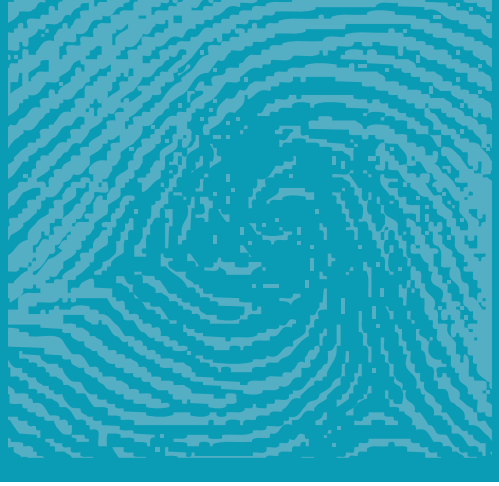
Health and sexual diversity

A health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians



Action plan

Ministerial Advisory Committee on Gay and Lesbian Health

Victoria
The Place To Be

Health and sexual diversity

A health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians

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Ministerial Advisory Committee on Gay and Lesbian Health

Prepared by William Leonard on behalf of the Ministerial Advisory Committee on Gay and Lesbian Health

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Forewords

A letter from Mr Tony Keenan, Chair of the Ministerial Advisory Committee on Gay and Lesbian Health

It has been a privilege and a pleasure to chair the first ever Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH). The Committee was established in April 2000 to provide expert advice to Government on gay, lesbian, bisexual, transgender and intersex (GLBTI) health and wellbeing. Among its key tasks was the production of a GLBTI health and wellbeing action plan for the consideration of the Minister for Health and the Department of Human Services (DHS). This document is that action plan.

The Bracks Government is to be commended for establishing a number of GLBTI advisory bodies and for recent legislative reforms that seek to protect GLBTI people from discrimination and that recognise the rights and responsibilities of same sex couples. However, social change often lags behind legislative reform perhaps nowhere more so than in the overheated arena of sexual and gender identities and personal relationships. As current research demonstrates and recent events confirm GLBTI people are still subject to systematic and ongoing discrimination. This is particularly true for young GLBTI people, GLBTI people living in rural and regional areas and GLBTI couples and families.

Health and sexual diversity: a health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians offers a framework for understanding patterns of health and illness specific to GLBTI people, details their major health concerns and makes recommendations to Government aimed at improving the health and wellbeing of GLBTI Victorians. The majority of the recommendations do not involve creating new or GLBTI specific services. Rather, they involve making existing programs and services responsive to the health and wellbeing needs of all Victorians, including GLBTI people. The plan is the outcome of a review of GLBTI health research and extensive GLBTI community consultations.

The action plan provides a coordinated approach to improving the health and wellbeing of GLBTI Victorians by improving the quality of health care they receive. Its recommendations operate on two related fronts. At one level they address the consequences of sexual orientation and gender identity discrimination on the health and wellbeing of GLBTI people. These include the effects of violence, isolation and social invisibility on the physical and mental health of GLBTI people and their reduced access to quality health care as a result of a number of factors including ignorance or prejudice on the part of some health service providers.

At the same time the action plan makes recommendations that address GLBTI specific health issues that are not directly linked to discrimination. These include sexual health, transgender and intersex physical health and areas of legislative reform in reproductive health. They also include patterns of ill health and drug and alcohol use that are linked to cultural practices and values specific to gay and lesbian communities.

Clearly these two levels are linked. Legislative and social reforms aimed at reducing discrimination against GLBTI people raise public awareness of GLBTI issues–including that of health service providers–and will have a positive impact on the quality of services they receive. Similarly, targeted initiatives that increase health service providers' knowledge of, and sensitivity to, GLBTI health issues are part of wider social reforms leading to a reduction in sexual orientation and gender identity discrimination.

The health and wellbeing action plan and its recommendations go hand in hand with ongoing processes of legislative and social reform. In the absence of such reform, targeted health initiatives can do little more than provide band-aid solutions to many of the major health problems confronting GLBTI Victorians.

Thank you to all those involved in producing this action plan. In particular I would like to thank: the members of the MACGLH, the Deputy Chair, Anne Mitchell and the Executive Officer, Liam Leonard for their dedication and hard work and for straddling the at times perilous divide between political imperatives and community interests; the members of the Transgender and Intersex Subcommittee for their expert advice and editorial input; the Public Health staff who have overseen the management of the Committee; Community Concepts, the research consultancy responsible for running the GLBTI community consultations and the individuals, organisations and health professionals who gave generously of their time, experience and knowledge during those consultations and who have ensured community ownership of the action plan.

Thank you also to the Minister for Health, the Hon Bronwyn Pike, for her support of the MACGLH, this action plan and broader Government initiatives that recognise the rights and responsibilities of GLBTI Victorians. Finally, many thanks to the Hon John Thwaites, MP. His commitment and support have been instrumental in the genesis and development of a Victorian GLBTI health agenda.

I look forward to working with the MACGLH and the State Government to implement the action plan's key recommendations and to the continued improvement in the health and wellbeing of GLBTI Victorians.

Tony Keenan
Chair, MACGLH

A letter from The Hon Bronwyn Pike MP, Minister for Health

I am very pleased to present *Health and sexual diversity: a health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. The action plan is the first of its kind at state, territory or federal level in Australia.

The action plan is an expression of the Government's commitment to valuing diversity within the Victorian population as a whole. The Bracks Government values the contribution made to Victoria's political, social and cultural life by gay men, lesbians, bisexuals and transgender and intersex people. At the same time it acknowledges the negative effects that ongoing and systematic discrimination has had on their health and wellbeing.

Over the past three years the Government has funded a number of same sex attracted youth (SSAY) suicide prevention initiatives, an exploratory study of the needs of older gay men and lesbians and a Victorian study of alternative parenting practices and arrangements. It has also provided financial support to the Gay and Lesbian Switchboard Telephone Counselling Service. Late in 2002 the Government committed itself to funding a Gay and Lesbian Health and Wellbeing Resource Unit at a cost of $250 000 per year over four years. The Unit is one of the key recommendations arising out of this action plan and will act as a clearinghouse for gay and lesbian health research and resources. It will also provide information and training on GLBTI health and wellbeing issues for health care providers.

The development of the action plan owes much to the work of the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) and in particular to the Chair, Mr Tony Keenan and Deputy Chair, Ms Anne Mitchell. The Committee has provided the Government with expert advice on GLBTI health and wellbeing issues, overseen the development of a range of government funded GLBTI specific projects, developed GLBTI health resources and has provided advice to a number of other Victorian Government health advisory bodies. That the Committee has done so with limited resources and funds is testimony to the hard work and dedication of its members.

I look forward to the implementation of many of the recommendations arising from this action plan and to the continued improvement in the health and wellbeing of GLBTI Victorians.

Hon Bronwyn Pike MP
Minister for Health

Ministerial Advisory Committee on Gay and Lesbian Health

Current membership*

Current member	Current position	Appointed
Rowena Allen	CEO, Cutting Edge Youth Service – Uniting Care	12 April 2000
Ian Anderson	Deputy Head, Department of Public Health and Director, Centre for Study of Health and Society and VicHealth Koori Health, Research and Community Development Unit	12 April 2000
Sandy Anderson	Nurse Consultant, *PapScreen Victoria*, Cancer Council of Victoria and Women's Health Worker, Women's Health Grampians	12 April 2000
Maria Bamford	Committee member Victorian Gay and Lesbian Rights Lobby (VGLRL)	18 Oct. 2001
Marilyn Beaumont	Executive Director, Women's Health Victoria	12 April 2000
John Daye	President of People Living with HIV/AIDS Victoria	12 April 2000
Tony Keenan, *Chair*	General Secretary, Victorian Independent Education Union	12 April 2000
Mike Kennedy	Executive Director, Victorian AIDS Council (VAC)/GMHC	12 April 2000
Ruth McNair	General Practice, Carlton Clinic, and Senior Lecturer in General Practice, Melbourne University; Convenor, Fertility Access Rights Lobby	12 April 2000
Anne Mitchell, *Deputy Chair*	Manager, Community Liaison and Education Unit, Australian Research Centre in Sex, Health and Society (ARCSHS)	12 April 2000
Ian Seal	Youth Project Worker, Family Planning Victoria	12 April 2000
Craig White	Executive Director of Clinical Services, Austin and Repatriation Medical Centre	12 April 2000
Jonathan Anderson *ex officio*	General Practice, Carlton Clinic and Research Lecturer, National Centre in HIV Epidemiology and Clinical Research	12 April 2000
Liam Leonard	Executive Officer, MACGLH, Department of Human Services	12 April 2000
Departmental Representative	**Current Position**	**Attendance**
Ruvani Wicks *Observer AGs*	Assistant Director, Civil Law Branch, Department of Justice	5 May 2000
Gary Buckeridge *Observer DE&T*	Senior Project Officer, Middle Years, Department of Education and Training	15 June 2001
Jennifer McDonald	Manager, Food and Health Development, Department of Human Services	26 Sept. 2001

**As of 30 November 2002*

Past membership

Past member	Position at time of appointment	Period of appointment
Megan Jenner	Co-convenor, Victorian Gay and Lesbian Rights Lobby	12 April 2000–19 March 2001
Dennis Rhodes	General Practice, Middle Park Clinic, Alfred Hospital Infectious Diseases Unit	12 April 2000–28 March 2001
Bernadette Brown	Community Development Manager, The ALSO Foundation	12 April 2000–16 May 2001
Rosemaree McGuinness	Executive Officer, The ALSO Foundation	23 Oct. 2001–18 Oct. 2002
Gary Dowsett	Associate Professor and Deputy Director, Australian Research Centre in Sex, Health and Society (ARCSHS)	12 April 2000–17 Oct. 2002
Kay White	Former co-convenor, Transgender Victoria and Transgender Activist	12 April 2000–20 Nov. 2002
Departmental representative	**Position while attending**	**Attendance**
Martin Turnbull, DHS	Manager, Health Development Section	12 April 2000–27 Feb 2001
Michael Flynn, DEET	Ministerial Advisor to the Minister for Education, Employment and Training	12 April 2000–17 Jan. 2001
Tony Blackwell, DHS	Team Leader, Population Health, Food and Health Development	28 Feb 2001–25 Sept 2001

Glossary of terms[1]

Affirming gender

The process of adopting a lifestyle and/or body that matches a person's sense of their gender. The process may take some time, involve a number of different but related processes and often starts before an individual undertakes any changes to his or her public identity (see **Transsexual**).

Bisexual

A person who is sexually and emotionally attracted to people of both sexes.

Coming out

The process through which an individual comes to recognise and acknowledge their sexual orientation. Coming out often involves a decision to be open about one's sexual orientation. In the action plan, 'coming out' is also used to describe the processes through which transgender and intersex people come to recognise and acknowledge their gender identity and intersex condition respectively.

Cross-dresser

Someone who has an inescapable emotional need to identify as a member of the opposite gender, on a temporary or permanent basis.

Gay

Refers to a person whose primary emotional and sexual attraction is toward people of the same sex. It is often used to describe individuals who are open about their sexuality and who self-identify as gay. However, the term is most commonly applied to men. The term lesbian is commonly used to describe women whose primary emotional and sexual attraction is for other women.

Gender identity

A person's sense of identity defined in relation to the categories of male and female. In the action plan, the term is primarily used to describe people whose gender identity does not match their biological sex. However, it is important to note that not everybody identifies exclusively with one sex or the other. Some people may identify as both male and female, while others may identify as male in one setting and female in other. This suggests a gender continuum, rather than simply an opposition between one gender (male) and another (female).

1 These are provisional or working definitions. A number are open to debate within and outside the GLBTI community reflecting the fluidity of sexual and gender identities and the importance members of marginalised groups attach to the processes of self-definition and redefinition.

Heterosexism
The belief that everyone is, or should be, heterosexual and that other types of sexuality are unhealthy, unnatural and a threat to society. Heterosexism also assumes that sex and gender (and the relationship between the two) are fixed and not open to change. In the action plan, heterosexism includes both homophobia and transphobia.

Homophobia
The fear and hatred of gay and lesbian people and of their sexual desires and practices.

Homosexual
An individual whose primary sexual attraction is toward people of the same sex.

Internalised homophobia
The internalisation of negative attitudes and feelings toward homosexuality, on the part of gay men and lesbians.

Internalised transphobia
The internalisation of negative attitudes and feelings toward transgenderism, on the part of transgender people.

Intersex
A biological condition where a person is born with reproductive organs and/or sex chromosomes that are not exclusively male or female. The previous term for intersex was hermaphrodite.

Lesbian
A woman whose primary emotional and sexual attraction is toward other women. The term is often used to designate women who identify as same sex attracted, as opposed to women who have sex with other women, but who do not self-identify as lesbian.

Men who have sex with men (MSM)
Men who engage in sexual activity with other men, but who do not necessarily self-identify as gay.

Queer
An umbrella term that includes a range of alternate sexual and gender identities, including gay, lesbian, bisexual and transgender.

Same sex attraction
Attraction toward people of one's own gender. The term has been used in the context of young people whose sense of sexual identity is not fixed, but who experience sexual feelings toward people of their own sex.

Transgender

Refers to someone whose identity or behaviour falls outside stereotypical gender norms. In the action plan, it refers to individuals who do not identify with the gender assigned to them at birth. The terms male-to-female and female-to-male transgender persons are used to refer to individuals who are undergoing or have undergone a process of gender affirmation (see **Transsexual**)[2].

Transphobia

Fear and hatred of people who are transgender or transsexual.

Transsexual

Refers to individuals who are born anatomically male or female but have a profound identification with the gender opposite to that assigned to them at birth. In the action plan, transsexual refers to people who are making, intend to make, or have made the transition to the gender with which they identify. It also includes people who wish to make the transition, but are prevented from doing so. Transition refers to a number of different though related processes, including changes to a person's outward appearance, hormone treatment and surgical gender reassignment (see **Affirming gender**).

Women who have sex with women (WSW)

Women who engage in sexual activity with other women, but who do not necessarily self-identify as lesbian.

2 The terms 'transgender' and 'transsexual' are currently subject to vigorous debate within the transgender, transsexual and intersex communities. A number of transsexual representative organisations do not recognise transgender as an umbrella term. Rather, they understand transsexualism as a medical condition where an incongruity exists between chromosomal and anatomical sex and the sexed structure of the brain (see ***Appendix A***).

