

Policy Document

LGBTQIA+ Health (2019)

Position Statement

AMSA believes that:

1. Healthcare systems should not negatively discriminate against individuals on the basis of their gender identity/expression, sexuality/sexual orientation and/or sex characteristics;
2. Medical graduates in Australia should be competent in providing inclusive, respectful, culturally safe and sensitive care of LGBTQIA+ individuals and that addresses LGBTQIA+ health specific needs to a standard applicable to their qualification and speciality;
3. Medical schools have a responsibility to provide appropriate and effective curricula in LGBTQIA+ healthcare and cultural safety to medical students;
4. Medical care should respect the individual's right to bodily integrity, physical autonomy and self determination regardless of their own identities within the LGBTQIA+ community;
5. It is important to engage key stakeholders in the LGBTQIA+ community in health strategy-making in order to appropriately address the diverse needs of the community;
6. Current research into the discrimination and health inequities faced by the LGBTQIA+ community is insufficient;
7. LGBTQIA+ individuals often have intersecting identities which must also be considered in the healthcare context.

Policy

AMSA calls upon:

1. Australian governments to:
 - a. Protect and build upon current rights held by the LGBTQIA+ community;
 - b. Implement goals, policies and strategies to minimise the health inequities experienced by LGBTQIA+ communities;
 - c. Direct research, using appropriate data collection and health monitoring methods, into the healthcare needs of LGBTQIA+ communities (including with intersecting identities) to better address health inequities;
 - d. Develop healthcare services and practices which are inclusive to LGBTQIA+ communities, and ensure LGBTQIA+ specific healthcare initiatives are continually supported and funded;
 - e. Promote the education of LGBTQIA+ issues in the wider community and mandate LGBTQIA+ inclusive curriculum in schools both for being inclusive of and about LGBTQIA+ identifying individuals;
 - f. Conduct themselves in a culturally safe and sensitive manner, especially in regards to new or changing legislation such as doing so with consultation with relevant LGBTQIA+ stakeholders;
 - g. Implement legislation to categorically outlaw LGBTQIA+ conversion practices as per recommendations in the 'Preventing Harm, Promoting Justice: Responding to LGBT conversion therapy in Australia' report;
 - h. Implement legislation to outlaw involuntary or coerced sterilisation of people with variations in sex characteristics as per recommendation in

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'Community Affairs Reference committee: Involuntary or coerced sterilisation of intersex people in Australia' report;

- i. Advocate for international human rights for those of diverse sexual orientation, gender identity and sex characteristics, acknowledging existing principles and guidelines such as:
 - i. The Darlington statement;
 - ii. The Yogyakarta Principles Plus 10;
 - iii. World Professional Association for Transgender Health (WPATH) guidelines;
2. The Australian Medical Council to include LGBTQIA+ health knowledge, cultural safety and respectful care of communities into their accreditation standards for medical schools;
3. Medical Deans Australia and New Zealand to make LGBTQIA+ health a priority area in addressing health inequities and ensuring appropriate healthcare;
4. Australian medical schools to:
 - a. Address gender identity/expression, sexuality/sexual orientation and sex characteristics as social determinants of health in medical curriculum by including:
 - i. Teaching of health issues specific to LGBTQIA+ communities;
 - ii. Teaching of the vulnerabilities of LGBTQIA+ populations and the barriers to healthcare;
 - iii. Teaching cultural safety with LGBTQIA+ individuals as a core learning objective;
 - b. Ensure staff undergo cultural safety training and are adequately educated to deliver LGBTQIA+ health content;
 - c. Ensure administrative support processes are culturally safe and produced with consultation from the LGBTQIA+ community, particularly with regard to:
 - i. Students who may need to alter gender markers;
 - ii. Upholding individuals' preferred pronouns;
 - iii. Altering names in university records;
 - d. Address the health of minority groups within LGBTQIA+ communities within the medical curriculum, this includes, but is not limited to, Aboriginal and Torres Strait Islander people, migrant and refugee populations, culturally and linguistically diverse (CALD) individuals, those from low socioeconomic backgrounds, and people with disabilities;
 - e. Develop strategies for competent engagement with LGBTQIA+ populations, including:
 - i. Highlighting the use of appropriate, safe and inclusive language (including terminology for bodily differences and body parts, and the usage of preferred names, pronouns and titles) as paramount to providing adequate healthcare;
 - ii. Creating teaching materials that explore the needs of LGBTQIA+ populations in a positive and non-stigmatising way, in particular through problem-based learning (PBL) scenarios, clinical cases and lectures:
 1. Using culturally safe representations of LGBTQIA+ individuals;
 2. Consulting with a broad range of diverse LGBTQIA+ stakeholders to ensure representation is not tokenistic;
 3. Highlighting the specific needs of people with diverse gender identities/expressions and sex characteristics;
 - iii. Allow for increased exposure to LGBTQIA+ communities through clinical rotations and national and international electives;

