, no. 10, vol. 12, 2015, pp. 1-16.
[262] G Bauer et al, 'Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey', *The Practice of Emergency Medicine/Original Research,* vol. 63, 2014, pp. 713-720.
[263] K L Seeman et al, 'Transgender non-inclusive healthcare and delaying care because of fear: Connection to general health and mental health among transgender adults, *Transgender health*, vol. 2.1, 2017, pp. 17-28.
[264] T M Witten, 'Elder Transgender Lesbians: Exploring the Intersection of Age, Lesbian Sexual Identity, and Transgender Identity', *Journal of Lesbian Studies*, vol. 19, no. 1, 2015, pp. 73-89.

Findings

The demographics: the women who completed the survey

Three hundred and fifty nine same sex attracted women filled out the survey in a 6 week period in November. Table 1 shows the age groups of women who responded to the survey.

Age	Number	Per cent
16-24 years old	78	22%
25-34 years old	120	33%
35-44 years old	63	17%
45-54 years old	67	19%
55 years plus	31	9%

Table 1 Ages of women who responded to the survey

Ten women identified as Aboriginal (but not Torres Strait Islander). Two women preferred not to answer.

Women were asked if they were from a migrant or refugee background. Fifty three women reported that they were (15%). Most said their preferred language was English.

Sixty four women reported they were living with a disability, accounting for 18% of the respondents. Seven women preferred not to answer.

Figure 1 shows where the respondents lived in the ACT. The largest number of respondents lived in the inner north.

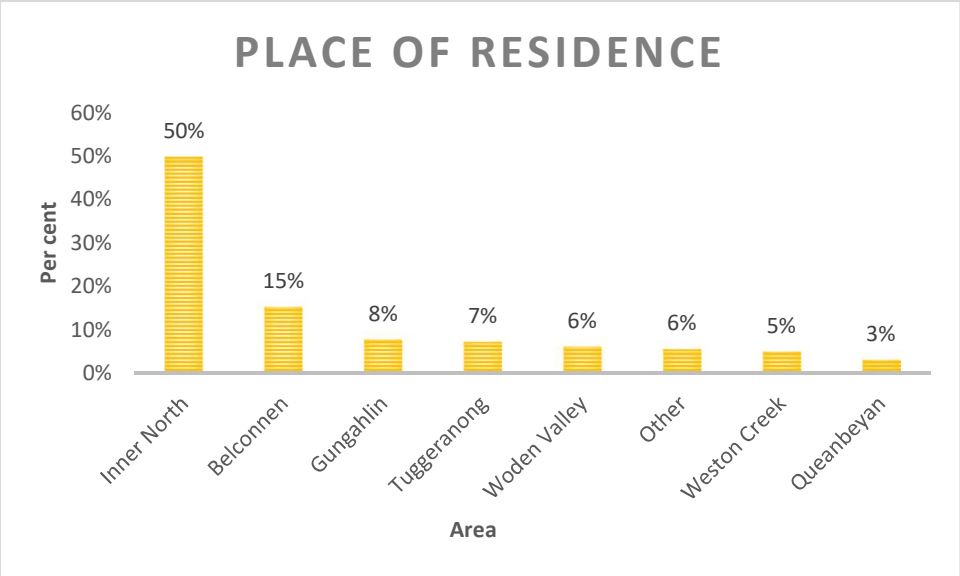

Figure 1 Place of residence of respondent.

Women were asked to select their sexual identity from a list of options. Most women described themselves as lesbian (n=151), followed by bisexual (n=92) and queer (n=62), as shown in Figure 2.

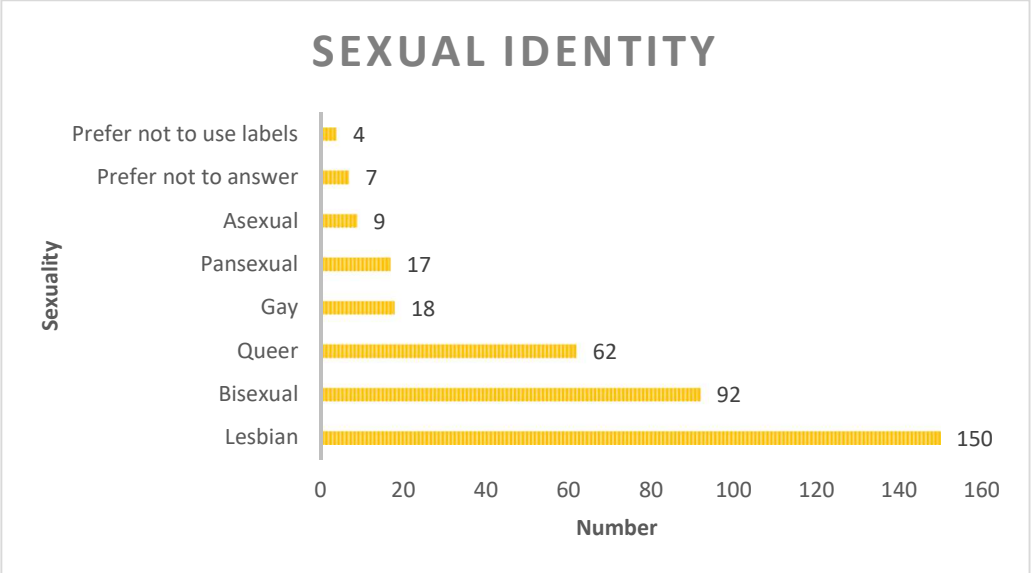

Figure 2 Respondents' sexual identity

Most respondents in all age groups except those in the 16-24 year old group identified as lesbian when asked to describe their sexuality (Figure 3).

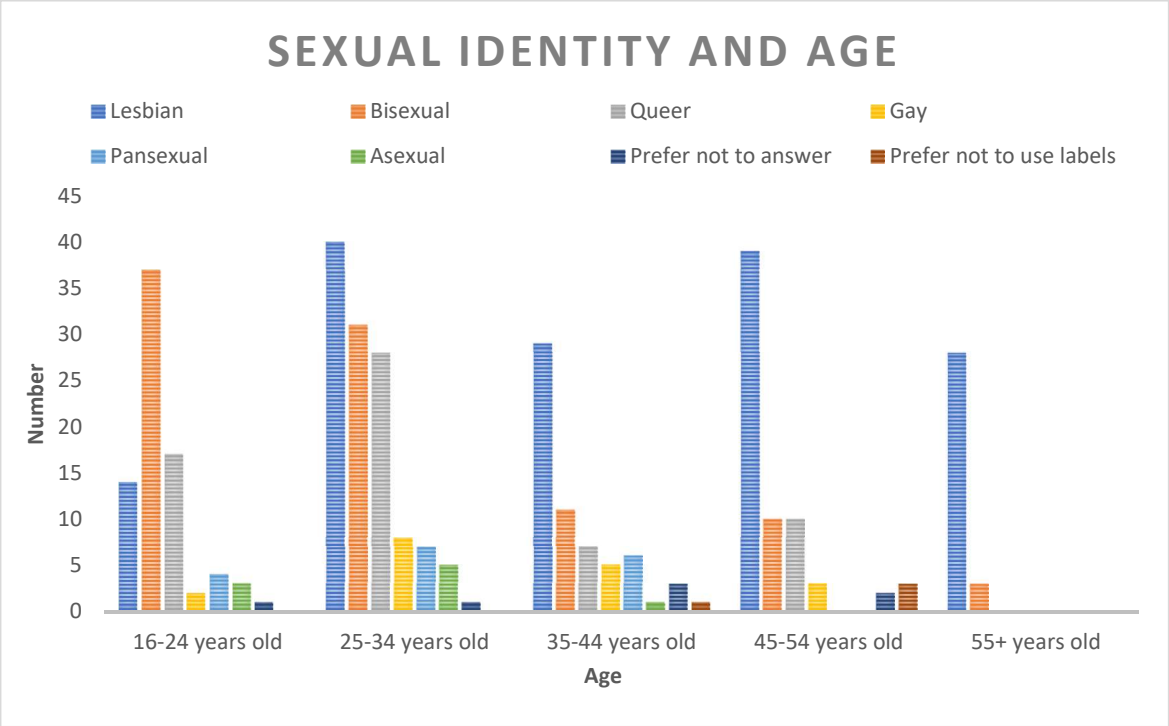

Figure 3 Sexual identity disaggregated by age

Women who were assigned a different sex at birth (referred to in this report as trans women) made up 5% (n=19) of the respondents.

Women born with a variation of sex characteristics made up 2% (n=8) of the respondents. Eighteen women reported that they didn't know if they had a variation of sex characteristics and three women preferred not to answer.

Women were asked to identify their employment or study status and could pick more than one option to indicate multiple roles. Over half of the respondents were working in full time employment (n=199), as shown in Figure 4. Forty seven women were in full time, part time, or casual employment and also studying. Fifteen women listed that they were underemployed.

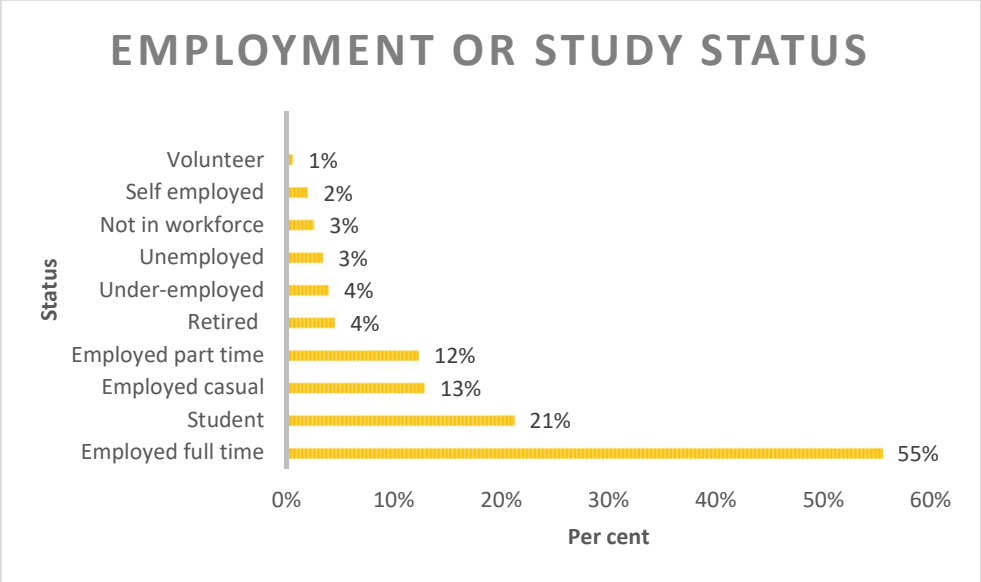

Figure 4 Respondents' employment or study status

Women's understanding of what good health means

Survey participants were asked to describe what good health meant to them, and they acknowledged that good health can encompass many areas in life. Women mostly defined good health holistically. A holistic approach to good health looks at the whole person and ensuring there is balance in every part of their lives.

They also talked about maintaining both physical and mental health, living a life without sickness, free from pain or needing medical intervention, and autonomy.

> *"A state of wellbeing that encompasses mental, physical and social needs. It's not just about being free of disease or disability, but being able to live life to the fullest within your limits."*

> *"Good health means being fit and active to suit your lifestyle, eating a wholesome diet and keeping your mental health in mind too. Good mental health is being able to express emotions safely and to get help when you feel out of control. Sexual health is extremely important, as poor sexual health can lead to poor physical and mental health."*

> *"Good health is being able to choose healthy foods, monitor exercise, take time for your spiritual and mental health as well as complete day to day tasks. Good health is the ability to wake in the morning with[out] pains, worry or anxiety and steer away from negative influences such as smoking. It is a combination of physical genes, healthy life choices and a strong support network if needed."*

Many women looked at good health as encompassing body and mind.

> *"Feeling physically and mentally healthy, being comfortable with your body and your mind."*

> *"Healthy mentally and physically, not just free from illness but thriving."*

> *"Feeling good physically and mentally."*

> *"Being physically and emotionally well, having energy."*

Being free from sickness or pain was also a frequent part of their definitions of good health.

> *"Minimising risk factors for future disease and death; avoiding disease, being at peace with myself and my life, having the freedom to enjoy my life."*

> *"Being pain and disease free. Well managed mental health issues."*

> *"Being able to manage complex/chronic illnesses."*

> *"Essentially being able to function to your full ability without being affected by an illness or condition. Physically being free from illness or pain caused by any condition, and being in good mental health, either without a mental health condition or managing one successfully."*

> *"Able to lead a fulfilling life without limitation due to good health. No ongoing illness that limits your ability to participate in activity of varying degree/s."*

Many women reported that good health meant having the independence and ability, whether it mental or physical, to do things they wanted to do. This autonomy allowed them to live how they wanted to live.

"Life is not slowed down or disrupted by physical or mental impediments or issues. Feel generally good within oneself"

"The ability to exercise my agency and will to the best of my ability. Basically, for me, being healthy means not having impediments to living my life in the way that I want. Sometimes impediments are internal to my body, sometimes they are external – including institutional and structural barriers."

Happiness and feeling good was mentioned by some women as their definition of good health.

"Active lifestyle and happy mindset."

"Happiness, comfortability in life."

"Happy and healthy."

"Happiness."

Self-rated health

Women were asked to rate their physical and mental health on a five point scale (very poor, poor, fair, good, excellent).

Sixty one per cent of women rated their physical health as either good or excellent (n=219), shown in Figure 5.

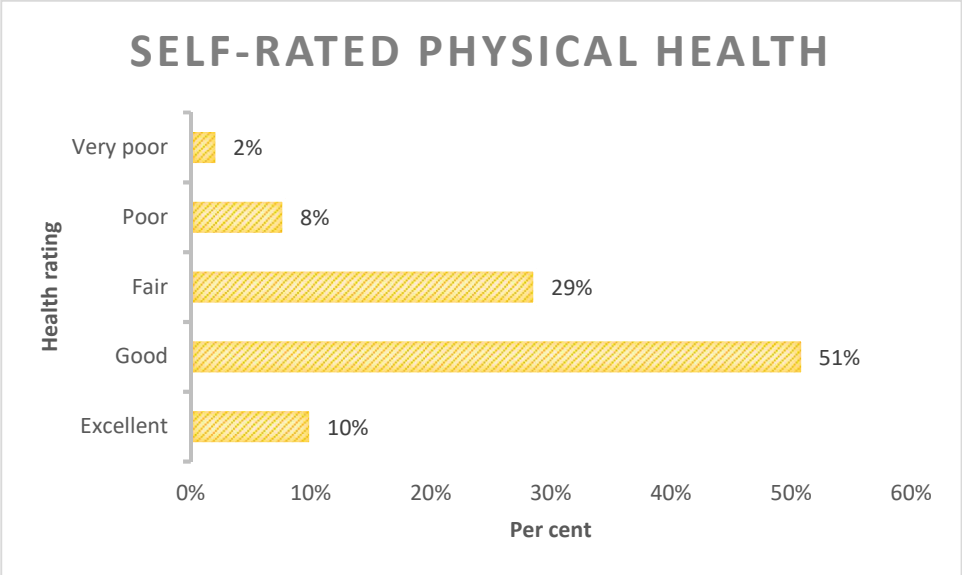

Figure 5 Self-rated physical health of same sex attracted women

One hundred and forty four women (40%) rated their mental health as either good or excellent. Twenty one per cent described their mental health as poor and very poor as shown in Figure 6 (n=74).

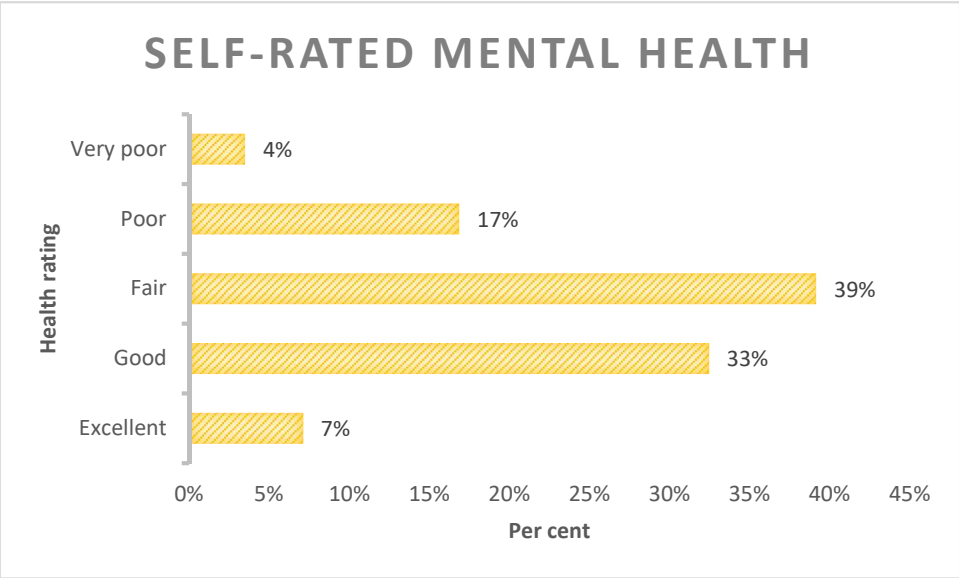

Figure 6 Self-rated mental health of same sex attracted women

A higher percentage of bisexual and pansexual women rated their health poorer than lesbian women, as shown in Table 2.

		Excellent	Good	Fair	Poor	Very poor
Bisexual and pansexual	Number Per cent	10 9%	49 45%	32 29%	12 11%	6 6%
Lesbian	Number Per cent	19 13%	80 53%	41 27%	10 7%	1 1%

Table 2 Self rated physical health of bisexuals and lesbian women

There were differences in the self-rated physical and mental health in the different age groups. Most women who were 55+ years rated their health good or excellent, as shown in Figure 7 below. No 55+ year old women rated their health very poor.

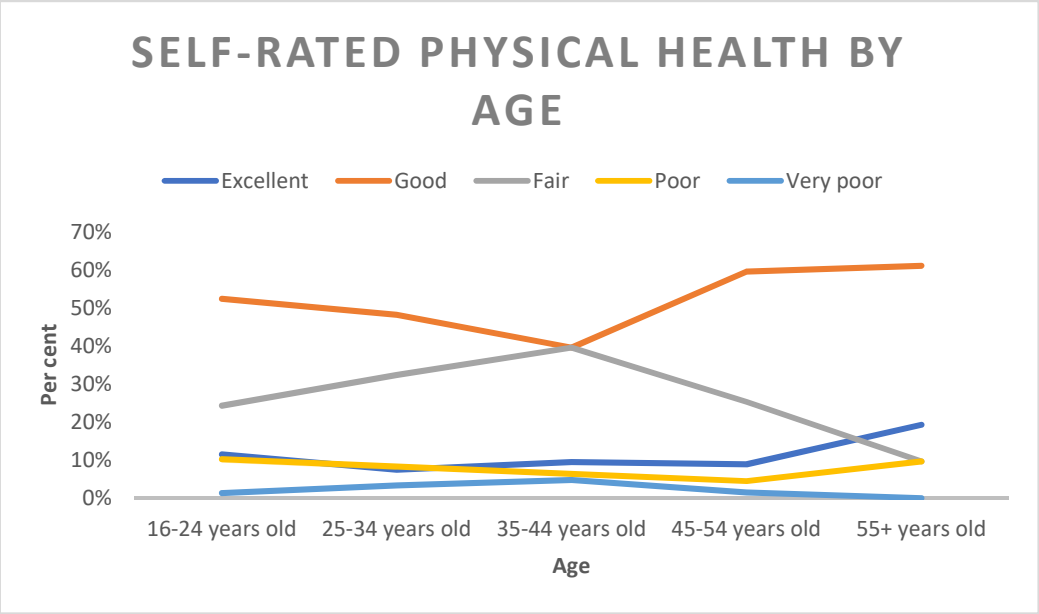

Figure 7 Self-rated physical health disaggregated by age

Self-rated mental health was more likely to be good or excellent in women aged 55+ than in younger age groups (Figure 8).

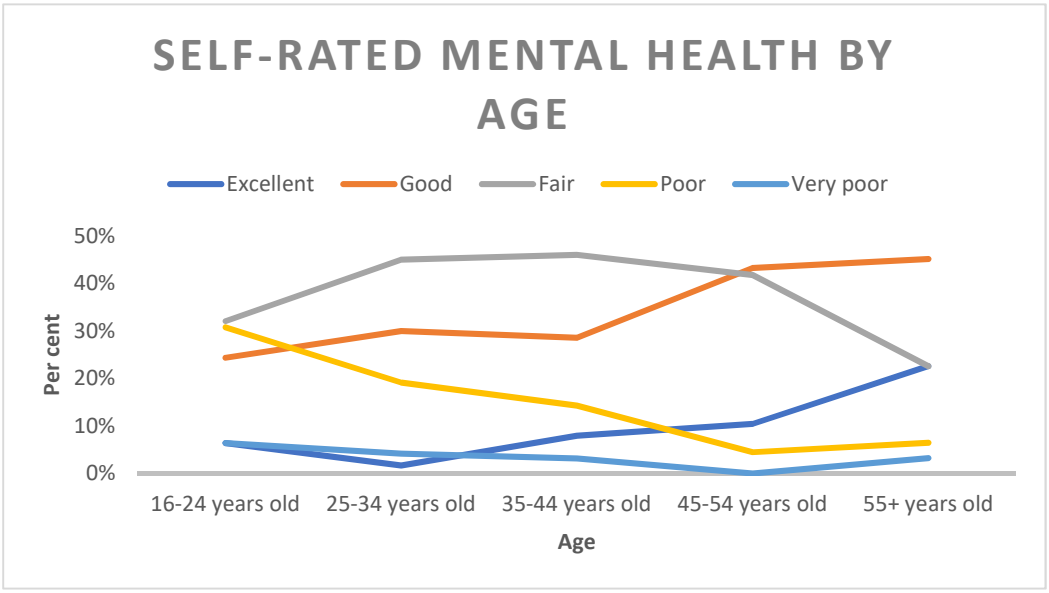

Figure 8 Self-rated mental health disaggregated by age

More bisexual and pansexual women rated their mental health as poor or very poor compared to lesbian women, as shown in Table 3.

		Excellent	Good	Fair	Poor	Very poor
Bisexual and pansexual	Number	4	33	41	26	5
	Per cent	4%	30%	38%	24%	5%
Lesbian	Number	16	58	57	14	6
	Per cent	11%	38%	38%	9%	4%

Table 3 Self rated mental health of bisexuals and lesbian women

Accessing GP services

Women were asked about their access to GP services. Just over 60% of women had a regular GP (n=229, 64%), and 36% did not (n=130). Three hundred and six women accessed a GP in the last 6 months (85%). Thirty six per cent had accessed one GP only (n=131), 23% reported accessing two GPs (n=86), and 26% said that they accessed more than two (n=92) in the last 6 months.

Women who had a regular GP were more likely to have seen one GP only in the last 6 months (n=111, 48%) compared to women who didn't have a regular GP (n=20, 15%) as shown below in Figure 9.

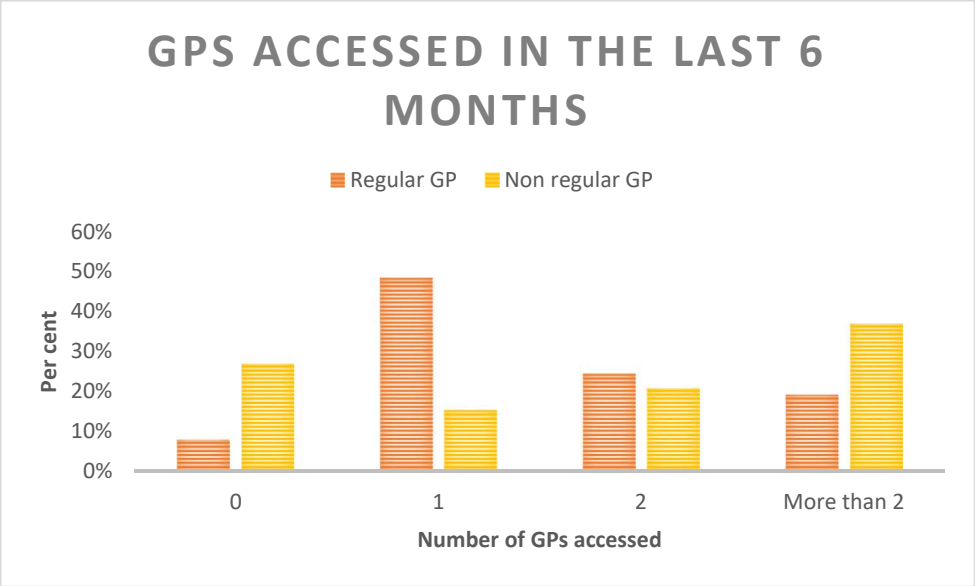

Figure 9 The number of GPs accessed in the last 6 months by women who had a regular GP, and women who did not have a regular GP

Women were asked if they disclosed their sexuality to their GP or health professional. Two hundred and ten said they do disclose their sexuality (58%), whereas 149 (42%) women reported that they don't.