Abbreviations

ABS	Australian Bureau of Statistics
ACON	AIDS Council of New South Wales
AFAO	Australian Federation of AIDS Organisations
AGs	Attorney Generals (Victoria)
AIDS	Acquired immunodeficiency syndrome
ART	Assisted reproductive technologies
DE&T	Department of Education and Training
DHS	Department of Human Services (Victorian)
EO	Equal Opportunity
GAMMA	Australian Bisexual Men's Association (Gay and Married Men's Association)
GLBTI	Gay, lesbian, bisexual, transgender and intersex
GLMA	Gay and Lesbian Medical Association
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
IS	Intersex
IVF	In vitro fertilisation
MACGLH	Ministerial Advisory Committee on Gay and Lesbian Health
MSM	Men who have sex with men
NHMRC	National Health and Medical Research Council
NWHP	National Women's Health Policy
PLWHA	People living with HIV/AIDS (Victoria)
SMASH	Sydney Men and Sexual Health Study
SSAFE	Same sex attracted friendly environments
SSAY	Same sex attracted youth
STI	Sexually transmissible infection
TG	Transgender
TS	Transsexual
VAC/GMHC	Victorian AIDS Council/Gay Men's Health Centre
VGLRL	Victorian Gay and Lesbian Rights Lobby
WHO	World Health Organisation
WSW	Women who have sex with women

1. Background

This document presents an action plan for promoting the health and wellbeing of gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. The plan was drafted by the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) in conjunction with the Department of Human Services and is the first plan of its kind at state, territory or federal level in Australia.

The action plan draws on recent Australian and international research on the health status of GLBTI people, outlines the key health concerns they face and documents a range of GLBTI health and wellbeing initiatives currently being undertaken within the Department of Human Services and other Victorian Government departments. It outlines suggested priority areas for action on the part of Government, primary health care providers and a range of other institutions aimed at improving the wellbeing of members of Victoria's diverse GLBTI communities and the quality of health care they receive. The plan provides a compelling case for the development and implementation of a coordinated state-based GLBTI health and wellbeing strategy.

The action plan is an expression of the Government's broader commitment to valuing and encouraging diversity and extending to all Victorians the right to participate fully in the social and political life of the State.[3] It reflects the Government's commitment to:

- promoting rights and respecting diversity
- building cohesive communities and reducing inequalities
- sound financial management
- providing high quality, accessible health and community services.[4]

1.1 Development of the GLBTI health and wellbeing action plan

This action plan is the result of a review of research on the health status and needs of GLBTI Victorians and extensive statewide consultations with GLBTI individuals, health professionals and community organisations (Figure 1).

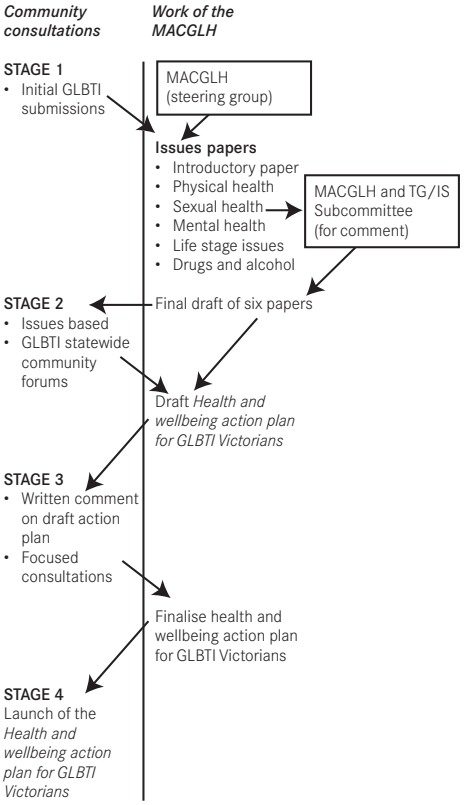
Stage 1 Production of GLBTI health research papers

- The MACGLH was established in April 2000. As part of that process, submissions were sought from GLBTI organisations and individuals regarding the major health issues they faced. Fifty-six submissions were received, providing more than 150

3 These values are listed in full in the Government's Policy Framework document, *Growing Victoria Together: innovative state. caring communities* (November 2001) Department of Premier and Cabinet: Melbourne, Victoria.

4 See *Rural and Regional Health and Aged Care Services Division: policy and funding plan 2002–2010* Victorian Government Department of Human Services: Melbourne, Victoria for how the Government's broader principles apply to health policy and the delivery of primary health care.

Figure 1 – Development of the GLBTI health and wellbeing action plan



recommendations with supporting anecdotal and documentary evidence. The MACGLH grouped the health issues raised in the submissions into five key areas:

- physical health
- sexual health
- mental health
- life stage
- drug and alcohol issues.

- Research papers were commissioned covering each of these five areas. Edited versions–along with an introductory paper that develops a framework for understanding patterns of health and illness common to GLBTI people–were developed by the MACGLH with input and advice from members of the Transgender and Intersex Subcommittee. A collection of these papers has been published by the Department of Human Services titled: *What's the difference? Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians.* The collection includes the original authors' names and organisational details.

Stage 2 Statewide GLBTI community forums and production of a draft of the GLBTI action plan

- Community Concepts, a private consultancy with strong links to GLBTI communities, was commissioned to undertake and provide written reports to the Department of Human Services and the MACGLH on stages 2 and 3 of the GLBTI community consultations. Stage 2 consisted of a series of statewide GLBTI community forums seeking feedback on the issues raised in the research papers. A total of 150 people, including GLBTI consumers and health service providers, attended the 13 forums held at rural, regional and metropolitan locations across the State.
- The MACGLH produced a draft GLBTI health and wellbeing action plan using:
  - research findings on GLBTI health
  - feedback from the statewide GLBTI community forums
  - a GLBTI audit of current (2001) Department of Human Services policies, programs and services.

Stage 3 Comment on the draft health and wellbeing action plan for GLBTI Victorians

- Written feedback on the draft GLBTI health and wellbeing action plan was sought from key GLBTI health service providers, research institutes and community organisations across the State.

Stage 4 The health and wellbeing action plan for GLBTI Victorians

- A final version of the action plan has been developed by the MACGLH and includes feedback from stage 3 of the consultation.

1.2 A brief history of GLBTI legislative and social reform

The development of a Victorian GLBTI health agenda parallels the development of health agendas for other minority and disadvantaged groups, including women, Indigenous Australians and ethnic minorities and, more recently, initiatives that target older people and people with disabilities. These initiatives have relied on broader processes of legislative and social reform that recognise the rights and responsibilities of members of minority and disadvantaged groups while seeking to redress the deeper social forces responsible for their marginalisation.

The emergence of a minority rights agenda signals a dramatic shift in the Australian social landscape, a movement away from a belief in an homogeneous society to an awareness of the growing diversity of the Australian population. Difference and diversity have moved from the margins to become a defining feature of contemporary Australian society and the campaign for GLBTI rights has been a crucial part of that story.

1.2.1 Gay, lesbian and transgender legal and medical reform

In October 1972, South Australia became the first Australian jurisdiction to decriminalise male homosexual behaviour.[5] Victoria followed suit in 1980. It was not until the enactment of Tasmanian legislation in 1997 that male homosexuality was decriminalised in all states and territories. Although there were no formal statutes in federal or state legislation against lesbianism, the public expression of same sex intimacy between women was also an object of homophobic abuse and discrimination.[6]

Changes to state and territory anti-discrimination laws have accompanied the decriminalisation of homosexuality.[7] Amendments to the Victorian *Equal Opportunity Act 1995* (EO Act) prohibited discrimination on the grounds of 'lawful sexual activity'.[8] In 2000, to provide further protection, the EO Act was amended to include

5 The initial legislation set the age of consent at 21 years of age. This was lowered to 17 years in August 1975 and later to 16 years.

6 The story goes that when legislation was passed in the British parliament outlawing homosexual acts Queen Victoria could not countenance the possibility of same sex sexual activity between women. As a result only male homosexuality entered the British criminal code.

7 As Danny Sandor notes 'So far as anti-discrimination laws are concerned, protection under Commonwealth statute is negligible despite the past attempts of individual parliamentarians to introduce legislative reform'. See Sandor, Danny (March 2002) 'No Mr Muehlenberg, there's no sex with labradors: flat-earthers come round to the ordinary family lives of sexual outsiders', a paper presented at the Law Council of Australia, Family Law Section 10th National Family Law Conference, Melbourne 17 March 2002.

8 See *Same sex relationships and the law* (March 1998) Equal Opportunity Commission of Victoria. Since that resource was produced a number of states and territories have enacted legislative changes that recognise the rights and responsibilities of same sex couples. However, the scope of these legislative changes varies from one jurisdiction to the next.

'sexual orientation' and 'gender identity'. In 2001, Victorian legislation was enacted that extended to same sex couples many (but not all) of the rights afforded married and de facto heterosexual couples.[9]

Legislative reform has paralleled the declassification of homosexuality as a psychiatric or mental disorder. In 1973, the Australian and New Zealand College of Psychiatrists and the American Psychiatric Association declassified homosexuality.[10] However, it was not until 1999 that the *International Classification of Diseases (ICD)* no longer assigned homosexuality a disease code.

While homosexuality has been declassified, major diagnostic manuals continue to pathologise transgenderism with the latest edition of the *ICD (ICD-10)* listing 'transsexualism' and 'gender identity disorders' as sexual deviations and disorders of psychosexual identity.

1.2.2 The emergence of a GLBTI health and wellbeing agenda

The development of a GLBTI health and wellbeing agenda within government has drawn on earlier and ongoing initiatives in women's, lesbian and gay men's health and wellbeing and on more recent developments in transgender and intersex health.

Women's health policies were first produced in South Australia in 1984, in New South Wales in 1985 and in Victoria in 1987.[11] In 1989, a National Women's Health Policy (NWHP) was endorsed by all Commonwealth and state governments and continues to inform women's health policy development across the country.[12]

The development of national and state-based women's health strategies owe much to the women's health movement.[13] Representative women's health groups lobbied governments to consider the effects of gender and gender inequality on women's health and to develop programs and models of service delivery that were aware of and sensitive to their needs.

9 The *Statute Law Amendment (Relationships) Act 2001* (Vic) and the *Statute Law Further Amendment (Relationships) Act 2001* (Vic). This story of progressive social change is complicated by recent challenges at the federal level to the Sex Discrimination Act that seek to restrict women's access to IVF in particular and to assisted reproductive technologies more generally on the basis of sexual orientation and marital status.

10 See the ANZ College of Psychiatrists (1973) 'Homosexuality' *Clinical Management No.6*.

11 Beaumont, Marilyn (November 2000) *Victorian women's health program – what is it? past, present and future.* Paper presented at the Women's Health Victoria Forum, 16th November 2000.

12 *Victorian Women's Health and Wellbeing Strategy: discussion paper* (2001) Victorian Government Department of Human Services: Melbourne, Victoria

13 Broom, D.H. (1991) *Damned if we do: contradictions in women's health care* Allen and Unwin: Sydney

The women's health movement, however, was slow to take up lesbian health. In part this was due to a lack of research into lesbian health and data showing that lesbians might have different health outcomes to women generally. This absence is reflected in the development of women's health policy at state and national levels. The NWHP, for example, includes sexuality in its terms of reference but understands it solely in terms of women's reproductive health.

The Victorian Government has addressed this gap and consulted with the lesbian community in the development of its current Women's Health and Wellbeing Strategy.[14]

The gay men's health agenda has developed against the backdrop of HIV/AIDS. In 1983, Sydney's gay community established the AIDS Action Committee. The Melbourne gay community followed suit in July 1983, establishing the Victorian AIDS Action Committee, which later became the Victorian AIDS Council (VAC). In November 1985, the state-based AIDS councils formed a national body, the Australian Federation of AIDS Organisations (AFAO).[15]

Australia's response to HIV/AIDS has been characterised by a partnership between government, non-government and professional organisations and community groups. This partnership has been vital to the development of the four successive national HIV/AIDS strategies that have informed Australia's approach to the epidemic since 1989. The Victorian Government has just released its first Victorian HIV/AIDS Strategy, acknowledging the need to compliment a national approach with knowledge of state-based variations in the nature and impact of the epidemic.[16]

More recently, a number of community and professional organisations attempted to forge a common lesbian and gay men's health and wellbeing agenda. This involved exploring how sexual orientation interacts with other social determinants–in particular with gender–to produce patterns of health and illness specific to gay men and lesbians. It has also involved shifting focus from sexual health narrowly defined to the impact of wider social forces on the health **and wellbeing** of sexual minorities.

At the same time there is a push by transgender and intersex groups to have their respective health and wellbeing issues placed on the political agenda. These issues include access to a range of surgical procedures and hormone treatments and to a broader range of information and counselling services.

14 *Victorian Women's Health and Wellbeing Strategy: information kit* (2002) The Victorian Government Department of Human Services: Melbourne.

15 *Protecting our investment: 1997 report to the Minister for Health and Family Services* (February 1998) Australian National Council on AIDS and Related Diseases.

16 *Victorian HIV/AIDS Strategy: 2002–2004* (July 2002) Victorian Government Department of Human Services: Melbourne, Victoria.

1.3 Current GLBTI health and wellbeing policy context

1.3.1 International

The World Health Organisation (WHO) is undertaking a review of the literature related to sexuality and sexual behaviour that includes gay and lesbian sexualities in its terms of reference.[17] The review outlines the strengths of a robust, social definition of sexuality and suggests that such a definition is crucial to understanding the complexities of sexual behaviour and the development of effective sexual health policy.

The US Gay and Lesbian Medical Association recently produced a document on lesbian, gay, bisexual and transgender health to accompany *Healthy people 2010*, the US Department of Health and Human Services' 10 year blueprint for public health.[18] Like the WHO review, the companion document adopts a social model of health and lists a number of key social factors that shape patterns of health and illness specific to GLBT people.

The *American Journal of Public Health* recently dedicated an entire issue to lesbian, gay, bisexual and transgender health.[19] 'LGBT health is clearly an issue whose time has come', notes the editorial. The Journal argues that sexual orientation and gender identity discrimination underpin many of the health problems and patterns of ill health specific to GLBT(I) people.[20]

In 1999, the European Union (EU) included in its charter non-discrimination on the grounds of sexual orientation.[21] It is currently considering strengthening the charter to include provisions for non-discrimination on the basis of gender identity (understood in current legislation as a form of sex discrimination) and the recognition and protection of family diversity and the right of same sex partners to found a family.[22] In 2002, the American Academy of Pediatrics released a position statement endorsing the legitimacy of same sex parenting.[23]

17 Work in progress, Couch. M., Pitts, M. and Dowsett, G. (2002) *Searching for sex: systematic literature review of international research related to sexuality and sexual behaviour.* Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

18 *Healthy people 2010: companion document for lesbian, gay, bisexual and transgender health* (2001) San Francisco, CA: Gay and Lesbian Medical Association.

