Submission to:

Development of a New National Women's Health Policy

November 2009

1. INTRODUCTION

ACON applauds the Australian Government for instigating the important dialogue around the development of a new National Women's Health Policy. We are pleased to participate in this significant consultation process regarding the health of all Australian women. Encouraging dialogue amongst community groups and individuals in an effort to ensure that the planning and delivery of health services meets the needs of Australian women – both today and in the future – is both welcome and timely. By working within a framework that acknowledges gender as a significant social determinant of health, a broad range of issues associated with women's health can be addressed.

ACON would like to commend the Department for its commitment to addressing gender as a significant social determinant of health in developing both National Women's and Men's Health Policies.

We would also like to congratulate the Department for explicitly mentioning lesbians and same-sex attracted (hereafter SSA) women as a priority population group in the consultation forums that took place in October 2009 across NSW. The inclusion of these women as a priority group demonstrates the Government's recognition of the complex relationship between gender, sexual orientation, and access to healthcare and the need for specific efforts to be made for this group of women.

The experiences faced by these women are diverse and include the intersections of age, gender identity, ethnic background, education, culture, religion, geography and socio-economic status. Addressing the multiplicity of the social determinants that affect health is a challenging task. ACON commends the Government's leadership in this and looks forward to working together to improve the health and wellbeing of lesbians and SSA women by ensuring health gains are equally shared across all sections of the population in Australia.

2. BACKGROUND

ACON was formed in 1985 as part of the community response to the impact of the HIV/AIDS epidemic in Australia. Today, ACON is Australia's largest community-based gay, lesbian, bisexual and transgender (GLBT) health and HIV/AIDS organisation. ACON provides information, support and advocacy for the GLBT community and people living with or at risk of acquiring HIV, including sex workers and people who use drugs.

ACON is home to the Community Support Network (CSN), the Positive Living Centre (PLC), the Lesbian and Gay Anti-Violence Project (AVP) and the Sex Workers Outreach Project (SWOP). ACON has its head office in Sydney as well as branches in the Illawarra, Northern Rivers, the Hunter region and the Mid North Coast.

The organisation has a strong history of working with government, community and mainstream health services for an improvement in the health and wellbeing of the GLBT community, not just in relation to HIV/AIDS.

In 1999, ACON conducted a community consultation resulting in it formally broadening its agenda to include the overall health and wellbeing of the GLBT community in its guiding *Strategic Directions 2000-2003*. The need to establish specific lesbian health services was first formally identified during this consultation phase.

To date, the Lesbian Health Project at ACON has delivered a range of successful outcomes and service provision to lesbians and SSA women has expanded across many areas of the organisation. However, funding lesbian health work has proven challenging in a context where significant gaps in research limit our evidence base, therefore impacting on our ability to advocate for sustainable sources of funding. Equally compounding is the absence of consideration given to lesbians and SSA women in any national and state health policies.

It is for these reasons that in 2008, ACON's commitment to improving the health and wellbeing of lesbians and SSA women in NSW saw the development of the first ever lesbian health strategy in Australia titled, *Turning Point.* This strategy focuses on the need to build programs which inform, educate and assist the health system and women to tackle the root causes of health problems such as social exclusion. The development of the strategy was informed by a community consultation process with this group of women, which is evidence of ACON's unique ability to engage and advocate for lesbians and SSA women in NSW.

In recent years, various non-government agencies have made significant contributions to improving the health and wellbeing of lesbians and SSA women in NSW. ACON's Lesbian Health Strategy seeks to build on these past and current initiatives. This clearly stated Strategy provides strategic direction, allowing ACON to focus and develop new and innovative responses in this area of health using evidence-based practice.

PRINCIPLES

The work of ACON is influenced by a range of principles that underpin our work with lesbians and SSA women, and our communities more broadly, from within a health promotion framework. These principles inform the basis of our submission to the National Women's Health Policy.

Social Justice
ACON recognises a fundamental link between health and social justice. Social justice includes the equal right to health for all people regardless of gender, sexual orientation, ethnicity or religious affiliation.

Evidence Base
An evidence-based approach is the most effective method of addressing public health issues. Accordingly, such an approach should be adopted to address the health and wellbeing needs of lesbians and SSA women. ACON is committed to encouraging research and increasing the evidence base for our work with lesbians and SSA women.

Harm Minimisation
Harm minimisation aims to identify the harms to individuals and society that may arise from particular behaviours, and to minimise them. It recognises that, owing to a variety of factors, engaging in the use of harmful substances and harmful behaviour will continue to be part of society. ACON acknowledges the importance of developing culturally appropriate harm minimisation responses for lesbians and SSA women.

Sex Positivity
Sex positivity is the affirmation that sex can be a positive force both in personal development and society. The work of ACON embraces the belief that consensual sexual expression is a basic human right, and that lesbians and SSA women have the right to accurate sexual health information. Sex positivity in service and program development recognises that it is not appropriate to judge others' consensual choices regarding who to have sex with, how to have sex, and how one defines their sexual orientation and identity. It is equally important to focus on the positive aspects of sexuality, like sexual pleasure, and not just disease prevention.

Diversity & Inclusion
ACON encourages the recognition and celebration of diversity in the lesbian and SSA women's community. The dual principles of diversity and inclusion apply across the entire spectrum of ACON's work with lesbians and SSA women. Diverse responses are required given the multiple dimensions of diversity that exist in the lesbian and SSA women's community, including ethnicity, geographical location, ability, age and Aboriginality.

Collaboration
ACON is committed to a partnership approach in all of its work. Collaboration between ACON, the GLBT community, other community organisations (both GLBT and mainstream) as well as government agencies is essential to ensuring a coordinated and effective response to the health needs of lesbians and SSA women.

Integration
The health and wellbeing of lesbians and SSA women is a whole-of-community responsibility. ACON recognises that responses to lesbians and SSA women's health are strengthened when placed in the context of community. This context must be supported by actively fostering a culture of care in the GLBT community.

Advocacy
Advocacy is an influential tool for changing social and structural barriers that exist for lesbians and SSA women. ACON has a strong history of advocacy activities on a diverse range of issues. The advocacy work of ACON is framed by the *Ottawa Charter for Health Promotion* which recognises that people do not exist in isolation but within networks, communities, societies and geographies.

ACON is committed to continuing and expanding a range of advocacy work for lesbians and SSA women. ACON's advocacy work, both at a structural and individual level, aims to improve the health of our communities through activities to address issues such as inequality, access to quality services and social support and to minimise social exclusion.

Resourcing and Sustainability
ACON's lesbian health work has been limited by insufficient and short-term funding. A lack of research and understanding about lesbian health has meant that resource support from government and other funding agencies has been piecemeal and isolated to specific issues. While recognising the important achievements that ACON and its partners have made in this area, ACON is adamant in the principle that the health and wellbeing needs of lesbians and SSA women cannot be adequately met without ongoing funding commitments from government and other funding agencies.