Women who responded to the survey had the opportunity to explain why they did or didn't disclose their sexuality to GPs or health professionals (n=171).

Thirty three women reported that it was important for them to disclose their sexuality as they felt it was relevant to their care. Nine women responded that it was just part of who they were as a person and a part of their lives. Other women told us that they disclose because they trusted the GP (n=5), it was on the form, or they were asked (n=8).

"They asked on the form and I filled it out because I thought it might be relevant to their decision of the scans I needed to get. Sometimes it's also empowering to feel represented. This time it was just practical."

Twelve women reported that they had to disclose their sexuality to stop doctors questioning why they weren't using birth control or weren't at risk of unplanned pregnancy.

"I was seeing a doctor for a matter unrelated to my sexual health. When I mentioned that I do not take any medication they got concerned that I was not on the pill/taking birth control. I had to explain that it wasn't really necessary for me."

One woman mentioned that behaviour is more important than how she identifies:

"I disclosed gender in a paper form when asked by the service. I disclosed my sexuality in the form of 'these are the people I have sex with and this is why it might be relevant to my sexual health check', rather than 'this is how I identify'"

Fifty four women said that they thought it wasn't relevant to disclose at all or wasn't relevant for an issue that was unrelated to their sexual identity.

"I did not believe that my concerns were different to that of a heterosexual person."

"I go to GP for specific concerns, which were not relevant to my sexuality."

"My sexuality has never been a factor in my mental or physical health so far, so it hasn't seemed relevant to bring up, and my doctor hasn't asked."

Nineteen were ambivalent, saying *"it hasn't really come up".*

Twenty three women said they were worried about judgement by health professionals, and eight had experienced that judgement first hand.

"In matters of sexual health, or when they ask about relationship status, sometimes I have the energy to come out, sometimes I don't - often people will make the assumption that I am with a man and I need to make the decision as to whether or not I decide to come out and correct those assumptions that day."

"I find it hard to raise my sexuality with doctors because I am afraid they will judge me or ask awkward questions."

We asked women if they had disclosed their gender to a GP. The 19 trans women had all disclosed their gender to a GP, and six explained that it helped them access gender reaffirming treatment.

"As a trans woman I've had to talk to multiple GPs regarding medical transition."

"My doctor prescribes my hormone therapy and is aware of my gender id and trans status."

Women in the focus group talked about having to make decisions about disclosing based on numerous factors. They needed to decide if it was worth risking the quality of health care and potentially facing stigma. They worried about what they would face if they disclosed, and whether the vulnerability of disclosing was worth the potential negativity.

"One of my previous GP's who was very judgemental I, I had to take kind of a hard stance of saying I need an STI test and I was having sex with a partner who did not have a penis and I wasn't willing or really capable of giving them any information of my who partner was beyond that because I knew I would be judged."

"You always have to do a test, you know what I mean? Like you never can be sure about how it's gonna go and so if you don't need to bother with that, why would you expose yourself?"

"Because they are going to treat you like shit, not do what you want or make assumptions about your sexuality."

"That's why a lot of the time we just don't bother disclosing unless it's an ongoing specialist or an ongoing GP then they know that we are a couple. But if we just turn up to a clinic or need a particular test run then we just use the word carer."

Often, they relied on the health professional for cues on whether to disclose. Some women made the decision to disclose if the health care centre appeared inclusive or if the health professional asked. For example, one woman said that even though she thought it was relevant to her care, the health professional did not ask so she did not disclose.

"Just thinking about my gynaecologist, that would have been relevant information, but they just didn't think to ask. It can actively affect the quality of healthcare you get if you can't disclose to doctors what your situation is. What your lifestyle is, what risk factors you have. And I am sure it's the same for some people, people who take drugs. Who are too scared to tell doctors about it. We should be able to expect some security and privacy but I just don't think it's the case."

The chart below (Figure 10) shows the differences in the rates of GP access between women who disclose and those who don't. Women who disclosed their sexuality were more likely to have accessed a GP in the last 6 months.

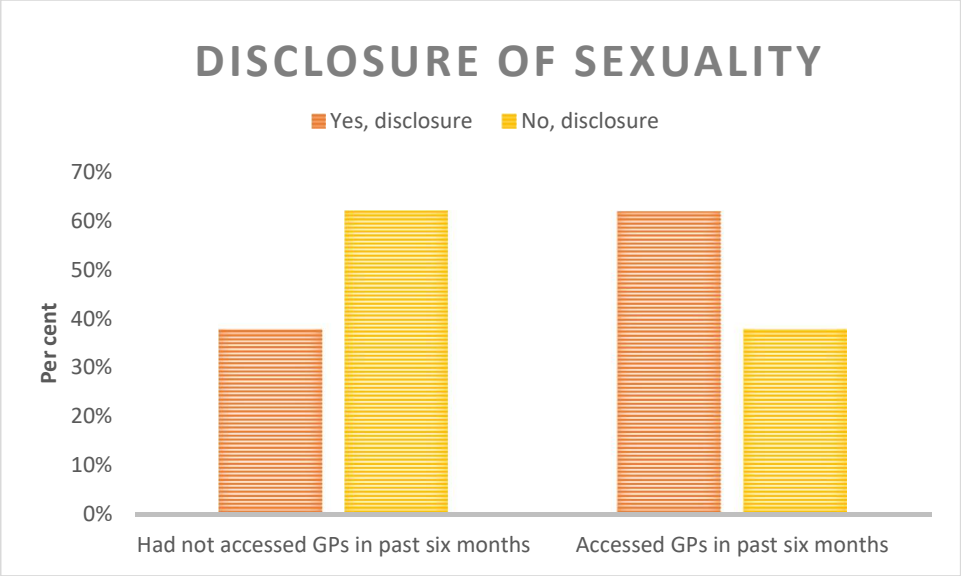

Figure 10 Disclosure rates: Women who accessed GPs in the last 6 months

Sixty eight per cent of women who had a regular GP reported that they disclose their sexuality (n=156). Fifty two per cent of women without a regular GP disclosed their sexuality (n=67), as shown in Figure 11.

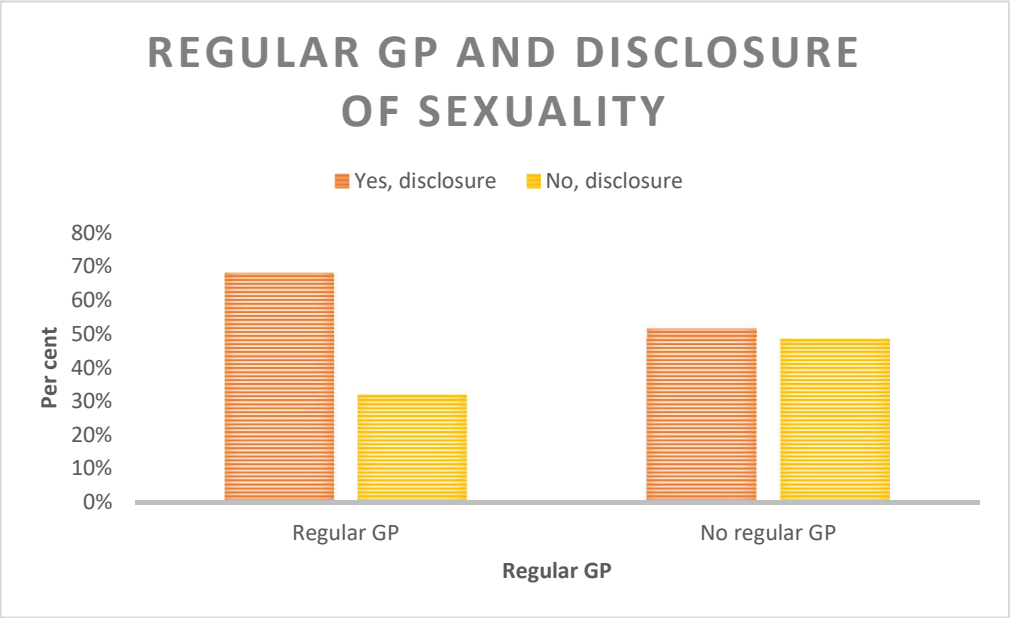

Figure 11 Disclosure rates: women who have a regular GP

There were differences in the reasons between women in the survey who did disclose to GPs and health professionals about their sexuality, and those who didn't shown in Table 4 below.

Comments or reasons for disclosure/ or nil disclosure of sexuality to GPs	Number of women who disclosed sexuality	Number of women who did not disclose sexuality
Trusts the health professional	5	0
It was on the form/ or they were asked	7	1
Relevant to care	32	1
Relevant to them	9	0
Hasn't come up	1	18
Wasn't relevant	2	52
Worried about judgment or discomfort	5	18
Not to male doctors	2	2
Experienced judgment	6	2
Disclosed so they stopped asking about contraception and birth control	12	0

Table 4 Comments and reasons that same sex attracted women disclosed or did not disclose to GPs and health professionals

The health services that ACT women accessed

The majority of women who responded to the survey reported that they were able to find services in the ACT that helped them obtain and maintain good health (n=296, 82%).

Women accessed a variety of health services in the ACT, as shown in Figure 12 below. GPs were the most common services accessed (n=320, 89%), followed by filling a prescription (n=292, 81%), and accessing a psychologist/counsellor (n=209, 58%).

Figure 12 Services accessed by respondents in the last 12 months

When asked who they had accessed services for in the last 12 months, women most accessed health services for themselves, then for their child, for their partner/s, for their parents, and for others (Figure 13).

Services most accessed by women for themselves were GPs (n=299, 83%), followed by filling a prescription (n=278, 77%), and dentist (n= 187, 52%). GPs were also accessed by women for their children (n=55, 15%) and their partners (n=53, 15%).

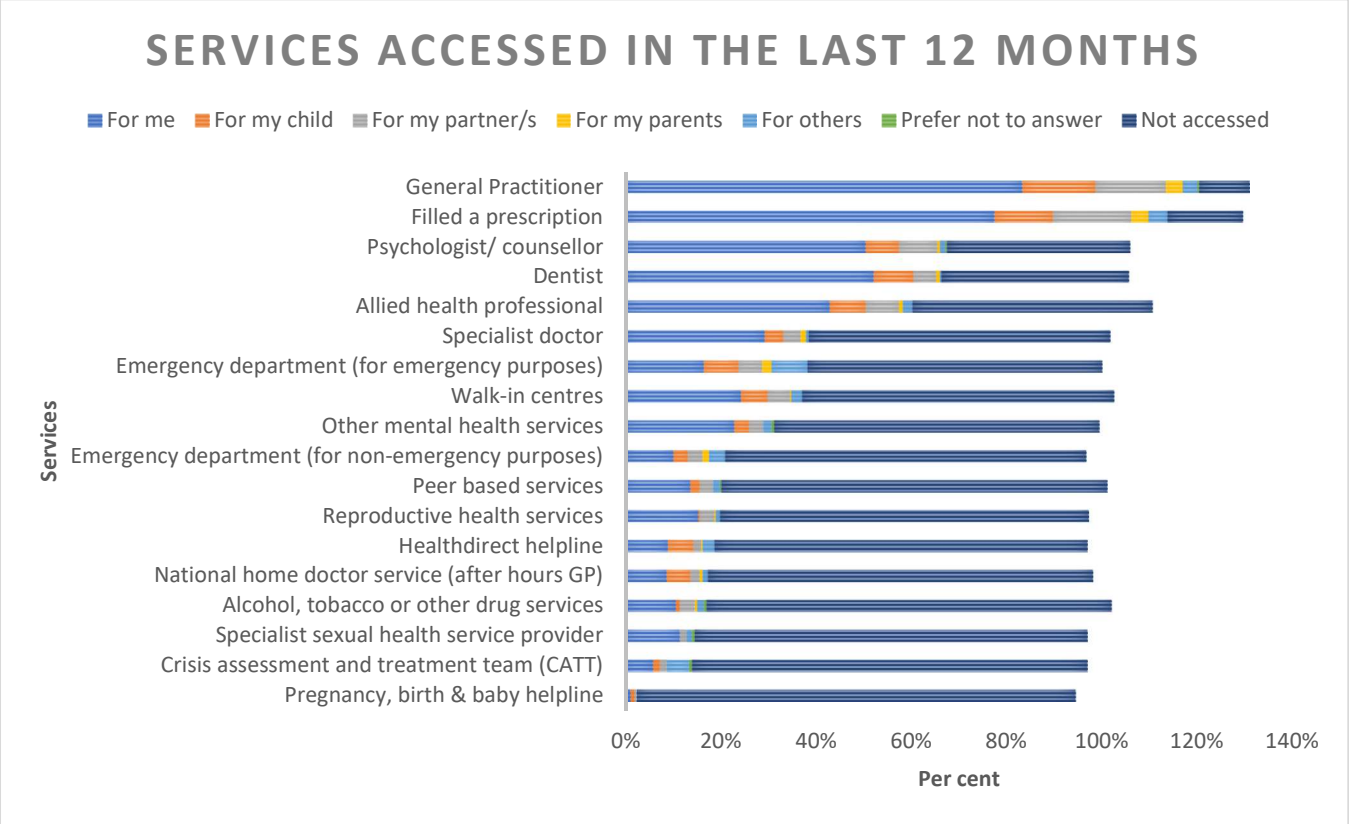

Figure 13 Services accessed by respondents and who they accessed it for

In the focus groups, women were asked if there were any services that they couldn't access in the ACT. The most discussed service was psychologists and psychiatrists, including ones who can diagnose autism and Attention Deficit Disorder (ADD) in women.

> *"If you are looking for an autism diagnosis you have to especially as a girl you have to go to like Sydney because there's a lot of problems with being diagnosed with autism if you're a girl … like a lot of the a lot of the people for more specialised things than just like general mental health and general physical health are not in Canberra."*

> *"Trying to get treated or diagnosed for various mental health issues related things I've had to pop off to Sydney and as well as paying an awful lot of money to the psychiatrist also have to go to and from Sydney which especially for those who can't or don't drive… isn't a party if you're from Canberra."*

> *"A while ago I tried to find a psychiatrist and everyone is retired. I ended up not needed one but if I did needed one I would have had to use telehealth which is expensive or go to Sydney which does seem ridiculous."*

> *"There are no psychiatrist options at all in the ACT. None with open books at all."*

Some trans women told us that health professionals who specialise in trans health were not widely advertised. Women wanting to address trans issues found it hard to access suitable services. It was often through luck or word of mouth that they found those services. They recognised that there may not be enough health providers who specialise in trans issues.

> *"…there are a limited number of… GP's who can deal with transgender health in ACT, you can count them on one hand, and they all seem to have closed books."*

"…I think there are some other GP's practising in that clinic now who are being sort of streamed in but that really seems to be an individual initiative not anything centrally organised or centrally publicised in any way so there's a lot of people in the community I think are unaware of that."

The barriers or difficulties experienced when accessing health services

Women were asked if they experienced any difficulties or barriers to accessing health services. They were able to choose more than one answer. Twenty four per cent of women reported that they did not have any barriers to accessing services (n=85), shown below in Figure 14.

Affordability of services was the most common barrier (n=199, 55%), followed by appointment availability (n=172, 48%), and long wait times (n=142, 40%). The 'other' category consisted of discrimination or harassment due to transphobia (n=5, 1%), accessibility for disability (n=7, 2%), discrimination on grounds other than sexuality or gender identity (n=14, 4%) and discrimination or harassment due to homophobia (n=14, 4%).

"…doctors are not well versed in how to deal with same-sex couples trying to have children. Doctors are also often misgendering my partner in this space, which is disheartening."

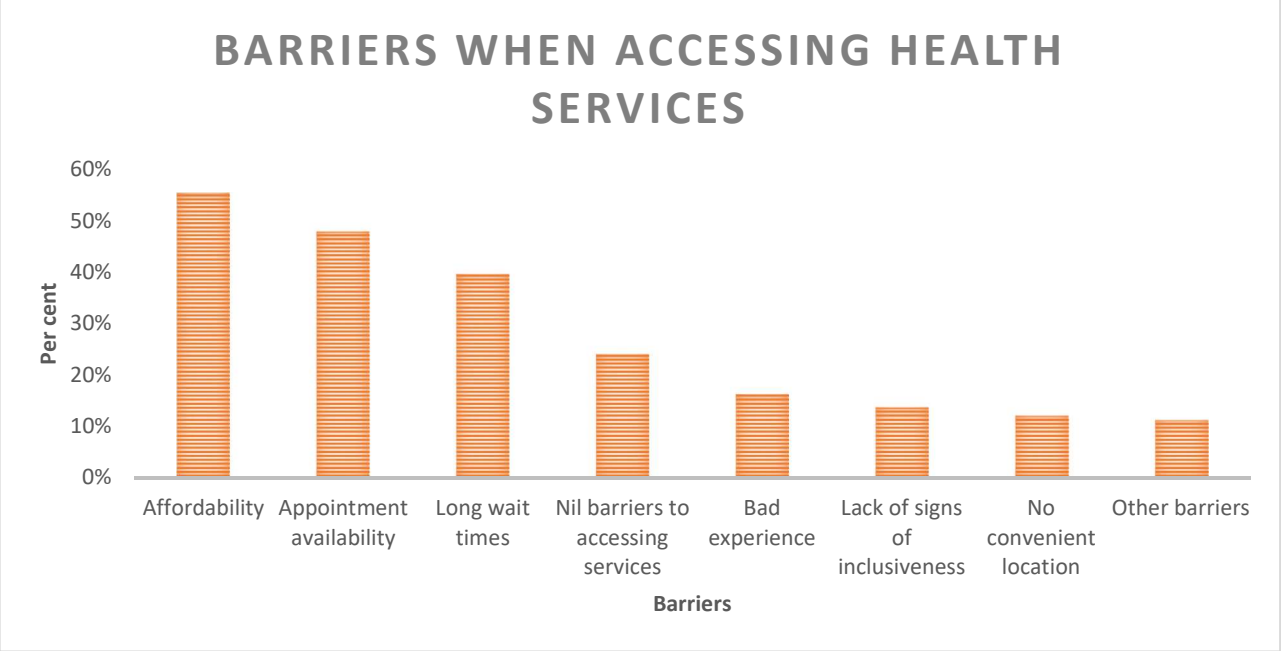

Figure 14 Barriers for accessing health services

Affordability

Women who participated in the focus groups discussed affordability as a barrier to accessing health services. Women talked about having to be selective about the health professionals that they use, with affordability being one factor limiting choice.

> *"There was a practice near London Circuit that was really good. And then they stopped bulk billing. And they need a healthcare card and I don't have a healthcare card."*

> *"And then there is cost which is prohibiting in terms of how much you can go and see a doctor. I have lots of friends who just don't go to the doctor or don't go to the dentist when they need it and that's because they can't afford it."*

> *"Money is a pretty big issue. Also just transport is a big one because I don't drive and various disabilities get in the way of one form of transport or the other… So if I'm having a day where my arthritis is flaring up, I've got to take a $30 Uber. And it's already an expensive GP to go to. And I go to her specifically because she's good with women's health. She's friendly to me and she just gets it. She's worth the money, but then you add the cost and hassle of transport on top."*

Women who needed to access trans health services talked about expensive surgeries and treatment to transition gender. They strongly felt that transitioning, whether medical and / or surgical, was not a choice as such, but necessary to ensure that they reduce the psychological impact of living as the wrong gender.

> *"The fact that a lot of our surgeries are not considered essential, but rather they're like still cosmetic. I am looking at when I'm having GRS (gender reassignment surgery) in Jesus, 4 and a half more months, and it's gonna cost me an arm and a leg. And I'm a student and trying to scrape up almost $18,000 and Medicare are covering squat. And the only reason why I'm getting an amount back is cause I'm still covered by my mum's healthcare which is very good… it'd be nice if the Government kind of sat up and went oh shit … cause it doesn't feel optional, a lot of this stuff doesn't feel optional"*

> *"you know there were trans people that have been on disability pension for 15 years because they've had mental issues because they couldn't get surgery."*

Not being believed or listened to

Women from the focus group said they had experienced not being believed or listened to as a difficulty when seeking help for their medical issues. They reported that this was a major barrier to accessing health care.

> *"If my mum is not there I bring a buddy because of the way that so many women and female-bodied people are treated by the system. I see in me and in my friends so much trauma that people just aren't able to stick up for themselves because they know that they'd just be smacked down by the system if they are with an unfamiliar doctor."*

> *"I didn't realise I was lactose intolerant for four years. I had so much pain. I went to so many doctors and specialists and gastroenterologists. And they said do more exercise, eat more fibre, drink more water. And I was at university and now I'm nearly finished PhD and I still struggle to talk to doctors. And I have this level of English literacy. What happens if you don't? What happens if it's just a second language or if you're really socially anxious and you can't, which was me the first 20 years of my life. But you can't say your things or if your doctor speaks over you you're just like, okay, you're the doctor."*

Some women in the focus group also discussed refusal of treatment, even if they had a diagnosis or a treatment plan from previous health professionals.

> *"I just wrote I wrote to my doctor back in Sydney and said can you send me some scripts. He did and that got me out of trouble. I was just flabbergasted you know that sort of situation might've been outside his expertise, but I had medical histories et cetera from my previous GP clearly showing my medications and all sorts of stuff. I'm going… 'have I moved to the back waters of the world? no I don't believe I have'..."*

> *"And the majority of those GPs, even though I have existing prescriptions from specialists they won't fill them because of the type of medication I am on. So that makes coops and free health clinics useless to me. Even though I have a diagnosed medical health condition. That I have been on medication for years, you can turn up to a free clinic and have all of your print outs and they will still turn around and say "oh no I don't believe in prescribing xyz." It really shouldn't be a belief thing."*

Heteronormative and homophobic behaviour

Women who attended the focus group talked about feeling worried about mistreatment due to their sexuality. Some women said they had experienced health providers using heteronormative language and making heteronormative assumptions.

> *"I've sat in front of a doctor and you know with my son there and had to make a decision whether I will out myself you know to the doctor. Am I able to trust the doctor? The fact that yeah I'm not his biological mother, my partner is his biological mother and I am his mother. That complex kind of processing that goes on as queer born woman sitting in front of somebody trying to access help because it's such a vulnerable position. You need their help and you don't know whether or not you're going to get the same help. I grew up in Sydney, in the 90s, hearing about men who would have been deliberately injured by the chiropractor and things like that. You sort of get this mistrust to almost all of the health profession. … I'd probably feel fairly comfortable going to St Vincent's in Sydney and being open about my sexuality um but you know the public hospital here, I have to make that choice every single time."*

> *"It's the assumptions. Every time you see someone new you have to go through the same thing, it's like coming out all over again, they don't know and they just make assumptions. When I say a partner they automatically think he, they just make those assumptions."*

> *"When you realise your doctor is just a raging homophobe, they will say something or mention something in politics and you feel unsafe, you don't know what kind of service that you will get from that doctor, it's really unfair and not appropriate that we have to fear for our safety when we are paying to get treatment but I do think it's true. When you're in the disabled community, and you're a woman, and you're queer... and you're disabled and you're trying to find doctors who will give any credibility to my opinion it's so difficult. There's not enough female doctors or female oriented resources. Bad doctors are not getting named and shamed, but it can be quite a scary situation."*

Trans women were worried about how they were going to be treated if they identified as being trans.

> *"That's my other thing where I'm like I don't want to disclose it because they might be transphobic and problems might arise or they might just not know what it means, I've*

had that encounter with someone before where they just did not know what it meant."

Appointment availability and wait times

Women in focus groups talked about the difficulty finding appointment times that were suitable for them and wait times to see a specialist.

"Appointment availability is a problem across the board. Often I have to take time off work to see a GP and it ends up being several hours even though my appointment is still only 15 minutes. Specialists are difficult to access, some wait time are years and in two cases I have been told to go back to my old specialists or find new ones in Sydney "if I have the means". It was a 2 year wait in Canberra to see a psychiatrist to have my medication reviewed, despite a rheumatologist in Canberra originally prescribing it."

Health care navigation

Some women in focus groups said that services were difficult to find. They acknowledged how hard it is to navigate services and had to trust GPs to refer them to professionals that addressed their issues.

"Is it a question that services… don't exist in Canberra or that they're almost impossible to discover?"

"The only person here from Adelaide with me is my partner of nine years and that's about it. What happens if I get cramps? It's like navigating the health thing on your own and it's different state-to-state. And Canberra is a shit place for health anyway."

Inclusive health services

Women in focus groups were asked how they know a health service is inclusive.

Known safe service

Women said they prefer to go to places that have been tried by other same sex attracted women. They get referrals from friends and colleagues about which places felt inclusive.

"Like recommendations of friends and colleagues and other people that you know… go to the services cold. I try and go somewhere someone I know has gone before so that they do have spidey sensing for me."

"It's also word of mouth, you know the queer women community is small enough that you know probably plenty of people who could give a review, positive or otherwise, of a health care service that they've accessed."

Some women went out of their way to continue going to a service that made them feel comfortable and was non-judgemental.

"I still keep going there and I think I go there because it is inclusive and… there's a huge array of different people for different things and whatever else and it's all fine and it's always very comfortable… I could just go around the corner, there's a doctor there, I'm sure they know what they're doing, but I go 'no I'd rather go over to Belconnen and to them because it's safe', yeah it's safe to go there."