- iv. Consulting with LGBTQIA+ organisations to develop accessible and relevant resources on LGBTQIA+ health for medical students;
- v. Teaching LGBTQIA+ health in an integrated manner throughout the medical curriculum, where appropriate;
- vi. Inviting participation of LGBTQIA+ health professionals and community members in teaching and curriculum development;
- f. Avoiding stigmatising models of gender identity/expression, sexuality/sexual orientation and sex characteristics, including:
 - i. Rejecting stigmatising representations of, and terms for, non-binary, intersex and gender-diverse individuals;
 - ii. Utilising the most current version of the WPATH guidelines, the Darlington Statement and the Yogyakarta Principles as the basis for developing an inclusive curriculum around individuals with diverse gender identities/expressions and sex characteristics;
 - iii. Promoting the use of gender-neutral and non-discriminatory language throughout teaching; particularly in genitourinary & reproductive anatomy and health;
- g. Developing modules on anti-discrimination legislation and the legal responsibilities of medical professionals to LGBTQIA+ individuals;
5. AMSA volunteers to promote awareness of LGBTQIA+ health issues nationally by:
 - a. Ensuring the interests and well-being of LGBTQIA+ medical students are being represented within AMSA;
 - b. Where applicable, lobbying for anti-discrimination laws, policies and legislation in alignment with statements 1-3 above;
 - c. Fostering and supporting initiatives to better LGBTQIA+ health;
 - d. Updating and reviewing current AMSA policies to ensure they are inclusive of LGBTQIA+ communities;
 - e. Affirm the Darlington statement and the Yogyakarta Principles Plus 10;
6. Medical students and medical students' societies to promote LGBTQIA+ health issues locally by:
 - a. Ensuring the interests and well-being of LGBTQIA+ medical students are being represented within the medical student body;
 - b. Promoting the teaching of LGBTQIA+ health issues within their medical schools;
 - c. Advocating against prejudice and discrimination of LGBTQIA+ people particularly LGBTQIA+ medical students among the medical community;
7. Health professionals to:
 - a. Engage with ongoing training and education to ensure safety in providing LGBTQIA+ healthcare, to address needs such as the recent PBS approval of PrEP and the re-scheduling of alkyl nitrates;
 - b. Ensure that their clinics are culturally and physically safe locations for LGBTQIA+ individuals, through the use of inclusive practices;
 - c. Advocate on behalf of LGBTQIA+ individuals with regard to the health inequities they face;
 - d. Work within culturally safe frameworks such as the National LGBTI Health Alliance's 'LGBTI Cultural Competency Framework';
8. Australian Medical Association (AMA) and specialty colleges to:
 - a. Develop comprehensive policies around LGBTQIA+ health;
 - i. And where relevant, ensuring to mandate LGBTQIA+ health education as part of official training standards;
 - b. Advocate for the standardised inclusion of gender identity/expression, sexuality/sexual orientation and sex characteristics as social determinants of health in medical curriculum;