2. A SOCIAL MODEL OF HEALTH

The 1989 National Women's Health Policy (hereafter referred to as NWHP) established a strong policy platform towards a social view of health that recognised a broad range of aspects such as social, environmental, economic and biological factors contribute to differences in health status and health outcomes and that these are linked to social determinants such as gender, age, socioeconomic status, ethnicity, disability, location and environment.[1]

Following this model and 20 years later, a social perspective to health remains fundamental towards reducing health inequities between women and men and importantly, across all sub-sections of women. ACON is committed to working within a social model of health in tackling the social determinants that lead to poor health outcomes for lesbians and SSA women; principles outlined by the first NWHP.

In building upon the solid foundations of the 1989 NWHP, the new Policy must continue to address individual and population health inequity by tackling the multi-dimensional features of society, socioeconomic characteristics, health behaviours and biomedical factors, which interact with each other.[2]

Furthermore, it is equally important that the new Policy consider that like gender, sexual orientation is a key social determinant of health. While being a lesbian or a SSA woman is not a health problem in itself, sexual orientation can be a social determinant of health in much the same way as factors such as gender, socio-economic status, or ethnicity.

Sexuality is a complex aspect of people's lives made up of biological, social and environmental influences that may shift and change across life spans. These experiences greatly influence patterns of health and can act as markers of disadvantage or increased vulnerability. More specifically, these indicators of disadvantage can often be contextualised by the experiences of discrimination.

Those who identify as lesbian or SSA face social and systemic inequalities which pose significant barriers to achieving optimum health and wellbeing. These inequalities are marked by a combination of systemic experiences of discrimination that influence the experience of social exclusion from the broader community.

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[1] Commonwealth Department of Community Services and Health, *National Women's Health Policy Advancing Women's Health in Australia: Summary of report present to Australian Health Ministers* (1989) Canberra: Commonwealth of Australia.
[2] Department of Health and Ageing. *Development of a New National Women's Health Policy: Consultation Discussion Paper 2009*. Canberra: Commonwealth of Australia; 2009.

Like the wider Australian female population, lesbian and SSA women will experience similar general health issues. However, in light of the impacts of social and systemic inequalities, these women can experience a variety of lower health outcomes through a combination of lifestyle choices such as smoking and alcohol consumption, and through the effects of discrimination. Ultimately, these health risk factors are firmly embedded in social exclusion and marginalisation.[3]

Diversity is a social reality in all aspects of Australian society. Proactively acknowledging and engaging with diverse communities is essential for government policy to reflect the modern Australia. As the *National Compact Consultation Paper* states, "equal respect and opportunity for all, regardless of culture, ethnicity, age, disability, gender, sexual orientation or religion is an important aspect of diversity." Upholding a social model of health that emphasises prevention, health inequalities and the social determinants of those inequalities, requires explicit inclusion of sexual orientation and gender identity as key social determinants of health in the NWHP.[4]

It should be noted that there is a degree of overlap between lesbians and SSA women across all the priority sub-groups addressed in the NWHP Discussion Paper - Aboriginal and Torres Strait Islander women; women in rural and remote areas; women from culturally and linguistically diverse backgrounds (including refugees); and women from disadvantaged backgrounds. In developing a national policy that addresses the range of health issues affecting women across the country, we would like to point out that these women would suffer a double disadvantage in society by virtue of being a sub-group of women as well as being SSA.

Identity

Gender identity is used to express a person's self-identified gender which may or may not be in relation to their biological sex. It is important to recognise that some gender identities encompass both or neither of the societal binary representations of male and female genders. Identity is a socially constructed and important way of recognising that individuals have a distinct experience of gender and self-identification is an important part of self-determination – an intrinsic process in achieving human rights.

While exploring the notion of identity is beyond the scope of this submission, ACON recognises the importance that identity plays as a social determinant of health. Although ACON recognises there are other peak bodies better placed to speak on behalf of transgender and intersex people in Australia, we feel it is important to support in the advocacy efforts of the specific health needs of this population group.

A Partnership Model

Working with priority populations requires a multi-disciplinary approach to health. This means engaging all key players in developing and implementing health specific initiatives.

The GLBT community in Australia, most specifically in NSW, has a unique position in the history of the rapid spread of HIV/AIDS over two decades ago, which saw activists from the GLBT, sex worker and people who inject communities mobilise themselves in order

[3] Ibid at 14.
[4] The Australian Government, *Social Inclusion Principles for Australia*, 2008. http://www.socialinclusion.gov.au/Principles/Documents/SIPrincilpes.pdf

to engage in swift and meaningful dialogue with the government to find ways of halting the epidemic. Today, as outlined in national and state HIV, STI and Hepatitis strategies, this sustained partnership approach to planning, policy and service delivery remains integral to meeting the priorities and outcomes of the strategies they sit under.

This model, while historically focusing on gay men and HIV in the community, has illustrated by experience, how a partnership model works effectively in tackling the determinants that affect the transmission of HIV, viral hepatitis and STIs across population groups most at risk. Principles developed in HIV, particularly partnership and engagement with affected communities, have been replicated due to demonstrable efficacy.

Since ACON's transition from an HIV/AIDS specific organisation to one that focuses more broadly on GLBT health and wellbeing, the Lesbian Health project at ACON has implemented a similar approach to partnership, work that has largely been driven in the absence of a broader policy framework. It remains limited by a lack of an evidence base and funding and is therefore confined. ACON believes that formal recognition of lesbians and SSA women is required in order to build the evidence base in addressing the specific health needs of these women.

A NWHP focusing on a life course approach to prevention, health inequities and the social determinants of those inequalities needs to look to engaging with organisations with proven experience in working in a social model of health with positive health outcomes.

ACON, like many other community based organisations, work within peer based models. That means we provide unique services that cannot be duplicated by non-peer based organisations. We are able to access at-risk communities because we are, in fact, part of the community and we have credibility. This distinct placement means our peer based programs and services build trust with population groups who may otherwise feel apprehensive about approaching mainstream services. The low rates of HIV amongst people who inject drugs can be attributed to the work within this model.

The efficacy of the response to HIV/AIDS in NSW has largely been attributed to the relationship between government, and community controlled organisations – a fact recognised at state, federal and international levels.

To take this partnership to the highest level, ACON would like to see a Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender Health and Wellbeing established (similar to the Victorian model) to provide advice to Government on action required to promote and support the health and wellbeing of GLBT people. This Advisory Committee would also provide advice on departmental programs under all policy initiatives in the areas of inclusivity and service responsiveness and promote access to mainstream and, where appropriate, specialist health and human services.[5]

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[5] Victorian Ministerial Advisory Committee on Gay, Lesbian, Bisexual Transgender and Intersex Health and Wellbeing Correspondence, *Endorsement of the National LGBT Health Alliance's submission to the National 6Women's Health Policy*, 30 June 2009. Viewed at: http://www.health.vic.gov.au/glbtimac/downloads/endorsement.pdf

Lack of Evidence Base

While there is no routinely collected nationwide data on sexuality or gender identity, it is estimated that GLBT people account for approximately 2-3% of the Australian population.[6] Not only is this estimate broad given the lack of data collection, but also, many women may not necessarily identify as lesbian or SSA for a number of reasons related to stigma, or due to the fluid nature of sexuality which may change across a lifespan.