Outward visibility

Women said that they looked for outward signs of visibility. They looked for very obvious signs such as rainbow flags or descriptions of inclusivity on a provider's website. They also looked for less obvious signs such as whether they had a diversity of people working at the clinic.

> *"And then when I joined ANU, I guess I trusted the ANU reputation. The ANU would not, maybe, as an institution, be discriminatory."*

> *"If I see sexuality, I think it means LGBTI friendly, because very few places ask. So if they ask they actually care about knowing."*

One woman discussed the contradiction in choosing to decorate clinics with traditional religious paraphernalia during holiday periods but won't show signs of inclusivity to other groups.

> *"If you go to a doctor's surgery around this time of year there's Christmas wreaths and all this religious iconography they're forcing on us, which is insensitive in a lot of ways but what it's too much to have a couple of rainbow flags around? It's just interesting the double standard in regards to culture that they are willing to force on their patients. It's like filling out a questionnaire that doesn't have a box for you."*

Women's top health issues

Respondents were asked to identify their top three health issues. This question allowed women to manually enter the three health issues they were concerned about.

The top three health issues identified by 79% (n=292) of the total survey respondents were mental health, weight/diet fitness and chronic conditions.

Sixty six per cent of women said that they were concerned about their mental health, as shown in Table 5.

Main health issue	Number of women	Per cent of women
Mental health	238	66%
Weight, diet and fitness	108	30%
Chronic conditions	107	30% (rounded up)

Table 5 Top three health issues mentioned by women.

Other issues that were significant for women were sex and reproductive issues (n=64, 18%); drug, smoking and alcohol (n=53, 15%); and skeletal and soft tissue injury or pain (n=52, 14%). Below, Figure 15 shows the health issues described by same sex attracted women.

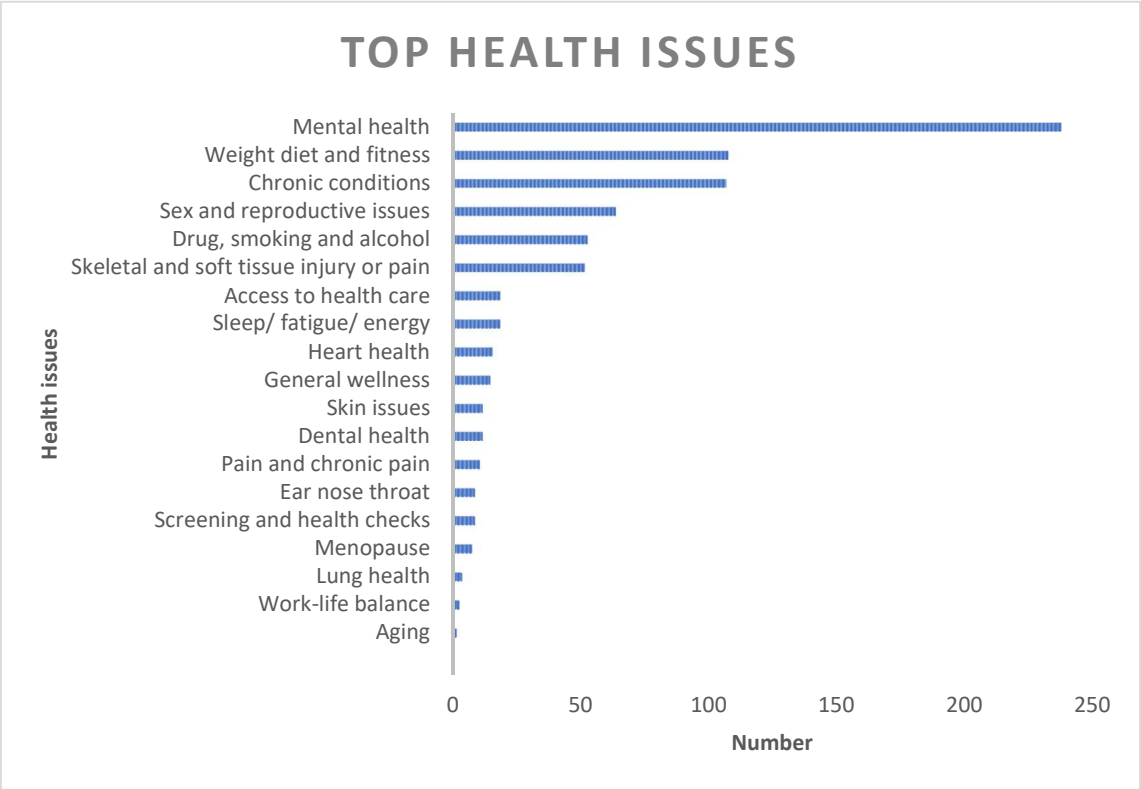

Figure 15 Distribution of top three health issues

The six most common health issues by age group are shown in Figure 16. Mental health was the top issue for all age groups, however 25-34 year olds listed it as the top health issue more than other age groups (n=97, 77%). Women aged 45 or older listed fewer sex and reproductive issues. Drug, smoking, and alcohol concerns increased as a health issue for women in the age group of 45-54 years (n=24, 36%), where all responses except for one included either alcohol or drugs. Women listed skeletal and soft tissue injury or pain throughout the different age groups.

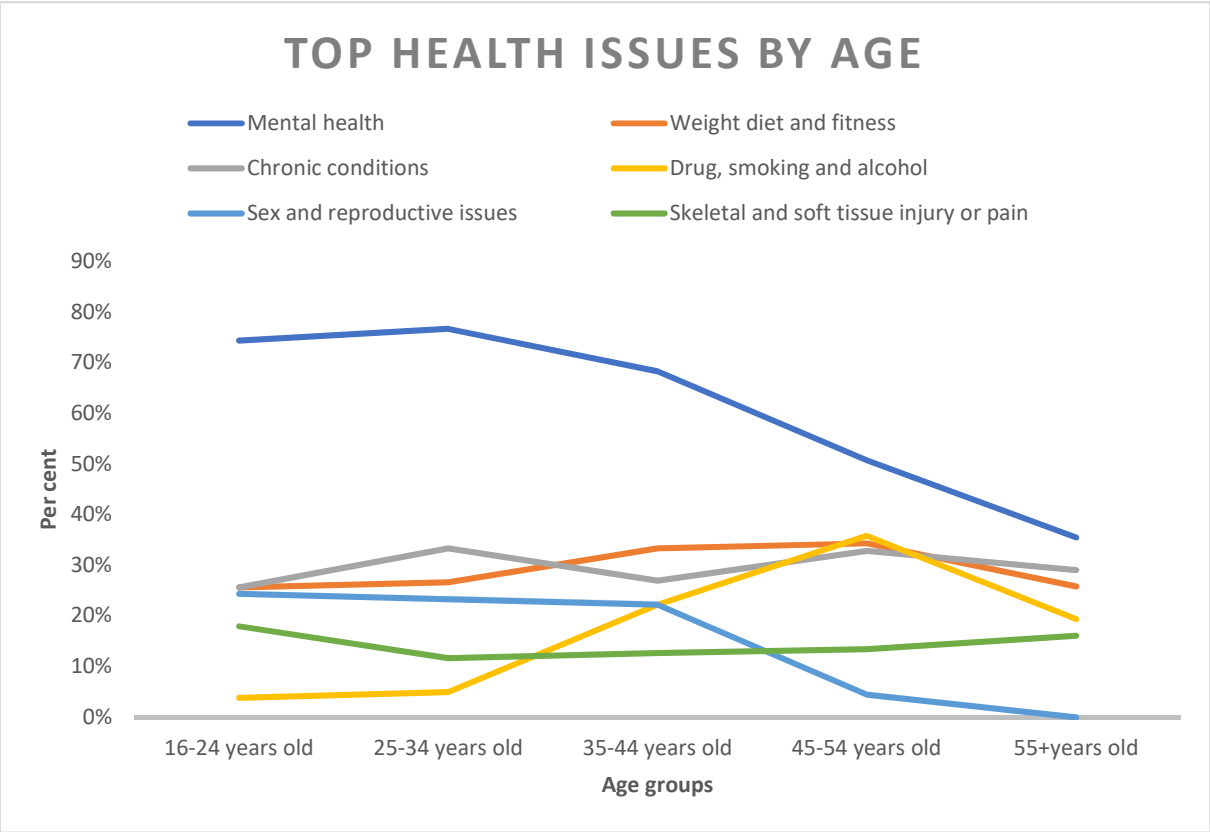

Figure 16 Distribution of top three health issues by age groups

Mental health

Survey respondents described mental health issues in different ways. Forty one per cent of women who reported mental health as one of their top three health issues did not identify a specific mental health issue but listed 'mental health' (n=108). The top condition identified was anxiety (n=39, 15%), followed by depression (n=25, 10%). An additional eight per cent of women put both 'depression and anxiety' (n=21), as shown in Figure 17 below. 'Other' conditions mentioned were self-harm and suicidality, compulsive disorders, ADHD, BPD, autism, and eating disorders.

Figure 17 Respondents top mental health issues

Mental health issues reported reduce as age increases, although more than 50% of women were still concerned about their mental health in the 45-54 years age group, depicted in Figure 18. Fifty eight women of the 16-24 year old group and 92 of the 25-34 year old group reported mental health among their top three issues.

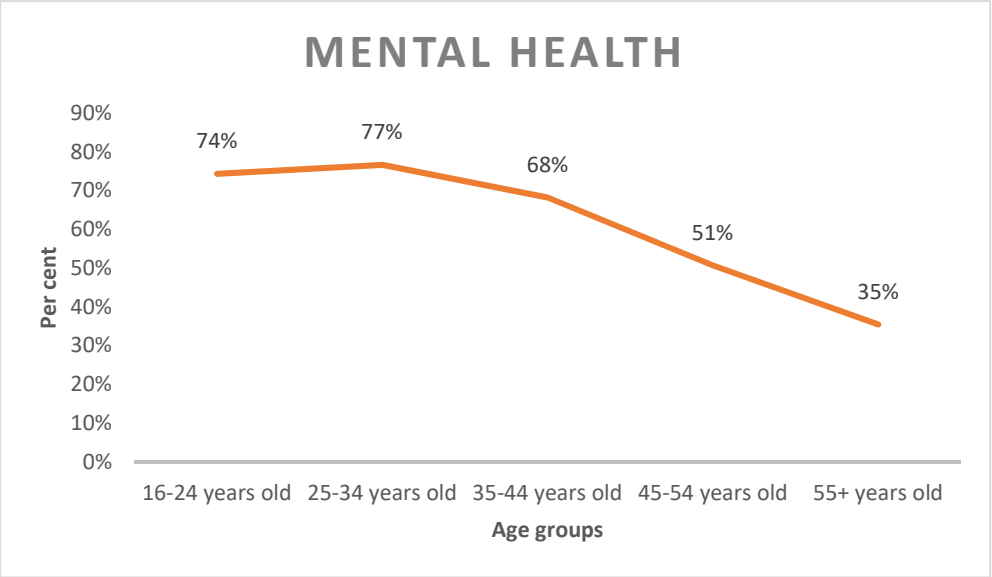

Figure 18 Mental health issues by age groups

Differences existed between the age groups and the types of mental health issues reported. Younger groups, 16-24 and 25-34 years old, talked about anxiety more than older groups, as shown in Figure 19. Stress appeared to be consistent as a mental health issue throughout the age groups. Depression was of greater concern for those in the 35-44 year old group, compared to other ages.

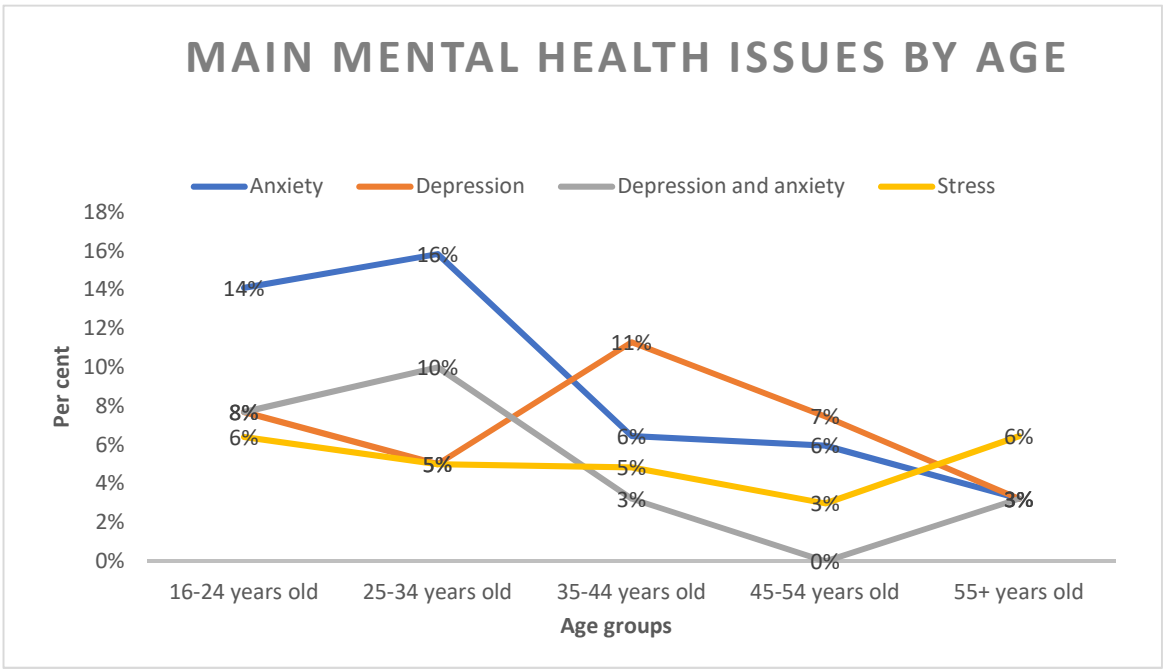

Figure 19 Respondents top mental health issues by age

Table 6 shows that women who identified as lesbian were less likely to list mental health in their top three issues.

Sexual identity	Number of women reporting mental health issues	Per cent of women
Lesbian	83	55%
Bisexual (including pansexual)	73	67%
Queer	43	69%

Table 6 Differences in mental health issues and sexual identity

Seventeen out of the 19 trans women reported mental health issues as one of their top 3 health issues.

Weight, diet and fitness

Women reported that one of their top three health issues was weight, diet, and fitness (n=108, 30%). As shown in Figure 20 below, weight was mentioned the most (n=43, 38%). Fitness was coded differently to exercise as it is considered a state of overall wellbeing encompassing aspects of nutrition and exercise. Twenty four women reported this as one of their top three health issues (21%). Nutrition and diet encompass wanting to make diet improvements, as well as food intolerances and nutrient deficiencies that can be managed through diet.

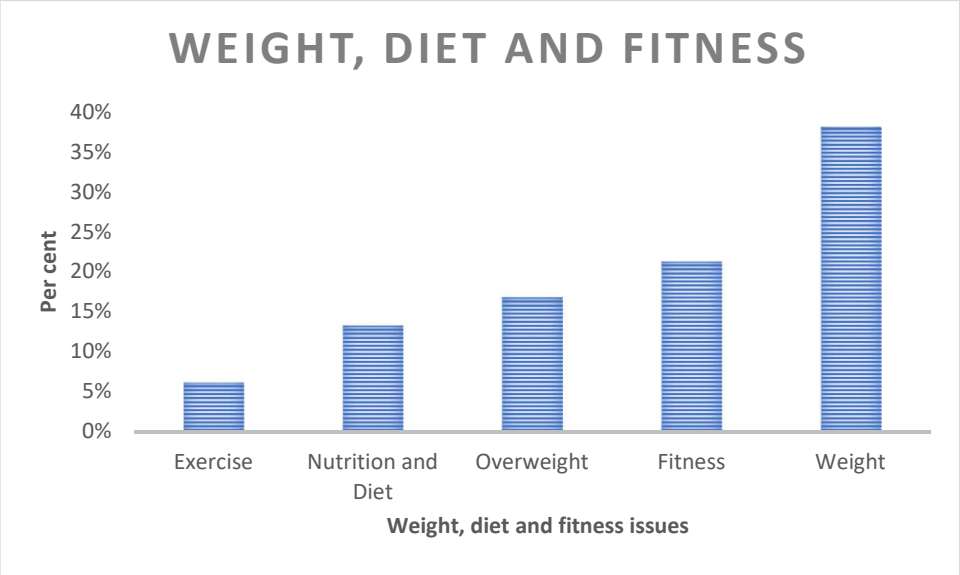

Figure 20 Respondents' top weight, diet and fitness issues

There were differences in the age groups in mentioning weight, diet, and fitness as a health issue (Figure 21). More women identified weight in the age groups 35-44 years old (n=13, 21%) and 45-54 years old (n=13, 19%).

Only 8 women in the 55 years and older group mentioned weight, diet and fitness.

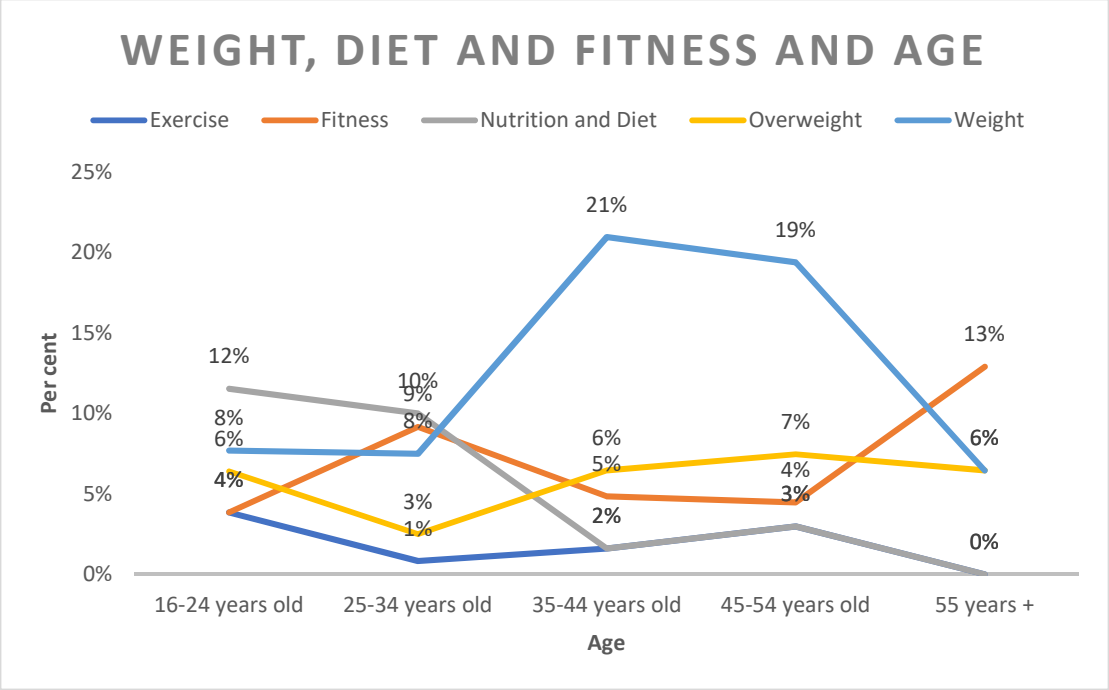

Figure 21 Respondents' top weight, diet and fitness issues by age

Chronic Conditions

Chronic conditions (n=107, 30%) were listed by women as one of their top three health issues. Figure 22 below shows the types of chronic conditions identified. Twenty five per cent of women who listed a chronic disease named an endocrine condition (n=29). Endocrine conditions included poly-cystic ovary syndrome (PCOS), diabetes, and endometriosis. Women who specified gastrointestinal issues named irritable bowel syndrome (IBS), gall bladder, diverticulitis, stomach pains, and gastrointestinal issues. Circulatory conditions included heart conditions, blood pressure and heart health. Autoimmune conditions that women described were Hashimoto's disease, Crohn's disease, multiple sclerosis, and rheumatoid arthritis.

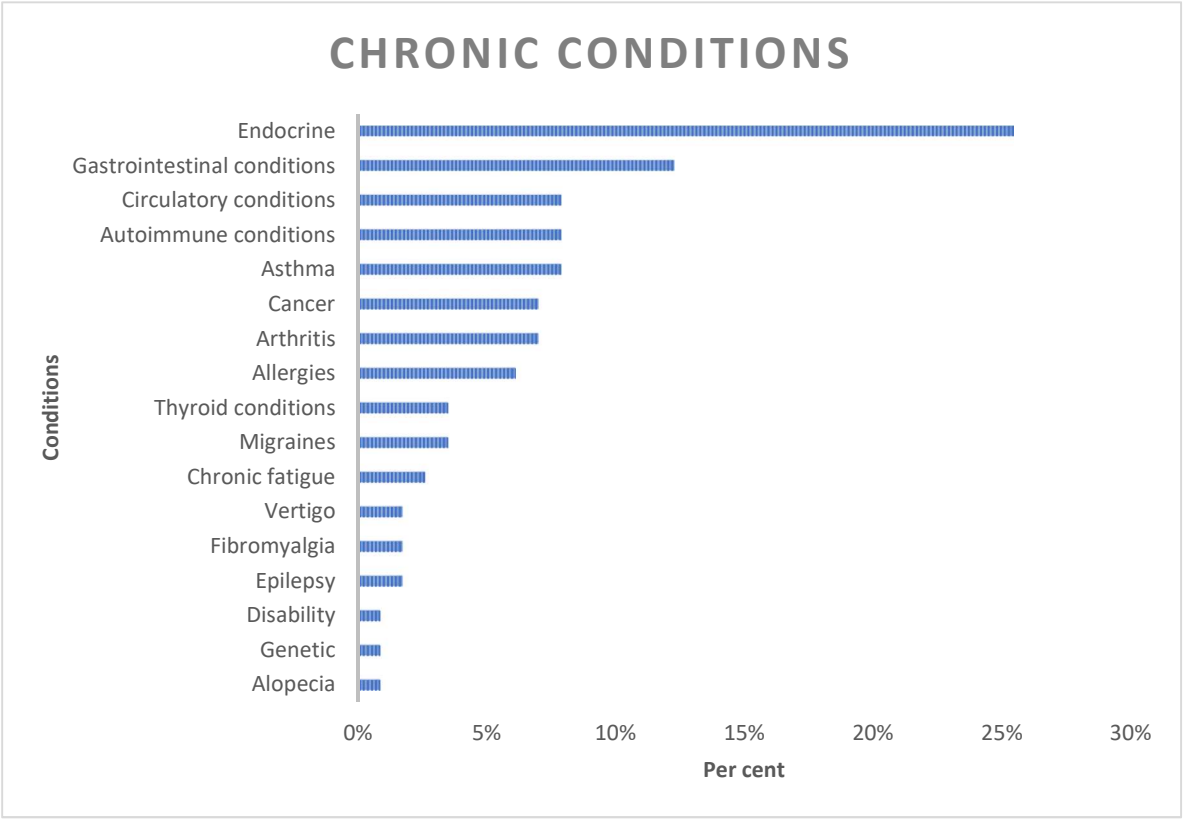

Figure 22 Respondents top chronic conditions

Figure 23 shows the percentage of respondents by age group who identified chronic conditions as one of their top 3 health issues.

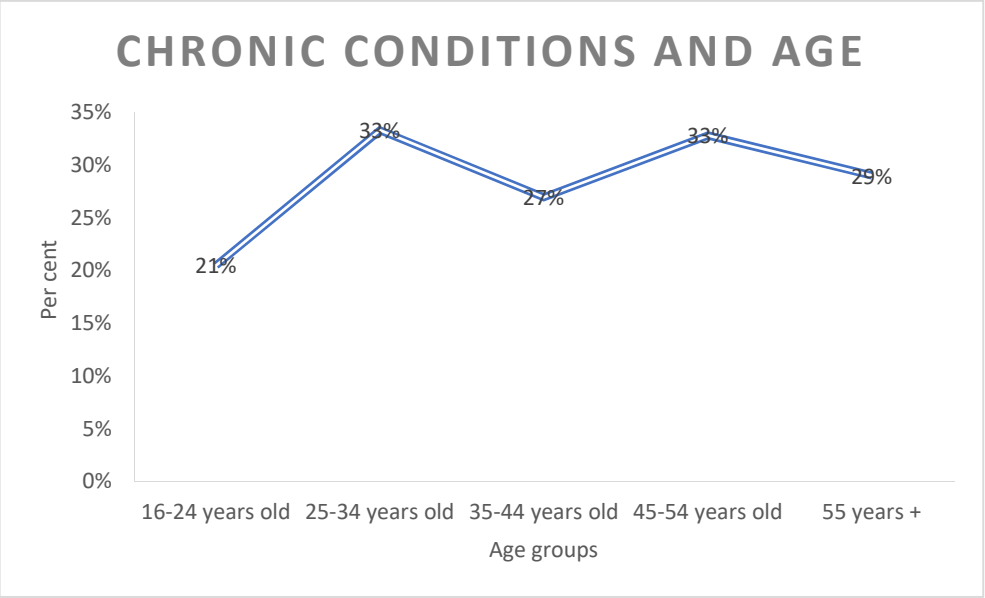

Figure 23 Respondents who listed chronic conditions in their top three health issues by age

More women aged 25-34 years reported endocrine conditions than the other age groups.