19 *American Journal of Public Health* (June 2001) 91 (6)

20 'LGBT people share remarkably similar experiences related to stigma, discrimination, rejection and violence across cultures and locales'. Meyer, I. H. (2001) 'Why lesbian, gay, bisexual, and transgender public health?' *American Journal of Public Health* 91 (6): 856–58.

21 Article 13, *The Amsterdam Treaty*, 1999. Article 13 commits member states to 'combat[ing] discrimination based on racial or ethnic origin, religion or belief, disability, age or sexual orientation'. The EU Charter is the first international treaty to reference sexual orientation.

22 International Gay and Lesbian Association (ILGA) Europe (June 6, 2002) *Submission to the Convention of the Future of Europe*, Brussels.

1.3.2 Australian – Federal

The Federal Government's recent support for changes to the Sex Discrimination Act[24] runs counter to international and Australian state and territory legislative reform. Nonetheless, a number of key national strategies acknowledge the specific needs of GLBTI people and have direct implications for the funding and development of state-based GLBTI health and wellbeing initiatives. They include:

- National HIV/AIDS, Hepatitis C and Related Diseases Strategy
- National Suicide Prevention Strategy
- National Mental Health Strategy
- National Drug Strategy
- National Homelessness Strategy
- National Families Strategy
- National Public Health Partnerships
- Health Promoting Schools.

The Australian Medical Association (AMA) produced a position statement on sexual identity and gender diversity, which was endorsed by the AMA federal council in October 2002.[25] This also supports an anti-discrimination approach to GLBTI health care, and the need to improve the training of medical professionals at all levels.

1.3.3 Other states and territories

A number of other states and territories have enacted legislative changes that acknowledge to varying degrees the rights and responsibilities of sexual and gender minorities and same sex and non-heteronormative couples.[26]

23 American Academy of Pediatrics, Committee on Aspects of Child and Family Health. Policy Statement: Coparent or second-parent adoption by same-sex parents (2002) *Pediatrics* 109 (2): 339–40

24 The changes would make marital status and homosexual orientation legitimate grounds for refusing women access to ART services generally and IVF technologies in particular.

25 Australian Medical Association. Position statement on sexual identity and gender diversity, www.ama.com.au

26 Sandor, D, (March 2002), op cit.

Western Australia recently enacted wide-ranging legislative reforms that move toward equality for lesbians and gay men. The reforms equalise the age of consent, give all women access to donor insemination services and legally recognise same sex couples in areas as diverse as IVF, adoption, superannuation, organ donation and guardianship.[27] Tasmania is considering legislation that matches the Western Australian reforms in scope and intent, while a proposal is currently before the Northern Territory Government calling for similar comprehensive reforms.[28]

The Tasmanian Government has established a Gay, Lesbian, Bisexual and Transgender Reference Group that provides the Tasmanian Department of Health and Human Services with advice on GLBT health and wellbeing.[29] The South Australian Government is considering establishing a similar advisory body.

1.3.4 Victoria

The Victorian Government has undertaken a process of legislative reform that seeks to redress systematic discrimination against GLBTI people and same sex couples. It includes:

- changes to the Equal Opportunity Act which prohibit discrimination on the grounds of a person's sexual orientation or gender identity[30]
- legislative reforms that acknowledge the rights and responsibilities of same sex couples.[31]

The Government signalled its commitment to improving the health and wellbeing of GLBTI Victorians by establishing the MACGLH. The committee, in conjunction with representatives from Public Health (Department of Human Services) has overseen the development and implementation of a range of government-funded GLBTI health and wellbeing projects. These are listed in **Appendix F**.

27 These include the Acts Amendment (Lesbian and Gay Law Reform) Bill which was passed on 21 March 2002 and two further Bills, The Family Court Amendment Bill 2002 and The Coroners Amendment Bill 2002. The former allows de facto couples, including same sex couples, to access the Family Court while the latter will add same sex partners to the next of kin provision describing who has standing before the Coroner's Court.

28 In May 2002, the Darwin Community Legal Service launched a major submission with the new Northern Territory Government calling for comprehensive gay and lesbian law reform including recognition of same sex couples.

29 The reference group was established in May 2000.

30 The *Equal Opportunity (Gender Identity and Sexual Orientation) Act* 2001.

31 *The Statute Law Amendment (Relationships) Act 2001 and the Statute Law Further Amendment (Relationships) Act 2001*.

Many of these initiatives are a response to the specific needs of GLBTI people identified in a range of government strategies including:

- Victorian drug prevention initiatives
- Women's Health and Wellbeing Strategy
- Victorian HIV/AIDS Strategy 2002–2004
- Victorian Homelessness Strategy
- State Disability Plan
- Forward Agenda for Senior Victorians
- Primary Care Partnerships.

The MACGLH has also liaised with a number of other government advisory bodies to provide them with expert advice on the needs of GLBTI Victorians.[32]

32 See ***Appendix F*** for a list of other relevant advisory bodies.

2. Framework

A social model of health

The WHO defines health 'as a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity'.[33] Health and illness are effects of how physiological and psychological processes are influenced by and interact with wider social, economic and cultural factors.

A social model of health demands that health planning and service delivery take into account the broader contextual factors that influence patterns of health and illness including public policies, environmental factors and different socio-cultural practices and values.

2.1 A social model of health

The action plan uses a social model of health in developing a framework for understanding GLBTI health and wellbeing. A social model of health underpins the development of current government health policy and programs and has been used to target the health needs of marginalised and disadvantaged groups within the Victorian population.

The Government has used a social model of health to identify a number of key social factors or **social determinants** that lead to patterns of health inequality within the Victorian population. These include socioeconomic status, race, gender, ethnicity and geographic location. Each of these social determinants can be understood as a social gradient along which resources–including health and wellbeing–are distributed. For example, socioeconomic status can be thought of as a gradient with those at the top enjoying better health than those at the bottom.[34] Similarly, race or racial difference acts as a social gradient in the Australian context. Research demonstrates that Indigenous Australians experience poorer health outcomes for a number of preventable illnesses than non-Indigenous Australians.[35]

However, the social determinants of health do not operate independently of each other. Rather, patterns of health and illness within any given population are the result of the interaction or interdependence of different social determinants.[36] So, for example, patterns of health within Indigenous communities vary according to the interaction between race and socioeconomic status. Similarly, patterns of health and illness specific to ethnic minorities are an effect of the intersection of ethnicity with other key social determinants including gender, location and socioeconomic status.

2.2 Sexual orientation and gender identity as social determinants of health

There has been very little Australian research on how sexual orientation (or sexuality) and gender identity influence patterns of health and illness. Although there is an emerging awareness of sexual orientation and gender identity as key social determinants in the international literature,[37] this awareness has yet to be

33 World Health Organisation (1958), cited in Wass, A. (2000) *Promoting health: the primary care approach*. Second edition, Harcourt Saunders: Sydney.

34 Turell, G. and Matthews, C.D. (2000) 'Socio-economic status and health in Australia'. *Medical Journal of Australia* 172: 434–438.

35 *The National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99: a report on the ANCARD Working Party on Indigenous Australians' Sexual Health* (March 1997). Commonwealth Department of Health and Family Services: Looking Glass Press.

36 This point was made in a submission received from Women's Health Victoria on the draft *GLBTI health and wellbeing action plan*, Nov. 2002.

37 Two excellent and comprehensive US examples are the June 2001 edition of the *American Journal of Public Health* dedicated solely to GLBT health and the *Healthy people 2010: companion document* (2001), op cit.

Defining heterosexism, a common source of discrimination

Heterosexism describes a social system that privileges heterosexuality and that uses this heterosexual presumption to justify discrimination against alternative sexual and gender identities.[38] Heterosexism assumes that sex and gender and the relationship between the two are fixed at birth: men are born masculine, women are born feminine and sexuality is an attraction between male and female.

Heterosexism is a rigid system that has difficulty placing gay men and lesbians whose primary sexual and emotional attraction is for someone of the same sex or people whose sexuality is fluid and open to change (such as bisexuals or a person whose sexual identity changes over time from hetero- to homosexual). It has difficulty acknowledging transgender and transsexual people whose gender identity does not match the sex assigned to them at birth and intersex people who do not fit neatly into the binary categories of male and female.

incorporated into mainstream health policy and the design and delivery of programs and services.

The five research papers commissioned by the Department of Human Services on behalf of the MACGLH demonstrate that sexual orientation and gender identity determine patterns of health and illness specific to GLBTI people in at least three distinct, though related, ways:

1. Dominant understandings of sexuality and gender identity continue to marginalise and discriminate against GLBTI people. Systematic and ongoing discrimination against sexual and gender minorities results in primary health issues and patterns of illness specific to GLBTI people and a reduction in their access to mainstream health services and the quality of care they receive.
2. Sexual orientation and gender identity operate as **independent** indicators for a range of GLBTI health issues. That is, they lead to patterns of health and illness specific to GLBTI people independent of their experiences of discrimination and abuse. These include sexual health issues specific to gay men, reproductive health issues for lesbians and a range of physical health needs specific to transgender and intersex people respectively.
3. Sexual orientation and gender identity interact with other social determinants including socioeconomic status, race, ethnic and religious affiliation and geographic location to produce patterns of health and illness **within** GLBTI communities.

38 The Gay and Lesbian Medical Association of America (GLMA) adopts a somewhat narrower definition of heterosexism as 'the belief that all people are and should be heterosexual and that alternative sexualities pose a threat to society'. This definition, though useful, does not explain how transgender and intersex people might also be subject to heterosexist discrimination. *Healthy people 2010* op cit.

3 Health issues specific to GLBTI people[39]

3.1 The health effects of sexual orientation and gender identity discrimination

Heterosexism impacts on the lives of GLBTI people in profound and contradictory ways. At the individual level, evidence suggests that in order to cope with heterosexism GLBTI people may develop a range of social skills and a high degree of personal resilience.[40] At the collective level, the interaction between GLBTI people's experiences of heterosexist discrimination and their alternative sexual and gender identities have resulted in the formation of unique GLBTI community norms, values and practices. They provide GLBTI people with social support, connectedness and a positive sense of personal and collective identity.[41]

Nonetheless, the major effects of heterosexism on the health and wellbeing of GLBTI people are negative. Despite recent legislative changes, GLBTI people continue to experience high levels of violence and discrimination.

The impacts of heterosexism on GLBTI people include:

- violence and the ongoing threat of violence
- discrimination and social marginalisation
- isolation
- social invisibility
- self-denial, guilt and internalised homophobia and transphobia.

The priority is to deal with stigma and discrimination. If these are dealt with the other issues will not continue to exist.[42]

Violence against GLBT Victorians

In a report by the Victorian Gay and Lesbian Rights Lobby (VGLRL), 84 per cent of GLBT respondents had experienced discrimination as a result of their sexual orientation.[43] Seventy per cent reported having experienced at least one form of public abuse, from physical violence (7 per cent) to verbal abuse (63 per cent). Transgender people reported consistently higher levels of public abuse and all rates were higher than those reported in the Australian Bureau of Statistics (ABS) report for Victoria in 1997.

The Australian Institute of Criminology study of 74 gay homicides in NSW from 1980 to 2000 found that many of the crimes were random and more violent than similar crimes committed against the general population and that those responsible often received substantially reduced sentences.[44]

39 For a fuller discussion of the health issues confronting GLBTI Victorians consult Leonard, W. ed (July 2002) *What's the difference? Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Victorian Government Department of Human Services: Melbourne, Australia

40 Lock, J. and Steiner, H. (1999) 'Relationships between sexual orientation and coping styles of gay, lesbian and bisexual adolescents from a community high school'. *Journal of Gay and Lesbian Medical Association* 3(3): 77–82.

41 Lienert, T. (1999) 'Lesbians and mental health: importance of friendship'. Paper presented at the *Health in difference* 3 conference, Adelaide.

42 Community Concepts (May 2002) *Consultation report on health in gay, lesbian, bisexual, transgender and intersex (GLBTI)communities in Victoria.* The Victorian Government Department of Human Services.

43 Victorian Gay and Lesbian Rights Lobby (June 2000) *Enough is enough: a report on the discrimination and abuse experienced by lesbians, gay men, bisexuals and transgender people in Victoria.* VGLRL: Melbourne.

44 Reported in Pollard, R. (13 Aug. 2002) 'Attacks against homosexuals often marked by extraordinary brutality: report', Berry, J. 'Sentences for bashing pair branded unjust'. (13 Aug. 2002) *The Age* newspaper. Original report, Tomsen, S. (2002) 'Hatred, murder and male honour: anti-homosexual homicides in New South Wales, 1980–2000'. *Research and Public Policy Series* 43. Australian Institute of Criminology: Canberra.

3.1.1 Common problems and shared patterns of illness

3.1.1a Depression and suicide

An Australian study of 403 gay men reported that 27 per cent of respondents were suffering major depression.[45] In a study of 200 lesbians, 60 per cent of respondents reported feelings of depression related to their sexual orientation while 63 per cent had contemplated suicide and 30 per cent had attempted suicide.[46]

Studies suggest that the suicide rate among homosexuals is 2–7 times higher than that among heterosexuals.[47] Estimates of the percentage of same sex attracted people who have contemplated or attempted suicide range from 31 per cent to 63 per cent.[48] There is some evidence that bisexual Australians have higher levels of anxiety, depression and suicide than gay men and lesbians.[49] This study also indicated that both young and middle aged GLB people had higher levels of mental illness than heterosexual people, with more adverse life events and less positive support from family.

Rates of depression among transgender people are reported to be even higher than among gay men and lesbians. One US study reports that 62 per cent of male-to-female transgender people and 55 per cent of female-to-male transgender people were depressed, while 32 per cent of both groups had attempted suicide.[50] The *Healthy people 2010: companion document* notes that for a small percentage of pretransition people, their experiences of gender dysphoria can lead to genital and other forms of bodily mutilation. Results from the Amsterdam Gender Clinic suggest that for some transgender adolescents, early intervention with puberty delaying hormones allows them to explore gender issues under expert medical supervision.[51]

45 Rogers, G. (October 2000) 'Gay men, depression and dysthymia'. Paper presented at the Australian Society for HIV Medicine Conference, Melbourne.