While many GLBT people live in major cities, there are GLBT Australians in every electorate across the country, with most major towns and rural centres having GLBT communities. Like all communities, GLBT people are not a homogenous group, with considerable diversity in terms of income, employment status, education levels, religious beliefs, cultural heritage and family structure.

In developing effective health policy it is crucial that it be informed by strong evidence, arising from comprehensive research. Australia's relative success in containing the spread of HIV is partly the result of a strong research and evidence base that has been useful for policy development.[7] Although some data collection and research explicitly include sexuality indicators (such as HIV), the vast majority of research data does not include sexuality as an indicator. While there has been GLBT specific research that has provided some data on key health issues facing women and SSA women (such as STI transmissions, levels of alcohol, tobacco and other drug use, mental health, violence and abuse, domestic violence, cancer and ageing), it is a limited evidence base that informs this submission. However, the evidence we do have, when compared to mainstream health research, shows that lesbians and SSA women are uniquely or disproportionately affected in relation to several of these key health issues than the broader population.

While these targeted research initiatives are very important to inform policy and service delivery, mainstream research projects need to include sexuality indicators so that more robust data can be collected on this specific population group and then be examined comparably with mainstream populations. This can be done through asking a question about sexuality in health research surveys, as we understand has been recently agreed to in the National Drug Strategy Household Survey, enabling disaggregation of data based on sexuality so that issues can be clearly identified and compared between lesbians and SSA women and heterosexual women.

While we recognise that accurate and meaningful data collection remains an issue to varying degrees across all health sectors, we would like to point out that the GLBT community faces a distinct lack of a rigorous evidence base across national and state levels. The lack of a sexuality question in almost all national and state data collection, and other major research efforts, prevents a broad based understanding of health issues for lesbians and SSA women. To put it simply, outside GLBT specific research – our community is unacceptably evidence-poor.

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[6] Smith, A, Pitts, M, Shelley, J, Richters, J, (2005), *Australian Longitudinal Study of Health and Relationships: Wave 1 Summary*, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

[7] NSW Health, *A Think Tank: Why are HIV Notifications Flat in NSW 1998-2006?*, (2007), p. 1.

The ALMA ACON Research Grant

The ALMA ACON research grant was established by the Australian Lesbian Medical Association (ALMA) in 2004, and joined by ACON in 2005. The aim of the grant is to improve the health and health care of Australian lesbian and bisexual women through enabling small projects in education or research. This is particularly pertinent in consideration of the absence of substantial evidence base for work in the field of lesbian and SSA women's health.

The grant maintains a focus on a social model of health including ensuring equity and access to health care. Research and education proposals that utilise collaborative, partnership models are favoured within the selection criteria. The grant application process asks that proposals focus on at least one of the following goals:

- To produce quality Australian research evidence in lesbian and bisexual women's health, including determinants of health and experiences of health care.
- To develop specific health promotion initiatives for lesbian and bisexual women.
- To support the education of Australian health care providers on issues relevant to lesbian and bisexual women and in culturally competent health care provision.
- To support lesbian and bisexual women working in the health care sector through research or education.

The grant has been awarded to a number of innovative research projects that have assisted in establishing a solid evidence base for health promotion work in lesbian and SSA women's health.

3. KEY HEALTH ISSUES FACING LESBIANS AND SSA WOMEN

As has been mentioned, recognising the unique health needs of lesbians and other SSA women remains an under-addressed area in Australia. Traditionally, the Australian health care system has maintained a position that lesbian health is synonymous with women's health; consequently there have been misconceptions around the risks facing this group of women. Not until recently has some research focused on the practices and health needs of lesbians and other SSA women, which upon closer inspection has revealed a number of potentially health-impacting issues.

A number of key Australian academics have published research around the correlations between sexual orientation and the health and wellbeing of lesbians and SSA women. Reported behaviour by these women has shown significant trends that could hold serious health implications for lesbians and other SSA women and highlights a strong need for further research as well as a programmatic focus. While the data below has been organised in thematic health areas, it is important to recognise that many, if not most, of these issues in practice are interconnected and may stem from similar psychosocial bases.

Sexual health

Sexual practices often go undisclosed in clinical settings and the risks posed by the lack of enquiry during consultation can have serious health implications. For example, sexually transmitted infections (STI) are a very real risk for lesbians and other SSA women, yet sexual health campaigns and education around sexual behaviour targeting this group are almost non-existent.

A report titled, *What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex Victorians*, reports that GLBT people's experience of sexual orientation and gender identity discrimination impacts negatively on their sexual health and wellbeing and on rates and patterns of STI within these communities.[8] There is still minimal knowledge around safe sex practices for SSA women amongst health professionals and the lack of this information and a perceived idea that lesbians are immune to STIs has led SSA women to be under-screened, under-informed and under-diagnosed.[9]

There is evidence that the prevalence of STIs among SSA women is at least as high as among heterosexual women, if not higher among some sub-groups.[10] Findings from the *Writing Themselves in Again* report, published by the Australian Research Centre in Sex, Health & Society reveal that compared with the results of an Australian study of the health of secondary school students, SSA young women were almost five times more likely to have had an STI and three times more likely to have contracted some form of hepatitis.[11] Interestingly, the rate of STI for SSA young women (9%) was almost as high as SSA young men (10%). While it is recognised that SSA young men are much more susceptible to HIV and Hepatitis C, these figures challenge the misconception that SSA young women are not a high risk group in terms of STIs.

Another misconception about lesbians and other SSA women is that if they are not sexually active with men, they are not in need of pap smears or cervical screenings as male to female sex has been traditionally understood as the only risk factor for women in contracting human papilloma virus (HPV) or developing cervical cancer. In order to investigate the impacts of this mainstream medical belief, a 2004 Sydney Women and Sexual Health Survey (SWASH) checked the screening history of SSA women. A noticeable 28% of respondents who reported having had sex with a male at some point had not been screened for up to 3 years or had never had a screening before.[12]

In addition, women who reported never having had sex with a man were more likely to be overdue for screening.[13] It is clear that education regarding the sexual health needs of SSA women for general practitioners, as well as for lesbians and other SSA women themselves, is necessary.

Lastly, a minority of lesbians and SSA women engage in sex work as an occupation. *Private Lives*, a national report on the health and wellbeing of GLBT Australians, also published by the Australian Research Centre in Sex, Health & Society, indicated that

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[8] *What's the Difference?: Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians.* The Ministerial Advisory Committee on Gay and Lesbian Health, Melbourne, 2002.
[9] Ibid.
[10] McNair, Ruth. '*Risks and Prevention of Sexually Transmissible Infections Among Women Who Have Sex with Women.*' CSIRO, Vol.2, 2005.
[11] Hillier L, Dempsey D, Harrison L, et al. *Writing Themselves In: a national report on the sexuality, health and well-being of same-sex attracted young people.* Australian Research Centre in Sex Health & Society, La Trobe University, Melbourne, 1998.
[12] Richters, J., Song, A., Prestage, P., Clayton, S., & Turner, R., Health of lesbian, bisexual and queer women in Sydney: The 2004 Sydney Women and Sexual Health Survey, National Centre in HIV Social Research, The University of New South Wales. Sydney, 2005.
[13] Ibid.