Availability of supports for addressing top health issues

Women were asked to tell us what supports or services they accessed to help them address their top three health issues. Nineteen per cent of women reported that they didn't have any supports or services that were able to address their health issue (n=67).

Mental health

Women who said one of their top health issues was mental health reported accessing a variety of services and supports, including GPs, psychologists, counsellors, and mental health services. GPs were often used in collaboration with another mental health care provider. Some women mentioned that they relied on their GP to access Medicare rebates through a mental health plan.

> *"I have a supportive GP, & psychologist in Canberra, and a wonderful psychiatrist in Adelaide who has been treating me for 15 years (now we have FaceTime consultations)."*

> *"Mental health care plan through GP and psychologist."*

> *"GP and psychologist."*

Some women had community services supporting them with their mental health conditions. AIDS Action Council was a service that was mentioned multiple times, along with ANU counselling, A Gender Agenda, and Headspace. Some women said they had a number of supports wrapped around them to help them deal with their mental health. This might be assistance from community services, as well their friends, family, partner, workplace, GP, or other specialist services.

> *"AAC [AIDS Action Council] counselling, anti-anxiety meds, as well as support from friends, house mates and work place."*

"Yes, I have a psychologist but I cannot afford to see them as regularly as I would like. My friends also do support work for me (in the sense that they lend an ear, make me dinner, etc.)."

"Supportive GP, have done hypnotherapy this year, in contact via Skype with a counsellor regularly."

Nineteen per cent of women (n=21) who listed mental health in their top three issues had no services or supports to help them.

Focus group participants were asked what supports they used to help them when they were having a hard time with their mental health. They discussed many of the service options that were mentioned in the survey: GPs, psychologists, counsellors (including workplace EAP programs) and mental health services. They also reached out to their partner, family, and friends for support. Some women acknowledged that they needed to be careful of the other person's mental health too.

"My partner, my family, but it takes some time to even think that there is something wrong yourself, could be a long time before you even think you need help or feel comfortable even approaching someone who's close to you. But I think the first would be partner and family, and close friends."

"Well, my queer friends on the other hand, because I remained straight friends with my male friends, everyone's supporting each other but we're all mentally ill. And it's just like that, everyone's emotionally overworked and overloaded."

"I find it difficult to talk about my stuff with a lot of the people around me because of the intersectionality it tends to be about me being chronically ill or disabled and queer and my family and my partner don't really have the capacity to understand that in a lot of ways."

Weight, diet and fitness

Respondents from the survey identified the supports and services they accessed to help with their health issues regarding weight, diet, and fitness. Some relied on specialist services to help with managing eating and exercise habits, and some sought GP help. Others adopted healthy options and had friends and family for support.

"Saw a dietitian who showed me I need to read labels regarding hidden calories."

"Attending fitness club regularly. Spending time with friends being physically active. Plenty of information and options available about healthy diets."

"Personal trainers/gyms/fitness classes."

Some women reported that it was difficult to focus on health behaviours for weight, diet and fitness when they had mental and physical health issues overshadowing their overall wellness.

"Mental health is making physical fitness difficult to achieve."

"I am too tired, poor and sick to manage my diet and weight as well as I would like to. I simply don't have the means to manage it with all my other health issues."

Chronic conditions

Women said that they had services and supports in place to address chronic conditions and health issues. They often needed to rely on many different services to ensure that their condition was under control.

GPs/ specialists

GPs were the commonly accessed service to help women address their chronic conditions. Many of the health issues were more complex and so they needed more health professionals involved.

> *"I have a good GP who knows where to look for resources. I am lucky in that regard."*

Others needed more specialised treatment and so relied on their specialist:

> *"Yes, visits to rheumatologist every 6-12 months."*

Accessing a sexual health clinic was particularly important for some women for specific sexual health issues such as endometriosis:

> *"The Canberra Sexual Health Clinic is an incredible free resource that provides fantastic advice, free of charge." [from a participant with endometriosis]*

> *"Marie Stopes clinic - one of the doctors there is amazing." [from a participant with endometriosis for contraception]*

> *"Endo clinic at TCH and private doctors"*

Some women advised that they accessed a GP as well as used therapeutic medication:

> *"Yes - supportive doctors, pain relief, gynaecologist."*

> *"GP and medication."*

Allied health/ Alternative therapies

Women also used allied health services to help them address their health issues. Physiotherapists were the most frequently mentioned allied health service.

> *"Physiotherapy was helpful as long as I could afford to pay for it."*

> *"I have a regular physio and practice yoga. Having flexible hours at work makes it possible to attend physio/yoga or to have short days during flare ups."*

<u>Other services and supports</u>

Some of the Canberra services where women also said they accessed supports included:

- Canberra Sexual Health Centre at The Canberra Hospital
- Headspace
- Walk-in-Centres
- AIDS Action Council
- Sexual Health and Family Planning ACT

Barriers preventing women from addressing top three health issues

Women were asked what barriers prevented them from addressing their top three health issues. Nineteen per cent of women reported that they didn't have any barriers (n=70).

Affordability

The barrier that was most mentioned was affordability (n=165), whether for ongoing services or for one-off procedures or supports. Most women reported more generally about the affordability of healthcare.

> *"Healthcare affordability, specialist appointments were crazy expensive until I got into the public system, but also other practitioners like pelvic physio are really expensive."*
>
> *"Healthcare is expensive."*
>
> *"Lack of funds to cure it."*
>
> *"Lack of free services."*

The cost of health services that are not covered by the public health system was the next most common concern. Women told us that they were unable to address their health issues as they were unaffordable it through the private system.

> *"Financial issues and I'm not sick enough to access concessions - the medication and appointments cost a fortune and getting other therapies (OT or PT) is too hard to access without financial help."*
>
> *"The tumours are benign, so their removal is classified as superficial surgery (quote $8000) the tumours press on a previous back injury and cause a lot of pain/immobility but as they are not classified as painful tumours, generally they are not covered by Medicare."*
>
> *"Lipoedema isn't recognised by Medicare, even though it has WHO recognition as a disease."*
>
> *"Financial issues - some clinics won't offer Medicare rebates for same-sex couples."*

Some women talked about the expense of allied health professionals and adjunct health services or supports. Women reported not being able to afford these services and therefore were not able to access them.

> *"Cost. Physiotherapy and massages are expensive."*
>
> *"… cost of seeing a nutritionist."*
>
> *"Can't afford physio."*

There were thirteen mentions of mental health services that were unaffordable, particularly to get access to the number of sessions that may be needed to treat the mental health condition. Women said they needed counselling and mental health services that met their needs, were of good quality, were LGBTIQ friendly, and were affordable.

> *"Lack of affordable mental health care options that are staffed by appropriately trained and qualified staff."*

"Lack of affordable mental health professionals with a reputation for being LGBT friendly."

"Impossible to book affordable mental health care out of work hours."

"Price of psychologists/psychiatrists."

Focus group participants expressed the difficulty in affording mental health professionals and the limited number of visits reimbursed by Medicare.

"They learn of depression you've had since you were born. You can't learn that in six sessions."

"I was seeing a psych outside of my studies it was really prohibitively expensive. Nearly $300 an appointment. And really hard to get to."

Time

Time was the second most mentioned (n=51) concern for some women to be able to address their health issue. They reported that they were too busy. A few women talked about their lack of time due to working multiple jobs.

"Time scarcity – I am working 3 jobs and studying full time, so often find it hard to find or predict availability for appointments in business hours."

"Diagnosis takes time but I'm working on it."

"Time: too busy to see doctors often."

Some women said that it was the combined barriers of time and money that reduced their ability to address their health condition.

Experience with health professionals

Women reported that at times they were not happy with the health care that they were receiving. This was the third most mentioned barrier (n=40). Women were concerned that health professionals were not helping to address the health issues they faced, not doing proper investigation, or not having the knowledge to address concerns. And not connecting them to other suitable services or supports.

"Lack of clear diagnostics pathway. Difficulty finding the right expertise."

"Wary about a lot of advice and opinions that are ill informed or not suitable for me don't like being told what I need."

"Lack of knowledge about root cause."

"Finding a doctor who will investigate."

"Medication is effective, but counselling to date has been less helpful than I had hoped."

Women told us that at times they weren't treated well by health professionals. They reported times when they faced stigma, where they needed help but weren't getting any, or they weren't being listened to.

"Attitude that queerness or bisexuality are promiscuous sexual orientations and therefore any sexual health issues must be a result of this 'lifestyle choice'."

"Difficult to treat pain or for pain to be taken seriously. Emergency is the worst, especially when they think you're just a codeine junkie."

"Regular GP is apprehensive to pursue further diagnosis options for reproductive system pain I've been having."

"My GP wants me to have weight loss surgery, I just want support (eg dietitian)."

"I have two hernias and specialist won't do surgery."

Survey respondents who accessed mental health services identified that it was difficult to find and trust a mental health provider.

"Finding counsellors who understand the lived experience of bipolar, rather than just having read about it in a book."

"Often difficult to access adequate treatment, especially when mental health isn't the worst my regular GP has ever seen it as."

Women from the focus group were frustrated that it was difficult to find a mental health professional who understood their circumstances and who they trusted.

"Your health record can be subpoenaed. It's not a lot of trust already, from the beginning."

"But also, I think, coming back to the point of misogyny but very broadly, I think sometimes it's really hard to find a counsellor who would be understanding of the structural issues you may be experiencing on top of any mental health stuff when it comes to queerness, when it comes to feminism and things like that."

"[the] therapist here is very clearly incredibly straight and so sometimes, I hesitate to talk to her about everything and so that's an extra thing… it's hard to find mental health professionals who you actually feel comfortable talking to about everything."

Respondents report the stigma they face accessing mental health services and accessing services that may not be LGBTIQ friendly.

"Stigma around accessing mental health services, particularly the potential to limit career options or ability to gain higher security clearances. Ten sessions often not enough."

"Difficulty getting and appointment with someone who understands being queer isn't the root of depression / anxiety."

"...it can be tricky to work out beforehand whether someone will be queer friendly."

<u>Wait times and service availability</u>

The fourth most mentioned barrier was that there were services that they couldn't find, or the wait times were too long in the ACT (n=18). Services reported included rheumatologists and other specialists, pain management clinic, and queer friendly and inclusive services. Waiting for services had a detrimental effect on the women's lives:

"No dermatologists are available in Canberra unless it's for a serious problem."

"Yes, there seem to be a limited number of dentists available in Canberra."

"I am also on a long public waiting list for the pain management clinic."

"Yep - long waiting lists, lack of appropriate services."

"Long wait times for public specialists / pain clinics."

"Neurologist has retired new one required."

"Long wait times for a rheumatologist."

There were ten mentions of wait times and availability of mental health services as a barrier to good health.

"Lack of professionals who have the time/energy/expertise/compassion to assist. After my first suicide attempt a Dr told me to go outside more and sent me on my way. Each time I find a Dr/psych who is interested and begins exploring the issues they leave the practice and I have to start again."

"There are no psychiatrists in the ACT who will treat/prescribe adult ADHD sufferers. I have to go to Sydney."

"Long waiting lists for community psychiatrists."

Women in the focus group also talked about wait times for mental health services.

Energy and motivation

Some women reported a lack of motivation or energy (n=54 mentions) in addressing their health issue. They felt that addressing the issue was insurmountable and that the barriers appeared too hard to overcome. This was a barrier mentioned in addressing all three of the top health issues: mental health; weight, diet, and fitness; and chronic disease.

"Reluctance to engage in the long process of finding a good psychologist (time, money, self-doubt, discomfort)."

"Unsure how to access GP, also procrastination."

Other issues

Women talked about other reasons why accessing health services and supports were difficult for them. They reported that they couldn't find the information they needed to access the service, and at times the health system was hard to navigate.

"Unsure where to go, scared of being judged for wanting frequent checks."

"Shy, nervous and unsure of how to find somebody to talk to."

"I'm not really sure what is involved/ lack of information."

"Don't actually know what to do next."

Barriers that stopped them from accessing health services also came from their immediate environment such as their family or work life.

"Full time, non flexible work conditions (employees say they're flexible but still require you to be in the office 38 hrs a week- even with modern technology)."

"Stress in intimate relationships and busy work life, no proper habits around eating well."

"Work stressors can be difficult or a barrier to prevention."

"Caring for 3 children."

Top 3 information seeking sources

Women in the survey were asked what their top three preferred sources of information were for both general health information and for more specific health information.

Forty seven per cent of the women sought information from online sources of health information (n=169) as their first choice, as seen in Figure 24. Online sources included responses ranging from 'Dr Google' to 'online support groups' to reputable sources such as the 'Better Health Channel' or 'Government websites'.

The most reported second choice was to seek information from their support network which included family, friends, and colleagues (n=104, 32%). The "other" group encompassed seeking information from books and other media, and support services.

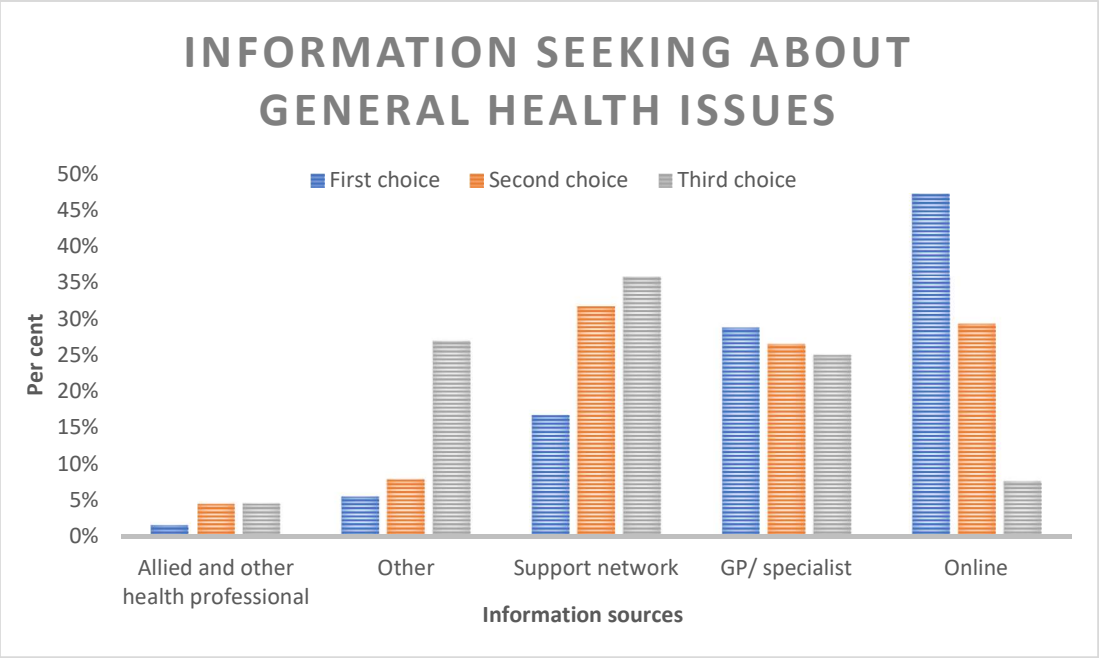

Figure 24 Top three information sources for general health

<u>Top 3 sources of specific health information</u>

Women were asked what sources they accessed to find out information about specific health issues. Most women accessed information about specific health issues from online sources (n=158, 45%) and from their GP (n=151, 43%). Figure 25 shows that their third choice was their support network of family, friends, and colleagues (n=98, 42%).

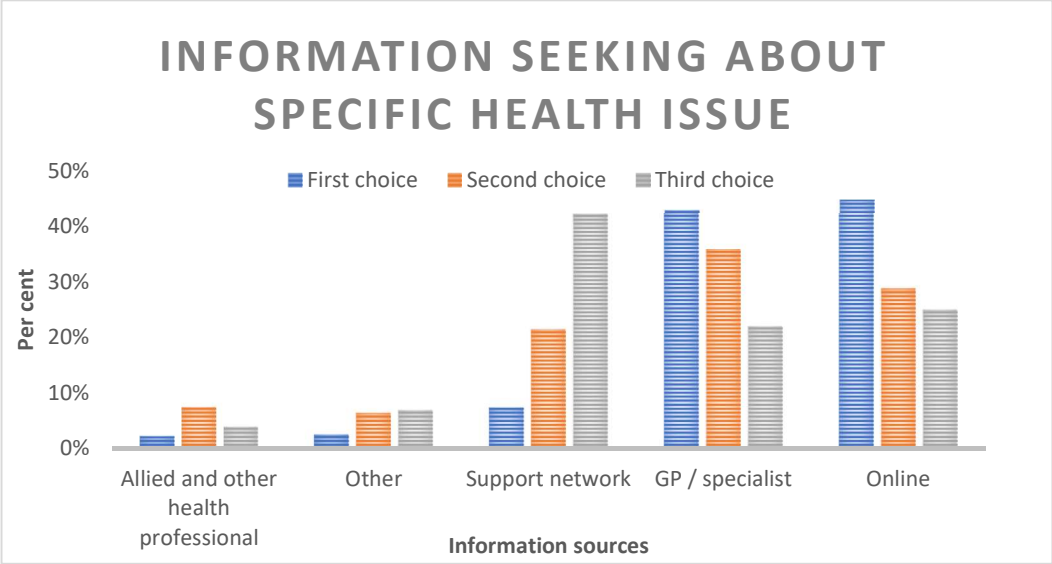

Figure 25 Top three information sources for specific health issues

Information seeking by age

Seeking health information was different for each age group. Seeking health information online for general health was highest in all age groups except for those over 55 years of age where they preferred to access their GP for general health information (Figure 26). Younger age groups (16-44 year olds) sought health information from their support network more than those 45 plus.

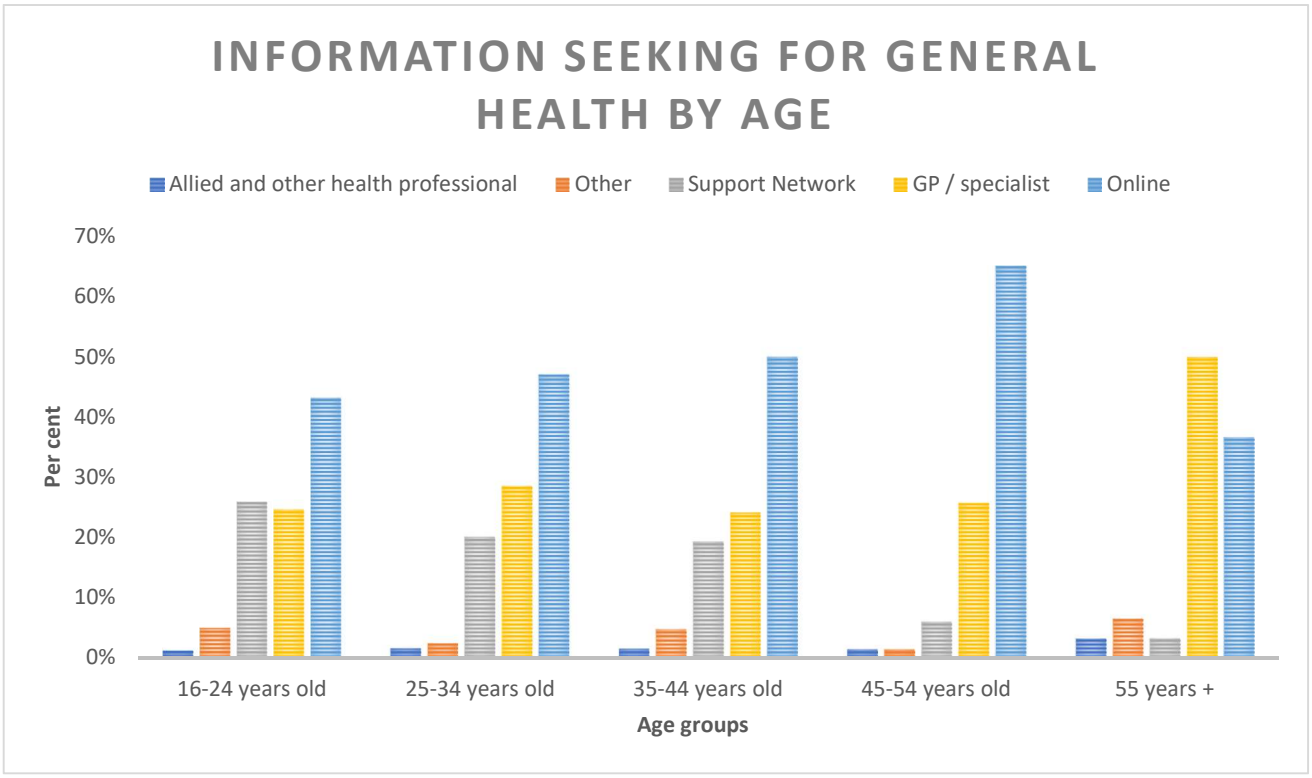

Figure 26 First choice information sources for general health by age group

Women aged 25-54 said that they sought information for specific health conditions more from online sources, shown in Figure 27. Whereas, women who were 16-24 and 55 years plus sought the information from their GP or specialist.

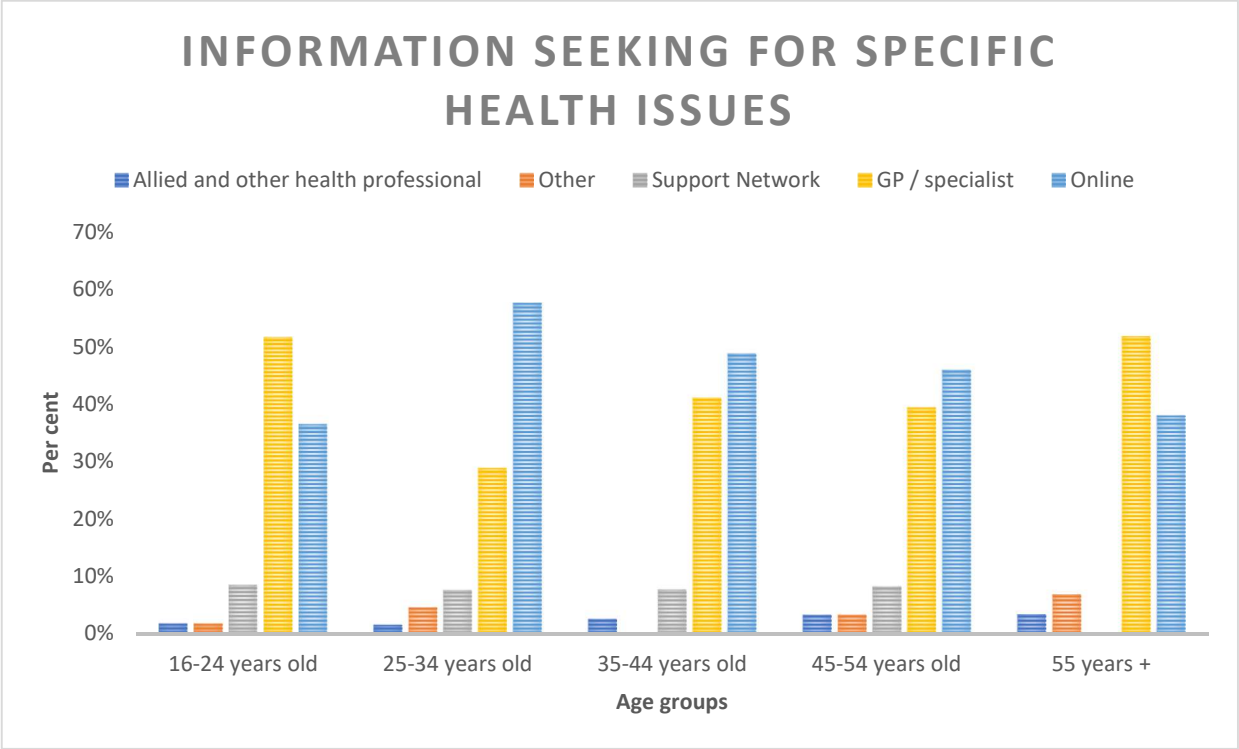

Figure 27 First choice information sources for specific health issues by age group

Determining the best source of information

Women who participated in the focus group accessed mostly online sources of information followed by GP and family and friends. They said they used online sources to help inform them and as a way of developing health language to converse with health professionals. They also used the online platform to discuss conditions, treatments, and health practices with others who were going through the same situation.

> *"I do invest a lot of time in doing my own research which has been quite beneficial just recently because I've had a few health problems."*

> *"Yes, women's health. They're so good and I was looking at some stuff recently. And Victorian government's health website on women's health was really good with a lot of fact sheets. And information was explained in a very plain way with charts. What happens if you don't treat it, what happens if you treat it this way or that way?"*

> *"I went to this support group and went what's the actual truth? What are your experiences? And, yes, you've got to filter because everyone accounts things differently. But you're actually going to get real experiences, which is better than nothing. So, at least with chronic conditions, I found that really helpful. And a great local example, the Canberra Endometriosis Network, is really good. So, there's things like that."*

> *"In terms of social media as well, I've got quite a few friends as well who've got chronic illness so sometimes we will talk to each other in terms of "oh who has tried this medication? What was your experience of it, what was your recommendations?*

Because that information doesn't really come from any of the medical practitioners or even the pharmacists."