- c. Support healthcare services and practices which are inclusive to LGBTQIA+ communities, and ensure LGBTQIA+ specific healthcare initiatives are continually supported and funded:
 - i. Such as ensuring robust processes are in place to support students and staff who choose to transition to ensure safe working environments;
- d. Advocate for legislation to categorically outlaw LGBTQIA+ conversion practices as per recommendations in the 'Preventing Harm, Promoting Justice: Responding to LGBT conversion therapy in Australia' report;
- e. Advocate for legislation to outlaw involuntary or coerced sterilisation of intersex people as per recommendation in 'Community Affairs Reference committee: Involuntary or coerced sterilisation of intersex people in Australia' report;
- f. Affirm the Darlington statement and the Yogyakarta Principles Plus 10.

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's 17,000 medical students. AMSA believes that all communities have the right to the best attainable health. Accordingly, AMSA advocates on issues that may impact health outcomes.

LGBTQIA+ refers to lesbian, gay, bisexual, transgender, queer and questioning, intersex, and asexual individuals, with the '+' denoting other individuals with diverse gender identities/expressions, sexualities/sexual orientations and sex characteristics. LGBTQIA+ people in Australia continue to face significant barriers to care, resulting in poorer health outcomes in addition to unique health challenges associated with their sexuality, gender or sex characteristics. LGBTQIA+ people have unique experiences with their identities being impacted by different social contexts and intersecting identities, including ethnic backgrounds and socioeconomic classes. With their diverse identities, LGBTQIA+ people share an ongoing exposure to associated societal stigma. This stigma plays into all levels of the social determinants of health and can manifest as individual internalised shame, interpersonal discrimination, and systemic structural, legal and administrative challenges. These factors impact LGBTQIA+ individuals' health and confidence in Australia's healthcare system.

While attempting to access healthcare, LGBTQIA+ individuals experience interpersonal barriers in the form of systemic discrimination [1] and the inadequate education of health professionals [2, 3]. This has led to transphobia and homophobia in healthcare settings [4, 5], highlighting a need for cultural safety when interacting with patients of the LGBTQIA+ community through an understanding of the interconnected needs, histories and identities of LGBTQIA+ individuals [5, 6]. In particular, this failure in cultural knowledge has led to the inappropriate and often times intrusive questioning of LGBTQIA+ people, hostility and even verbal abuse from healthcare practitioners [5]. Cumulatively, these acts of cultural indifference have resulted in a mistrust from LGBTQIA+ people, resulting in the avoidance of healthcare professionals, with a consequent decrease in health seeking behaviours [7, 8]. Research indicates that many LGBT individuals hide their sexuality or gender identity for fear of discrimination [9, 10].

The following paragraphs outline the key specific issues that LGBTQIA+ community face in healthcare, and highlight areas where strategies could be employed to address these needs. Although some sections of the community are not specifically mentioned, the issues faced by them form part of the umbrella of LGBTQIA+ health issues.

Mental health inequities

Although many LGBTQIA+ Australians live happy and healthy lives, research has demonstrated that a disproportionate number experience poorer mental health

outcomes. LGBTQIA+ Australians have a higher risk of suicide attempts, suicidal ideations, self-harm and psychological distress than the general population, experiencing twice as many mental health diagnoses and treatment [11]. Within the LGBTI population aged older than 15, the rate of suicidal ideation and behaviour is over five times that of the general population [12]. Similarly, self-injury amongst same-sex attracted youth has been shown to be twice as high, while people who are transgender being over 6 times as likely to self-harm than the general population. Those with variations in sexual characteristics such as intersex faced similar issues with 60% reporting suicidal thoughts and 19% attempting suicide specifically related to having a congenital sex variation [13]. It is acknowledged that normalising surgical intervention at infancy is damaging to the mental health of intersex individuals [14].