1.1% of women respondents had been paid for sex in the previous year[14], as compared to 0.5% of Australian women generally who had *ever* been paid for sex.[15]

Research of sex workers shows that 17% of women working in the sex industry are bisexual and between 2% and 5% are lesbians, depending on the type of workplace.[16] This has implications for service delivery in sexual health, as sexual orientation should not be assumed to preclude male sexual partners, as this may occur in occupational or social settings.

Smoking, Alcohol and Other Drug Consumption

The use of alcohol and tobacco is a growing area of concern amongst lesbian and SSA women. Many studies indicate an extremely high number of women using alcohol and tobacco on a regular basis. Understanding why is an area that requires more research.

The Longitudinal Study of the Health of Australian Women found that SSA women in the younger cohort (aged 22-27 years) were significantly more likely to report risky alcohol use (7% compared to 3.9%) than their heterosexual counterparts.[17]

Similarly, the SWASH report, based on Sydney data, found rates of use of alcohol, tobacco and party drugs were several times higher than in the general population.[18] Of the women surveyed, 50% had used one or more illicit drug in the past six months.

A table comparing 2008 SWASH data with data from the 2007 National Household Survey appears below. It should be noted that ACON acknowledges that SWASH research represents a Sydney-specific sample and the Household Survey is a national sample limiting data comparability. However, given the limited evidence, these studies provide some indication of the marked difference of drug use among SSA women and the broader female population.

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[14] Pitts Marian; Anthony Smith; Anne Mitchell & Sunil Patel. '*Private Lives: A report on the health and wellbeing of GLBTI Australians.*' ARCSHS, La Trobe University, Melbourne. March 2006.

[15] Experiences of commercial sex in a representative sample of adults, Australian and New Zealand Journal of Public Health 2003, Vol 27 No 2, p196.

[16] Perkins, R., & Lovejoy, P. *Call Girls: Private Sex Workers in Australia*, 2007.

[17] Hillier L, Dempsey D, Harrison L, et al. *Writing Themselves In: a national report on the sexuality, health and well-being of same-sex attracted young people.* Australian Research Centre in Sex Health & Society, La Trobe University, Melbourne,1998.

[18] Ibid at 12.

Drug	SWASH 2008	Household Survey 2007[19]
Tobacco	36.9%	17.7%
Weekly (or more often) risky alcohol use	18.7	6.2
Ecstasy	32.4	2.7
Cannabis	38.0	6.6
Speed	25.4	1.6
Cocaine	18.2	1.0
Benzodiazepines	14.7	3.6
Amyl	10.9	0.2
LSD	7.1	data not collected
Ketamine	6.2	0.1
Crystal	6.5	data not collected
GHB	3.2	0.1
Heroin	1.8	0.1
Injecting drug use	1.5	0.3

The Ecstasy and Related Drugs Reporting System (EDRS) is a national monitoring system for ecstasy and related drugs that is intended to identify emerging trends in drug markets. The study includes regular ecstasy users and as such, is not representative of the general population.

The study collects information about drugs that are routinely used in the context of entertainment venues including nightclubs, dance parties, pubs and music festivals. These include ecstasy, methamphetamine, cocaine, LSD, ketamine and GHB. This study is unusual in that it is a national survey that includes a sexuality question.

The 2009 study was a sample of 756 people, and of the sample, 14% identified as GLBTQI, with an average age of 24 years. A total of 36% of this sample were female.

Of interest to ACON are the high levels of drug use within this sample and the problems associated with that drug use. For example, 30% of the sample reporting using ecstasy at least weekly, and one in four report that drugs caused repeated problems with family, friends or colleagues. Also, 35% report that they recurrently found themselves in at-risk situations when under the influence and a similar proportion (39%) reported that drugs recurrently interfered with responsibilities at home/work/school.

These data underline our concerns about the risk behaviours of GLBT people and the complex intersection that social factors, such as discrimination and stigma, play in these contexts.

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[19] Australian Institute of Health and Welfare 2008, 2007 *National Drug Strategy Household Survey: First Results*, April 2005, Australian Institute of Health and Welfare, 2004.

While there is a dearth of national, high quality research evidence regarding links between mental health issues and alcohol and other drug use (comorbidity) within the GLBT community, the available research does, however, show high levels of both mental health issues and alcohol and other drug use patterns amongst the GLBT community.[20] Thus, it is reasonable to conclude that co-morbidity is a problem of disproportionate scale amongst lesbians and other SSA women.

Mental health
Historically, lesbians have been subjected to significant pathologisation, stigma and discrimination. Homosexuality was only removed as a psychiatric disorder from the General Assembly of the World Health Organisation (WHO) in 1990. Further, it was as recent as 1999 that the WHO removed all codes of homosexuality from the *International Classification of Diseases.*

Fear of discrimination and homophobia can cause reluctance to approach mental health systems. Services and health care professionals tend to have limited access to information on the intersections between sexuality and health. Lack of knowledge can lead to lack of a comprehensive assessment.

A number of studies have suggested that mental health issues such as anxiety, depression and self-harm are more common amongst GLBT people.[21] Available research on lesbians and mental health has identified that lesbians experience higher rates of mental illness than the general population.

In 2003, the *Longitudinal Study of the Health of Australian Women* showed that SSA women in a younger cohort (22-27 years) were significantly more likely than the other women in the study to report being depressed (38% vs. 19%). This group of SSA young women had higher levels of anxiety (17.1% vs. 7.9%) and significantly more reported having tried to harm or kill themselves in the last 6 months (12.6% vs. 2.7%).[22] The *What's the Difference?* report suggests a link between rates and patterns of mental illness among GLBT people, and their shared experiences of sexual orientation and gender identity discrimination.[23]

ACON works with our communities to improve mental health in various ways. This work takes the form of counselling and group discussions, but is also complemented by work in other areas that have a significant impact on the mental health of our communities, such as drug and alcohol work, but also importantly, violence.

ACON's Anti-Violence Project (AVP) maintains a Violence Report Line in order to monitor levels, locations, and types of violence being experienced by members of our community. The Report Line receives around 100 reports annually. While verbal abuse accounts for the largest number of reports to the AVP (340 incidences), physical assault (205) reports were also reported in very high numbers.

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[20] *Pills and Powders, Parties and Pubs*, ACON's strategy for addressing alcohol and other drug use in the GLBT community 2009-2012.
[21] Pitts, Marian; Anthony Smith; Anne Mitchell & Sunil Patel. '*Private Lives: A report on the health and wellbeing of GLBTI Australians*.' ARCSHS, La Trobe University, Melbourne. March 2006.
[22] Ibid.
[23] Ibid at 8.

Young people are particularly vulnerable to violence because they often do not yet have the skills or resources to remove themselves from harmful situations. The mental health impacts of this violence are very significant for the GLBT community.