A few women preferred the anonymity of accessing information from an online source.

"I think that a lot of the reason why I like seeking it myself is that privacy side of it, you can just look for it yourself and I mean I know that everything on the internet is cached somewhere, I think it's the "no judgement" with comes with looking on the internet."

"Google is convenient, it's anonymous. And you get access to a lot of information. If you really wanted to go to get a journal article you could find it."

They acknowledged that they needed to be critical of the information they receive online.

"Google is just for general knowledge- "what is this"? Not for a final answer, that would be a little bit stupid in my point of view. I also use social media, not just google different forms of engagement."

"Any symptoms into even a good government site could come up with anything."

Likewise, they acknowledged that they needed to be critical of information given to them by health professionals. Some reported that some GPs didn't understand their particular circumstance or gave them the wrong information.

"For some of the questions that I'm asked by a GP are not cognisant of my relationships, so they don't necessarily understand all the issues."

"In the case of my specialists even then I might go through several before I find one that is in a good position that understands my particular kind of problem. So like I'm on my second neurologist and I have been through at least a dozen GPs trying to find someone. With sexual health as well, the amount of doctors who were giving me wrong information, but I didn't know till much later they were giving me the wrong information."

Regardless of the difficulties and barriers that women faced in getting information from GPs, the women in the focus groups still reported that they would rather get information from that source.

Health and wellbeing information that women could not obtain

Eighty seven women who filled in the survey reported that there was health information that they weren't able to obtain. There were three main reasons why women had difficulty finding information: they could not get the right or helpful information from GPs; they needed information on their chronic disease and specific needs but had trouble getting it; or there was no information targeted at them.

Information on specific issues

Women told us that they were missing information on specific issues, including information about their diagnosis and their symptoms.

"I have a chronic condition and often journal articles are behind pay walls. I don't have the money to spend $35 on buying access to an article that may or may not answer my questions."

"There is no source for comprehensive health information for any illness that I can find. Everything seems to be either a short article, or academic papers."

"Yes - auto immune disorders are hard to get helpful information."

"Re breast pain. Haven't found anything online about what it may be, or where to go to get help eg can I just get a mammogram or ultrasound somewhere? What do I even ask for? The discomfort/problem doesn't seem to be like the issues described in online health info."

Targeted information for same sex attracted women

Women told us that they want targeted information about same sex attracted women that reflect their life experiences and is representative of them for a wide range of issues.

"Nothing that is targeted at me – a young lesbian – this is missing"

"Specific info for lesbians - we are invisible"

"Specifically targeting queer women"

"Specific support for lesbians and alcohol'

"Nothing on safe sex for lesbians around generally. Also my partner had trouble dealing with doctors as she had not been penetrated sexually, but had endometriosis. Doctors very unprepared to work around the fact that her hymen was still intact, very insensitive and gave her little to no information about her options. We basically had to research it ourselves online to get the facts."

Some of the women in focus groups talked about the lack of information in sexual education that they experienced.

"There was… a cursory bit of information about it not exactly in depth I learned most of what I know about it just again from doing my own research rather than from the schools and I did go to a public school."

"I think my catholic school assumed that we'd only ever have sex with one man and then that would be it so we'd never have to have STI checks because the man that we would have sex with would be the only man and we'd be the only woman we'd be the only woman that he'd ever have sex with cause that's what good catholic people do and I think it was like we might have gotten told about getting STIs but not like you need to get checked."

Information from GPs

Women talked about not being able to access information from GPs. Some women reported feeling frustrated with their GP's lack of knowledge regarding their conditions, which meant a lack of information being provided to patients.

"In the past 12 months, I have visited a doctor in Canberra and mentioned my past history of anorexia. She then googled anorexia symptoms in front of me, which did not make me feel very confident in her and soon I stopped going back!"

"No one can explain what the heck PCOS even is, no one can figure out anything else that is wrong with me either - doctors don't listen, won't spend time to answer questions, often can't explain things adequately, are very patronising."

"I have to see specialists for general health care as GPs are likely to bias their treatment to blaming my being trans for other health issues."

“Plenty of symptoms that doctors have considered 'outside their area' and thus not their problem, with no recourse for further referral or investigation, let alone diagnosis or treatment.”

Women in the focus group said that often they weren’t able to get information that they trusted.

“A lot of doctors mock you for seeking information online - "Doctor Google". It's really belittling and there are many good sources online which support good health literacy and enable us to understand what's happening better. The same doctors often also don't answer questions or answer them poorly, so you have to go online - my neurologist at TCH said there were "no side effects" for a drug that ended up making me very ill, which I only know about because I checked online.”

“With sexual health as well, the amount of doctors who were giving me wrong information, but I didn’t know till much later they were giving me the wrong information. I could have had a stroke because they were giving me the wrong medication for a long period of time. … now I’m at the point where I always double check with a practitioner or I get friend’s opinions on practitioners if they have worked with them before, particularly often women or AFAB (assigned female at birth) individuals they have a really particular experience with doctors and they are like “don’t go to this doctor, do go to this doctor”. So I think I need that second level of consolidation.”

They also talked about doctors not having time to explain conditions, which meant they get some advice but often missed out on important health information.

“The GP usually only has a 15 minute slot for each person and they see patient after patient all day long. It's hard to go in with an issue you feel is serious to be told each time to just come back if it doesn't rectify itself and take pain medication. Or worse, when you get the generic response... ie you just need to get more exercise and eat more healthy - how is that going to rectify my tumors and hearing? (plus I have a normal BMI and healthy life style).”

Sexual and reproductive health information

Women were asked where they get their sexual and reproductive health information from. Most women sought information from the internet for their sexual and reproductive health needs (n=182, 51%). Twenty per cent told us that they sought it from a GP, and 6% accessed specific services, such as SHFPACT, for information (n=23). Many women mentioned a combination of services and supports.

Women also told us that finding sexual and reproductive health information specific to same sex attracted women is difficult, and 9% said they did not know where to go (n=32).

“It is very difficult to find sexual health information for women who sleep with women (information on safe sex).”

“Little information available regarding sexual health for w/w relationships.”

“I have genital warts since 18 years old. I still don’t know if I can be treated or how.”

Sexual and reproductive health

Access to sexual and reproductive health services

When we asked women if they had accessed a sexual and reproductive health service 143 survey respondents reported that they had (40%). Women reported that it was to gain advice and access regarding fertility, for sexual health such as STI testing and cervical cancer testing, and for female reproductive health issues such as endometriosis.

When asked if they experienced any difficulties or barriers in accessing those services, as shown below in Figure 28, most women did not have barriers to sexual and reproductive services (n=212, 59%). Twenty per cent of women experienced barriers of affordability (n=73), appointment availability (n=57, 16%), and long wait times (n=38,11%) when trying to access sexual and reproductive health services.

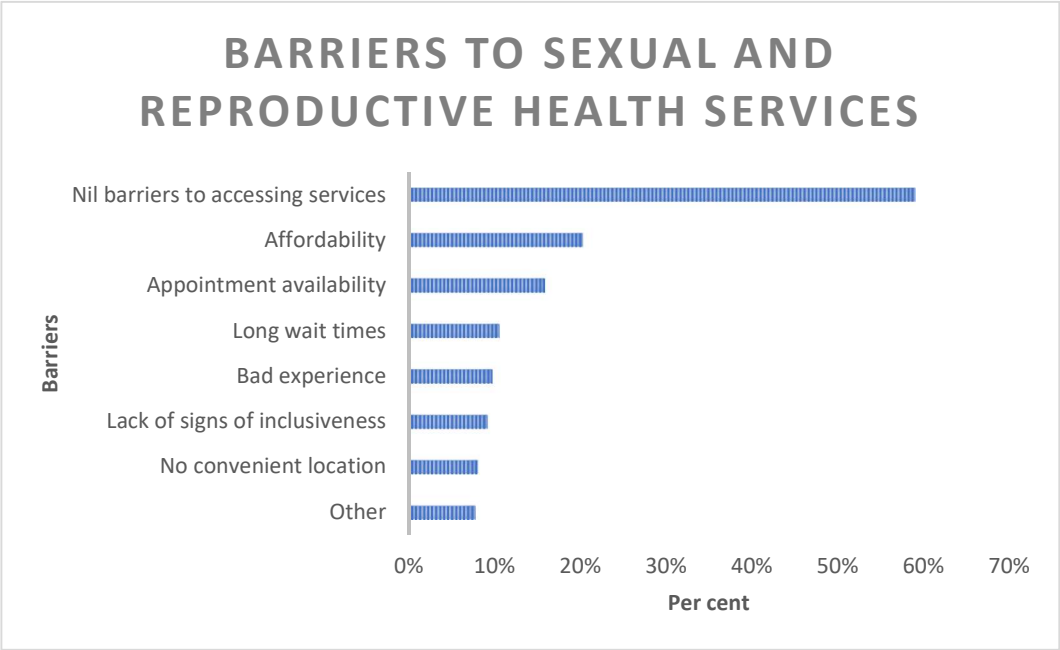

Figure 28 Barriers to accessing sexual and reproductive health services

'Other' barriers that were mentioned included discrimination or harassment due to homophobia (n=11, 3%), discrimination on grounds other than sexuality and gender (n=11, 3%), discrimination or harassment due to transphobia (n=5, 1%), and lack of accessibility for disability (n=1, 0.3%).

Women had the opportunity to provide comments on their access to sexual and reproductive services.

> *"Negative stigma surrounding the requirement for these appointments."*
>
> *"Bad experiences. Fed up with shitty judgemental treatment or attitudes. Painful. Wet the bed because of procedures."*
>
> *"I wanted information about lesbian sexual health issues, and where to buy dental dams when I went to [a sexual health clinic]. They weren't able to help me. The service is geared for heterosexual women. Disappointed."*
>
> *"Uncomfortable situation and many doctors/professionals assume I must be taking birth control and are flustered that I am not. They do not usually ask about orientation first or what kind of partners I have."*

They also talked about the need for LGBTIQ inclusive fertility specialists. Women who were in same sex relationships and were yet to start their family were worried that they would be discriminated against due to their sexual orientation.

> *"My partner and I have some interests in having a family later and access to IVF for us would be full fee basically we have no Medicare support and so it would be considered social infertility rather than clinic infertility and I think that might be the case Australia wide for all same sex partners."*

> *"I don't even know which services in Canberra are dealing with the things I care about. In Melbourne it's really clear as there are rainbow IVF clinics and queer women's specific health services. I find it very tricky accessing generic non queer services it always takes too much emotional energy to asses them first and take the risk they might not be helpful and set me even further back."*

One woman said her bad experience had a detrimental impact on her mental health.

> *"My wife and I have tried IVF four times in the last two years. It is prohibitively expensive, difficult to navigate and entirely centred around the heterosexual experience. The hormones, drug withdrawals, disappointments and pressure made me want to kill myself. It was not a good time for anybody. The clinic was particularly insensitive, unhelpful and unprofessional. I've stopped because a baby just might not be worth being dead. Depressing I know."*

Same sex attracted women who required Assistive Reproductive Technologies (ART) to be able to have children also described having out of pocket for services when health providers refused access to public funding.

> *"Reproductive health services are really expensive for lesbians."*

> *"We are having positive experiences at IVFA (after a negative experience at [another clinic]), but the problem really lies with Medicare and requires significant structural changes."*

> *"When we first went to the fertility clinic we saw [a doctor at a clinic] - we went on a recommendation from friends and our GP. After one year of meeting with her we found her to be judgemental and queerphobic as she continued to misstep - she would mis- gender me, make assumptions about how we wanted to parent and conceive (based on heteronormative ideas), and refused to support us to access Medicare rebates where heteros would have direct unquestioned access. Since changing clinics we've had a totally different experience immediately."*

<u>Sexual relationships and barrier protection</u>

We asked women to tell us about their sexual relationships and their safe sex practices in the last 6 months. Forty eight per cent of women had sex in a monogamous relationship in the last 6 months (n=173), 24% of women had sex in non-monogamous relationships and/or casual sex in the last 6 months (n=87), and 27% reported that they had not had sex in the last 6 months (n=98).

Of the women who had had sex in the last 6 months (in monogamous or non-monogamous / casual relationships) 77% advised that they rarely or never used barrier protection such as condoms or dams. For those in monogamous relationships 89% (n=154) rarely or never used barrier protection, and for those in casual or non monogamous relationships 55% (n=48) rarely or never used barrier protection.

Twenty percent of women who had sex in non-monogamous relationships and/or casual sex were using barrier protection 'always' or 'usually' (n=18), as shown in Figure 29. Some women reported

that it depended on what they were doing - they use condoms when they have penetrative sex with men and when using sex toys.

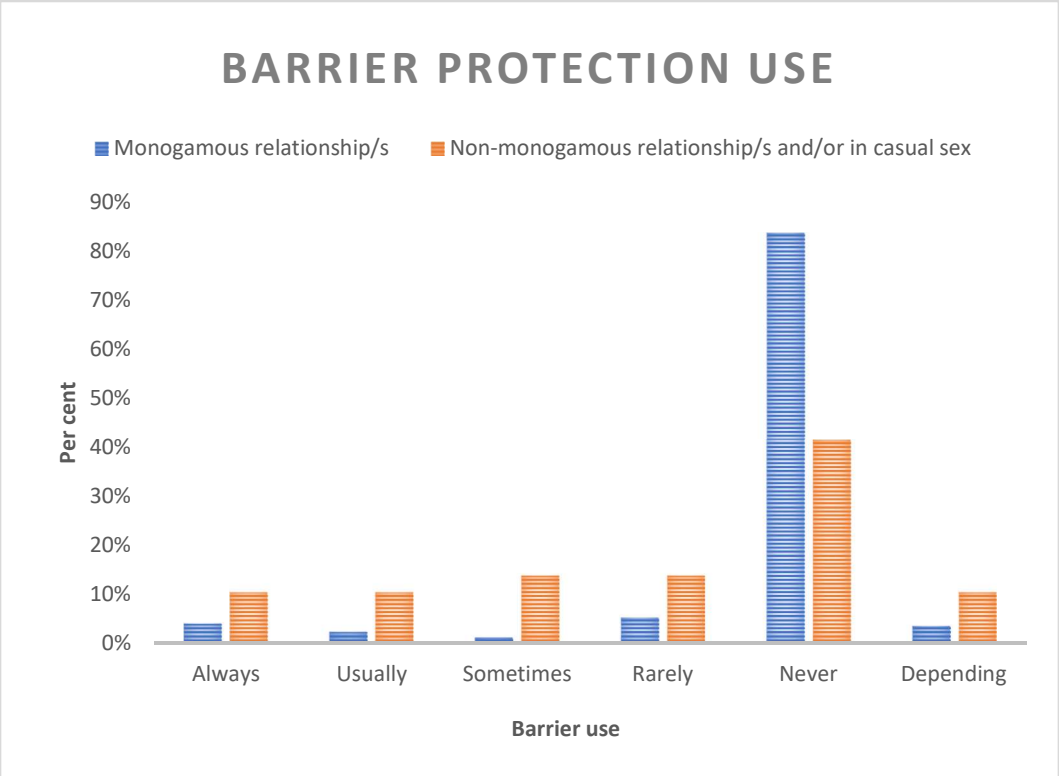

Figure 29 Barrier protection use compared to sexual relationships

Protection against sexually transmitted infections

Women who responded to the survey and women who attended the focus group were asked what strategies they used to lower their risk of contracting an STI.

The most common response from the survey participants was that they didn't protect themselves against STIs (n=74). Likewise, in the focus groups there were some women who reported nil protection.

> *"Like yeah, lesbians do not practise safe sex. Or don't use barrier protection let's say."*

> *"Well, see, I didn't even know that women versus other women could even get STDs."*

> *"I feel like a lot of us know what we shouldn't do. But I get the feeling that a lot of women who have sex with women or female-bodied people tend to be pretty blasé about protection. I try not to be but frankly, I still am."*

One hundred and two women who responded to the survey talked about using being in long term relationships as a protective strategy to prevent STIs. Thirty seven of those women who mentioned being in a monogamous relationship talked about testing for STIs either regularly or before the relationship started.

> *"No strategy other than we went in clean and stayed monogamous. I am my partner's first sexual relationship and I was clean at my last sexual health checkup (like, 2 years ago), barring HPV that had been picked up in a pap smear 3 years ago."*

> *"Both me and my partner went to the sexual health walk in clinic before we had sex in the relationship and don't have sex with other people."*

Thirty eight women mentioned barrier protection when asked what methods they use to protect themselves against STIs (11%). Some of those used a combination such as barrier protection and STI testing (n=5), barrier protection and communication (n=8), and some used a combination of all the methods (n=12).

> *"Barrier protections, spermicidal products, regular STI checks."*

> *"Talking about STIs with prospective partners before sex - maintaining my knowledge of STIs - barrier protection - regular testing."*

Most women in the focus group had not used barrier protection before. They said it wasn't user friendly, many of their lesbian friends had not used barrier protection either, and they did not even know where to find it.

> *"I don't think I could [use one]. I wouldn't even know where to buy one."*

> *"But they're really hard to get. If you go to the condom aisle they're rarely there."*

> *"I also found, just taking it back to dental dams, many of my lesbian friends don't know and have never even heard of them."*

> *"With such innovations can we not come up with something better than a dental dam, please?"*

STI testing

Forty five per cent of women who answered the survey said that they never get tested for STIs, as shown in Figure 30 (n=161). Twenty three per cent reported every few years (n=83), and 21% said that they get STI testing before every new sexual partner (n=75).

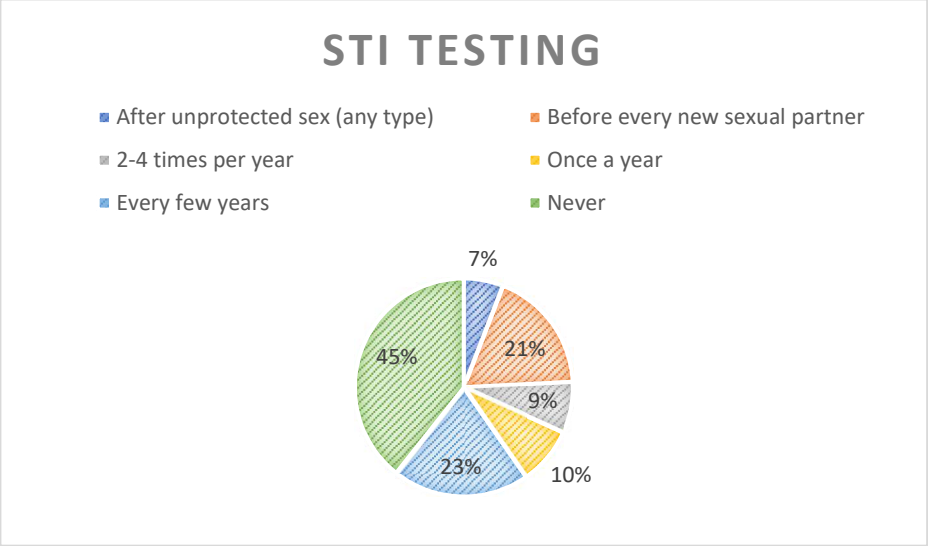

Figure 30 STIs testing rates in respondents

Women were asked to tell us why they didn't get tested regularly. The most frequent response was because they were in a monogamous relationship.

> *"Am in a monogamous (and trusting) relationship."*
>
> *"Low risk being in a long term lesbian relationship."*
>
> *"Have been in a long term (17 years) monogamous relationship."*
>
> *"I know I probably should but I hate going to the doctor and since I've been married for a while now and neither of us have had another partner in years and years it doesn't seem worth the hassle."*

The second most common response was that they don't need to because they never had, or they considered themselves low risk.

> *"Haven't bothered."*
>
> *"Didn't feel like it applied."*
>
> *"Have never had any symptoms, I have never had sex with a man so I consider myself low risk I have always communicated with my sexual partners and implemented protection or safe practices, and neither I nor my partner have never experienced signs or symptoms of an STI."*

Other women had never had sex before or were not sexually active.

> *"Never had sex."*
>
> *"I'm asexual and rarely have sex."*
>
> *"Haven't been sexually active for a few years, and I was tested after my last experience."*

Some women reported that they have been meaning to or that they are too embarrassed about talking to a GP.

Some women in the focus groups were worried that they were going to be judged or rejected for getting an STI test.

> *"I remember when I was younger, this is when I used to live in Sydney so before I had my daughter, I asked could I have an STI check - just to check everything's ok and I got the impression from the doctor that like "why do you need one, you need to be more careful."*

> *"Where I would like to go to is the sexual health clinic ACT, that turn you away [unless you are] like a sex worker on the concession card."*

> *"it's easier to get the skin test or the bowel cancer screening and all that sort of things."*

Focus group women were asked where they would go, or where do they go to get STI tests. Most women reported they would go to their GP, others report wanting to go to SHFPACT, Canberra Sexual Health Service, or an LGBTIQ specific centre.

Health screening

Respondents were asked about health screening: if they know how to do breast exams, and if they regularly access cervical screening, mammograms, or prostate checks.

Breast checks

When asked if they knew how to do a breast self-exam 264 women woman reported that did (74%), 6 listed N/A as their answer.

Of the 88 women who reported that they did not know how to do a breast self-exam (25%), most said that they had never been taught.

> *"I've never been taught, it's not something young women are really taught."*

> *"I have seen instructions but wouldn't be confident to do it."*

> *"Don't know. Never been taught. Never thought to search it up."*

> *"Not really. I know you'd feel lumps but I don't know a proper way of self-examining breasts."*

Eight trans women said that they didn't do breast exams or didn't know that they had to.

> *"Was never taught this as a transgender woman / not sure if necessary"*

> *"Trans and hadn't thought about the need to do that yet."*

Cervical screening

When asked if they accessed regular cervical cancer screening 27 per cent of the women said they did not (n=96), compared to 66% of women who did (n=238). Seven per cent of the women chose 'not applicable'.

Responses about why they didn't have cervical cancer screening regularly included that they didn't think that they needed to do it, they were too young, or that they didn't want to because of worry about the procedure or embarrassment.

"Cervical screening - don't know if you need to if not having penetrative sex with men."

"I am a lesbian, not a risk factor for cervical cancers and warts."

"Have not made it a priority as still under the required age."

"I'm terrified of pap smears and doctors can't tell me if I've been sexually active or not (full penetration was never achieved and there's no agreement if this "counts")."

Most women in the focus groups had cervical cancer screening regularly. They felt it was an uncomfortable but necessary part of reducing risk of cervical cancer.

"We have had all the Pap smears and the mammograms and all the breast checks and all those tests and that as well. Yes, it's uncomfortable having to do all that but it's momentary and it's for a good cause. I'd rather be healthy than have a scare, to be honest, have something go wrong down there. That would always be embarrassing have something going on there that could have been avoidable."

Some women from the focus group found that the cost and discomfort of having a cervical cancer screening was prohibitive.

"Why would I want to get my cervix screened and a speculum in me and pay money for that?"

Others reported that they did not need to get screened, they felt they weren't of eligible age yet (25 years old), they no longer had a cervix, or they and their current partner had never had sex with anyone else.

Focus group women were asked where they would prefer to go for cervical cancer screening. Most reported they would prefer their GP. Others reported wanting to see a women's health service, or sexual and reproductive health service.

Mammograms

Twenty five per cent of women reported having regular mammograms (n=91), compared to 65% of women who didn't. Sixty five of the women who do get regular mammograms are over 45 years of age (66%) as shown in in Figure 31.

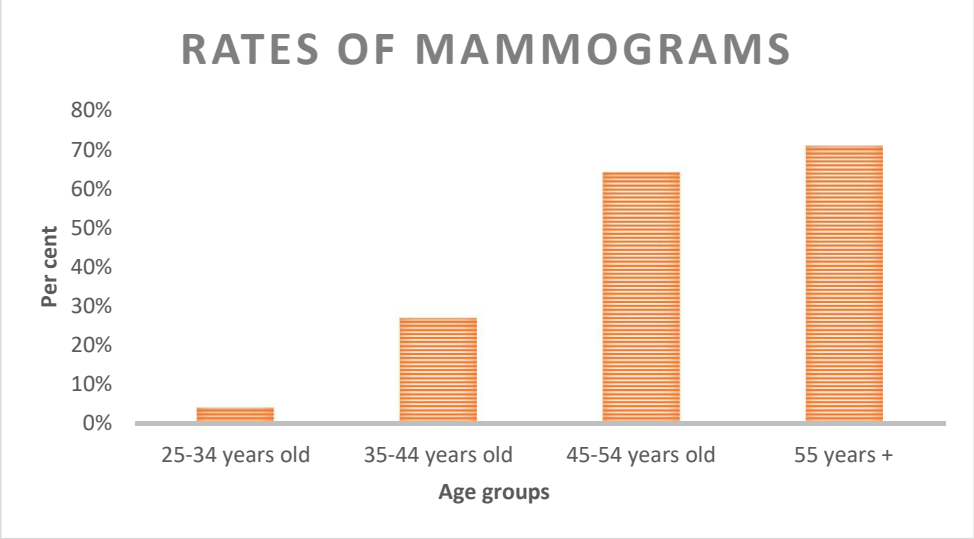

Figure 31 Mammogram rates by age group

Most women who weren't doing mammograms reported that they weren't old enough to.