46 Barbeler, V. (1992) *The young lesbian report: A study of attitudes and behaviours of adolescent lesbians today.* Twenty Ten Association, Sydney.

47 Cochran, S.D. and Mays, V.M. (2000) 'Lifetime prevalence of suicidal symptoms and effective disorders among men reporting same sex sexual partners: Results from NHANES III'. *American Journal of Public Health* 90: 573–78 and Barbeler (1992), op cit.

48 D'Augelli, A.R. and Hershberger, S.L. (1993) 'Lesbian, gay, and bisexual youth in community settings: personal challenges and mental health problems'. *American Journal of Community Psychology* 4: 421–47 and Garofalo, R., Wolf, R.C. et al. (1999) 'Sexual orientation and risk of suicide attempts among a representative sample of youth'. *Archives of Paediatric and Adolescent Medicine* 153(5): 487–93.

49 Jorm, A.F., Korten, A. E. et al. (2002) 'Sexual orientation and mental health: results from a community survey of young and middle aged adults'. *British Journal of Psychiatry* 180: 423–427.

50 Clements-Nolle, K., Marx, R. et al. (2001) 'HIV prevalence, risk behaviours, health care use, and mental health status of transgender persons: Implications for public health intervention'. *American Journal of Public Health* 91(6): 915–21.

51 *Healthy people 2010: companion document*, op cit.

Violence against same sex attracted youth (SSAY)

A comparative study of school aged young women showed that lesbian/bisexual women were more likely to report physical abuse (19 per cent) and sexual abuse (22 per cent) than heterosexual women (11 and 14 per cent respectively).[52]

In an Australian same sex attracted young people's study, 46 per cent of respondents had been verbally abused (52 per cent and 39 per cent of same sex attracted young men and women respectively) and 13 per cent reported being physically abused.[53] Seventy per cent of the abuse occurred within the school environment, while 10 per cent was carried out by family members.

- **GLBTI youth**

  SSAY are reported to be six times more likely to attempt suicide than the population as a whole. In one US survey, 20 per cent of SSAY reported having attempted suicide, while in another study the percentage was considerably higher at 62 per cent.[54] The mean age for suicide attempts for SSAY is 15–17 years.[55] Most suicide attempts occur after a person self-identifies as gay or lesbian, but prior to their having a same sex relationship or publicly coming out.

  Australian research suggests that SSAY in rural areas are at particular risk of depression and attempted suicide.[56]

- **People living with HIV and AIDS (PLWHA)**

  There is growing evidence that depression, anxiety, dementia and other general psychological issues are critical factors in the wellbeing of positive people. An Adelaide study reported high rates of depression among gay men living with HIV.[57] A national survey of PLWHA reported that over a six-month period 25 per cent of respondents had been taking medication prescribed for depression, while 26.5 per cent had taken medication for anxiety.[58]

52 Saewyc, E.M., Bearinger, L.H. et al. (1999) 'Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference?' *Family Planning Perspectives* 31(3): 127–31.

53 Hillier, L., Harrison, L. and Dempsey, D. (1999) 'Whatever happened to duty of care? Same-sex attracted young people's stories of schooling and violence'. *Melbourne Studies in Education* 40(2): 59–74. See also Baker-Johnson, M. (2000) *To turn a blind eye: a report into discrimination based upon sexuality and transgender identity in Victorian Secondary Schools–Causes, Effects, Responses.*

54 Remafedi, G. (1999) 'Sexual orientation and youth suicide'. *Journal of the Gay and Lesbian Medical Association* 4(3): 116–20 and Bagley, C. and Tremblay, P. (1997) 'Suicide behaviours in homosexual and bisexual males'. *Crisis* 18(1): 24–34.

55 Fontaine, J.H.(1997) 'The sound of silence: public school response to the needs of gay and lesbian youth'. *Journal of Gay and Lesbian Social Services* 7(4): 101–09.

56 Hillier, L., Dempsey, D. et al. (1998) *Writing themselves in: a national report on the sexuality, health and wellbeing of same-sex attracted young people.* Australian Research Centre in Sex, Health and Society. La Trobe University, Melbourne.

57 Evans, P. (1999) 'Blues Busters': a new approach to depression and HIV'. Workshop presented at *Health in difference 3 conference*, Adelaide.

58 Grierson, J.. Bartos, M. et al. (2000) *HIV Futures II: the health and wellbeing of people living with HIV/AIDS in Australia*. The Living with HIV Program, the Australian Centre in Sex, Health and Society: La Trobe University, Melbourne.

3.1.1b Alcohol and drug use

The ADF's 1998 study of drug and alcohol use among gay, lesbian and queer communities in Victoria found that alcohol and drug use within these communities was two to four-fold higher than in the Victorian population as a whole.[59] However, this preliminary survey focused primarily on the dance party and commercial scene. It is likely that there are different patterns of alcohol and drug use among GLBTI people who are not part of the commercial scene.[60]

The Victorian statewide GLBTI community forums highlighted that many GLBT people use drugs and alcohol to deal with, and in some cases escape, the pressures of being gay, lesbian, bisexual or transgendered.[61]

Drugs and alcohol are bigger issues because we are all brought up in traditional families. We are conditioned that heterosexuality is the 'go', that homosexuality is wrong and bad.[62]

Participants spoke of using drugs and alcohol to cope with:

- coming out
- hiding their sexual orientation or gender identity in an environment perceived as hostile
- entering the gay and lesbian social or commercial scene.

- **GLBTI youth**

The same sex attracted national youth survey reported higher rates of illegal drug use for SSAY compared to the general population[63]. In particular, SSAY were more likely to have used marijuana and party drugs such as speed and LSD (acid). The report argued that these patterns of drug use were linked to higher rates of absenteeism, depression and suicidal behaviour among SSAY. These results are consistent with US findings that also highlight the problem of multiple substance or polydrug use among GLBT youth.[64]

59 Murnane, A. et al. (2000) *Beyond perceptions: a report on alcohol and other drug use among gay, lesbian, and queer communities in Victoria*. Australian Drug Foundation, Melbourne.

60 Comment on the draft action plan from Graeme Kane, Eastern Drug and Alcohol Service, November 2002.

61 *Consultation report on health in GLBTI communities in Victoria,* op cit.

62 *Consultation report on health in GLBTI communities in Victoria (2002)*, op cit.

63 *Writing Themselves In*, op cit.

64 Garofalo, R., Wolf,R.C. et al. (1998) 'The association between health risk behaviours and sexual orientation among a school-based sample of adolescents'. *Paediatrics* 101(5): 895–902.

SSAY in rural areas were more likely to have injected drugs than young people from metropolitan areas. They often use drugs alone or belong to 'heterosexual' injecting networks associated with street contexts that include speed and heroin.[65]

- **People living with HIV and AIDS (PLWHA)**

  The findings of the 1999 *Sydney men and sexual health* (SMASH) report show that a percentage of HIV positive men continue to use recreational drugs.[66] Continued, or in some instances increased, recreational drug use among HIV positive men may reflect their greater involvement in a drug-tolerant culture. However, it may also reflect attempts to manage increased levels of stress, worry and depression associated with HIV infection and with increased discrimination from within and outside GLBTI communities.[67]

3.1.1c Sexual health

US studies suggest that negative attitudes toward same sex relationships and to sexual and gender minorities more generally may place GLBTI people under unique and increased pressure as they begin to explore their sexuality.[68] In an attempt to cope with these pressures, GLBTI people may link sexual activity to increased drug and alcohol use or may place themselves at greater risk of contracting a sexually transmitted infection (STI) or getting pregnant.

- **GLBTI youth**

  Studies have linked increased drug and alcohol use–including binge drinking–to an increase in sexual activity.[69] The same sex attracted national youth survey found increased substance abuse and rates of unsafe sex among SSAY compared to heterosexual young people.[70] Another Australian school-based survey found that 24 per cent of SSAY had had an STI compared with an estimated 8 per cent of heterosexual youth.[71]

65 Southgate, E. and Hopwood, M. (1999) *The drug use and gay men project*. National Centre in HIV Social Research, University of New South Wales, Sydney.

66 *Changes in behaviour over time* (1999) Sydney Men and Sexual Health (SMASH). Joint Research Project, National Centre in HIV Epidemiology and Clinical Research and the AIDS Council of NSW, Sydney.

67 Greenwood, G. (2001) 'Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study'. *Drug and Alcohol Dependence* 61(2): 105–12

68 Lock and Steiner (1999), op cit.

69 *Dangerous liaisons: substance abuse and sex* (1999) The National Centre on Addiction and Substance Abuse at Columbia University, USA.

70 *Writing Themselves In*, op cit.

71 Lindsay, J., Smith, A. et al. (1997) *National survey of Australian secondary students HIV/AIDS and sexual health, 1997: final report*. Centre for the Study of Sexually Transmissible Diseases: Melbourne.

The same sex attracted youth survey also showed that same sex attracted young women were more likely to have sex with men compared to their heterosexual counterparts. A study comparing pregnancy rates among adolescent women showed that 12 per cent of those who identified as lesbian had been pregnant, versus 5 per cent of heterosexual respondents.[72] These results suggest that young lesbian women choose overtly heterosexual behaviours in an effort to deny or hide their same sex sexual attraction, or as part of their exploration of their sexuality.

- **Bisexually active men**

  The Australian Bisexual Men's Association (GAMMA Project) reports that many bisexually active men do not want to be associated with the gay community.[73] As such they have reduced access to safe sex materials and are under pressure to maintain their anonymity in sexual encounters with other men. This may lead to increased sexual risk taking, including unsafe sexual practices. A study of 26 men who had been married and had sex with men found that 38.5 per cent reported having unsafe sex with men prior to marriage, 23.1 per cent while married and 60 per cent after their marriage.[74]

- **Transgender people**

  The Victorian Transgender Community Working Party reported that the pressure associated with being transgendered can lead to low self-esteem and an increase in drug taking and unsafe sex.[75] A US study found that transgender sex workers were stigmatised within the sex industry and were more likely to engage in unprotected sex on client demand.[76] A Chicago study of the needs of transgendered people found that 46 per cent of respondents were HIV positive, 22 per cent had had an STI and 48 per cent of male-to-female and 85 per cent of female-to-male transgender people had had sex without a latex barrier.[77]

72 Saewyc, E. M. , op cit.

73 The Australian Bisexual Men's Association (March 2000) *Submission on scope and priorities for the Victorian Ministerial Advisory Committee on Gay and Lesbian Health.*

74 Higgins, D. J. (2002) 'Gay men from heterosexual marriages: attitudes, behaviours, childhood experiences, and reasons for marriage'. *Journal of Homosexuality* 42 (4): 15–34.

75 The Victorian Transgender Community Working Party (March 2000) *Submission on scope and priorities for the Victorian Ministerial Advisory Committee on Gay and Lesbian Health.*

76 Dean, L., Meyer, H.H. et al. (2000) 'Lesbian, gay, bisexual and transgender health: findings and concerns'. *Journal of the Gay and Lesbian Medical Association* 4: 101–51

77 Kenagy, G.P., Bostwick, W.B. et al. (2001) *Health and social service needs of transgendered people in Chicago.* College of Social Work, University of Illinois: Chicago.

3.1.1d Discrimination against GLBTI relationships

Discrimination against GLBTI people may have a negative impact on their ability to form and sustain relationships. This may lead to feelings of inadequacy, guilt and depression and further isolation from key social structures, including school, family and work.[78]

- **Friends and community relationships**

  An Australian study of the mental health of lesbians showed that friendship networks enhance their health and wellbeing.[79] Young GLBTI people may have difficulty forming friendships due to intense pressure not to be open about their sexual orientation, gender identity or intersex status.[80]

  Older GLBTI people, particularly those who come out later in life and those living in rural communities, may experience difficulty maintaining friendship, family and social networks and contacting GLBTI community groups for support. During the Victorian statewide community forums one woman's response was indicative of the experience of a number of women who came out as lesbian later in their lives.

  I lost a whole community of friends, family and contact from people I had been involved with for many, many years.[81]

- **Religious affiliation**

  For many people, spirituality and religious affiliation provide a sense of community and social connectedness and contribute to their overall health and wellbeing. However, submissions received during the final stage of the GLBTI community consultations highlighted the negative mental and physical health effects on GLBTI people who had been ostracised by their religious community because of their sexuality or gender identity.[82]

  At the same time a number of submissions also identified religious intolerance as contributing to discrimination against GLBTI people and same sex couples more generally.[83]

78 Sandfort, T., de Graaf, R. et al. (2001) 'Same-sex behaviour and psychiatric disorders: findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS)'. *Archives of General Psychiatry* 58: 85–91.

79 Lienert, T. (1999), op cit.

80 *Writing themselves in*, op cit.

81 *Consultation report on health in GLBTI communities in Victoria (2002)*, op cit.

82 Comment on the draft *Victorian GLBTI health and wellbeing action plan* from Acceptance Melbourne Inc. Nov. 2002.

83 Comment on the draft *Victorian GLBTI health and wellbeing action plan* from Lesbian and Gay Solidarity Melbourne, Nov. 2002 and from Acceptance Melbourne, op cit.

- **Intimate relationships**

  Sydney research indicates that the single most important source of emotional support for gay men is their partner.[84] Despite recent legislative changes, same sex couples and couples in which one or both partners are transgender or intersex do not receive the same level of social affirmation and support given to normative heterosexual relationships. There are few mainstream venues in which GLBTI people can meet potential partners and limited social spaces in which expressions of same sex intimacy are tolerated, let alone encouraged.

  Health-related issues specific to same sex and non-gender normative couples include:

- Internalised homophobia or transphobia of one or both partners which may inhibit the integration of sexual expression and emotional intimacy in the relationship.[85]
- The underreporting of domestic violence. GLBTI people may not report violence in their relationships because of fear that it will lead to increased levels of discrimination.[86]
- **Transition from a heterosexual to a same sex relationship**

  A large number of GLBTI people have been in heterosexual marriage or de facto relationships. While living in a heterosexual relationship they may experience a sense of conflicting sexual or gender identities that may have a negative impact on their mental and physical health.

  Stress and depression are common during and following transition from a heterosexual to a same sex relationship. Transition may involve rejection by family (including children), friends and work colleagues and a radical shift in a person's sense of identity.[87]

  There is evidence that men who move from a heterosexual to a gay way of life may be at increased risk of STIs, including HIV, and that while they remain heterosexually active they may pose a health risk to their female partners.[88]

84 Prestage, G. (1997) 'Gay men and health: findings form the Sydney men and sexual health (SMASH) study'. *Proceedings from Health in difference 1*. Australian Centre for Gay and Lesbian Research: Sydney.