A report from La Trobe University states that having experienced verbal or physical abuse dramatically increased the likelihood of self harm. In a sample of 1750 SSA youth, having experienced verbal abuse doubled the likelihood of self harm, and having experienced physical abuse tripled the likelihood of self harm.[24] This is consistent with other reports of much higher numbers of attempted suicides and self harm reported for the GLBT community and demonstrates the very real consequences of discrimination.[25]

Unfortunately, these statistics are also confirmed by ACON's counselling work, where a very high proportion of people who seek counselling from ACON report having had suicidal thoughts. Data from our Counselling Team shows that in the 2008-2009 financial year, 37 out of 121 clients presented with suicidal ideation (31%). Included in this figure and of deep distress to us, one client committed suicide, three clients attempted suicide and 26 clients presented with suicidal ideation serious enough to require more high intervention work.

Suicide Prevention Australia recognises that while not all of the risk factors experienced by SSA and transgender people may necessarily be related to sexual orientation and/or gender identity, that sexuality and gender identity, "may play a distal or proximal role and interact with numerous other risk factors." Nonetheless, it is important that health care be provided in ways that recognise and support lesbian and SSA women's sexual identities, relationships and support networks.

It is deeply concerning that GLBT people in Australia experience a higher prevalence of risk factors related to suicide than their non-GLBT counterparts. These include previous suicide attempts or deliberate self-harm; current or past mental health difficulties (notably, depressive and affective disorders); exposure to attempted or completed suicide by a friend or relative; social isolation; family/relationship stress; harassment, physical or sexual abuse; discrimination; and substance use problems.[26]

Homophobic Violence

Homophobia is the irrational fear, intolerance and sometimes hatred of others perceived to be, or who are, homosexual. It can take the form of social, institutional, legal or individual discrimination. When homophobia is the motive for violence, it is called a hate crime. The most common homophobic hate crime is street-based violence. Homophobia can, however, take many forms. The *What's the Difference* report suggests that sexual orientation and gender identity discrimination lead to common patterns of physical ill health amongst the GLBT community.[27] In this context, physical health problems can be directly related to experiences of discrimination, violence and abuse, including same-sex domestic violence.

[24] NSW Attorney General's Department, *You Shouldn't Have to Hide to be Safe*, (2003), p. 45.
[25] Suicide Prevention Australia, *Position Statement: Suicide and self-harm among gay, lesbian, bisexual and transgender communities*, (2009), p. 2.
[26] Suicide Prevention Australia, Position Statement, *Suicide and Self-harm among GLBT communities*. August 2009.
[27] Ibid at 8.

In 2003, the NSW Attorney-General's Department produced '*You shouldn't have to hide to be safe' - A Report on Homophobic Hostilities and Violence against Gay Men and Lesbians in NSW*. Just under half of the lesbian respondents reported abuse in the past year. The three types of abuse most commonly experienced, both in the past year and ever, were verbal abuse; harassment such as spitting, offensive gestures, being followed etc; and threatened or attempted physical attack.[28]

The same report detailed that just under half of lesbian respondents reported that they felt 'less safe than most other women', and 65% of gay men felt less safe than most other men. For respondents aged between 20-29 years, almost three quarters (74%) reported feeling less safe.

The NSW Police Service *Out of the Blue* study demonstrates a similar pattern and found that in Sydney, lesbians were four times more likely to be assaulted than other women. In addition, the report found that 90% of gay men and lesbians, compared with 56% of the general NSW population were "concerned" that they or their friends would be assaulted. According to this report, about 60% of reported anti-lesbian and anti-gay violence occurs in the inner-Sydney suburbs of Darlinghurst, Surry Hills, Newtown, and Kings Cross. However, the police and ACON's *Anti-Violence Project* (AVP) have received reports of homophobic violence from all major regional centres and rural areas across New South Wales. Only 10% of the respondents who had suffered a physical injury had reported it to the police.[29]

The AVP delivers an annual average of 500 individual occasions of service to support and refer victims of violence. This work within ACON receives very little support in terms of funding. ACON's unique placement within the community context, and experience in partnering with government, ideally positions us to do more work to prevent violence as well as provide psychosocial support for victims of violence in our community.

Same-Sex Domestic Violence

To date, there is little accurate Australian research that records the level of domestic violence in lesbian relationships. However, a very high proportion of lesbians in the *Private Lives* survey indicated that they had been in a relationship where the partner was abusive. Abuse was reported more frequently by lesbians and SSA women than gay and SSA men (40.7% compared to 27.9%).[30] A number of overseas studies also suggest that general patterns and levels of domestic violence in same-sex relationships are about the same as in heterosexual relationships. These studies also show that once the violence starts it is likely to get worse.

The police, domestic violence services, gay and lesbian organisations, the courts and other services all report that they are working with lesbians and SSA women who have experienced or are experiencing same-sex domestic violence. Domestic violence in same-sex and heterosexual relationships share many similarities, including the types of abuse and the impact on the abused partner. However, there are a number of aspects that are unique to same-sex domestic violence.

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[28] NSW Attorney General's Department, *You shouldn't have to hide to be safe: a report on homophobic hostilities and violence against gay men and lesbians in New South Wales*, (2003).

[29] Out of the blue : a police survey of violence and harassment against gay men and lesbians / NSW Police Service; Price Waterhouse Urwick, 1995.

[30] Pitts, Marian; Anthony Smith; Anne Mitchell & Sunil Patel. '*Private Lives: A report on the health and wellbeing of GLBTI Australians*.' ARCSHS, La Trobe University, Melbourne. March 2006.

These can include:

1. "Outing" (as a lesbian or SSA woman) as a method of control,
2. The abuse becoming associated with sexuality,
3. Domestic violence not being well understood in the GLBT community,
4. Difficulty in disclosing sexual identity to service providers,
5. Services not being developed to meet the needs of same-sex couples in domestic violence relationships.

According to ACON's 2006 *Fair's Fair* report which surveyed GLBT community members on issues relating to same-sex domestic violence, only one third of all respondents who indicated one or more abusive behaviours in a current or previous relationship sought any assistance, either formal or informal.[31]

Cancer and reduced screening
Cancer is an issue of huge concern for the Australian population. The *Cancer in NSW Incidence and Mortality 2005* report, launched in December 2007, listed 34,227 new diagnoses in 2005, of which 14,911 were for females.[32] Four sites accounted for 59% of new cancers in women: breast (27%), bowel (14%), melanoma (10%), and lung (8%).

Breast cancer is the most common invasive cancer among Australian women, as well as the most common cause of cancer-related death in women in Australia.[33] Research has shown that some factors might increase a woman's risk or chance of developing breast cancer.[34]

The most significant risk factors for developing breast cancer include:

• Getting older
• Having a strong family history of breast cancer
• Having previously been diagnosed with breast cancer
• Never having birthed a child
• Obesity
• Smoking
• Alcohol use

The risks of cancers for lesbians are interconnected to a range of other health factors. It is important to note that being a lesbian or other SSA woman in it self does not increase the risk of breast cancer; however research indicates that lesbians are less likely to have children, more likely to smoke and more likely to engage in harmful alcohol consumption.[35]

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[31] Farrell, J & Somali Cerise. *Fair's Fair: A Snapshot of Violence and abuse in Sydney LGBT relationships,* 2006.
[32] *The Cancer in NSW Incidence and Mortality2005 Report*, December 2007. NSW Cancer Council.
[33] The Report is compiled by the NSW Central Cancer Registry (CCR). The registry is funded by the NSW Department of Health and managed by the Cancer Council.
[34] *Breast Cancer in Australia: An Overview*, 2006, (Australian Institute of Health and Welfare and National Breast Cancer Centre*, 2006).
[35] Ibid at 25.