> *"Have not been offered to me yet. I assume because I am under 50."*
>
> *"They don't do mammograms for young people I don't think."*
>
> *"I will have a mammogram when they also test testicles by squashing them. I have breast ultrasounds."*

Three per cent of the women reported that they get regular prostate tests (n=11).

Tobacco, alcohol and drug use

Women were asked about their tobacco, alcohol and drug use.

Sixty two per cent (n=221) of women had never smoked cigarettes or other tobacco, 14% of women smoked socially (n=51), and 8% smoked daily (n=30). Fifteen per cent of women were ex-smokers (n=57).

As shown in Figure 32, age was a factor in tobacco use. Younger age groups, 16-24 (n=17, 22%) and 25-34 years old (n=24, 20%) were more likely to be social smokers than the other groups. The 55 years and older group of women had more ex-smokers than the other four age groups (n=12, 39%).

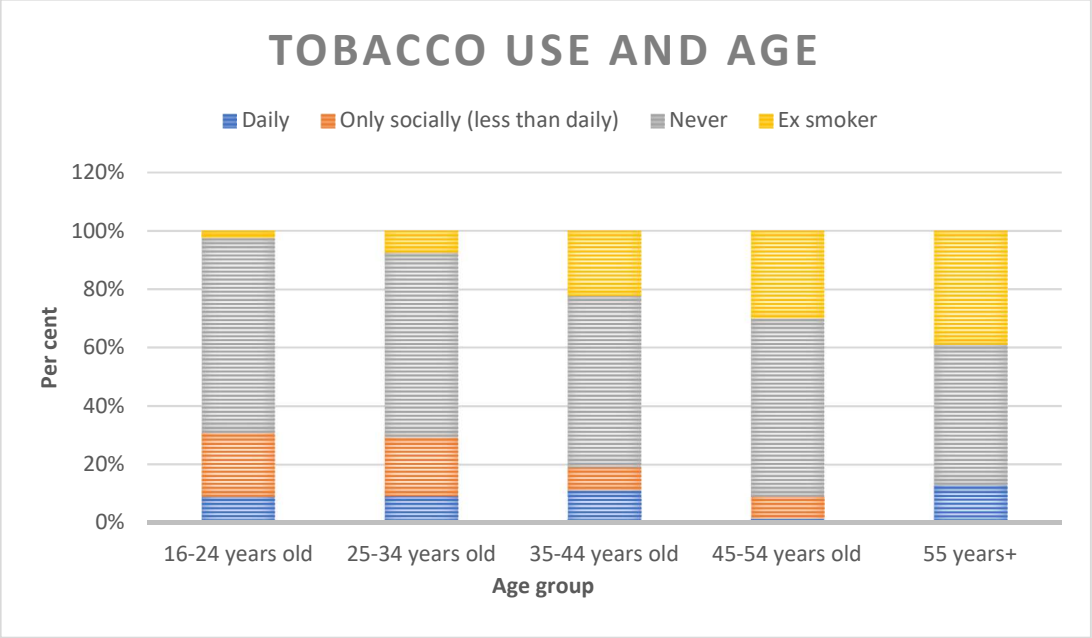

Figure 32 Tobacco use by age group

There were differences in tobacco use between sexual identities. Thirty four per cent of bisexual women (n=31) who accessed the survey were smokers (daily or socially), compared to 15% of lesbian women (n=23).

Fifty three per cent of women who reported that they smoke daily or socially had tried to quit (n=43), 33% reported that they hadn't tried to quit (n=27), and 14% reported that they don't want to quit (n=11).

Most women who responded to the survey question advised that they don't or very rarely drink alcohol (37%, n=132), or only had 1-2 standard drinks per week (23%, n=84). Fifteen per cent of women (n=55) advised that they had more than ten standard drinks per week.

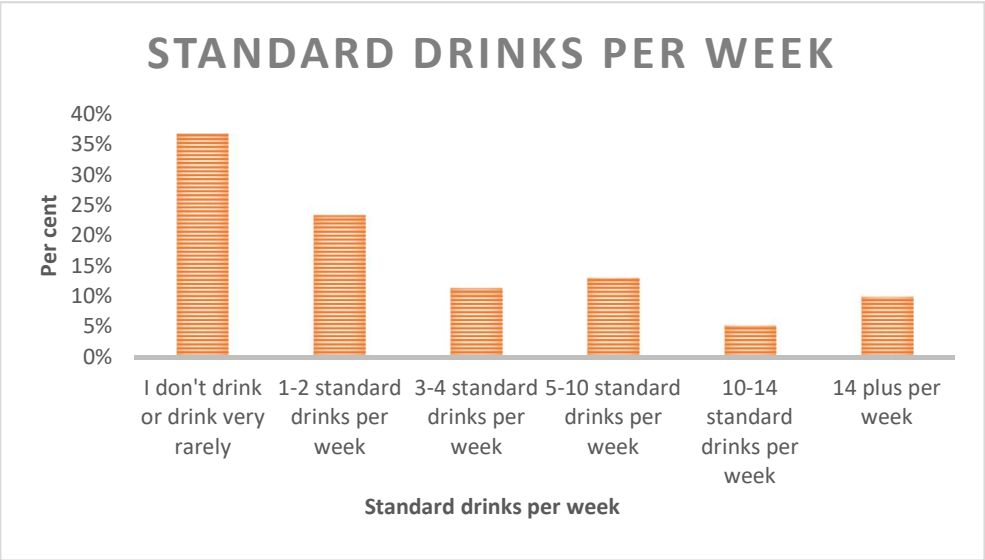

Figure 33 Drinking rates of women who answered the survey

When asked how often they had four drinks or more in one occasion, most women said that they never or rarely have four drinks or more in one occasion, 23% of women had four or more drinks in one occasion every couple of weeks. Six per cent (n=22) of women had four or more drinks more than four times per week, as shown in Figure 34. Of those, 16 women were 35-54 years old.

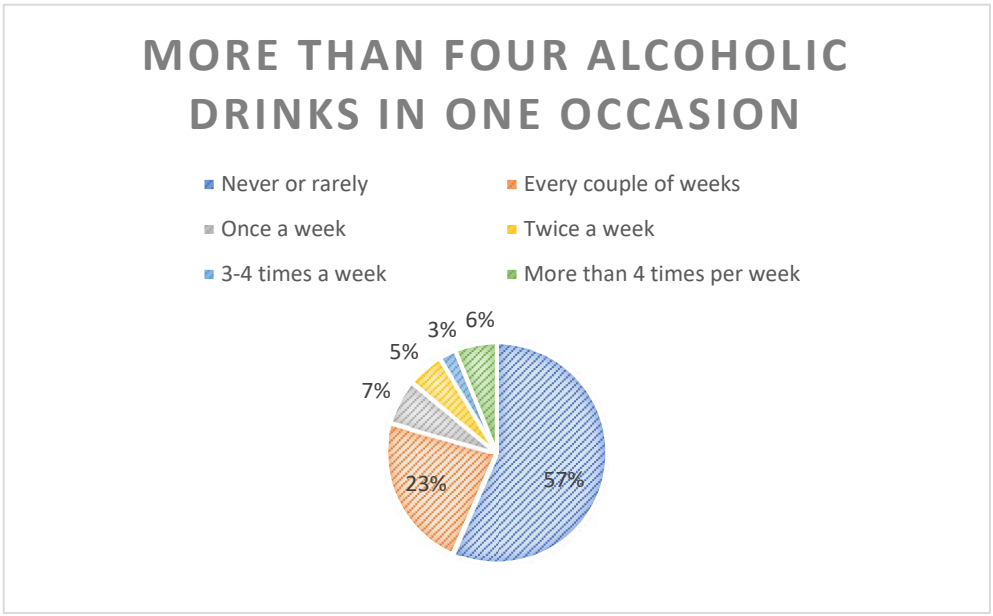

Figure 34 Frequency of more than four standard drinks in one occasion

As shown in Table 7, more women aged 35-54 years old (n=24) reported that they had accessed alcohol, tobacco, and drug services than other age groups of whom 18 were lesbian women.

Age group	Accessed alcohol, drug and tobacco services	Drinks more than 10 std drinks per week	Drinks 4 std drinks more than 4 time per week
16-24 years old	5	7	0
25-34 years old	5	9	2
35-44 years old	11	14	7
45-54 years old	13	18	9
55 years +	4	7	4

Table 7 Differences in alcohol consumption between age groups

Twenty eight women had listed alcohol as one of their top three health issues, and 25 of those had accessed alcohol, tobacco, and drug services in the last 12 months. Eighteen of those 25 women had also listed mental health as one of their top three health issues.

All fifteen women who reported drugs as one of their top three health issues also listed alcohol, and of those 12 had also listed mental health as one of their top three health issues.

One hundred and fourteen women reported that they used non prescription or illicit drugs in the last 6 months (39%).

Information about drug use was collected in the survey through a separate question asking which, from a list of drugs, they had used in the past 6 months, and in which settings.

Sixty nine per cent of the women who responded (n=247) said they had not used drugs in the last 6 months, and 11% of them (n=40) advised they had used drugs more than 6 times in the last 6 months.

Women were able to identify more than one drug, and identified the following as the most used drugs. Marijuana (n=79, 69%), cocaine (n=52, 46%), and MDMA (ecstasy) (n=45, 39%) were used most in the last 6 months, followed by amyl (poppers) (n=20, 18%) and speed (n=19, 17%).

Women who had used drugs in the last 6 months reported having used them most often in a party venue setting (56%, n=57), followed by at home (43%, n=44), and (12%, n=12) while having sex. Women were able to identify more than one setting.

Violence

When asked if they had ever experienced violence (with a choice of domestic, family or sexual violence), 213 women had experienced some form of violence (59%), 38% of the women said that they had never experienced violence (n=137), and 9 preferred not to say (3%).

Of the women who said they had experienced violence, 123 women said that they had experienced domestic violence (58%) and 131 women said that they had experienced sexual violence (62%). One hundred and three women reported that they had experienced family violence (48%). Forty six women reported they had experienced all three forms of violence (22%).

Seventy five per cent of the women who had experienced violence said that mental health was one of their top three health issues (n=160).

Of the women who said they had experienced violence 34% of bisexual (bisexual including pansexual) women (n=73) reported they had experienced some form of violence, and 39% of lesbian women (n=84).

Of the women who said they had experienced sexual violence, 38% were bisexual (including pansexual) women (n=50) and 36% of lesbian women (n=47).

Seven of the 19 trans women survey respondents reported that they had been the victim of family violence.

Women who identified that they experienced violence usually experienced it from a partner or ex-partner (n=129, 61%), from a family member (n=125, 59%), or from someone they knew (n=83, 39%), while 27% of women experienced violence from a stranger (n=57). Women were able to identify more than one option.

When asked if they had experienced anti-LGBTIQ behaviour in the last 12 months, 129 women had experienced no anti-LGBTIQ behaviour, whereas 197 reported that they had (55%). Women experienced verbal abuse or harassment and unwanted disclosure more often than other forms of anti-LGBTIQ behaviour, as shown in Figure 35. Twelve out of the 19 trans women reported experiencing verbal abuse or harassment, and 12 out of 19 experienced unwanted disclosure of their gender or sexuality.

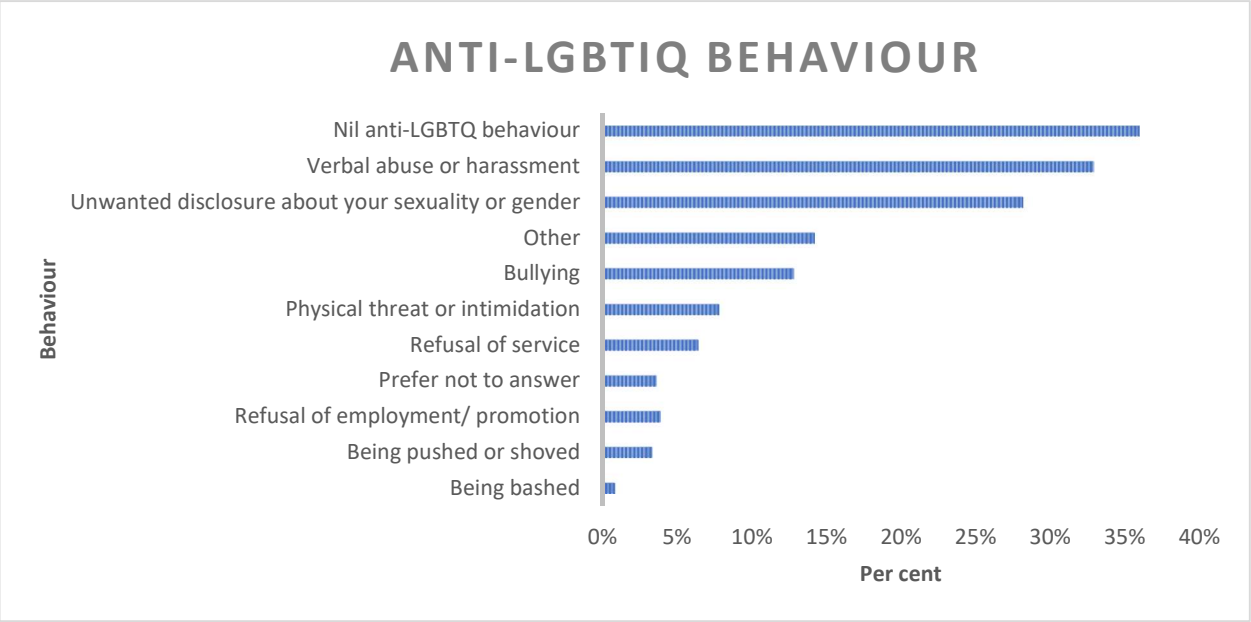

Figure 35 Anti-LGBTIQ behaviour experienced by respondents

Women spoke of experiencing anti-LGBTIQ behaviour during the marriage equality debate in 2017.

> *"The main anti-LGBTQ that I have experienced has been through the media, some public opinion and politics as part of the lead up to the postal vote on same sex marriage."*

> *"All around the marriage equality debate almost 12 months ago! Social media, TV- we couldn't avoid. It was horrible. Comments and opinions from strangers about my life and whether I could marry or not. Very sad and depressing. I unfriended a family member because of it."*

> *"I do have mental health problems, it's chemically there. But, also, me and a lot of other people have problems because of things that happen in their lives. We talk about queer issues in terms of trauma. And the plebiscite was a nice one for me."*

Discussion

Women in the ACT have different life experiences, health needs, and caring responsibilities, and these differences impact on the way that women interact with and experience health services and supports.

The recently released National Women's Health Policy 2020- 2030 recognised that women with diverse sexualities, intersex women and transgender women need to be included *'not only because they experience a persistently high health burden, but because the prejudice and discrimination often faced can have a profound effect on all aspects of health and wellbeing*'.[265]

As a result, health services and responses must appropriately cater for them.

LGBQ women have significant barriers to maintaining health and accessing health services in the ACT. Women understood what good health is, but 39% did not rate their health as good. In particular, they described having difficulties accessing good health information that is specific to their health needs as LGBQ women.

Mental health was their top health issue, which the literature shows to be linked to heterosexism, violence, discrimination, and stigma about their identity as an LGBQ women, especially in women who are attracted to more than one gender. Some women's use of alcohol, drugs, and tobacco may well contribute to poor health outcomes. Their preventative health screening was hindered by embarrassment when using health services, perceived or actual discrimination by the health providers, and limitations in both the women's and health providers' understanding of LGBQ women's health needs.

Like many women in the ACT, affordability, appointment availability, their experience with their health care providers, and time were significant barriers to addressing health needs. Unlike other women, LGBQ women may experience access issues such as heterosexism and non-inclusivity which make their experience unpleasant and stigmatising. Most women in the current study had experienced domestic, family, or sexual violence, and discriminatory or homophobic behaviour. This had effects on their individual health and the health of the LGBTIQ community.

There are some sections of the discussion that are particularly noteworthy. LGBQ women in the current study screened for STIs less than the general ACT women's population as many felt that it wasn't necessary to do so.

A significant number of LGBQ women reported that one of their top three health issues were mental health issues. Mental health issues were more concerning for bisexual and younger LGBQ women than other women in the current study. The women who were smokers were more likely to report mental health as one of their top three health issues, and ACT data shows that smoking rates for LGBQ women are double that of the total ACT women.

LGBQ women between the ages of 35 to 54 reported higher alcohol consumption weekly and per day compared with other age groups. Significant numbers of LGBQ women in the current study reported that they had experienced sexual, family, or partner violence. Women who had experienced violence were more likely to report mental health in their top three health issues.

And 55% of respondents had experienced anti-LGBTIQ behaviour in the last 12 months.

Many of the women were healthy and well and could access good services and supports to help them improve and maintain their health. LGBQ women actively sought health information to improve their health circumstances and help them be well informed. But accessing health information was challenging because information was often from a heteronormative perspective and stigmatising.

[265] Department of Health, *National Women's Health Strategy 2020-2030,* Canberra, 2018, Retrieved on 9th July 2019. https://www.health.gov.au/internet/main/publishing.nsf/Content/national-womens-health-strategy-2020-2030

Cervical and breast screening were on par with the general population of women in the ACT. Mental health and wellbeing increased as LGBQ women aged, and women spoke of relying on friends and the community when needing support for mental health. They also used multiple supports such as mental health services and community organisations like AIDS Action Council, who have affordable counselling services.

Women's views on their health

LGBQ women in this study appreciated that health is holistic and encompasses whole of body and mind, with a focus on balance.

> *"Includes health and physical, mental, sexual and spiritual."*

> *"Overall physical, mental, emotional and social wellbeing."*

This broad explanation of what health means to the women in the current study is similar to the women in WCHM's research report, the 2018 ACT women's health study[266] and the WHO definition *"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."*[267]

Just over a third of women (39%) rated their physical health as fair, poor or very poor, which is similar to the 2018 ACT women's health study (42%).[268] Some studies show that bisexual women rate their health poorer than lesbian women,[269] and this was certainly the case in the current study.

While the literature says that the poor self rated health of some bisexual women is associated with violence and threats of violence more than their sexuality, in the current study, there was not enough evidence to determine if there were significant differences between self-rated health, the sexual identity groups and their experiences of violence.

There were significant differences in the self-rated mental health of LGBQ women in our study when compared to the 2018 ACT women's health study. In our study, 60% of women rated their mental health fair, poor and very poor, compared to 40% of women in the 2018 ACT women's health study who rated their mental health the same way.[270]

In the current study self-rated mental health improved with age, with only 31% of 16-24 years old rating their mental health as good or excellent compared to 68% of women age 55 years and above. Likewise, Veldhuis et al found that LGBQ women above the age of 55 years reported better self-rated mental health.[271]

Literature shows that more bisexual women have been found to rate their mental health as poor and fair than lesbian.[272] This was consistent with the findings in this study.

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[266] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[267] World Health Organisation, *From Alma Ata to the year 2000, Reflections at the midpoint*, WHO, Geneva, 1988.
[268] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[269] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[270] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
271 C B Veldhuis et al, 'Alcohol use, age, and self-rated mental and physical health in a community sample of lesbian and bisexual women', *LGBT Health*, vol. 4, no. 6, 2017, pp. 419-426.

Accessing health information

Accessing health information is very important for women to understand and manage their health.[273] However, accessing health information for LGBQ women is challenging because information is often from a heteronormative perspective and can be stigmatising.[274]

> *"Figuring out what "safe sex" was with another woman when I was younger was super hard - not a lot of information and lots of contradictions."*

The first choice for women in the current study for accessing health information was online rather than from a GP, when seeking information for general health as well as for a specific health condition. This finding is different to the 2018 ACT women's health study, where women preferred to seek information from their GP for specific health conditions.[275]

There was some variation in general health information sources in different age groups. Women in the current study who were older than 55 years tended to seek information from their GP, whereas all age groups younger than 55 years of age sought information online for general health. This is the same finding as for the 2018 ACT women's health study.[276]

Women in the current study talked about the online sources that they considered to be useful or reputable:

> *"If you know which sites to go to, and they're a reputable source like the Mayo Clinic, for example, amazing source of information. You're automatically skipping that barrier of personal prejudice."*

> *"I have endometriosis… so a lot of my information I actually get from Facebook groups because it is something that often doctors are really shit about."*

Those that participated in the focus groups reiterated how important it was to be well informed when seeing a health professional. Researching or talking to others online assisted their diagnosis and treatment. Likewise, the 2018 Jean Hailes survey found that women accessed information online before attending a health professional.[277] A very small group of women in the current study talked about how the internet preserved their anonymity and there was no judgment when searching for information. Accessing information from health professionals opened them up to stigma and discrimination. Hillier et al also found this to be the case.[278]

Some women in our study accessed health information from an online community. Other studies show that young same sex attracted people access peer support online, especially when coming out.[279]

Many women in the current study were not able to access information from GPs, explaining they were frustrated with the lack of information provided. Even so, women in the focus groups said that they preferred to get information from a GP. Trusting a GP is very important when accessing health information.[280] Receiving correct information was found to be important, particularly when it came to specific conditions or information more suitable to LGBQ women.

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[273] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[274] G Alencar Albuquerque et al, Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review', *BMC International Health and Human Rights*, vol. 16, no. 2, 2016, pp 1-10.
[275] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[276] Ibid
[277] Jean Hailes for Women's Health, *Women's Health Survey 2018: Understanding health information needs and health behaviour of women in Australia*, Melbourne, 2018.
[278] Hillier et al, *Writing themselves in 3, The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*, LaTrobe and Australian Research Centre In Sex, Health & Society, Melbourne, 2010.
[279] L Baams et al, 'Internet use and online social support among same sex attracted individuals of different ages', *Computers in Human Behavior,* vol. 27, 2011, pp 1820-1827.
[280] Jean Hailes for Women's Health, *Women's Health Survey 2017: Understanding health information needs and health behaviour of women in Australia*, Melbourne, 2017.

"When you're not quite sure what's actually happening to your body or mind - and not wanting to self-diagnose, but just not being sure so can't find specific info."

Sexual health is an important part of a women's health. Studies show that sexual health information that is reliable and comprehensive is not always easily available and accessible.[281] [282] [283] Women in the current study said information relevant to their sexual experiences was difficult to find.

Top health issues

Women in this study reported that their top health issues were mental health (66%); weight, diet, and fitness (30%); and chronic conditions (30%). Women in the 2018 ACT women's health study listed the same three top health issues similarly, but chronic conditions were the top issue above mental health and weight, diet, and fitness.[284]

Sixty six per cent of women in our study told us that their top health issue was mental health. Research shows that LGBQ women have higher levels of anxiety, depression, and self-harm in comparison to the general population of women.[285] [286] [287]

Fifty two per cent of women from the 2018 ACT women's health study reported that mental health was one of their top health issues.[288] Similarities also exist between the 2018 ACT women's health study and the current study when looking at age and concerns about mental health. Although mental health as an issue was higher in the younger age groups in both the 2018 ACT women's health study and the current study compared to older age groups, the percentages were higher in the current study than the 2018 ACT women's health study. Large studies found that psychological stress appeared to reduce as age increased.[289] [290]

In the current study, 'stress' was mentioned by all age groups, whereas in the 2018 ACT women's health study 'stress' wasn't mentioned by any of the 16-24 year old group.[291] 'Anxiety' was mentioned by 16-24 and 25-34 year old groups more than any other age groups in the current study, whereas in the 2018 ACT women's health study 16-24 year olds talked about depression more.

[281] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health*, vol. 6, 2009, pp. 15-18.
[282] J Tran, Improving choices and options: The views of ACT women about their sexual and reproductive health needs, Women's Centre for Health Matters, Canberra, 2018.
[283] L L Lindley, D B Friedman & C Struble, 'Becoming visible: Assessing the availability of online sexual health information for lesbians', *Health Promotion Practice*, vol. 13, no. 4, 2012, pp. 472-480.
[284] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[285] M Pitts et al, *Private lives, A report on the health and wellbeing of GLBTI Australians*, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2006.
[286] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[287] J Mooney-Somers et al, Women in contact with the Sydney LGBTQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018, The University of Sydney, ACON, Sydney, 2018.
[288] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[289] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[290] W Leonard, A Lyons & E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[291] Ibid

As with other studies,[292] [293] [294] the current study found that bisexual women rated mental health as one of their top three health issues more often than lesbian women. In fact, all other sexualities reported more concern with mental health issues than lesbian women did.