85 Polansky, J. S., Karasic, D.H. et al. (1997) 'Homophobia: therapeutic and training considerations for psychiatry'. *Journal of the Gay and Lesbian Medical Association* 1(1): 41–47.

86 Meyer, I., Rothblum, E. et al. (2000) 'Lesbian, gay, and bisexual health concerns: mental health and mental disorders'. *Journal of the Gay and Lesbian Medical Association* 4(3): 116–20.

87 *Consultation report on GLBTI communities in Victoria*, op cit.

88 The Australian Bisexual Men's Association (March 2000), op cit.

- **Family formation and parenting**

  Prejudice against sexual and gender minorities is often most pronounced around issues to do with family formation. Current legislation prohibits surrogacy and prevents lesbians and gay men accessing adoption in most states and territories, including Victoria (*Adoption Act 1984*). However, WA has recently passed the Acts Amendment (Lesbian and Gay Law Reform) Bill, which allows same sex couples to access adoption.[89]

  In Victoria, the current ruling on the *Infertility Treatment Act 1995* is that only clinically infertile women can access assisted reproductive technologies (ART).

  ### GLBTI parents

  GLBTI parents must consider whether or not to be open about their sexual orientation or gender identity and how that decision is likely to affect not only their own health but also that of their children. These complex negotiations are specific to GLBTI families. Ongoing lack of recognition of the non-biological parent as a legal guardian creates difficulties when dealing with the health care, welfare and school systems and can cause delays in accessing health services.

  Research shows that children of GLBT parents are subject to increased harassment and bullying at school.[90] A study of the children of lesbian parents shows that they are concerned about being stigmatised because of their parents' sexuality.[91]

  ### GLBTI children

  Evidence suggests that rejection by family is a major health risk for GLBTI youth. A US study shows that those adolescents who came out to family and friends reported higher rates of suicide ideation that those who did not.[92] A high percentage of those who came out were subject to verbal and physical abuse by family members. Australian data show higher rates of homelessness for SSAY due to rejection by family and friends.[93]

89 The Act was passed on 21 March 2002 and represents the most progressive same-sex relationship reform in Australia. The Bill includes wide ranging legislative reforms including permitting all infertile women access to IVF technology and all women access to donor insemination services.

90 Ray, V. and Gregory, R. (2001) 'School experiences of the children of lesbian and gay parents'. *Family Matters* 59: 28–34 and *Writing themselves in*, op cit.

91 Patterson, C.J. (2000) 'Family relationships of lesbian and gay parents'. *Journal of Marriage and the Family* 62: 1052–62.

92 Armesto, J. C. and Weisman, A. G. (2001) 'Attributions and emotional responses to the identity disclosure ('coming out') of a homosexual child'. *Family Process* 40(2): 145–61.

93 Hillier et al. (1999), op cit. and *To turn a blind eye*, op cit.

3.1.2 Reduced access to quality health care and under-utilisation of services

3.1.2a Prejudiced attitudes of health care providers

I have had the same practitioner for the past 15 years and when my sexuality changed, I told him and his attitude changed too.[94]

Amongst GLBT Victorians, 23 per cent have experienced discrimination in relation to medical care.[95] These figures compare with a review of several international GLB surveys showing that between 31 and 89 per cent of GLB people had experienced health care professionals displaying negative attitudes toward them because of their sexuality.[96]

US research shows that negative attitudes on the part of mental health service providers toward homosexuality can lead to a deterioration in the mental health of their GLB clients.[97]

The Australian Intersex Support Group (Androgen Insensitivity or AIS Support Group Australia) reports that intersex people often undergo unnecessary medical treatment and examination as children and adults and that medical students may be present without the prior consent of the patient. The AIS Support Group notes a number of other quality of care issues for intersex people, including lack of consent for childhood surgical procedures, lack of support and counselling for intersex individuals and their families, and lack of information of alternative treatments.

GLBTI people also report experiences of discrimination and reduced standards of health care in services run by religious organisations. A number of submissions received during the final stage of the GLBTI community consultations noted the difficulties that GLBTI people face in being open about their sexuality or gender identity when accessing such services.[98] One submission suggested that these problems were acute for older GLBTI people and may result in their not accessing aged care services run or staffed by members of particular religious groups.[99]

94 *Consultation report on health in GLBTI communities in Victoria (2002)*, op cit.

95 *Enough is enough*, op cit. In a separate study of young lesbians in Sydney 89.5 per cent of participants had experienced discrimination as a result of their being lesbian. Barbeler V. (1992), op cit.

96 Harrison, A. E. (1998) 'Primary care of lesbian and gay patients: educating ourselves and our students'. *Family Medicine* 28(1): 10–23.

97 Division 44/Committee on Lesbian, Gay, and Bisexual Concerns (2000) 'Guidelines for psychotherapy with lesbian, gay and bisexual clients'. *American Psychologist* 55(12): 1440–451.

98 Comment on the draft *Victorian GLBTI health and wellbeing action plan* from Lesbian and Gay Solidarity Melbourne and from Acceptance Melbourne Inc., op cit.

99 Lesbian and Gay Solidarity Melbourne, op cit.

3.1.2b Communication with health care providers

A US study showed that lesbians who disclosed their sexual orientation to their health care providers were more likely to seek preventative health care, such as Pap smears, than lesbians who had not.[100] However, non-disclosure is common due to fear of negative responses and reduced standards of care. Over 50 per cent of respondents in a Canadian study of lesbians' and bisexuals' experiences of health care had never come out to their health care providers.[101]

As disclosure enhances health outcomes for GLBTI clients, health care providers have a duty of care to provide an environment in which clients feel safe and are encouraged to be open abut their sexual orientation, gender identity or intersex status. Lesbian consumers report that health service providers often assume their clients are heterosexual, while surveys of service providers' knowledge of lesbian health reveal that many perceive they have few, if any, lesbian clients.[102]

3.1.2c Limited health service provider knowledge

A review of a number of physician surveys relating to their level of knowledge of lesbian health concludes that the vast majority of physicians have not received adequate training in human sexuality and nothing to do with homosexuality.[103] Fifty-seven per cent of respondents to the Royal Women's Hospital staff survey rated their knowledge of lesbian health as low, though a majority expressed an interest to learn more.[104]

There are limited specialist health services available for transgender and intersex clients and often the costs of meeting their physical health needs are prohibitive. This is especially so for a number of surgical procedures linked to gender affirmation for transgender people. There is limited professional knowledge concerning hormone therapies and their long-term physical effects. There are also issues relating to accessing hormones and, in particular, prescription of testosterone to female-to-male transgender people.

100 White, J.C. and Dull, V.T. (1998) 'Room for improvement: communication between lesbians and primary health care providers'. *Journal of Lesbian Studies* 2(1): 95–110.

101 Mathieson, C. M. (1998) 'Lesbian and bisexual health care: straight talk about experiences with physicians'. *Canadian Family Physician* 44: 1634–340.

102 Horsely, P. and Tremellen, S. (1996) 'Legitimising lesbian health – challenging the lack of a demonstrated need argument'. Healthsharing Women 6(4): 8–11 and McNair, R.M. (2000) 'Do GPs contribute to lesbian invisibility and ill-health?' *Australian Family Physician* 29(6): 514–16.

103 Harrison A. E. (1998), op cit.

104 Brown, R. (2000) *More than lip service: the report of the lesbian health information project*. Royal Women's Hospital of Victoria.

3.1.2d Under-utilisation of health services

- **Delayed attendance**

  While transsexual and intersex populations tend to access health services more due to ongoing health care needs, GLB populations use health services less than the general population.[105] This may be due to a belief that they will receive a reduced standard of care due to the prejudicial attitudes of some health care providers. International surveys show that GLBTI people are more likely to attend health care services after specific problems arise and present later in an illness when it is potentially more severe and less amenable to treatment.[106] There is no national Australian data on health seeking patterns of GLBTI people. However, a New Zealand national survey confirmed that there was a delay in lesbians seeking health care from both mainstream and alternative systems.[107]

- **Reduced screening**

  GLBTI people's under-use of health services may lead to reduced screening for a number of health conditions. This may be compounded by a lack of health promotion within GLBTI communities highlighting the need for screening and a false belief that GLBTI people are at minimal risk for a range of conditions because of their sexual orientation, gender identity or sexual practices.

  Some areas of major concern include:

  Cancer detection and early screening

- Smoking related cancers

  Numerous studies have documented higher rates of smoking among GLBTI people and, in particular, among lesbians.[108]

- Pap smears and mammogram screening

  Reduced use of national screening programs such as cervical (Pap tests) and breast screening (mammograms) has been identified as a health risk for lesbians and bisexual women.[109] Studies suggest that lesbians are at risk for human papilloma

105 Diamant, A.L., Wold, C. et al. (2000) 'Health behaviours, health status and access to and use of healthcare: a population-based study of lesbian, bisexual and heterosexual women'. *Arch Fam Med* 9(10): 1043–051.

106 Roberts, S. J. and Sorenson, L. (1995) 'Lesbian health care: a review and recommendation for health promotion in primary health care settings'. *Nurse Practitioner* 20(6): 42–47.

107 Saphira, M. and Glover, M. (2000) 'New Zealand National Lesbian Health Survey'. *Journal of the Gay and Lesbian Medical Association* 4(2): 49–56.

108 Beyond Perceptions, op cit.

109 Rankow, E.J. and Tessaro, I. (1998) 'Cervical cancer risk and Pap smear screening in a sample of lesbian and bisexual women'. *Journal of Family Practice* 46: 139–143 and Rankow, E.J. and Tessaro, I. (1998) 'Mammography and risk factors for breast cancer in lesbian and bisexual women'. *American Journal of Public Health Behaviour* 22: 403–410.

virus, one of the major causes of cervical cancer, through contact with women alone (and with men).[110]

- Prostate screening

  There is a lack of technical information on the effects of removing the prostate on male-to-female transgender people.

- Anal cancer screening

  Anal cancer is 80 times more common in gay and bisexual men than in the general population, and yet few doctors are aware of the need to recommend anal Pap screening for such men.[111]

- Gonadal (testicular and ovarian) and other cancers

  Lesbians may be at higher risk for ovarian and breast cancer due to a higher prevalence of obesity and lower protective factors, such as oral contraception and childbearing.

  Exposure to hormone therapy over many years may place transsexual and intersex people at increased risk of certain cancers.[112] Breast cancer in male-to-female transgender people and ovarian cancer in female-to-male people have been reported.

Bone mineral density screening

Bone mineral density loss has been reported in a significant proportion of both male-to-female and female-to-male transgender people after gonadectomy and appears to be related to underdosing of sex hormones.[113] It has also been reported in people with intersex conditions, especially those who have either had their gonads removed or have been lax in complying with their hormone therapy.

Diabetes

Obesity is a known high risk factor for diabetes. US studies show that the prevalence of obesity is higher among the lesbian community.[114] No comparable studies have been done in Australia.

110 Ferris, D. G., Batish, S. et al. (1996) 'A neglected lesbian health concern: Cervical Neoplasia'. *Journal of Family Practice* 43: 581–584.

111 Biggar, R.J. and Rabkin, C.S. (1996) 'The epidemiology of AIDS-related neoplasms'. *Hematol Oncol Clin North Am* 10: 997–1011.

112 Van Kesteren, P. J., Asscheman, H. et al. (1997) 'Mortality and morbidity in transsexual subjects treated with cross-sex hormones'. *Clinical Endocrinology* 24(3): 337–324.

113 Van Kesteren, P. J., Lips, P. et al. (1998) 'Long-term follow up of bone mineral density and bone metabolism in transsexuals treated with cross-sex hormones'. *Clinical Endocrinology* 48(3): 347–54.

114 *Healthy people 2010: companion document*, op cit.

3.2 Sexual orientation and gender identity specific health issues

Sexual orientation and gender identity lead to health issues specific to GLBTI people independent of their experiences of heterosexist discrimination. These include a range of physical health issues specific to each of these groups and increased risk for a number of health problems linked to gay and lesbian cultural practices and values.

3.2.1 Health issues specific to each group

3.2.1a Gay men's sexual health

- **HIV/AIDS**

Gay men continue to be the group most at risk of, and affected by, HIV and AIDS in Victoria. In 2000, 197 notifications of HIV were recorded, representing a 41 per cent increase over 1999 figures.[115] The increased level of notifications was maintained in 2001.

- **Other STIs**

There is a continuing outbreak of gonorrhoea in Victoria, concentrated in men who have sex with men (MSM).[116] The incidence of infection in 1999 was the highest in more than ten years.

There was an increase in the number of cases of chlamydia trachomatis notified in 1999. Sixteen per cent of men notifying with chlamydia identified as homosexual, indicating a significant effect for this group.

Homosexually active men are at risk of hepatitis A and hepatitis B. Hep B infection has been linked to unsafe sexual practices and injecting drug use, while a Sydney study has found an association between drug use and increased rates of Hep A infection. The National Health and Medical Research Council of Australia (NHMRC) recommends hepatitis A and B virus immunisation for gay men.

US evidence shows that rates of anal pre-cancer and cancer are on the rise among gay men. This may reflect increased rates of infection with strains of the human papilloma virus that have been associated with the development of pre-cancers and cancers of the anus and penis. The virus is responsible for genital warts.

3.2.1b Reproductive health issues for lesbians

About one in four lesbians care for children, conceived either within the context of a same sex relationship or from a previous heterosexual relationship.[117] Under the

115 *Victorian HIV/AIDS strategy: 2002–2004*, op cit.

116 Public Health Division (2000) Department of Human Services.

117 Horsley, P., McNair, R. and Pitts, M. (2001) 'A discussion paper on lesbian health issues' developed for the *Women's Health and Wellbeing Strategy*, Department of Human Services, Victoria. The Australian Research Centre in Sex, Health and Society: Melbourne.

terms of the Infertility Treatment Act , lesbians do not have access to donor insemination and must demonstrate clinical infertility before they can access IVF.

For lesbians in Victoria who wish to have their own biological children, their first option is self-insemination, their second is interstate donor insemination.[118] Interstate donor insemination guarantees access to screened donor sperm. However, the financial and emotional costs and the time and effort involved in interstate travel are high and the resulting stress may lead to reduced fertility. Furthermore, many lesbians are reluctant to access reproductive services or disclose their sexual orientation because of prejudiced attitudes on the part of some service providers toward lesbian clients.[119]

Self-insemination can carry a number of health risks if the donor is not screened for potential transmissible infections, such as chlamydia, gonorrhoea, syphilis, hepatitis B and HIV. The recipient may be reluctant to access pre-pregnancy health advice. She may also not have access to information regarding the recognition of ovulation so that she can time insemination.