According to the *ILGA Lesbian and Bisexual Women's Health Report*, lesbians have the richest concentration of risk factors for breast cancer than any subset of women in the world.[36]

The risk of breast cancer increases with age. About 24% of new breast cancer cases diagnosed in 2002 were in women younger than 50 years; 50% in women aged 50-69; and 26% in women aged 70 and over. The average age of Australian women diagnosed with breast cancer is 60 years. This issue raises particular concern when considering service delivery to older lesbians and SSA women.

Research indicates that lesbians are less likely to seek routine health care because of the discomfort of disclosing (or 'coming out') to health care providers. With fewer doctor visits, lesbian and bisexual women are less likely to have pap smears, mammograms or professional breast examinations. Studies also show that lesbian and bisexual women are less likely to perform breast self-examinations regularly. For these reasons, lesbians and bisexual women may be less likely to have cancers detected at earlier, more treatable stages.

Considerable research is required to facilitate a better understanding of shifts in knowledge around health checks for lesbians as well as for service providers who are often a first point of contact. For example, the recent *SWASH* surveys indicate that around 95% of respondents in the last two surveys indicated 'false' to the question 'Lesbians do not need pap smears' which may indicate that some health misconceptions are fading.[37] Of particular concern, however, is that this increase in knowledge was not reflected in increased rates of testing.

The Lesbians and Cancer Project

The Lesbians and Cancer Project delivers a range of both prevention and support focused on LGBT specific and mainstream health organisations.

The concept was initiated in early 2005 by the ACON Lesbian Health Project and the NSW Cancer Council and it holds two main objectives:

- Provide specific support and information to lesbians and SSA women diagnosed with cancer and their partners.
- Develop relevant and appropriate health promotion material and education initiatives focused on cancer prevention strategies for lesbians and SSA women.

Since early 2006, the project has produced a number of successfully measurable outcomes including:

- The recruitment and training of lesbian identified volunteers in the 'Cancer Connect' program, a telephone peer support service run by the NSW Cancer Council.
- The alteration of The NSW Cancer Council database intake procedure to reflect non-heterosexual relationship options.

[36] *Lesbian and Bisexual Women's Health Report, Women's Health, Common Concerns, Local Issues*. The International Lesbian and Gay Association, March 2006.
[37] The 2004 Sydney Women and Sexual Health survey. (Monograph 2/2005).

- The development and implementation of two community forums at ACON addressing the issue of lesbians and cancer.
- The design and delivery of the 'Be Breast Aware' health promotion campaign aimed at educating lesbians and SSA women on early breast cancer detection and prevention strategies.
- The establishment and maintenance of the 'The C-Word', a monthly support group named for lesbians diagnosed with cancer and their partners.

Future plans for the project include a series of *'Understanding Cancer'* forums for lesbians and SSA women, and the development of a new resource addressing sexuality for lesbians and SSA women living with cancer.

Ageing

Australia has an ageing population that presents a challenge for government in addressing the transitional needs related to health care which includes access to affordable and quality community and residential care. Within this growing demographic exists an ageing GLBT population and relevant Commonwealth and State departments are under-prepared for this population group.

In the context of mainstream aged services and programs, there is a shortage of fully equipped responses to meet the needs of openly identifying lesbians and SSA women. Older lesbians and SSA women have reported experiencing stigma and discrimination either through exclusion, social constructions of invisibility or overt homophobia in these settings.[38] Of particular note is that there is no central GLBT-sensitive entry information point for the ageing GLBT population.

A lack of data collected on GLBT people in general means we do not fully understand current health, welfare requirements and service expectations for this population group and nor can we appropriately plan future patterns of need within an ageing cohort.

There is evidence that older lesbians and SSA women experience isolation, depression, anxiety, a lack of social support and inadequate health care interventions.[39]

The Australian 'baby boomer' generation has lived through a period of tremendous cultural change, including significant shifts in social attitudes towards lesbians and SSA women. As older lesbians and SSA women plan for retirement, long term care and end of life needs, they share many of the concerns and issues that characterise the largest generation in Australian history. At the same time, lesbians and SSA women reflect certain unique family structures and gender role differences – and they confront distinct concerns about care-giving, social support networks, retirement and end of life planning.[40]

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[38] *Ageing Disgracefully - Strategy for Addressing Ageing in the GLBT community*, ACON, 2005.
[39] Harrison, Jo, PhD, *Older Lesbian, Bisexual and Transgender women and aged care concern*, Submission to National Women's Health Policy Consultation, University of South Australia, July 2009.
[40] Metlife Mature Market Institute, Lesbian and Gay Aging issues Network, Zogby International, *Out and Ageing, The MetLife Study of Lesbian and Gay Baby Boomers*, November 2006.

ACON welcomes the recent legal reforms allowing for the recognition of same sex couples across over 80 areas of Federal jurisdiction (including amendments to the Aged Care Act 1997) which are being implemented by agencies such as Centrelink, particularly in relation to assessment for residential care fees. However, no broad based Federal policy or strategic approach exists to ensure that the aged care industry itself is culturally competent.[41]

Youth

The health and wellbeing of young lesbians and SSA women is as multifaceted as the health and wellbeing of lesbians and SSA women in general. However, research reveals there are significant health issues that play a larger role for younger lesbians and SSA women as a group. According to *Writing Themselves in Again: the 2nd National Report on the health and wellbeing of young same-sex attracted people in Australia*, there are several key areas where risk is higher for young lesbians and SSA women than for other lesbians and SSA women.

These include:

- Homophobia
- Social isolation
- Self esteem
- Mental health (including suicide)
- Sexually transmitted infections
- Alcohol and other drug use[42]

In some contexts the health and wellbeing of young lesbians and SSA women reveals parallels to that of young gay and SSA men, both in nature and implication. Overall, however, young women display more fluidity than other age groups or genders with regard to their sexual feelings, behaviours and identities. Young lesbians and SSA women are more likely to be engaged in private explorations of lesbianism, concurrent with participation in heterosexual sex and relationships.[43]

Young SSA people often experience estrangement from family, bullying and marginalisation at school, which can lead to such problems as underachievement and school drop-out, low self-esteem and mental health problems. These in turn have a negative impact on the capacity of young SSA people to manage the transition from school to work and to become confident and independent adults who can contribute to society.[44]

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[41] Ibid at 37.

[42] Hillier L, Dempsey D, Harrison L, et al. *Writing themselves in: a national report on the sexuality, health and well-being of same sex attracted young people*. Melbourne: Australian Research Centre in Sex Health & Society, La Trobe University, 1998 p34.

[43] Dempsey, D., Hillier, L., Harrison, L., *Gendered(s) explorations among same-sex attracted young people in Australia*, Journal of Adolescence Volume 24, Issue 1, February 2001, Pages 67-81.

[44] Takacs, J. Social exclusion of young lesbian, gay, bisexual & transgender people, ILGA, 2006.