Even though the cohort of trans women we surveyed was small, it is noteworthy that 17 of the 19 trans women listed mental health in their top three health issues. Studies show that trans women have poorer mental health than other populations of women.[295] [296] They have higher levels of depression, anxiety, post-traumatic stress disorder, body dysmorphia, autism spectrum disorder, self-harm, suicidal ideation, and gender dysphoria.[297]

Thirty per cent of women in the current study listed 'weight, diet and fitness' as one of their top three health concerns. This finding is far lower than the 2018 ACT women's health study in which 49% identified this issue.[298] Respondents in the 35-44 and 45-54 age groups in the current study reported 'weight' and 'overweight' more than other age groups, which was similar to the 2018 ACT women's health study.[299]

Mental health concerns can play a role in how difficult it is to change certain lifestyle behaviours, such as reducing weight and doing physical activity.[300]

> *"My weight is related to my anxiety so cannot be resolved without help with the anxiety."*

> *"I am too tired, poor and sick to manage my diet and weight as well as I would like to. I simply don't have the means to manage it with all my other health issues."*

Women in the current study mentioned physical activity, and nutrition or healthy eating, within the theme "weight, diet, and fitness".

Thirty per cent of women in the current study mentioned chronic disease as one of their top three health issues. This is consistent with the 2018 ACT women's health study,[301] and the 2018 report on women aged 18 to 50 years in the ACT with chronic conditions.[302] The most mentioned chronic conditions were endocrine conditions such as PCOS, diabetes, and endometriosis.

Women in the focus groups discussed the impacts on their chronic disease of stigma and discrimination on the basis of sexual identity, and feeling that they are not understood by health professionals.

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[292] B Loi, T Lea & J Howard, 'Substance use, mental health, and service access among bisexual adults in Australia,' *Journal of Bisexuality*, vol. 17, no. 4, 2017, pp. 400–17.
[293] W Leonard, A Lyons, E Bariola, *A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[294] B Loi, T Lea & J Howard, 'Substance use, mental health, and service access among bisexual adults in Australia,' *Journal of Bisexuality*, vol. 17, no. 4, 2017, pp. 400–17.
[295] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[296] W Leonard et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, *Monograph Series Number 86*, The Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne, 2012.
[297] P Strauss et al, *Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results*, Telethon Kids Institute, 2017, Perth, Australia.
[298] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[299] Ibid
[300] S J Roberts, E M Stuart-Shor & R A Oppenheimer, 'Lesbians' attitudes and beliefs regarding overweight and weight reduction', *Journal of Clinical Nursing*, vol. 19, no. 13-14, pp. 1986-1894.
[301] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[302] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, Women's Centre for Health Matters, Canberra, 2018.

Drugs, alcohol and tobacco use

Fifteen per cent of women listed alcohol, smoking, and drugs as one of their top three health concerns. More women in the age groups 35-44 and 44-54 years reported this as one of their top three health issues than other age groups.

Twenty two per cent of LGBQ women in the current study smoked cigarettes. This is double the percentage of smokers in the general population of women in the ACT,[303] and is comparable to the newest SWASH report where 22% of women said they were smokers.[304]

In our study, 31% of those who were 16-24 years old reported that they were smoking but tended to be socially smoking rather than daily smokers. The percentage of women aged 16-24 years in the SWASH study who smoked had reduced from previous years (42% in 2016 to 24% in 2018).

Thirty seven per cent of women in the current survey never drank or rarely, which matches the SWASH study.[305] Forty four per cent of women in the current study were drinking four drinks or more per occasion, which is far higher than the result of 29% for general women in the ACT drinking four or more drinks in a single occasion.[306]

The age groups drinking the most were 35 to 54 years olds, with 25% reporting drinking more than 10 standard drinks per week, and 12% drinking four standard drinks or more four times a week. In comparison the 16-24 year olds in our study weren't drinking as much per occasion, which is a contrast to 63% of the 16-24 year olds in the SWASH study who reported drinking more per occasion than the NHMRC guidelines.[307]

Thirty nine per cent of women in the current study told us that they had taken drugs in the last 6 months. In comparison, 45% of women in the SWASH study had taken drugs in the last 6 months.[308] In the current study, the most used drugs were marijuana, cocaine, and ecstasy which is similar to the SWASH study.[309]

Health screening and STI prevention

There are perceptions from both health professionals and LGBQ women that LGBQ women don't need certain health screening. [310] Despite LGBQ women having higher risks for some cancers, such as cervical, and breast cancer , due to behavioural factors, barriers to accessing health services, lower screening rates, and perceptions around screening.[311]

Sixty six percent of women in our study advised that they participated in cervical cancer screening, which is lower than the screening rates from WCHM sexual health survey (73%), but higher than the ACT average of just under 60%.[312] One woman in the study explained the importance of cervical screening.

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[303] Australian Bureau of Statistics, *National Health Survey: First Results, 2017-2018*, Canberra, 2018, retrieved on the 23rd of April 2019; http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001?OpenDocument

[304] J Mooney-Somers et al, *Women in contact with the Sydney LGBTQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018,* The University of Sydney, ACON, Sydney, 2018.

[305] J Mooney-Somers et al, *Women in contact with the Sydney LGBTQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.

[306] Australian Bureau of Statistics, *National Health Survey: First Results, 2017-2018*, Canberra, 2018, retrieved on the 23rd of April 2019; http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001?OpenDocument

[307] J Mooney-Somers et al, *Women in contact with the Sydney LGBTQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018,* The University of Sydney, ACON, Sydney, 2018.

[308] J Mooney-Somers et al, *Women in contact with the Sydney LGBTQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018*, The University of Sydney, ACON, Sydney, 2018.

[309] Ibid

[310] Pap Screen Victoria and The Cancer Council Victoria, *Lesbians need pap tests too*, Victoria, 2006, retrieved on the 10th of January 2019: http://www.papscreen.org.au/downloads/resources/brochures/Lesbians_need_Pap_tests_too.pdf

[311] ACON, *Turning point. ACON lesbian health strategy, 2008-2011,* Sydney, 2008, retrieved on the 13th of September, 2018: https://issuu.com/aconhealth/docs/lesbian-health-strategy-a5-web

[312] Australian Institute of Health and Welfare, *Participation in the National Cervical Screening Program, by age, state and territory, Jan 2016–Jun 2017*, Canberra, 2019, retrieved on the 15th of May 2019; https://www.aihw.gov.au/reports/cancer-screening/national-cancer-screening-programs-participation/data

"you get it [cervical screening] so you don't get cervical cancer, that's what it is."

Twenty seven per cent of women in the current study did not participate in regular cervical screening despite the lack of cervical cancer screening being one of the main risk factors in poorer outcomes due to late diagnosis.[313] Women said that they did not realise that they needed to, they thought they weren't at risk, or that they were too young.

"I am a lesbian, not a risk factor for cervical cancers and warts."

"I'm terrified of pap smears and doctors can't tell me if I've been sexually active or not (full penetration was never achieved and there's no agreement if this "counts")."

Research supports the view that women who have not had sex with a cis man may not think they need cervical screening.[314] Other women did not want to because of worry about the invasiveness of the procedure or the embarrassment. The literature shows that LGBQ women who don't participate in cervical screening are more likely to report discrimination and have less knowledge of screening guidelines than women who screen regularly.[315] The barriers they are likely to face are fear of pain of penetration, worry about stigma, heteronormative presumption and discrimination when accessing health professionals, and a lack of perceived need.[316] Cost was an additional barrier mentioned by some women in the focus groups, sometimes in combination with barriers such as discomfort:

"I didn't come from a [place] where you have to pay for it and that makes it really inaccessible. Why would I want to get my cervix screened and a speculum in me and pay money for that?"

Forty five per cent of women in the current study reported that they never get tested for STIs, whereas 24% ACT women reported the same in the 2018 sexual and reproductive health study.[317] The most common reasons for not getting tested were monogamy, or that they did not believe that they needed to be tested. Research has shown that women who are same sex attracted believe the risk of transmission is minimal between women.[318] Even so, thrush and bacterial vaginosis can be contracted back and forth between LGBQ women couples. This common misconception may be due to the belief that they haven't been in sexual contact with a cis man. However, rates of LGBQ women having sex with a cis man sometime in their life are as high as 70% in some studies.[319] [320] [321]

Some women in our focus groups reported they felt judged, embarrassed, worried, or had a fear of being rejected. Other studies show that LGBQ women often feel worried about stigma and discrimination when accessing health services for STI testing.[322]

[313] H Henderson, 'Why lesbians should be encouraged to have regular cervical screening', *Journal of Family Planning Reproductive Health Care, vol. 35,* 2009, pp. 49–52.
[314] C Douglas, R Deacon and J Mooney-Somers, 'Pap smear rates among Australian community-attached lesbian and bisexual women: some good news but disparities persist', *Sexual Health*, 2015, vol. 12, pp. 249-256.
[315] J Tracy, A Lydecker & L Ireland, 'Barriers to cervical cancer screening among lesbians', *Journal of Women's Health,* vol. 19, 2010, pp. 229–37.
[316] C Curmi, K Peters & Y Salamonson, 'Barriers to cervical cancer screening experienced by lesbian women: a qualitative study', *Journal of Clinical Nursing*, vol. 25, 2015, pp. 3643-3651.
[317] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.
[318] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[319] J Mooney-Somers et al, *Women in contact with the Sydney gay and lesbian community: Report of the Sydney women and sexual health (SWASH) survey*, The University of Sydney, ACON, Sydney, 2017.
[320] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[321] D Drew et al*, Exploring the health and wellbeing of lesbian, bisexual, queer and same sex attracted women living in the Illawarra and Shoal haven regions*, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.

Health professionals lack knowledge about LGBQ women's sexual health needs and sexual behaviour. [323] [324] This can lead to the mistaken belief that women aren't sexually active.[325] The false paradigm that 'lesbian sex is not 'real sex'' has been a barrier for LGBQ women accessing health care, as sex between two women can be seen to be safe and low risk.[326] [327] [328] Women in the current study talked about this misconception in their reasons for not accessing STI testing:

> *"Was told lesbians don't need, never had sex before current relationship and we are both monogamous for 4+ yrs"*

Only 11% of women in the current study used barrier protection to reduce the risk of contracting an STI. This figure is comparable to other studies.[329] [330] Twenty per cent of women in non-monogamous relationship/s and/or casual sex relationships were 'always' or 'usually' using barrier protection, which is higher than the proportion of women who are monogamous and used protection (6%). Women in the current study who had tried to use barrier protection found that it wasn't accessible or user friendly (particularly dental dams), and wasn't often used by LGBQ women:

> *"I would not want latex on my tongue, thanks."*
>
> *"I don't think any of (my friends) use that (dental dams)."*
>
> *"We found it difficult to access dental dams commercially... It wasn't stocked anywhere in the ACT and I called everywhere. They wouldn't even order it in."*
>
> *"With such innovations, can we not come up with something better than a dental dam, please?"*

LGBQ women in the current study talked about ways other than barrier protection that they use to protect themselves against STIs. This is consistent with other studies that found LGBQ women weighed up potential risk of their sexual behaviour and used communication and other methods to lower risk, including good hygiene practices for hands, using condoms when sharing sex toys, and checking for visible signs of infection.[331] [332]

Self-examinations and breast screening are important to detect breast cancer.[333]

Most women in the current study told us they knew how to do a breast self-examination (74%), which is similar to LGBQ women in the Shoalhaven region (72%)[334] And the 83% from the WCHM sexual and reproductive health report[335] who knew how to do breast self examinations.

Sixty six per cent of women aged 45 years or older from our study reported they had mammograms, which is similar to the findings from the WCHM sexual and reproductive health

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[323] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.
[324] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[325] Ibid
[326] C Logie, '(Where) do queer women belong? Theorizing intersectional and compulsory heterosexism in HIV research,' *Critical Public Health, vol.* 25, no. 5, 2014, pp. 527–538.
[327] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health,* vol. 6, 2009, pp. 15-18.
[328] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
[329] J Richters et al, 'Do women use dental dams? Safe sex practices of lesbians and other women who have sex with women,' *Sexual Health,* vol. 7, 2010, pp. 165-169.
[330] L Yap et al, 'Sexual practices and dental dam use among women prisoners- a mixed methods study', *Sexual Health*, vol. 7, 2010, pp. 170-176.
[331] P Cox & R McNair, 'Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women', *Sexual Health*, vol. 6, 2009, pp. 15-18.
[332] J Richters & S Clayton, 'The practical and symbolic purpose of dental dams in lesbian safer sex promotion', *Sexual Health*, vol. 7, 2010, pp. 103-106.
[333] Breastcancer.org, *Breast Self-Exam*, Philadelphia, USA, 2019, retrieved on the 15th of May 2019; https://www.breastcancer.org/symptoms/testing/types/self_exam
[334] D Drew et al, *Exploring the health and wellbeing of lesbian, bisexual, queer and same sex attracted women living in the Illawarra and Shoal haven regions*, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.
[335] J Tran, *Improving choices and options: The views of ACT women about their sexual and reproductive health needs*, Women's Centre for Health Matters, Canberra, 2018.

report[336] but higher than the national average for mammograms for women over.[337] Both the current study and the WCHM sexual and reproductive health study found that women who were not the right age to get their breasts scanned were aware of the age from which mammograms are most effective.[338]

Violence and victimisation

Just over three out of every six women in our study had experienced sexual, domestic, or family violence (59%), and 13% had experienced all three. Only thirty eight per cent of the women reported that they had never experienced violence (n=137).

According to the Australian Institute of Health and Welfare, one out of every six women had experienced physical and/or sexual violence by a current or previous cohabiting partner.[339] Thirty four per cent of women in the current study reported that they had experienced violence from a partner or ex partners. It is unknown how many LGBQ women are affected by violence in Australia.[340] In the ACT report, '*Transforming domestic violence support in the ACT: Improving accessibility for lesbian, gay, bisexual, transgender, intersex and queer clients'*, in which 52% identified as women, 29% said that they had experienced domestic violence.[341]

Violence may be higher in LGBQ women[342] due to societal heterosexist norms that help to perpetuate stigma and discrimination amongst same sex attracted and trans people.[343]

Differences may exist between lesbians and bisexual women. Sixty seven per cent of bisexual women in the current study reported experiencing violence, compared to 56% of lesbian women. Thirty six per cent of the women in our study had experienced sexual violence. Forty six per cent of bisexual women reported experiencing sexual violence compared to 31% of lesbian women. Research has found that bisexual women may experience more violence and threats of violence,[344] and partner violence,[345] than women who are exclusively same sex attracted.

Thirty five per cent of women in the current study had experienced violence from an immediate family member or other family member. Studies from the USA have found that LGBQ women have often experienced abuse from family members.[346] [347]

Trans women may be the victims of family violence from parents or siblings who are not accepting of their gender transition, who punish and control through transphobic abuse.[348] Seven out of the nineteen trans women in the current study reported that they had been the victim of family violence from an immediate or other family member.

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[336] J Tran, Improving choices and options: The views of ACT women about their sexual and reproductive health needs, Women's Centre for Health Matters, Canberra, 2018.
[337] Cancer Control Indicators, Breast screening rates, Cancer Australia, Canberra, 2018, accessed on the 11th of January 2019, https://ncci.canceraustralia.gov.au/screening/breast-screening-rates/breast-screening-rates
[338] J Tran, Improving choices and options: The views of ACT women about their sexual and reproductive health needs, Women's Centre for Health Matters, Canberra, 2018.
[339] Australian Institute of Health and Welfare, Family, domestic and sexual violence in Australia, 2018, Canberra 2018, retrieved on the 15th of May 2019; https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary
[340] Australian Institute of Health and Welfare, Family, domestic and sexual violence in Australia, 2018, Canberra 2018, retrieved on the 15th of May 2019; https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/contents/summary
[341] M Greenhalgh & A Roberts, Transforming domestic violence support in the ACT: Improving accessibility for lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) clients, Women's Centre for Health Matters, Canberra, 2015.
[342] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', Australian and New Zealand Journal of Public Health, vol. 29, no. 3, 2005, pp. 265-271.
[343] B Fileborn, Sexual violence and gay, lesbian, bisexual, trans, intersex, and queer communities, Australian Institute of Family Studies, Canberra, 2012.
[344] J Axelsson, B Moden, M Rosvall & M Lindstrom, 'Sexual orientation and self-rated health: the role of social capital, offence, threat of violence and violence', Scandinavian Journal of Public Health, vol. 41, 2013, pp. 508-515.
[345] H L McCauley, 'Sexual and reproductive health indicators and intimate partner violence victimization among female family planning clinic patients who have sex with women and men', Journal of Women's Health, vol. 24, no. 8 2015, pp. 621-628.
[346] J Bateman & C Henderson, *Reframing responses stage two: Supporting women survivors of child abuse. An information resource guide and workbook for community managed organisations*, Mental Health Coordinating Council, Lilyfield NSW, 2010, retrieved on the 16th of May 2019: https://www.mhcc.org.au/wp-content/uploads/2018/05/reframing-responses-resource-guide-and-workbook.pdf
[347] C Zou & J P Anderson, 'Comparing the rates of early childhood victimization across sexual orientations: heterosexual, lesbian, gay, bisexual and mostly heterosexual', *PLoS ONE*, vol. 10, no. 10, 2015, pp. 1-15.
[348] M Rogers, 'Transphobic 'honour'-based abuse: a conceptual tool', *Sociology*, vol. 51, no. 2, 2017, pp. 225-240.

Fifty five per cent of women in the current study reported that they had experienced anti-LGBTIQ behaviour in the past 12 months. In comparison, 40% of the women in the 2016 SWASH report had experienced some form of anti-LGBTIQ behaviour.[349] The most reported anti-LGBTIQ behaviour reported in both our study and the SWASH was verbal abuse or harassment (33% and 38%, respectively).

One woman talked about discriminatory treatment by a café in a town outside of Canberra:

> *"My same-sex partner and I were served our takeaway meals, then physically walked out of a cafe in Yass. I'm still upset that I don't know how to effectively warn others in the community about it… I don't know how to warn the LGBTIQ not to go there and I don't want them to experience what I did because it hurts..."*

LGBTIQ people often need to change their behaviour or the way they dress in an attempt to reduce homophobic behaviour when going out in public. They may also be less likely to report violence to the police due to fear of not being believed.[350]

Women in the current study talked about not disclosing their sexual identity due to worries about anti-LGBTIQ behaviour or discrimination:

> *"Nothing pointed but still will not disclose sexual preference to particular kinds of people who I feel will not accept."*

Twelve out of the 19 trans women reported experiencing verbal abuse or harassment in the last 12 months. Forty nine per cent of trans women in Leonard et al, study had experienced heterosexist harassment or abuse.[351] Exposure to bullying, verbal abuse, harassment, discrimination, rejection, and abuse have been linked to high rates of poor mental health, self-harm, and suicidality among trans people.[352] Ellis, Bailey and McNeil show that one-off accounts of victimisation and discrimination of trans people can "invoke a heightened sense of fear in members of the wider trans community".[353]

Unwanted disclosure about sexuality or gender was reported by 28% of the women in the current study. Twelve out of the 19 trans women reported unwanted disclosure.

Young same sex attracted people are vulnerable to pressures of minority stress,[354] family rejection,[355] internalised homophobia, stigma, sexual assault and abuse and victimisation.[356] A participant in the current study described the impact of homophobia:

> *"This is what the real experience is like for me. It isn't as simple as just ignoring it and explaining to them the real impact of it. It's not just someone giving me a dirty look. Or if I'm having a bad mental health day, someone leaning out of the car and screaming flaming dyke or something at me either. It's not just something I can just let go."*

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[349] J Mooney-Somers et al, Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[350] W Leonard et al, Coming forward: The underreporting of heterosexist violence and same-sex partner abuse in Victoria, Australia Research Centre in Sex, Health and Society, La Trobe University, Victoria Law Foundation, Gay and Lesbian Health Victoria, Melbourne, 2008.
[351] W Leonard, A Lyons & E Bariola, A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians, Monograph Series Number 103, The Australian Research Centre in Sex, Health & Society, La Trobe University, Gay and Lesbian Health Victoria, Beyond Blue, Melbourne, 2015.
[352] Strauss P, Cook A, Winter S, Watson V, Wright Toussaint D, Lin A, Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results, Telethon Kids Institute, 2017, Perth, Australia.
[353] S J Ellis, L Bailey & J McNeil, 'Transphobic victimisation and perceptions of future risk: a large-scale study of the experiences of trans people in the UK', Psychology & Sexuality, vol. 7, no. 3, 2016, pp. 211-224.
[354] T Lea, J de Wit & R Reynolds, 'Minority stress in lesbian, gay, and bisexual young adults in Australia: Associations with psychological distress, suicidality, and substance use', The Lancet, vol. 43, no. 8, 2014, pp. 1571-1578.
[355] C Ryan et al, 'Family rejection as a predictor of negative health outcomes in white and latino lesbian, gay, and bisexual young adults, Paediatrics, vol. 123, 2009, pp. 346-352.
[356] T Lea, J de Wit & R Reynolds, 'Minority stress in lesbian, gay, and bisexual young adults in Australia: Associations with psychological distress, suicidality, and substance use', The Lancet, vol. 43, no. 8, 2014, pp. 1571-1578.

The marriage equality postal vote in 2017 gave rise to anti-LGBTIQ propaganda in the media and through other sources. This had a negative impact on some of the women in our study:

> *"Marriage equality debate both nationally across media and within my circles of family and work, [was] emotionally distressing at times."*

> *"I was so depressed. I don't have depression, never had formative depression. But it was so frustrating and I told my psychiatrist. And he said that's a major depressive episode. And I said: was it? It's not my brain, it's reacting to something. He said that counts."*

Australian and overseas research shows the mental health impact on LGBTIQ people of marriage equality votes.[357] [358] Bariola et al strongly express that this inequality is a public health and a civil rights issue in Australia.[359] Around the marriage equality debate, Australian LGBTIQ people who saw more support in the public health campaigns and had friends and family in their immediate networks that were supportive of same sex marriage experienced less psychological stress.[360] Having marriage equality improves social connection and belonging.[361]

Seventy five per cent of women who reported that they experienced violence also reported a mental health issue in their top three health issues. Older studies indicate that LGBQ women experience a lifetime of abuse, high levels of stress, and discrimination, which has been linked to poor mental health.[362]

Women in our study described ways in which experiences of violence affect their mental health:

> *"Mental health - dealing with harassment from ex-partner"*

> *"Can't close my eyes or sleep without having flash backs to abuse and rape."*

Poorer mental health of bisexual women has been correlated with internalised biphobia, being in a heterosexual relationship, having an un-supportive partner,[363] previous family violence, risky sexual behaviour, and not disclosing sexual orientation.[364]

Access to health services

Women in our study experienced barriers to accessing health services, both for general health issues and for more specific conditions. WCHM has outlined in previous work the need for accessible, affordable, appropriate, and timely health services and supports for women in the ACT.[365] [366]

Eighty nine per cent of women had accessed a GP in the last 12 months (85% in the last 6 months). This is similar to the 94% of women who reported accessing GP services in the past 12

[357] M L Hatzenbuehler et al, 'The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study', *American Journal of Public Health*, vol 100, no.3, 2010, pp. 452-459.
[358] S Verrelli et al, 'Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian marriage law postal survey', *Australian psychologist*, 2019, pp. 1-11
[359] E Bariola, A Lyons & W Leonard, 'The mental health benefits of relationship formalisation among lesbians and gay men in same-sex relationships', *Australian and New Zealand Journal of Public Health*, vol. 39, no. 6, 2015, pp. 530-535.
[360] S Verrelli et al, 'Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian marriage law postal survey', *Australian psychologist*, 2019, pp. 1-11.
[361] M V L Badgett, 'Social inclusion and the value of marriage equality in Massachusetts and the Netherlands', *Journal of Social Issues*, vol. 67, no. 2, 2011, pp. 316-34.
[362] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[363] J Taylor et al, 'Bisexual mental health: Findings form the 'Who I am' study', *Australian Journal of General* Practice, vol. 48, no. 3, 2019, pp. 138-144.
[364] T J Persson et al, 'Explaining mental health disparities for non-monosexual women: Abuse history and risky sex, or the burdens of non-disclosure?' *Social Science Medicine*, vol. 128, 2015, pp.366–73.
[365] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[366] A Carnovale & E Carr, *It goes with the Territory! Act Women's views about health and wellbeing information,* Women's Centre for Health Matters, Canberra, 2010.

months in the 2018 ACT women's health study.[367] Just over 60% of women in our study had a regular GP. Those with regular GPs were more likely to attend a GP in the last 6 months and to disclose their sexuality.

Forty two per cent of women in the current study reported that they did not disclose their sexuality to their GP or health professional. This is relatively high compared to 18% found by Durso and Meyer.[368] Disclosure of sexuality to health professionals is a necessary part of their health and influences their health care.[369] Even so, the most cited reason for not disclosing, in the current study, was because women felt it wasn't relevant to their care. Health professionals may be knowledgeable, but unable to educate women on relevant issues, if they are unaware of sexuality.[370]

Some of the women in the current study were worried about homophobia or discrimination by health professionals, and some had experienced this. Women said that they were worried about taking a risk by disclosing when it could expose them to discrimination or impact their healthcare. Women said they had to 'screen' health providers to check if they were safe.[371]

Health providers' attitudes towards LGBTIQ people, and asking about or having an awareness of a LGBQ women's sexual orientation, impact on satisfaction with health care.[372] One woman in the current study explained how it affected her:

> *"I just don't want to have a discussion with you right now or see that look in your eyes and whatever the hell it's gonna be, whatever your reaction is gonna be to certain things, I don't want to have to deal with it."*

LGBQ women in our study reported that they also accessed health services for others. Fifteen per cent of women accessed the GP for their children, and 15% accessed for their partner. Other studies also show that women access health services for others, their children, partners or parents.[373] LGBQ women often have a different support network. They may have a mixture of their biological family and their 'chosen family' consisting of close friends,[374] [375] and so take on caring roles[376] accessing services for others in their community. In this study, women accessed the mental health Crisis Assessment and Treatment Team (CATT) and the hospital emergency department for others (not parents, children, or partners) more than other services.