3.2.1c Transgender physical health issues

Current models of transgender care adopt a surgical and psychiatric focus and do not encompass a more holistic, social approach to the health and wellbeing of transgender people. The Monash Gender Dysphoria Clinic has adopted the Harry Benjamin Standards[120] in establishing guidelines for the medical assessment and management of gender affirmation. However, there are no established guidelines for individual medical practitioners, leaving them ethically and legally exposed and subjecting transgender clients to variable standards of care.

Most health care providers lack knowledge about transgender issues. Ongoing professional support through gender reassignment is often inadequate and little is known about the long-term effects of hormone therapy or the ongoing need for gynaecological services for female-to-male transgender people, or urological services for male-to-female transgender people.

Female-to-male transgender people who have not undergone gender reassignment surgery require cervical cancer screening. In addition, hormone replacement therapy with testosterone may increase the risk of breast, uterine, ovarian and cervical cancer. Female-to-male transgender people may also obtain steroids on the black market due to difficulties accessing testosterone or DHT through legal medical channels. Such individuals are at risk because their ongoing hormone levels are not

118 McNair, R.P., Dempsey, D. et al. (2002) 'Lesbian parenting: Issues, strengths and challenges'. *Family Matters* 63: 40–49.

119 Myers, H. and Lavender (1997) *An overview of lesbian health issues*. Prepared for the Coalition of Lesbians Activists (COAL).

120 *Standards of care for gender identity disorder*, 6th ed. (2000) The Harry Benjamin International Gender Dysphoria Association, USA.

being monitored. There is also a problem with testosterone rage resulting from the excessive use of testosterone in the hope of speeding up the process of masculinisation.[121]

Men's Australia Network (MAN) has argued that there is a need for research into improved surgical outcomes, including phalloplasty, for female-to-male transsexuals.

Currently male-to-female transgender people who have not undergone reassignment surgery but are taking hormones for breast development cannot access Medicare for rebates for diagnostic mammograms nor use breast screening programs.

3.2.1d Intersex physical health issues

The focus on genital difference, ambiguity and abnormality can create a very negative body image for intersex people and can have profound effects on their physical health and sense of wellbeing. These negative effects are compounded by early and often recurrent surgical interventions aimed at genital 'repair' and remodelling. The AIS Support Group reports that some intersex people have problems with body image and sexual intimacy due to the particularities of their intersex condition. Anecdotal evidence suggests that intersex people experience difficulties accessing a range of health services because of embarrassment about unconventional anatomy.

What little research has been done on intersex conditions has tended to focus on whether or not to surgically assign infants and children to one sex or the other. Follow-up research is rare, although very small international studies show that people often do not 'grow' into the gender assigned for them. Hormone therapy in intersex people has not been researched, with the bulk of grants on intersexuality going to genetic research. However, the Royal Children's Hospital, Melbourne, is conducting a follow-up study of children with intersex conditions treated at the hospital over the last 30 years.

3.2.2 Cultural practices and norms

Gay and lesbian cultural practices and values may act as risk factors for a number of health problems.

3.2.2a Smoking rates among lesbians

The Australian Drug Foundation (ADF) report on drug and alcohol use among gay, lesbian and queer communities expressed concern over the level of tobacco use among lesbians. Lesbians demonstrated higher rates of smoking and smoking over longer periods of time. Lesbians aged 30–39 years reported the highest rate of tobacco use (44 per cent).[122]

121 Submission to the transgender and intersex Subcommittee of the MACGLH from Men's Australia Network (MAN).

122 *Beyond perceptions*, op cit.

The Institute of Medicine (IOM) in the US argues that higher rates of smoking among lesbians may relate to lower socioeconomic status. It is also possible that smoking functions as a shared cultural practice among lesbians, linked to their sense of personal and collective identity, a link that varies according to socioeconomic status.

3.2.2b Recreational drug use on the commercial scene

Drug and alcohol use on the gay commercial scene is primarily a social, not a private, activity. For many GLBT people, especially young people and those moving between rural and metropolitan areas, the commercial scene is one of the ways in which they take on or assume a public identity as gay, lesbian or transgender.

Alcohol, marijuana, volatile nitrites, tobacco, amphetamines and ecstasy are the drugs most commonly used by gay men, with the 20–29 year age group demonstrating the highest rate of alcohol and other drug use.[123] Australian and US research has documented the popularity of ecstasy at dance parties and one US study suggests a strong link between the use of ecstasy and high risk sexual behaviours among gay men.[124]

Social identity is based on clubs/pubs and the party scene, therefore drugs and alcohol is the gateway for meeting/greeting and belonging–it becomes an ingrained way of life.[125]

The prominence of drug use on the commercial scene has led to the development of knowledgeable approaches to drug and alcohol use. The ADF report identifies a range of harm reduction practices or 'folk pharmacologies' widely adopted by GLBT people, including: planning drinking and how to get home; using drugs with reliable friends; knowing what they are taking and how much to take, and not mixing drugs with alcohol.

There are few drug and alcohol free alternatives on the dance party and commercial scene for young GLBTI people and people questioning their sexuality. However, it is important to remember that young people are engaged in a range of other social activities, including going to movies, playing sport, travelling and eating out.[126]

3.2.2c Body image

The importance of body image in gay male culture may improve health by encouraging exercise and an awareness of physique. However, it can also lead to an excessive valuation of an ideal bodily type, resulting in a range of eating disorders. Gay men have been identified in a number of studies to be more likely than heterosexual men to have a negative body image and to have experienced an eating

123 Beyond perceptions, op cit.

124 Klitzman, R.L., Pope, H.G. et al. (2000) '('ecstasy') abuse and high-risk sexual behaviours among 169 gay and bisexual men'. American Journal of Psychiatry 157(7): 1162–164.

125 Consultation report on health in GBTI communities in Victoria (2002), op cit.

126 Comments on the draft action plan from Graeme Kane, op cit.

disorder.[127] One retrospective study found that over 40 per cent of males presenting with bulimia identified as gay or bisexual and that, of these, a high percentage also reported substance misuse and depression.[128] By contrast, research shows that lesbians have a more positive body image than heterosexual women.[129]

The gym culture can be understood as a subculture within GLBTI communities that focuses as much on physical appearance as on physical health. There is anecdotal evidence of increased steroid use among gym goers. The long-term effects of drug use include increased risk of heart disease that can be compounded by fluctuations in weight associated with repeat dieting.

3.3 The effects of other key social determinants on GLBTI health and wellbeing

GLBTI people are not an homogenous group. Sexual orientation and gender identity interact with a number of other key social determinants–socioeconomic status, ethnic and racial background, gender, geographic location, disability and age–to produce health concerns specific to subgroups within GLBTI communities.

3.3.1 Socioeconomic status

Socioeconomic disadvantage is recognised as a powerful predictor of poor health.[130] For transgender people, loss of income during transition is commonplace. TransGender Victoria estimates that 95 per cent of its members have been forced to give up their job during gender reassignment. In a recent study of people living with HIV and AIDS, almost half the respondents were experiencing financial hardship, while approximately one third were living below the poverty line.[131]

127 Siever, M.D. (1994) 'Sexual orientation and gender as factors in socio-culturally acquired vulnerability to body dissatisfaction and eating disorders'. *Journal of Consulting and Clinical Psychology* 62(2): 252–60 and Herzog, D.B., Newman, K.L. and Warshaw, M. (1991) 'Body image dissatisfaction in homosexual and heterosexual males'. *Journal of Nervous and Mental Disease* 179(6): 356–59.

128 Carlat, D.J., Camargo, C.A. and Herzog, D.B. (1997) 'Eating disorders in males: a report on 135 patients'. *American Journal of Psychiatry* 154(8): 1127–32.

129 Herzog, D. B., Newman, K., Yeh, C. and Warshaw, M. (1992) 'Body image satisfaction in homosexual and heterosexual women'. *International Journal of Eating Disorders* 11: 391.

130 Turell, G. and Matthews, C.D (2000), op cit.

131 *HIV Futures* 1(2000), op cit.

3.3.2 Ethnic and racial background

There has been little work done on how ethnic differences interact with sexual orientation and gender identity. However, a study of Vietnamese gay men living in Sydney highlighted the importance of ethnic and family identity that often resulted in pressure for these men to marry while continuing to have sex with other men.[132]

Indigenous Australians have significantly higher rates of mortality and morbidity than the general population.[133] This may be due to cultural differences and to reduced standards of care resulting from racial discrimination and insensitivity within the health care system. However, research demonstrates that many of the health problems experienced by Indigenous Australians are the result of material disadvantage and social marginalisation.[134]

3.3.3 Gender inequality

Women's health and wellbeing are inextricably linked to their position in society. Women are the primary caregivers, have lower rates of income than men and suffer more domestic violence.[135] Although the action plan focuses on the health effects of sexual orientation and gender identity discrimination, research demonstrates that gender and gender inequality influence the health issues specific to lesbians, including patterns of illness and reduced access to and standards of care.[136] Gender inequality is also likely to play a role in the health issues specific to male-to-female transgender people.

3.3.4 Geographic location

Recent Victorian health data show significant variations in morbidity and mortality rates for people living in rural and regional areas, compared to those living in metropolitan centres.[137] There is little Australian research looking at variations in GLBTI health across different geographic locations. However, the five discussion papers identify a number of factors that may contribute to poorer health outcomes for rural and regional GLBTI people. These include:

132 McMahon, T. (1996) 'Passive men are more sissy you know: experiences of sexuality for men of Vietnamese background living in Sydney who have sex with men'. *Proceedings of the 1st Health in difference conference*, Australian centre for Lesbian and Gay Research, Sydney.

133 *The National Indigenous Australians' Sexual Health Strategy* (1997), op. cit.

134 *The National Indigenous Australians' Sexual Health Strategy* (1997), op. cit.

135 *Victorian women's health and wellbeing strategy: discussion paper* (2001), op cit.

136 *A discussion paper on lesbian health issues developed for* the Victorian Women's Health and Wellbeing Strategy (2001), op cit.

137 *Victorian Burden of Disease Study: mortality* (July 1999), op cit.

- fewer health service providers with a knowledge and expertise in GLBTI health issues
- increased levels of homophobia and transphobia
- reduced access to GLBTI community and support networks.

3.3.5 Disability

GLBTI people living with a disability may be subject to the combined effects of sexual orientation or gender identity discrimination and discrimination directed against people with a disability. For example a disabled lesbian may not feel supported or welcome within a disability support network, nor within the lesbian community.[138] This lack of connection to GLBTI or disability support networks makes it difficult for GLBTI people with a disability to access educational material. GLBTI people with a disability also face major barriers to the open expression and acceptance of their sexuality.[139] They must contend not only with heterosexism but also with widely shared prejudices that see people with a disability as lacking in sexual desire, irrespective of their sexual orientation or gender identity.

There are also support issues for GLBTI people caring for partners, friends or relatives with a disability. A study examining family care giving responsibilities among gay men and lesbians showed that 32 per cent of gay men and lesbians were care givers. Lesbians were more likely to be caring for children or elderly people, whereas gay men were more likely to be assisting working age adults with a disability.[140]

3.3.6 Age

The action plan addresses key health and wellbeing issues facing GLBTI youth. However, there are a range of health issues specific to GLBTI people as they age.

138 Myers, H. and Lavender (1997), op cit.

139 Johnson, Kelley, Hillier, Lynne et al. (2001) *People with intellectual disabilities: living safer sexual lives*. Australian Research Centre in Sex, Health and Society: La Trobe University, Melbourne.

140 Fredriksen, K.I. (1999) 'Family care giving responsibilities among lesbians and gay men'. *Social Work* 44(2): 142–155.

These include:

- ageism within GLBTI communities[141]
- exclusion from youth-oriented GLBTI social networks[142]
- GLBTI people caring for older partners, relatives and friends[143]
- loss of informal GLBTI support networks[144]
- invisibility in the aged care sector[145]
- ongoing sexual orientation and gender identity discrimination in institutionalised aged care.[146]

A number of studies have shown that the major concern for GLBTI people in relation to institutionalised aged care is whether or not to disclose their sexual, gender or intersex identity. Submissions received during stages two and three of the community consultations highlighted the need for service providers to ensure a non-discriminatory and welcoming environment for older GLBTI people.[147] This included aged care services provided by local councils[148] and by religious organisations.

141 Bennett, K.C. and Thompson, N.L. (1991) 'Accelerated aging and male homosexuality'. *Journal of Homosexuality* 20(3–4): 65–75.

142 Hockley, D. (2001 forthcoming) *Aged, grey and gay: who will look after me when I am old?* Honours Thesis, Social Work and Social Policy: University of South Australia.

143 Waite, H. (1995) 'Lesbians leaping out of the intergenerational contract: issues of ageing in Australia'. In Sullivan, G. and Wai-Teng Leong, L. eds. *Gays and lesbians in Asia and the Pacific: Social and Human Services*. New York: Haworth Press, pp. 109–127

144 Fortunato, V. (1993) *Homosexuality, ageing and social support*. Behavioural Health Sciences, La Trobe Thesis, Masters of Gerontology.

145 Harrison, J. (1999) 'A lavender pink grey power: gay and lesbian gerontology in Australia'. *Australasian Journal on Ageing* 18(1): 32–37.

146 Harrison, J. (1999), op cit.

147 Comment on the draft *Victorian GLBTI health and wellbeing action plan* from Lesbian and Gay Solidarity Melbourne and from Acceptance Melbourne Inc., op cit.

148 NSW research showed that local government does not include GLBTI people in needs analysis and few Councils include GLBTI people in Social Plans or in planning processes as a special population group. At the 1999 Annual Conference of the LGA (Local Government Council NSW) a resolution was passed that the LGA develop a policy regarding support for the social and cultural needs of gay men and lesbians. See Bird and Coco (1996) *Tolerance Report* carried out for Crossroad Community Care and the Sutherland Shire (Southern Sydney) and Comment from Lesbian and Gay Solidarity, Melbourne, op cit.

4. GLBTI health policy and program priority areas

4.1 Priority areas

Priority areas refers to those broad processes of social change and changes to health service provision that must occur if there is to be a sustained improvement in the health and wellbeing of GLBTI Victorians. The three priority areas identified are congruent with the MACGLH's terms of reference and are recurring themes of GLBTI health research and the community consultations. They are:

- combating homophobia and transphobia
- maximising GLBTI people's access to mainstream services
- providing GLBTI specific services where there is a demonstrated need.