Evidence suggests that the majority of young SSA people come to terms with their sexuality during puberty. In the *Writing Themselves In Again* report, 55% of respondents realised their sexual orientation around puberty.[45] This indicates that along with dealing with the usual pressures or issues associated with adolescence, young SSA people are also forming their sexual identity – and often may be experiencing homophobia due to this fact.

Research demonstrates that young people who have support feel significantly better about their sexuality, with friends being the most popular choice for disclosing sexual feelings.[46] Young SSA people are also more likely to access support and information in relation to sexual identity via the internet than any other age group. The majority of information regarding sex, sexual health and sexual identity is accessed via this modality for young lesbians and SSA women.[47]

Barriers to Accessing Health Care and Disclosure

GLBT people use health services less than the general population. Measuring this difference can be complex but a number of studies have concluded that a climate of heteronormativity, heterosexism and discrimination can result in lower rates of GLBT people accessing health services and disclosing their sexuality to health care providers.[48] This can lead to under-screening for a number of common conditions and presenting much later for treatment, which can be risky and have direct impacts on the physical health of SSA women. This raises a number of issues regarding lesbian and other SSA women's use of sexual health services, where disclosure of sexual practices and sexual identity can impact on quality of care and health outcomes.

> *"I was being asked about having a pap smear and I felt too uncomfortable to divulge my sexuality as the doctor assumed I was straight. I have never divulged my sexuality to a health person because I feel too embarrassed. I think I am worried they will judge me. It has probably affected me as I have never had a pap smear and I am 34!"*
>
> *– Anonymous respondent from online ACON data collection initiative titled, 'How were you treated?'*

Accessing the health system can be complex and difficult for many women. Apart from physical, linguistic and economic barriers, there also exist social and cultural barriers that can be hard to measure. For example, social and cultural barriers can include attitudes of health providers and their staff, the knowledge and ability of staff to work with clients from diverse backgrounds, and more pervasive, systemic issues within health services that do not take into consideration the unique health needs of working with GLBT people.

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[45] Ibid at 38.
[46] Ibid at 20.
[47] Hillier, L., Horsely, P., Kurdas, C., '*It made me feel braver, I was no longer alone': The Internet and same-sex attracted young people in* J. Nieto., *Sexuality in the Pacific.* Spanish Association of studies in the Pacific, 2006.
[48] Ibid.

Barriers to accessing healthcare for lesbians and other SSA women can exist when discrimination is actual, or perceived; direct, or indirect; or systemic. Discrimination can occur when negative comments are made, when an institution is perceived to be unfriendly towards GLBT clients or at a systemic level when health professionals do not have the expertise, understanding or sensitivities to appropriately provide health services to lesbians or other SSA women.

> *"I went to the local youth health service a few years ago, hoping to get some counselling and find out about sexual health procedures. When I told the support person at the centre about my sexuality (lesbian, having never slept with a man although I'd had four female partners) she told me that I didn't need to have any sort of STI testing or sexual health examinations because STIs don't get passed between women, only during heterosexual sex."*
>
> *– Anonymous respondent from online ACON data collection initiative titled, 'How were you treated?'*

In addition, privacy and confidentiality concerns are a barrier of access for many in the GLBT community. Some may not disclose their sexual orientation or sexual behaviour to mainstream service providers due to fear of judgement or for some for fear of being 'outed,' - thus appropriate and comprehensive care cannot be provided. This experience is most evident in rural and regional settings where smaller communities have more limited health care options. People in rural areas have been found to be less likely to have had a sexual health check up for STIs in the last year and are more likely to never have had a sexual health check than their counterparts in metropolitan areas.[49]

> *"…there are no lesbian counsellors to assist the lesbian population in Wollongong. There is one counsellor at the Illawarra Women's Health Centre to service the whole of the Illawarra. I am known to her and I do not wish to access her services…"*
>
> *– Anonymous respondent from online ACON data collection initiative titled, 'How were you treated?'*

The Australian Longitudinal Study on Women's Health (ALSWH), a longitudinal study that has been examining the health and wellbeing of Australian women since 1996, is the only national health survey that includes a sexuality indicator question to measure health and wellbeing of lesbians and other SSA women.

The study provides invaluable comparable data about the health of women in three age cohorts (young/middle/older) and specifically looks at the use of and satisfaction of health services across sub-sections of women.

In 2003, the younger cohort of women (aged 25-30) who identified as lesbian or bisexual reported seeing a GP or specialist more often than heterosexual women; however, the same group of women reported being the least satisfied with the health services accessed in comparison to heterosexual women. When asked the reason for satisfaction response, lesbians and bisexual women reported being dissatisfied with GP personal manner, doctor's technical skills and doctor's interest in their medical tests.[50]

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[49] *Private lives NSW, a Report on the health and wellbeing of GLBTI people living in NSW*, 2006 (unpublished).
[50] McNair R, Szalacha L, Hughes T. *Health status, health service use and satisfaction according to sexual identity of young Australian women.* Women's Health Issues. Submitted November 2009.

While more investigation needs to be given to better understand why lesbians and SSA report experiencing a greater dissatisfaction with health practitioners than their heterosexual counterparts, one can estimate that the issue of competency in addressing sexual diversity across health services and health practitioners is a barrier to meeting the health needs of this population group.

Environmental Scan

In order to get a better understanding of how health organisations work with lesbians and other SSA women, ACON undertook an environmental scan of peak health organisations in Australia to explore what strategies existed at an organisational level to support access of these women to their services. This involved sending a standard set of questions to explore what operational policies, service delivery guidelines, or other structures existed within these organisations, or within their members' services, in working with this population group.

The exercise illustrated a number of points. Firstly, responses received from participating peak health organisations reflected a genuine willingness to make services inclusive to this population group. The responses also reflected some awareness of a few of the issues facing lesbians and other SSA women. There was also an interest in resources or support about GLBT health issues, particularly staff professional development training on GLBT issues.

What became glaringly apparent was that if there was appropriate policy and program support that explicitly highlights this group as a priority, peak health organisations are willing to explore and implement strategies to achieve population health outcomes for the GLBT communities.

4. FOCUS ON PREVENTION

ACON supports the focus on prevention as the most effective and efficient way of addressing many health issues. Australia's experience in its response to the HIV epidemic provides a world's best practice model for future policies focused on prevention. Australia has one of the lowest rates of HIV prevalence, due to Commonwealth and state governments acting in partnership with researchers, academics and community organisations to deliver effective messages.

At the core of prevention is the process of empowering individuals and communities to be able to take responsibility for their own health and wellbeing. This approach necessarily includes the health care system and primary health care providers. However, prevention is much broader than merely early intervention by health care providers. The framework of health promotion, as set out in the *Ottawa Charter for Health Promotion*[51] has been an effective framework for ACON to promote health and prevent negative health outcomes.

[51] See: http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

An important aspect of the *Ottawa Charter for Health Promotion* is the focus on equity and enabling individuals and communities to take control of their health. Another aspect of a successful health promotion approach is the partnership between government, community and researchers, this is especially important in reaching marginalised or minority communities.

In order for GLBT people, specifically lesbians and SSA women, to have the social capital that enables one's ability to take control of their own health, the health system needs to shift its focus from a hetero-normative approach to one that is inclusive and representative of sexual diversity across all health promotion activities and programs.