Whilst most women in the current study reported that they could find services in the ACT to meet their health needs, 18% reported that were not able to find services. Mental health services were discussed as services missing from the ACT.

> *"A while ago I tried to find a psychiatrist and everyone is retired. I ended up not needing one, but if I did need one I would have had to use telehealth, which is expensive, or go to Sydney, which does seem ridiculous."*

> *"In Canberra there is a severe lack of adolescent psychologists and psychiatrists, and even less for those with LGBT+ issues."*

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[367] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[368] L E Durso & I H Meyer, 'Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, bisexuals', *Sexuality Research and Social Policy*, vol. 10, 2013, pp. 35-42.
[369] Ibid
[370] Ibid
[371] S Munson & C Cook, 'Lesbian and bisexual women's sexual healthcare experiences,' *Journal of Clinical Nursing,* vol. 25, no. 23-24, 2016, pp. 3497-3510.
[372] M Bjorkman & K Malterud, 'Lesbian women's experiences with health care: A qualitative study', *Scandinavian Journal of Primary Health Care*, vol. 27, 2009, pp. 238-243.
[373] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[374] J Power et al, 'Psychological wellbeing among same-sex attracted and heterosexual parents: role of connectedness to family and friendship networks', *Australian and New Zealand Journal of Family Therapy*, 2015, vol. 36, pp. 380-394.
[375] K E Hull & T A Ortyl, 'Conventional and cutting-edge: Definitions of family in LGBT communities', *Sexuality Research and Social Policy*, vol. 16, no. 1, pp. 31-43.
[376] N J Knauer, 'LGBT older adults, chosen family and caregiving', *Journal of Law and Religion*, vol. 31, no. 2, 2016, pp. 150-168.

"There are no psychiatrist options at all in the ACT. None with open books at all."

Fifty eight per cent of women reported that they had accessed a psychologist or counsellor in the last 12 months. McNair et al found 44% of participants accessed psychologists or counsellors in their 2016 study.[377] Sixty eight per cent of women in the SWASH study had accessed psychological services in the last five years.[378] By comparison, only 18% of women in the 2018 ACT women's health study had accessed mental health services.[379]

Eleven per cent of women in the current study had accessed alcohol, tobacco, and other drug services. Similarly, the SWASH study found that 11% of women sought help for drug and alcohol abuse. Most of the women went to counsellors or psychologists.[380]

Evidence shows an intersection between violence and discrimination; alcohol, tobacco, and drug use; and poor mental health in LGBQ women.[381] [382] [383] Health service response, particularly mental health, needs to be sensitive to the interplay of these potential health issues.

Barriers to access to health services

Fifty five per cent of women who responded to the survey reported that affordability was a barrier to accessing health services in the ACT, both for their general health and for specific conditions. Fifty per cent of the women in the 2018 ACT women's health study reported that they also had affordability barriers to health care. They reported that there were times that they skipped or delayed treatment, medical visits, tests and medications which had impacted their health.[384]

In a study in the Shoalhaven region, 40% of LGBQ women reported that they delayed health care, and 35% of women delayed mental health care due to cost (in the past two years). Bulk billing or free health care was one of the three factors for choosing or staying with a health care professional.[385] Women in our study expressed frustration with services that weren't covered by the public health system, therefore were not able to address their health issue as it was unaffordable:

"And I asked the doctor saying is anyone in Canberra cheapish and she says the only [psychiatrist for ADD] I know is $600 an hour. And I was like f… that."

And affordable services were commended:

"The Canberra Sexual Health Clinic is an incredible free resource that provides fantastic advice, free of charge."

This was particularly an issue for trans women in our study whose medical treatment for transition was an expensive but necessary health cost, to reduce the pain of being in a body that is the wrong gender:

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[377] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[378] J Mooney-Somers et al, *Women in contact with the Sydney LGBTQ Communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2014, 2016, 2018,* The University of Sydney, ACON, Sydney, 2018.
[379] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[380] J Mooney-Somers et al, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014. 2016*, ACON & Sydney Health Ethics, University of Sydney, Sydney, 2017.
[381] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[382] T Hughes et al, 'Sexual victimization and hazardous drinking among heterosexual and sexual minority women', *Addictive Behaviors,* vol. 35, 2010, pp. 1152-1156.
[383] T Hughes, L A Szalacha, R McNair, 'Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women'*, Social Science & Medicine*, vol. 71, no. 4, 2010, pp. 824–831.
[384] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[385] D Drew et al, *Exploring the health and wellbeing of lesbian, bisexual, queer and same sex attracted women living in the Illawarra and Shoal haven regions*, ACON, Women's Health, Illawarra Shoalhaven Local Health District & Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2017.

"Financial issues and I'm not sick enough to access concessions - the medication and appointments cost a fortune and getting other therapies (OT or PT) is too hard to access without financial help."

"you know rather than … $18,000 for re-assignment surgery"

Many women in the study reported long term chronic mental or physical health conditions as one of their top three health issues. Previous work by WCHM shows the ongoing affordability issues of having a chronic physical or mental health condition.[386] [387] Affordability issues stem from the complex interplay between trying to maintain their health by purchasing necessary but costly medications, specialty food, or equipment, attending health providers[388] [389] [390] and ensuring that they stay in full time secure employment despite ongoing sick days and absenteeism.[391]

With so many women telling us that mental health was one of their top health issues, it is concerning that many experienced significant barriers to accessing mental health services in the ACT. Affordability of services was the most talked about barrier. Some women told us they were frustrated that they had to pay a high cost for a service that may not meet their needs.

"Ten sessions often not enough. Difficulty getting an appointment with someone who understands being queer isn't the root of depression / anxiety."

"The times available to see my psychologist are during work hours so it makes it harder and more expensive to get a time."

LGBQ women in the focus groups described situations where they were wary of GPs, or chose particular GPs who were LGBTIQ inclusive, or were good at women's health, but then had to pay a premium to see them.

"And I go to her specifically because she's good with women's health. She's friendly to me and she just gets it. She's worth the money, but then you add the cost and hassle of transport on top."

"Health is multifactorial. So many things influence access and quality. When you have limited income, a disability, a number of health issues, and aren't hetero it is hard to find a compatible, qualified, knowledgeable, accepting health professional with whom to build an ongoing relationship."

This is particularly significant for LGBQ women who have higher rates of mental health conditions.[392] This shows how important free counselling services such as AIDS Action Council are to this community. A number of women in the current study specifically listed AIDS Action Council, ANU Counselling, and Headspace as helpful local health services offering counselling.

Our research also showed that appointment availability was a barrier to accessing health services in the ACT. Forty eight per cent of women found it difficult to access health services due to a lack of appointments available at times they can attend. Forty nine per cent of the women in the 2018 ACT women's health study also found that appointment availability was concerning. ACT women

[386] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, Women's Centre for Health Matters, Canberra, 2018.
[387] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.
[388] V Tran et al, 'Taxonomy of the burden of treatment: a multi-country web-based qualitative study of patients with chronic conditions', *BMC Medicine*, vol. 13, no. 115, 2015, pp. 1-15.
[389] L M Hunt, M Kreiner, H Brody, 'The changing face of chronic illness management in primary care: a qualitative study of underlying influences and unintended outcomes', *Annals of Family Medicine*, vol. 10, no. 5, 2012, pp. 552-560.
[390] Y Jeon et al, 'Economic hardship associated with managing chronic illness: a qualitative inquiry', *BMC Health Services Research*, 2009, vol. 9, no. 182, pp. 1-11.
[391] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, Women's Centre for Health Matters, Canberra, 2018.
[392] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.

had issues accessing health care at times of day that was suitable for them.[393] Women in the current study reported that it was difficult to book appointments for a time that they were available when they were already very busy. Women in the current study said:

> *"The times available to see my psychologist are during work hours so it makes it harder and more expensive to get a time…"*

> *"Appointment availability is a problem across the board. Often I have to take time off work to see a GP and it ends up being several hours even though my appointment is still only 15 minutes. Specialists are difficult to access some wait time are years and in two cases I have been told to go back to my old specialists or find new ones in Sydney "if I have the means". It was a 2 year wait in Canberra to see a psychiatrist to have my medication reviewed, despite a rheumatologist in Canberra originally prescribing it."*

Women in the current study said that valued and trusted services like the Sexual Health Clinic need longer opening hours to enable them adequate access.

> *"Opening hours of the sexual health clinic don't cater well to people who cannot attend during the day."*

Forty per cent of women in the current study reported long wait times as a barrier to health services in the ACT. They talked about needing health care providers but not able to get a timely appointment due to the wait time to see them.

> *"It took me 18 months to get into a rheumatologist for my rheumatoid arthritis. And you're supposed to get treatment within three months of symptoms. So the damage has been done and that's the same with most specialties. You've got to go to Sydney."*

The treatment by health care providers can be a barrier to accessing health care for LGBQ women. Some women told us that when they sought help or treatment from health professionals, the treatment was of poor quality, or the health professionals didn't believe or listen to them. This was the third most frequently mentioned barrier to accessing health services:

> *"I have had doctors in the past ignore my experiences and other medical issues and only focus on my weight."*

> *"It took me a while to find a good doctor who wasn't patronising or didn't treat me like I was an idiot because I was a young woman. Again, doctor shopping requires money!"*

Women who experienced this barrier said that they couldn't access the correct services, they were of poor quality, or that the health professional wasn't doing thorough investigation or wasn't knowledgeable.

> *"I had one neurologist because I have this really rare brain condition, and he said there are no side effects. It turns out there's a ton of side effects. I lost 15 kilos due to nausea."*

> *"Finding counsellors who understand the lived experience of bipolar, rather than just having read about it in a book."*

> *"I have strategies for the daily background level of depression & anxiety, I have found most clinical psychologist I've seen, not really up to dealing with*

[393] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.

my unique combination, and that I have mostly tried the strategies they promote."

As with other research,[394] [395] women in the current study felt rejected and dismissed when they were not believed or listened to. In research by Werner & Malterud, women felt that they had to justify why they were seeking health care. They felt constantly judged especially if they didn't look sick enough.[396] Women in the current study said:

"…it took me 13 years to be diagnosed from when I first ever tested positive because I had a male doctor who said 'you've been tested positive but it's really unlikely' and refused to follow it up and I couldn't even get a referral. It took me nearly 12 years to get a referral for a rheumatologist like I said I had to go through like a dozen GPs"

"Difficult to treat pain or for pain to be taken seriously. Emergency is the worst, especially when they think you're just a codeine junkie."

A lack of LGBQ sensitivity and inclusiveness was also highlighted as a barrier. A non-judgmental and non-stigmatising health care service is important for women in general, but especially LGBQ women who have already been subjected to a lifetime of discriminatory and stigmatising behaviour.[397] Fourteen per cent of women told us that they found lack of signs of inclusiveness a barrier to accessing health services. Determining the kind of treatment that they are going to receive before going to the service is important, so women in our study relied on word of mouth and opinions from the community to find a known safe service.

"Like recommendations of friends and colleagues and other people that you know ... I don't like to go to the services cold. I try and go somewhere someone I know has gone before so that they do have 'Spidey sensing' for me."

"We know these doctors are friendly and… inclusive and all of the good things, but can't actually access them"

"I mean I ask the people in my chronic disease group for recommendations. And that is a really good way to tell if it's inclusive if people have good experiences and individual doctors too from word of mouth."

Women said they were worried that they may experience stigma and discrimination from mental health services. One woman said:

"It can be tricky to work out beforehand whether someone will be queer friendly."

In McNair and Bush, participants reported discrimination and a lack of LGBTI sensitivity as a barrier to accessing mental health services.[398]

Nine per cent of women reported that lack of signs of inclusiveness was a barrier for accessing sexual and reproductive health services, compared to 14% reporting this as a barrier for health services.

[394] A Werner & K Malterud, 'It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors', *Social Science & Medicine*, vol. 57, 2003, pp. 1409–1419.
[395] C Durif-Bruckert, P Roux & H Rousset, 'Medication and the patient-doctor relationship: a qualitative study with patients suffering from fibromyalgia', *Health Expectations*, vol. 18, pp. 2584-2594.
[396] A Werner & K Malterud, 'It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors', *Social Science & Medicine*, vol. 57, 2003, pp. 1409–1419.
[397] R McNair et al, 'The mental health status of young adult and mid-life non heterosexual Australian women', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 3, 2005, pp. 265-271.
[398] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.

The Canberra Inclusive Partnership (formerly Canberra LGBTIQ Community Consortium) showed that word of mouth recommendations by others in the community is really important to know which services are safe.[399] Accessing services where they may receive discriminatory treatment is a significant barrier and negatively impacts health outcomes.[400]

It is important that health services show that they are inclusive. LGBQ women talk about how outward visibility helps to know how they may be treated. Similarly, Munson and Cook found that women said client communications and clinical environment is something they notice when looking for signs of inclusiveness.[401] One woman in the current study said:

> *"They never say or ask anything that gives you a hint that it would be ok to disclose to them without being more traumatised by their response. That combined with heteronormative at best or homophobic at worst makes the whole thing a tightrope."*

Women in the current study expressed worry and experienced homophobic behaviour from health professionals. This behaviour can be implied homophobia, such as implying that sex between two women is 'not real sex', or overt[402] like this example from women in focus groups:

> *"You need their help and you don't know whether or not you're going to get the same help. I grew up in Sydney, in the 90s, hearing about men who would have been deliberately injured by the chiropractor and things like that. You sort of get this mistrust to almost all of the health profession."*

> *"I often introduce myself as [my partner's] carer, often that makes it a lot easier. Since I've been doing that I've had a lot less anxiety."*

> *"The doctors treat you with respect when you say carer, they don't always treat you with respect when you say partner."*

Research shows that trying to be neutral in health provision can also have negative consequences, as it fails to recognise the specific health needs of LGBQ women.[403] Moreover, some health providers are not aware that LGBQ women have health inequalities and implications related to their sexuality.[404] For example, LGBQ women are twice as likely to smoke cigarettes than the general population of women. Health services and professionals need to 'acknowledge, understand and accommodate' sexual and gender diversity.[405]

One woman in our study spoke about how the intersection of ageing and homosexuality made her feel invisible when looking for health information and accessing health services.

> *"Access to health info for ageing lesbians would be great. I know hetero women talk about things like menopause and hetero sex all the time, but I feel disconnected from them and those issues. I have no kids and don't have sex with men so I never quite fit in there. I'd really like to find a healthcare provider that would consider my issues in a holistic way - they all dovetail together. It just feels as though health professionals can't really see it, or see me."*

Reproductive services to start a family was not only costly for the women in the current study, but women also talked about experiencing discrimination. Women stated that they were refused

[399] LGBTIQ Community Consortium, *CBR LGBTIQ Community Consortium consultation findings*, Canberra, 2016, retrieved on the 13th of September 2018: https://www.aidsaction.org.au/images/documents/LGBTIQ_Consortium_Report_2016_FINAL.pdf
[400] Ibid
[401] S Munson & C Cook, 'Lesbian and bisexual women's sexual healthcare experiences.' *Journal of Clinical Nursing*, vol. 25, no. 23-24, 2016, pp. 3497-3510.
[402] Ibid
[403] K Baker & B Beagan, 'Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients', *Medical Anthropology Quarterly*, vol. 28, no. 4, 2014, pp. 578-598.
[404] R P McNair, K Hegarty & A Taft, 'From silence to sensitivity: A new identity disclosure model to facilitate disclosure for same-sex attracted women in general practice consultations', *Social Science & Medicine*, vol. 75, 2012, pp, 208-216.
[405] K Baker & B Beagan, 'Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients', *Medical Anthropology Quarterly*, vol. 28, no. 4, 2014, pp. 578-598.

access to public funding for expensive ART. Medicare's education guide, *Billing assisted reproductive technology services,* states that couples or singles accessing ART will only receive publicly funded treatment if they are deemed medically infertile by the clinician.[406] This is incongruent with Commonwealth legislation, which does not indicate the type of infertility that the patient needs to have to be able to access the Medicare benefit.[407]

Women in the current study talked about their experiences of discrimination and anti-LGBTIQ behaviour when accessing fertility treatment:

> *"We are having positive experiences at a [fertility clinic] (after a negative experience at [another clinic]), but the problem really lies with Medicare and requires significant structural changes."*

> *"When we first went to the fertility clinic we saw [a doctor at a clinic] - we went on a recommendation from friends and our GP. After one year of meeting with her we found her to be judgemental and queerphobic as she continued to misstep - she would misgender me, make assumptions about how we wanted to parent and conceive (based on heteronormative ideas), and refused to support us to access Medicare rebates where heteros would have direct unquestioned access. Since changing clinics we've had a totally different experience immediately."*

Some women who are in same sex relationships and are yet to start their family were worried they would be discriminated against due to their sexual orientation.

> *"My partner and I have some interest in having a family later, and access to IVF for us would be full fee. Basically, we have no Medicare support and so it would be considered social infertility rather than clinic infertility, and I think that might be the case Australia wide for all same sex partners."*

Supports for addressing health issues

Many of the women in the current study reported that they had services and supports to help them address their health issues. As in the 2018 ACT women's health study, they sought support from a combination of services, primary care like GPs, as well as allied health, mental health services, community services, family and friends, and some used a combination of supports.[408] When accessing services and support, women were most likely to seek care from a primary health care professional such as a GP, as in other studies.[409] This is due to the GP's unique position as gatekeeper and provider of multiple services, such as treatment, prescriptions, and referrals to other health professionals.[410]

Women reported wanting to address their sexual health needs at different services. Some preferred to get STI testing and cervical screening with their regular GP, others preferred to get it from a sexual health service, while a few mentioned a specialist LGBTIQ service.

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[406] Australian Government, Department of Human Services, *Education guide – Billing assisted reproductive technology services*, Medicare, Canberra, 2018, retrieved on the 28 March 2019; https://www.humanservices.gov.au/organisations/health-professionals/enablers/education-guide-billing-assisted-reproductive-technology-services/42431

[407] Australian Government, Federal Register of Legislation, *Health Insurance (General Medical Services Table) Regulations 2018- In force- latest version F2019C00182*, Canberra, 2019, retrieved on the 28 of March 2019; https://www.legislation.gov.au/Details/F2019C00182/Download

[408] E Hoban, *ACT women's health matters! ACT women's views about their health; their health needs; their access to services, supports and information; and the barriers to maintain their health*, Women's Centre for Health Matters, Canberra, 2018.

[409] Ibid

[410] Australian Medicine Association, Gatekeeper role of GPs under scrutiny in MBS review, Canberra, 2015, retrieved on the 31st of May 2019; https://ama.com.au/ausmed/gatekeeper-role-gps-under-scrutiny-mbs-review

Women seek support for mental health issues from friends and family and online peer support.[411] Friendships are important to LGBQ women, who rely on friends for social support.[412] Relying on friends in the LGBTIQ community is not uncommon. Their network extends from friends – their 'chosen family' - to family, depending on how accepting their family is of their sexuality.[413] [414]

Women in the focus group were asked if they had supports or services in place when they were having a hard time with their mental health. Most women talked about having their friends to help, but some acknowledged that their friends are also facing mental health difficulties:

> *"Everyone's supporting each other but we're all mentally ill. And it's just like that, everyone's emotionally overworked and overloaded."*

Health promotion campaigns are important to address women's health issues. LGBQ women tend to be overlooked in health campaigns, as health promotion campaigns are often directed towards a heterosexual audience.[415] Health promotion has been significantly lacking in the areas of sexual health, such as cervical screening,[416] and health campaigns for smoking cessation,[417] weight, diet, and physical activity.[418] Women in the current study talked about the kind of health promotion they want:

> *"More health promotion specifically aimed at lesbian health issues ie pap smears, mammograms, weight issues, drug and alcohol issues, and mental health"*

Heteronormative sexual health promotion that centres around penetrative sex[419] is often known and understood by LGBQ women but cannot be applied to their own sexual experiences.[420] Sex education that focuses on heteronormative sex education has been found to remove same sex attracted people from the dialogue, preventing knowledge of safe sex practices[421] and leading to homophobic bullying and marginalisation.[422] Women in the current study talked about the need for sex education that is inclusive of same sex relationships:

> *"If I think back further to sex education in schools they don't talk about. They don't actually introduce the concept of same sex relations, same sex safety. You know, they don't talk about how you can transfer fluids or blood or diseases at all, they don't mention that in the curriculum in regards to same sex couples of any gender, and that's a massive issue because that means you have a lot of young people at risk out of ignorance."*

[411] R McNair & R Bush, 'Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study', *BMC Psychiatry*, vol. 16, no. 209, 2016, pp. 1-16.
[412] K L Blair, D Holmberg & C F Pukall, 'Support processes in same-and mixed-sex relationships: Type and source matters', *Personal Relationships*, vol. 25, 2018, pp. 374-393.
[413] J Power et al, 'Psychological wellbeing among same-sex attracted and heterosexual parents: role of connectedness to family and friendship networks', *Australian and New Zealand Journal of Family Therapy*, 2015, vol. 36, pp. 380-394.
[414] K E Hull & T A Ortyl, 'Conventional and cutting-edge: Definitions of family in LGBT communities', *Sexuality Research and Social Policy*, vol. 16, no. 1, pp. 31-43.
[415] J Mooney-Somers et al, *Women in contact with the Northern Rivers and Mid North Coast LGBTQ communities: Report of the SWASH lesbian, bisexual and queer women's health survey 2018,* The University of Sydney, ACON, Sydney, 2019.
[416] C Curmi, K Peters & Y Salamonson, 'Lesbian attitudes and practices of cervical cancer screening: qualitative study', *BMC Women's Health*, vol. 14, no. 153, 2014, pp. 1-9.
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[418] J Mooney-Somers, R M Deacon & J Comfort, *Women in contact with the Perth gay and lesbian community: Report of the Women's Western Australian sexual health (WWASH) Survey 2010,* Western Australian Centre for Health Promotion Research, Curtin University, Perth, 2010.
[419] J Power, R McNair, & S Carr, 'Absent Sexual Scripts: Lesbian and Bisexual Women's Knowledge, Attitudes and Action regarding Safer Sex and Sexual Health Information' *Culture, Health & Sexuality,* vol. 11, no. 1, 2009, pp. 67-81.
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[421] B Shannon, 'Comprehensive for who? Neoliberal directives in Australian 'comprehensive' sexuality education and the erasure of GLBTIQ identity', *Sex Education*, vol. 16, no. 6, pp. 573-585.
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Conclusion

Same sex attracted women are a diverse group of women, many of whom live healthy and happy lives. Even so, their lives are affected by both their gender and their sexuality, and impacted by a heteronormative society which gives rise to a mixed bag of stigma, discrimination, violence, and homophobia, which may impact on their access to the health services and information that they need.

Our research showed that looking for health information is challenging for same sex attracted women, because most information is directed at heterosexual women, who have different health needs and life experiences in areas such as sexual and reproductive health, mental health, and other areas. Women who can't access the right information may not be able to adequately look after their health. Heteronormative health promotion that leaves out LGBQ women leads to the erasure of this group and as a result LGBQ women may not recognise themselves in the health messaging.

This difficulty in accessing health information that is appropriate to the needs of LGBQ women has a direct impact on health behaviours, such as not getting STI testing because of a belief that their risk of infection is low based on heteronormative sexual health information.

Almost 60% of women had experienced some form of violence in their lifetime. Experience of violence correlated with mental health issues. Additionally, 55% had experienced anti-LGBTIQ behaviour. Verbal abuse or harassment and unwanted disclosure about sexuality or gender were the most commonly reported examples of anti-LGBTIQ behaviour.

Our research confirms previous research showing that bisexual women have poorer self-rated physical and mental health than lesbian women. A higher proportion of bisexual than lesbian women reported having experienced violence.

Trans women have significant barriers to good health, including experience of violence, mental health issues, and lack of affordable services for gender transition.

As with women in the ACT in general, LGBQ women in the ACT felt that they were not being listened to by health service providers, and their experiences weren't understood. Many LGBQ women did not feel safe to disclose their sexuality to health professionals, even though it is a significant part of their health. LGBQ women required health services in the ACT to be more inclusive. This means they are looking for health services who have an understanding of LGBQ women, their health needs, and the ways in which they live their lives, and make it known to the community that they are inclusive.

Health services and information for which LGBQ women in the ACT have the most need include:

- Mental health, such as counselling, psychologists, and psychiatrists;
- Sexual and reproductive health, such as cervical cancer screening, STI testing, sexual health practices to reduce risks, and assisted reproductive technology (ART) for fertility treatment;
- Drug and alcohol services; and
- GP services.

They need these services to be provided in a way that is available, affordable, accessible, and appropriate for them as LGBQ women.

Appendix

The online survey, conducted during October and November 2018, is available in the pdf version of the report on the Women's Centre for Health Matters website.

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