Efforts to combat homophobia and transphobia–including ongoing legislative and social reform–will reduce the discrimination and marginalisation that lead to many of the health problems and patterns of illness specific to GLBTI people. They are also likely to have a positive impact on GLBTI people's access to and use of mainstream health services and the quality of care they receive. At the same time, there is a need to develop specialist services that meet the specific needs of GLBTI people, independent of their experiences of discrimination and abuse.

4.2 Arenas for action

Arenas for action are those areas of government policy and service provision where interventions that are likely to achieve the outcomes identified under the key priority areas can be developed and implemented. They involve:

- legislative reform
- education campaigns and programs
- Department of Human Services policy and program development and coordination
- research
- GLBTI community participation.

GLBTI community participation includes involvement, wherever possible, of members of the relevant communities in GLBTI health policy and service planning, delivery and evaluation.

Table 1 maps these arenas for action onto the key priority areas to generate specific policy and program initiatives that are likely to lead to an improvement in the health and wellbeing of GLBTI Victorians.

These initiatives are outlined in greater detail in **Section 5**. The committee recommends that they be drawn together under the auspice of a single GLBTI Health and Wellbeing Policy and Research Unit.

Table 1 – GLBTI policy and program development

	Arenas for action				
Priority areas	**Legislative reform**	**Education**	**Department of Human Services**	**Research**	**GLBTI community participation**
Combating homophobia and transphobia	• Continue sexual orientation and gender identity legislative reform • Review the Infertility Treatment and Adoption Acts	• Support public education including the anti-violence project • GLBTI community eduction • School-based initiatives • Department of Human Services resources (such as Better Health Channel)	• Liaise with other relevant departments (such as Attorney Generals, Department of Eduction and Training)	• Establish best practice guidelines and standards of GLBTI quality health care • Include sexual orientation and gender identity as descriptors in data collection	• GLBTI community participation in the development, implementation and evaluation of resources
Maximising access to mainstream services		• Health service provider training in GLBTI health • Provider training in housing, welfare and legal sectors	• Review and coordinate GLBTI health related initiatives • Monitor/oversee implementation of GLBTI action plan	• Audit current levels of GLBTI health awareness among health service providers • Facilitate collection and dissemination of GLBTI health research	• Community-based GLBTI health resources, including health screening for a range of diseases
GLBTI specialist services			• Review gay and lesbian sexual health initiatives • Develop programs for specific subgroups • Transgender and intersex physical health • Review Monash Gender Dysphoria Clinic • GLBTI specific mental health and counselling services • Develop appropriate screening programs • Ongoing funding for Gay and Lesbian Switchboard	• Specific health needs of subgroups within GLBTI communities • Coordinate findings of GLBTI youth suicide prevention studies	• GLBTI community participation in the development, implementation and evaluation of services • Primary role for GLBTI community groups and professionals in establishing and running GLBTI support groups particularly for youth and ageing subgroups; transgender and intersex children and adults and for parents of GLBTI people

5. Recommendations

My initial response to these papers has been a feeling of awe at the data that has been collected and the breadth of research on health and social issues affecting the GLBTI community. …The next response is to wonder what exactly will happen as the result of gathering of all this information[149]

The following recommendations constitute this action plan. They meet the committee's original terms of reference, including providing advice to the Minister and the Department of Human Services on action required to:

- promote and support the health and wellbeing of gay men and lesbian women across Victoria
- ensure optimal access to all relevant mainstream and, where appropriate, specialist health services.

5.1 Recommendation one

Establishing a Gay and Lesbian Health and Wellbeing Policy and Research Unit

Many of the key issues raised in GLBTI research and during the community consultations could be addressed within existing government programs and services. However, this requires a coordinated response within the Department of Human Services and across a number of other government departments. It also requires ongoing input from an expert GLBTI advisory body and GLBTI community and professional organisations in policy and program development, implementation and evaluation.

The committee recommends that the Department of Human Services establishes a dedicated Gay and Lesbian Health and Wellbeing Policy and Research Unit with strong links to Public Health and Policy and Strategic Projects within the Department.

The unit would:

- further develop and coordinate existing government policies and programs
- work across those areas of government that have a major impact on GLBTI policy and programs, including Department of Human Services, Attorney General's and Education and Training
- work in partnership with GLBTI community and professional organisations to develop and implement programs and services that meet the health and wellbeing needs of GLBTI Victorians
- adopt a set of principles for conducting GLBTI sensitive research and GLBTI policy and program development similar to those listed in Appendices C and D respectively
- focus on gay and lesbian health but address bisexual, trans and intersex health issues insofar as they overlap with those of gay men and lesbians

149 *Consultation report on health in GLBTI communities in Victoria (2002)*, op cit

- be resourced to a level that gives it the capacity to oversee and monitor the implementation of the initiatives arising out of this action plan.

The work of the unit is outlined in more detail in the remaining recommendations, each of which addresses one of the key priority areas. The unit would oversee and coordinate initiatives located in each of the five arenas for action to ensure that the objectives associated with the three priority areas are met.

5.2 Recommendation two

Combating homophobia and transphobia and supporting diversity

Legislative reform

Recent legislative reforms in Victoria address the rights and responsibilities of GLBTI individuals and couples. There are some areas regarding the rights of same sex couples, especially superannuation, that require federal legislative reform.

The committee recommends that the following matters be referred to the Victorian Law Reform Commission for investigation:

- same sex couples and adoption
- Infertility Treatment Act and the limitations on lesbian access to:
  - assisted reproductive technologies
  - known donor sperm
  - relevant counselling services.

The committee also recommends that the Government considers:

- anti-vilification laws
- laws covering donation of body tissues and sperm by gay and other homosexually active men
- changes to birth certificates for transgender and intersex people.

Education

- **School initiatives**

Schools are well positioned to support young GLBTI people and they have a legal responsibility to provide a safe learning environment for all students. School programs should ensure that the needs of young GLBTI Victorians are catered for. Schools need to work actively to combat homophobia and transphobia and to promote diversity. Employment authorities need to ensure that staff are aware of the rights of GLBTI students.

The committee recommends that the Office of School Education within the Department of Education and Training:

- Undertakes an evaluation of student welfare and bullying policies to ensure inclusion of issues relevant to GLBTI students, including same sex attracted students. The design of programs that address students at risk should be cognisant of research in relation to GLBTI students including same sex attracted students.
- Ensures that relevant curriculum addresses the needs of GLBTI students including same sex attracted students. Schools also need to be provided with appropriate resources to assist in the provision of specific programs. Two such resources are *Talking Sexual Health* and *Catching On*.
- Ensures that student welfare coordinators and other relevant staff (such as school nurses) are equipped to provide support to students and teachers.

- **Better Health Channel**

The committee recommends that the Gay and Lesbian Health Research and Policy Unit regularly reviews and updates GLBTI material on the Better Health Channel, including updating Web-based lists of GLBTI support groups.

- **The Antiviolence Project**

One of the most extreme forms of homophobia and transphobia documented in this action plan is physical violence against GLBTI people.

The committee recommends that the current Antiviolence Project of Victoria be funded to conduct a public anti-homophobia and anti-transphobia campaign to address violence and hostility against GLBTI people. The project should be overseen by the Gay and Lesbian Health Policy and Research Unit and developed in consultation with:

- The Equal Opportunity Commission
- The Victoria Police GLBT liaison project
- Key community stakeholders
- The NSW Anti Violence Project.

- **Ongoing public education**

The committee recommends that the Gay and Lesbian Health Research and Policy Unit seeks ongoing opportunities through all Department of Human Services health promotion and information channels to promote positive and inclusive messages about GLBTI people.

Research

- **Standards of quality GLBTI health care**

The committee recommends that the Gay and Lesbian Health Research and Policy Unit, in conjunction with GLBTI community representatives and relevant professional bodies:

- develops best practice guidelines and standards of GLBTI quality health care and service provision
- ensures that implementation and monitoring of these standards is included in all funding and service agreements and evaluations of Department of Human Services programs.

- **Including sexual orientation and gender identity as descriptors in data collection**

The committee recommends that the Gay and Lesbian Health Research and Policy Unit:

- develops appropriate protocols for sexual orientation and gender identity to be used as descriptors in Department of Human Services data collection
- ensures that all of government-funded research complies with the principles for GLBTI inclusiveness developed by the MACGLH (Appendix D).

5.3 Recommendation three

Maximising access to mainstream services

Education

- **Health care provider awareness and training**

The committee recommends that the Gay and Lesbian Health Research and Policy Unit, in consultation with relevant professional bodies:

- Works with providers of graduate, postgraduate and ongoing health provider education to ensure their programs include GLBTI health and wellbeing issues and, in particular, knowledge of:
  - GLBTI specific health issues
  - health effects of sexual orientation and gender identity discrimination
  - lifestyle
  - cultural awareness/sensitivity
  - the legal responsibilities of providers including confidentiality and privacy.
- Targets such initiatives to key mainstream organisations including GPs, community health centres, public hospitals, aged care and drug and alcohol facilities and key sexual health and mental health providers.

- Ensures similar training and education is provided to providers working in the:
  - housing sector
  - aged care
  - youth sector
  - welfare
  - legal and foster agency services.
- Liaises with Aboriginal community organisations to ensure that the needs of Indigenous GLBTI Victorians are met by the relevant service providers.
- Works with GLBTI specific services to ensure that their programs and services meet the needs of clients with disabilities and those from various cultural and linguistic backgrounds.

Review and coordination of GLBTI initiatives within Department of Human Services

The committee recommends that the Gay and Lesbian Health Research and Policy Unit:

- Assists the Department of Human Services in undertaking a strategic review of departmental programs to ensure GLBTI health and wellbeing needs are being met.
- Liaises with relevant Department of Human Services program areas to ensure that those major GLBTI health concerns identified in the research and community consultations are adequately addressed including:
  - targeted drug and alcohol prevention and harm reduction initiatives including anti-smoking campaigns for lesbians and information on polydrug use and harm reduction campaigns for drug use on the party scene
  - mental health and depression initiatives, including the promotion of positive GLBTI mental health and self-esteem. Particular emphasis should be placed on working with Child and Adolescent Mental Health Services (CAMHS) to develop their expertise in sexuality and gender identity issues.

Research

- **Facilitate collection and dissemination of GLBTI health research**

The committee recommends that the Gay and Lesbian Health Research and Policy Unit:

- Acts as a clearing house for GLBTI research and promotes awareness of the availability of such research through a Web site and a 'research briefs' newsletter.
- Actively fosters and encourages public health researchers to incorporate GLBTI issues in their work, and to undertake specific projects where gaps are evident. For example:
  - health service usage among GLBTI populations
  - the risk taking behaviours of MSM
  - transmission of STIs among women
  - ongoing effects of hormone therapy for transgender and transsexual people
  - the specific needs of GLBTI clients with disabilities and those from various cultural and linguistic backgrounds
  - the specific health needs of Indigenous GLBTI Victorians.

5.4 Recommendation four

GLBTI specific and specialist services

GLBTI specialist services

The committee recommends that the Gay and Lesbian Health and Policy Research Unit, in conjunction with the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases (MACAHRD):

- conducts a review of current gay men's sexual health initiatives
- develops a sexual health strategy for gay men that addresses increases in HIV and gonorrhoea infection and hepatitis A and B immunisation.

The committee recommends that the unit assists intersex support groups to link with existing information networks, especially for the parents of intersex infants.

The committee recommends that the Unit works with relevant sections within the Department of Human Services to develop:

- Health screening programs that meet the specific needs of GLBTI people including:
  - anal Pap for gay and other homosexually active men
  - prostate, breast, cardiovascular and bone mineral density for transgender people
  - cervical and breast cancer screening for lesbians.

The committee recommends that a review of the Monash Gender Dysphoria Clinic be conducted in conjunction with transgender and transsexual community and professional organisations to:

- assess the appropriateness and comprehensiveness of its services
- develop a 21st century model of gender identity management combining best practice medical care and social support.

Transgender people face problems regarding the Medicare rebate for a number of services and procedures. These need to be addressed at a federal level.

Services specific to subgroups within GLBTI communities

The committee recommends that the Gay and Lesbian Health and Policy Research Unit, in conjunction with relevant sections within Department of Human Services, develops programs specific to:

- Indigenous GLBTI people
- GLBTI people with disabilities
- homeless GLBTI people
- MSM and WSW who do not identify as gay and lesbian respectively
- improving rural GLBTI people's access to health services and health information.

The committee recommends that the Gay and Lesbian Health and Policy Research Unit, in conjunction with the Department of Human Services Aged Care Division, develops a better understanding of the issues relevant to the health and wellbeing of GLBTI people who are in the aged care system.

The committee recommends that the Gay and Lesbian Health and Policy Research Unit, in conjunction with the Department of Human Services Aged Care Division, assists local government councils in addressing the needs of older GLBTI people in the development and implementation of aged care policy and services.

GLBTI youth suicide prevention

The Department of Human Services recently commissioned a number of studies relating to self-harm, suicide and attempted suicide in young people with sexuality issues.

The committee recommends that the Gay and Lesbian Health Policy and Resource Unit coordinates the findings of these studies and advises the Department of Human Services and Government on their key recommendations and on the development and implementation of appropriate programs, services and ongoing research, including data collection.

GLBTI support groups

- **Local government and non-government organisation (NGO) support groups for young and older GLBTI people**

The committee recommends that all local councils and relevant NGO youth services, particularly in rural areas, be encouraged and supported to run same sex attracted youth support groups that facilitate the role of parents as an important resource.

The committee recommends that all local councils be encouraged to run support groups for ageing gay men and lesbians who may feel excluded from mainstream support groups and from GLBTI social networks and community groups.

Support groups for younger and older GLBTI people need to be resourced adequately to ensure their sustainability.

- **Support for parents, family and relatives of gay and lesbian people**

The committee recommends that Parents and Friends of Gays and Lesbians (PFLAG) be resourced to provide resources and statewide support for parents.

- **Transgender, transsexual and intersex support groups**

Comments received during the final stage of GLBTI community consultation highlighted the difficulties and pressures faced by family and relatives of transgender, transsexual and intersex people. At present a number of unfunded community groups exist to provide these people with support.

The committee recommends government funding for support groups for intersex people and parents of intersex infants.

The committee recommends government funding for groups providing support and counselling for the partners, children, parents and in-laws of transgender and transsexual people.

Support groups for family and relatives of trans and intersex people need to be resourced adequately to ensure their sustainability and the employment of trained staff.