> *"I have regular pap smears and checkups at the local Women's Health Centre. This is always a positive experience because they never presume you as being heterosexual or homosexual. When I have had to advise that my next of kin was my female partner, they treated it as the norm. I always prefer to go to a WHC because of their attitudes. I have had numerous other experiences in public hospitals (Westmead and Nepean), where I have been made to feel uncomfortable because of my female partner."*
>
> *– Anonymous respondent from online ACON data collection initiative titled, 'How were you treated?'*

The focus on prevention in the NWHP needs to work within an integrated policy framework that aligns with other national health policies such as the National Preventative Health Policy, recognising lesbians and SSA women as a priority population, in achieving the 7 strategic directions outlined, such as in reducing inequity, acting early and throughout life, and engaging communities.[52]

The Young Women's Project

The Young Women's Project is aimed at SSA women 26 years and under and was initiated in Sydney in 2004 as a sister project to ACON's long running and successful Fun & Esteem Project. The project demonstrates the benefits of adapting and implementing successful models of service delivery previously used by ACON in the context of its past HIV education and early prevention work the GLBT community.

The Young Women's Project has several facets including peer education, resource production, arts based community development initiatives and mentoring programs. All components of the project are conceptualised, designed and implemented by young SSA women.

The central component of The Young Women's Project is a peer education based program called *Ins & Out*. The *Ins & Out* program is a closed group that runs one night a week over a six week period. The program addresses a broad range of topics within a structured workshop setting including; sexual and gender identity, alcohol and other drug use, 'coming out', sexual health and well-being, homophobia and discrimination, relationships and community engagement. The Young Women's Project runs several *Ins & Out* groups over a year. Each group is co-facilitated by two volunteer facilitators who have been through the program themselves and completed an additional six week competency based training program.

[52] Commonwealth Department of Health and Ageing, *National Preventative Health Policy: Overview*, 2009.

The Young Women's Project is the largest of its kind in Australia. To date the program has had over 300 young women complete the *Ins & Out* program, and currently holds an active group of over 40 trained volunteer facilitators.

The project has successfully created a structure that promotes capacity development, health promotion education and encourages community involvement for young SSA women early in their life course experience.

ACON equally supports alternative models in prevention by supporting initiatives that increase physical activity and social connectedness among lesbians and SSA women.

The ACON/Sydney Women's Baseball League (SWBL) Partnership

ACON & SWBL have been community partners for 3 years and have successfully promoted and engaged lesbians and same-sex attracted women in pro-active approaches to maintaining health and well-being by encouraging and facilitating social connection and physical activity.

The ACON/SWBL partnership was developed in recognition that participation in sport can impact positively on the health and well-being of lesbians and same-sex attracted women. Sport, and in particular team sports, not only offers an opportunity to increase physical activity and therefore positively impact on fitness levels and cardio-vascular health, but also provides an avenue for social connectedness, a crucial factor in addressing the social isolation and stigma attached some experiences of living as a lesbian or same-sex attracted woman. Research indicates that higher levels of physical activity also reduce the risk of a range of chronic illnesses such as diabetes, heart disease and even cancer.

The ACON/SWBL partnership is based on the principles of collaboration and harm minimisation, of social justice, integration, diversity and inclusion. SWBL is a women's baseball league running in Sydney inner city. The partnership includes sponsorship of an annual ACON All Stars baseball match, dissemination of health promotion material at baseball games, and reciprocal information promotion through the ACON and SWBL websites and networks.

5. RECOMMENDATIONS

Recommendation 1
The National Women's Health Policy explicitly mention lesbians and SSA women as a priority group throughout the Policy in keeping with the mention of lesbians and SSA women as a priority group during the consultation forums in NSW.

Recommendation 2
That following the inclusion of lesbians and SSA women as a priority group throughout the Policy, moves are made to recognise these women in all significant and related areas of government policy (e.g. the preventative health agency, mental health, drug and alcohol, violence, and ageing).

Recommendation 3
The Policy explicitly acknowledges that like gender, sexual orientation is a social determinant of health that impacts on individual and population health outcomes.

Recommendation 4
The National Women's Health Policy support the inclusion of a sexuality question in all health related research, as has been successfully done in the Longitudinal Study of the Health of Australian Women Survey, and for all future research to disaggregate data based on sexuality, in the same way that data is disaggregated based on gender.

Recommendation 5
A Ministerial Advisory Committee on GLBT Health and Wellbeing be established (drawing upon the Victorian model) to provide advice on health issues for GLBT to government.

Recommendation 6
A National Women's Health Policy that takes a life course approach to prevention needs to recognise the overlay that sexuality has across a life-course, and engage with organisations with proven experience in working with lesbians and SSA women in understanding the health inequities, and the social determinants of those inequalities, in determining the transition points necessary to accessing health care for these women.

Recommendation 7
National competency-based training focussing on sexual diversity issues be developed and rolled out across the health sector. This training would be developed and implemented by organisations with credibility and experience in working with sexually-diverse populations, and may include partnering with key groups such as the Royal Australasian College of Physicians, or University-based medical and allied health schools.

Recommendation 8
Evidence-based, targeted health promotion and education messages need to be developed for SSA women, including messages about cancer screening, sexual health, drug and alcohol consumption, nutrition, and cardio-vascular health.

Recommendation 9
Mental health literacy, mental health promotion and early intervention programs need to be developed for lesbian and SSA women, given the unacceptably high rates of mental health problems and suicidal ideation among lesbian and SSA women.

Recommendation 10
Suicide prevention programs that recognise critical transition points for young people, and in particular the increased vulnerability for SSA women, need to be developed and supported with adequate and sustained funding.

Recommendation 11
Community attitudes that lead to homophobic violence need to be addressed, and national leadership on this issue is vital. Further action following the identification of lesbians and SSA as a priority group in the Australian Government's policy on violence against women (*Time for Action*) is necessary.

Recommendation 12
Support for community-based organisations with experience in partnering with government, is required to develop and implement anti-violence projects and to provide psychosocial support for victims of violence in the GLBT community.

Recommendation 13
That in recognising lesbians and SSA women as a priority group in the NWHP, a policy framework be put in place for addressing same-sex domestic violence in tandem with the Australian Government's policy on violence against women (*Time for Action*).
The development and delivery of a national competency-based training program be developed for police and victims services to include the unique experiences of same-sex domestic violence.

Recommendation 14
Mainstream aged care service providers need to be equipped with the skills to appropriately provide for and respond to the needs of lesbians and SSA women, and national guidelines and training ought to be included as part of the policy and program response to aged care into the future.

Recommendation 15
A GLBT-sensitive information and referral point for the ageing GLBT population is required and could be provided by community-based GLBT organisations.

Recommendation 16
Programs that support ageing lesbian and SSA women in their homes as they age are required. Specifically, community-based GLBT organisations could be funded to provide aged care support services to people in their own homes.

Recommendation 17
Given that the overwhelming majority of GLBT youth access support and information in relation to sexual identity via the internet, online initiatives need to be developed that target key health priorities through this media – for example, online counselling, sexual health information and provision of peer support networks.