Some of the inequities in mental health may be attributed to the phenomenon known as 'minority stress', which LGBTQIA+ persons experience in their struggle for validation and societal acceptance [15]. Stigma and discrimination against sexual minorities has been extensively documented [16] and assessed as likely to be part of the reason for the higher rates of psychological morbidity observed [17, 18]. Other contributing factors across LGBT populations include higher rates of unemployment when compared to the general population, fear of disclosure, employer discrimination, social exclusion, hatred and violence, and higher rates of drug, alcohol, and substance use disorders [19, 20, 21, 22]. There is also overwhelming clinical evidence from psychological research that "conversion therapy" or practices aimed at reorienting LGBT individuals are ineffective, harmful and unethical, with up to 10% of LGBT Australians vulnerable to these practices [23, 24]. Such practices are currently opposed by all Australian health authorities, though only the Victorian government has pledged to outlaw them [23, 25].

These health outcomes are directly related to experiences of discrimination, prejudice, abuse and stigma on the basis of being LGBTQIA+. Importantly, significant knowledge gaps in the mental health of LGBTQIA+ Australians remain. While research is expanding, current data is unable to represent a holistic picture of LGBTQIA+ Australians, nor is it able to fully explore the experience or impact of intersecting identities [4].

Physical health inequities

LGBTQIA+ individuals may also experience poorer physical health. There are higher rates of alcohol consumption, tobacco intake and drug use amongst the LGBTQIA+ community compared to national averages [26]. Obesity is also more prevalent among lesbian and bisexual women [27]. Some studies have also claimed that gender diverse, intersex, and transgender people are at a higher risk of domestic and family violence [28, 29].

There is evidence suggesting that women who have sex with women (WSW) are at a higher risk of cervical cancer [30]. This is the result of a lack of awareness, amongst both patients and clinicians, around the transmission of sexually transmitted infections, specifically human papilloma virus (HPV), during cisgender woman to woman sexual contact. WSW are also less likely to undergo cervical screening tests [31]. Additionally, transgender men with a cervix face increased risk of cervical cancer morbidity, due to reported inconsistent condom use, increased risk for HPV infection and undetected disease progression [32]. Transgender men are less likely to be on cervical screening programs than cis women [33], and even when on such programs face further barriers to effective screening such as a lack of culturally safe practices, physical changes induced by testosterone therapy and provider/patient discomfort with the exam [34, 35].

In Australia, men who have sex with men (MSM) have a greater incidence of HIV [36] and are at an increased risk of having hepatitis B, HPV and herpes [30]. In NSW, MSM are more likely to report having a sexually transmitted infection (STI), particularly chlamydia, gonorrhoea, genital herpes, syphilis and anal warts [37]. As

some of these STIs are risk factors for anal cancer, MSM are therefore at a greater risk for anal cancer [38]. Only some states offer free vaccines for Hepatitis A, Hepatitis B, HPV, and Meningococcal C to MSM [39]. As a preventative measure against HIV, pre-exposure prophylaxis (PrEP) was PBS listed in 2018 reducing the cost of prevention from \$10,000 to \$474 a year, however, the availability for post-exposure prophylaxis (PEP) is still limited [40, 41].

Health inequities associated with variations in sex characteristics

As of 2019, there are no national best practice guidelines in Australia in relation to the provision of health care for people with intersex variations [42, 43]. Intersex variations are currently classified under the 'disorders of sexual development' (DSD) [44]. Such a categorisation sets a precedent with regards to the need to "normalise" intersex variations through medical interventions and may lead to unnecessary health barriers and stigmatisation of intersex variations. Indeed, a recent survey reported that only 24% of people rated their medical consultations positively [13].

Owing to the diversity of intersex variation health care needs, complications and/or risks resulting from individual bodily characteristics will vary from person to person [42]. It is, however, important to note that a recent Australian survey found that nearly 80% of people with intersex variations reported that they were physically healthy [13]. Nevertheless, people with intersex variations may encounter a range of medical interventions that may include therapeutic risk-reduction surgery, non-therapeutic "normalising" surgery and hormone replacement therapies which each carry their own risks and consequences [13, 45]. Despite calls for an end to non-consensual, non-therapeutic medical interventions, [46, 47, 48] people with intersex variations continue to encounter non-essential interventionist medical procedures; only 9% reported a solely positive experience from the intervention in a recent survey [13].