- **Gay and Lesbian Switchboard**

The committee recommends that the Gay and Lesbian Switchboard be provided with adequate ongoing funding to provide a statewide telephone counselling and referral service.

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Appendix A: Transgender, transsexual and intersex issues

The MACGLH's original terms of reference did not include transgender and intersex health issues. However, as part of the process of establishing the committee, the views of transgender and intersex groups were sought. When the committee was convened its terms of reference were expanded to include transgender and intersex health and wellbeing issues insofar as they overlapped with those of gay men and lesbians.

The committee developed a framework that accommodated sexual and gender identity minorities and traced out some of the health and wellbeing issues they shared as a consequence of systematic sexual orientation and gender identity discrimination. At the same time, the committee acknowledged that many of the physical health issues particular to transgender and intersex people were not covered by this framework and fell outside both the committee's expertise and terms of reference.

A Transgender and Intersex Subcommittee was convened in mid-2001 to provide the MACGLH with expert advice on transgender and intersex health in the drafting of a collection of GLBTI health research papers and *Health and sexual diversity: a health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. The subcommittee also provided the MACGLH with definitions of key terms including 'transgender', 'transsexual', 'intersex', and 'gender affirmation'.

However, those definitions have been questioned by two transsexual organisations[150] that argue that emerging research suggests transsexualism is not a form of transgenderism but rather a specific type of intersex condition. The research suggests that sexual differentiation occurs across three related but nonetheless discrete levels: chromosomal, genital and brain differentiation. It suggests that transsexualism results when the sexual differentiation or structuring of the brain is not congruent with that individual's chromosomal and genital sex.

It was not the MACGLH's role to adjudicate on these complex definitional and methodological issues. As a number of submissions to the committee have shown, sex, sexuality and gender are difficult to pin down and ongoing medical and scientific research continuously shifts people's understanding of the boundary or boundaries linking any one to the remaining two. The action plan has retained the definitions originally proposed by the Transgender and Intersex Subcommittee. The committee had hoped that these definitions were sufficiently fluid to allow for a range of understandings of transgender, transsexual and intersex. The committee acknowledges the disappointment felt by those transsexuals and their representative bodies who no longer find these definitions adequate to their own experiences and understandings. There may be a need for a separate advisory body to provide government with advice on the physical health needs of transgender, transsexual and intersex people.

150 Submissions from Men's Australia Network (MAN) and Australian WOMAN Network

Appendix B: Victorian Ministerial Advisory Committee on Gay and Lesbian Health: terms of reference

Role of the committee

The role of the ministerial advisory committee is to provide consolidated advice to the Minister for Health and Department of Human Services on action that may be required to:

- promote and support the health and wellbeing of gay men and lesbian women across Victoria
- ensure optimal access to all relevant mainstream and, where appropriate, specialist health services.

The committee is established in recognition of the specific health risks faced by Victoria's gay and lesbian communities and the need for health services to be relevant and sensitive to the needs and preferences of these groups.

The committee is expected to take a broad view of the determinants of health and wellbeing within a social model of health. It may make recommendations that relate to the need for action both by the health service system and by other portfolios.

Key tasks

1. To consult widely with the gay and lesbian community to identify priority health concerns and key issues relating to use of the health service system.
2. To develop for the consideration of the Minister an action plan on gay and lesbian health within 12 months of establishment.
3. To monitor the implementation of initiatives arising from the action plan and from other government programs that relate to the health of the gay and lesbian community.
4. To provide advice on broader government-led public health, health promotion and health service development strategies from the perspective of the gay and lesbian community and, where appropriate, facilitate consultation with the community on these strategies.
5. To consider and provide advice on other relevant issues as requested by the Minister.

Membership

The membership of the committee will be drawn from the relevant communities and from professionals with extensive experience in working to protect and enhance the health of these communities. Members will be appointed on the basis of both individual qualifications and ability to convey the needs and views of a wide range of people.

Members will be appointed for a term of two years. Membership will be on a voluntary basis and no sitting fees will be payable, although the Minister may approve reimbursement of some costs incurred in attending meetings.

A co-chairing arrangement will apply with an individual representative of gay men and an individual representative of lesbian women being invited by the Minister to lead the committee on a rotational basis.

Executive support will be provided by nominated officers of the Department of Human Services.

Procedures

The committee will meet at least quarterly with the option of more frequent meetings to be determined by the committee.

Where appropriate, the committee will establish sub-committees to address specific issues and projects.

Appendix C: MACGLH/Department of Human Services GLBTI-related publications and reports

MACGLH-related publications

Community Concepts (2002) *Consultation report on health in gay, lesbian, bisexual, transgender and intersex (GLBTI) communities in Victoria.* The Victorian Government Department of Human Services: Melbourne.

Community Concepts (2002) *Feedback on the draft Victorian GLBTI health and wellbeing action plan to the Ministerial Advisory Committee on Gay and Lesbian Health.* The Victorian Government Department of Human Services: Melbourne.

Leonard, W. ed (2002) *What's the difference? health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Victorian Government Department of Human Services: Melbourne.

McNair, R., Anderson, S. and Mitchell, A. (2001) 'Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities'. *Health Promotion Journal of Australia* 11(1): 32–38.

McNair, R.P., Dempsey, D. et al. (2002) 'Lesbian parenting: issues, strengths and challenges'. *Family Matters* 63: 40–49.

GLBTI-related government-funded reports

Dyson, S., Mitchell, A. et al. (2002) *Don't ask don't tell. hidden in the crowd: the need for documenting links between sexuality and suicidal behaviours among young people.* Report of the Same Sex Attracted Youth Suicide Data Collection Project. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

Frere, M., Jukes, J. and Crowhurst, M. (2001) *Our town: working with same-sex attracted young people in rural communities.* A report on the experiences of twelve projects established in rural Victoria to promote the mental health of same-sex attracted young people. VicHealth and Victorian Government Department of Human Services: Melbourne.

Johnson, Kelley, Hillier, L. et al. (2001) *People with intellectual disabilities: leading safer sexual lives.* Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

McNair, R. with Dempsey, D. et al. (2002) *Families, health and reproduction: An exploratory study of lesbian parents in Victoria.* Prepared for the Victorian Government Department of Human Services. The Department of General Practice, The University of Melbourne: Melbourne.

Linked Victorian Government strategies

Department of Human Services (2002) *Making this the age to be in Victoria: a forward agenda for senior Victorians (2002)* Office of Senior Victorians, Victorian Government Department of Human Services: Melbourne.

Department of Human Services (2002) *Victorian HIV/AIDS Strategy: 2002–2004* Victorian Government Department of Human Services: Melbourne.

Department of Human Services (2002) *Victorian women's health and wellbeing strategy: information kit* (2002) The Victorian Government Department of Human Services: Melbourne.

MACGLH Web Site

http://www.dhs.vic.gov.au/phd/macglh

Appendix D: MACGLH principles for GLBTI-sensitive research

Principles of inclusiveness of gay, lesbian, bisexual, transgender and intersex people

Preamble

The following principles have been developed and endorsed by the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) to assist with the assessment of applications for funding for gay, lesbian, bisexual, transgender and intersex (GLBTI) focused research. The first set of principles addresses the minimum requirements for GLBTI focused research. A second more detailed set of principles has been developed for research that targets same sex attracted and transgender young people and is applicable to vulnerable groups within GLBTI communities more generally.

It is important that the process by which any funds are distributed is not ad hoc but is open and fair, making clear what funding is available, who may apply and what the selection process will be. It is also desirable that the funds be distributed bearing in mind the importance of a spread of projects, for example, rural and urban projects, primary prevention, service provision, practical support for GLBTI people, research and 'big picture' projects that address homophobia in the community on a broader scale.

Principles to be applied to all funding applications

The proposed initiative must be able to demonstrate:

- That it is inclusive of the needs of gay, lesbian, bisexual, transgender and intersex people or those people experiencing confusion around these issues.
- That measures are in place to ensure that issues for gay, lesbian, bisexual, transgender and intersex people can be addressed in a confidential, informed and sensitive manner as they arise.
- That it does not pathologise issues of same sex attraction or gender identity but locates the problem in the society around the people who experience difficulties with these issues.
- That it addresses the issue of appropriate support and/or training in the area for all those involved in the project, whether they be GLBTI people themselves, families, community organisations or health care providers.

Principles to be applied to funding applications that specifically target gay, lesbian, bisexual, transgender and intersex (GLBTI) young people.

The proposed initiative must be able to demonstrate:

- An informed awareness, based on familiarity with research and on practical experience, of the pressures on and problems facing gay, lesbian, bisexual, transgender and intersex young people.
- An understanding that the problem is not located in the young people themselves but in the society around them.
- That it does not problematise or pathologise issues of same sex attraction or gender identity.
- That it places the confidentiality and personal safety of young people above all other considerations.
- That it applies no pressure on young people to 'come out' to families, friends and communities.
- That it addresses the support and/or training needs of all those involved in the project whether they be young people themselves, families, school communities or health care providers.
- That it has a capacity to raise awareness of the issues in the targeted community and to educate for change.
- That adequate monitoring and evaluation will be carried out, ideally in an action research framework.
- That it is sustainable in the future or will demonstrate clearly the effectiveness of a model that could be implemented on a wider basis.
- That it does not duplicate services or other initiatives already underway.
- That, if it is a research project, it has a clear plan to indicate how outcomes will be made accessible to research participants and the wider community.

Appendix E: Principles to guide GLBTI policy and program development[151]

The following principles will inform the development of policy and programs to promote and maintain the health and wellbeing of GLBTI people.

Equity

A social model of GLBTI health and wellbeing must inform action to reduce inequalities. A broad range of social, economic, cultural, biological and environmental factors determine health and wellbeing. Sexual orientation and gender identity are key social determinants of health and wellbeing, together with other factors such as socioeconomic status, gender, ethnicity, age, disability, location and environment.

Diversity

GLBTI people are diverse. Their multiplicity of experiences and needs relates to factors such as cultural background, religion, age, ability, and socioeconomic status. The roles undertaken by GLBTI people in the community are multifaceted and vary across the lifespan.

Access

GLBTI people require access to appropriate services and information in environments that recognise their needs, and provide privacy, informed consent and confidentiality.

Early intervention and prevention

Together with high quality treatment services, a focus on prevention, early intervention and active health promotion are critical in improving GLBTI people's health and wellbeing outcomes.

Consultation and participation

Consultation with and participation by GLBTI people in the planning, delivery and review of services is essential to providing a high quality, equitable and responsive service system. To participate fully, GLBTI people require access to relevant and accurate information.

Evidence and knowledge

Effective service responses for GLBTI people must be based on accurate data and on research and evaluation that acknowledges the diversity of their experience.

Partnership

Partnerships between GLBTI people, service providers, the Department of Human Services, other government agencies and researchers will strengthen the planning and delivery of services that promote GLBTI health and wellbeing.

151 These excellent principles are taken from the *Victorian women's health and wellbeing strategy: policy statement and implementation framework 2002–2006*, op cit.

Appendix F: Current and recently completed Government* funded GLBTI health and wellbeing initiatives

GLBTI project/service	Division/section responsible	Organisation/agency carrying out project	Current status
SSAY suicide prevention initiatives			
• Gay and Lesbian Youth Support Project	Metropolitan Health and Aged Care Services, Mental Health	Cobaw Community Health Service Inc. Knox City Council	2004
• SSAY Suicide and Self-Harm Data Collection Project	Acute Care and Mental Health°, Mental Health	ARCSHS, La Trobe University	Completed
Commonwealth funded youth suicide prevention initiatives			
• SSAY focused projects	Department of Health and Aged Care, Victorian Branch		
VicHealth Health Promotion Plan 1999–2002			
• 12 small scale projects (and evaluation) to promote mental health of rural SSAY	VicHealth and Rural Health and Development, Department of Human Services	A range of community-based organisations	Completed
Drug use among SSAY	Premier's Drug Prevention Council (PDPC), Drugs and Health Protection, Department of Human Services	Family Planning Victoria Inc. and ARCSHS, La Trobe University	2003
An Exploratory Study of Lesbian Parents in Victoria	Public Health, Department of Human Services	Department of General Practice, The University of Melbourne.	Completed
Needs Assessment of Older GLBT People	Acute Care and Mental Health°, Aged Care	ALSO Foundation	Completed
Lesbian Cancer Support Group	Premier and Cabinet, Community Support Fund (CSF)	Lesbian Cancer Support Group	Completed
FReeZA funding – rural and metropolitan GLBT Youth	Department of Education and Training, Office of Youth	Minus 18 and P-FLAG	Completed
GLBT telephone counselling service	Public Health, Department of Human Services	Gay and Lesbian Switchboard (Victoria) Inc.	2004

° Renamed and restructured in 2002

**These include a number of Commonwealth funded, state-based projects.*

Appendix G: Related Victorian State Government advisory bodies

Attorney General's Advisory Committee on Gay, Lesbian and Transgender Issues

Disability Advisory Council (DAC)

Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases (MACAHRD)

Ministerial Advisory Committee on Mental Health

Ministerial Advisory Committee on Senior Victorians

Ministerial Advisory Committee on Women's Health and Wellbeing (MACWHW)

Ministerial Advisory Council on Cultural and Linguistic Diversity

Ministerial Rural and Regional Health Advisory Group (MRRHAG)

Premier's Drug Prevention Council (PDPC)

Primary Care Partnership Strategy Consumer and Carer Advisory Group

Appendix H: Membership of the Transgender and Intersex Subcommittee*

Member	Position at time of appointment
Herbert Bower	Consultant Psychiatrist, Monash Gender Dysphoria Clinic
Tony Briffa	President, AIS Support Group Australia
Lauren Christopher	Secretary, Seahorse Club of Victoria
Jamie Gardiner	Chair, EO Commission of Victoria's Reference Groups on Sexual Orientation and Gender Identity
Tony Keenan	Chair, MACGLH; General Secretary, Victorian Independent Education Union
Nick Medland	General Practitioner, Centre Clinic, VAC/GMHC
Anne Mitchell	Deputy Chair, MACGLH; Manager, Community Liaison and Education Unit, ARCSHS
Marcus Patterson	Convenor, Men's Australia Network (MAN)
Kay White	MACGLH member; former co-convenor, Transgender Victoria and Transgender Activist

**The subcommittee met twice in 2001 and provided expert advice to the MACGLH in the editing of the GLBTI health research papers and on the drafting of the action plan. Individual members of the subcommittee also provided material out of session during the redrafting of the action plan.*


State Government
Victoria
Department of
Human Services