Individuals with variations in sex characteristics also face specific mental health stressors related to unnecessary medical interventions and finding out about their intersex variation [13]. Furthermore, there are barriers in accessing sensitive and appropriate mental health services, and a lack of policy in the National Mental Health strategy that specifically address the needs of individuals with variations in sex characteristics [13, 49].

Health inequities associated with transgender and gender diverse individuals

Gender identity and dysphoria is an important component of LGBTQIA+ health that has historically been poorly managed in the health sector. Despite evolution of the social and political landscape for transgender Australians, the impact of ongoing stigma is reflected in grim mental health statistics specific to this group in the LGBTQIA+ community.

Medical understanding of the totality of issues facing transgender individuals appears to be relatively poor, [50] highlighting a significant need for improvement, including both individual education and appropriate improvement of guidelines and access to care. Whilst this is improving, for example with the recent development of the first Australian standards of care and treatment guidelines for trans and gender diverse children and adolescents [51], it is important to acknowledge the ongoing limitations to care e.g. difficulties obtaining Medicare funded gender reassignment surgeries [52]. A 2013 survey of transgender individuals reported 35% of those choosing to have gender-reassignment surgery travelled overseas to do so [53]. Among ongoing limitations are human rights issues, such as the lingering need to have undergone reassignment surgery to change one's gender on a birth certificate in Victoria, Queensland and New South Wales [54, 55, 56], which contribute to stigma and must be addressed in order to improve health outcomes overall.

Health inequities and intersecting LGBTQIA+ identities

LGBTI people with disabilities face compounding systemic discrimination and stigma, resulting in even higher rates of poor mental health, violence and abuse when

compared to their counterparts without a disability. LGBTI people with a disability, particularly those with intellectual disabilities, face greater restrictions on their freedom to express their sexuality or gender identity [57].

LGBTI refugees experience significant social isolation, mental health issues, stress and post-traumatic stress disorders, with particular pressures identified to do with their gender identity/expression, sexuality/sexual orientation and sex characteristics. Studies of LGBTI mental health fail to account for intersecting CALD influences in significant depth, displaying a lack of understanding of compounding barriers to accessing mainstream services. LGBTI CALD individuals may also face significant social isolation, as they may feel rejected by their CALD community but also find LGBTI “communities” hard to access or unwelcoming due to racism and exclusionary attitudes [58].

Aboriginal and Torres Strait Islander communities and peoples have different cultures, languages and experiences which are often unique and may not reconcile to those of non-Indigenous Australia resulting in separate challenges and needs for LGBTQIA+ identifying Indigenous Australians. For example, some Indigenous communities use the terms sistergirl and brotherboy to describe individuals who would fit non-Indigenous definitions of transgender individuals [59]. LGBTQIA+ Indigenous Australians are poorly acknowledged by both traditional LGBTQIA+ health research and Indigenous health research, with no current mention of LGBTQIA+ individuals in health policies like “Closing the Gap” [60].

Of the sparse research that exists, Aboriginal and Torres Strait Islander LGBTI youths are more likely to have contracted or been exposed to an STI, and gay Indigenous men have higher incidences of drug use, imprisonment and sexual violence [61, 62]. Though there is no concrete data, anecdotal evidence suggests that LGBTQIA+ Indigenous Australians are at increased risk of suicide and mental health issues [63, 64]. These health inequities may partly be explained by the dual effects of heterosexism and racism. A Queensland survey of 160 gay Indigenous men found significant rates of heterosexism experienced from the Indigenous community and even higher rates of racism experienced within the LGBTQIA+ community [62]. Barriers to healthcare for Aboriginal and Torres Strait Islander are compounded by their geographic location, culturally inappropriate services and concerns about confidentiality when accessing local Aboriginal Medical Services [65].

Addressing LGBTQIA+ health inequities through literacy and education

The coverage of LGBTQIA+ health in Australian medical curricula is limited, and varies in the scope and type of training [3]. The majority of Australian medical schools dedicate only 0-5 hours of teaching to LGBTQIA+ health in both pre-clinical and clinical settings [3]. This education usually focuses on sexual history-taking or differences between sexual behaviour and identity. Teaching on transgender and gender-diverse health as well as diverse sex characteristics is sparser still [3]. Often, this content is not taught by, or in consultation with, LGBTQIA+ people. It is often tokenistic, overly pathologizing or reductive. The distinct lack of diverse representation in the medical curricula subtly endorses heteronormativity, over minority sexualities, genders and sex characteristics [66].

Many of the health issues that face the LGBTQIA+ community are largely able to be circumvented with access to appropriate and safe patient-centred healthcare. When formalised LGBTQIA+ health education is given, a marked positive response is shown with greater knowledge on access to healthcare, LGBTQIA+ relationships, increased willingness to treat patients with gender identity issues, and enhanced awareness that sexual identity and practices are clinically relevant [67].

There is currently no formalised standards or requirements for LGBTQIA+ health education in Australian medical school curricula, which has led to a noted lack of

basic skills around terminology, gender affirming care and finding population specific resources [2, 3].

In some medical schools, student-led initiatives play a role in peer-education to address the lack of adequate LGBTQIA+ health education in medical school curricula [3]. Role modelling by tutors and medical staff is purported to be effective in delivering the content safely and to counter opposing attitudes to LGBTQIA+ groups for future medical students [8]. The level of experience and expertise of the facilitator of any LGBTQIA+ educational intervention within medical curricular has shown to be important to achieving good outcomes [68] with the utilisation of “expert patients” following intergroup contact theory to reduce prejudice attaining similar aims [69]. While some of these methods individually may prove effective in addressing some issues with LGBTQIA+ health education, it appears that in order to achieve long lasting, sustainable change, comprehensive strategies that are tailored to fit individual curriculums are most likely to address the totality of structural deficits found within medical education [68].

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Appendix

Appendix 1: Terminology

There is no universal glossary of terms to describe identity and their definitions within the LGBTQIA+ community. Some terms may have multiple definitions, variations or are fluid, as they apply to personal experience which may not be transferable to others. Not all people may identify with terms that others might consider apply to them.

The Australian Institute of Family Studies (<https://aifs.gov.au/cfca/publications/lgbtiq-communities>) and the Victorian Government (<https://www.vic.gov.au/inclusive-language-guide>) provide accessible succinct glossaries of common terms used in the LGBTQIA+ context that correlate with the manner they are used in this policy. AMSA recognises that other interpretations are possible, and that some terms are controversial.

Appendix 2: Reproductive Health Barriers

As of 2018, all states and territories have legalised adoption for same sex couples, however, there are barriers that remain for the LGBTQIA+ people wanting children, such as the ability for foster-care agencies to discriminate against LGBTQIA+ people on religious grounds [70] and the reservation of altruistic surrogacy for heterosexual couples in Western Australia [71, 72].

With regards to assisted reproductive therapy (ART), there are currently four states that have relevant legislation allowing access for same sex couples (WA, VIC, NSW, SA). Elsewhere, health practitioners are guided by professional judgement and ethical guidelines in deciding same sex couple accessibility. In QLD and NT however, fertility clinics are able to refuse ART access based on relationship status or sexuality. Anti-discrimination acts in these regions do not apply to ART services [73, 74]. Currently, Rainbow Fertility exists as a Queer specific ART service provider [75]. Children of LGBTQIA+ people are equal in social, emotional and educational aspects as those of heterosexual people [76].

Furthermore, studies show that 19% of MSM surveyed in Melbourne reporting being a victim of stealthing; a term used to describe non-consensual condom removal during a sexual act, thus increasing the risks of contracting STIs [77, 78]. Stealthing is not specifically classified in the crimes act and has not yet been tested in courts.

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