DISCRIMINATION TOWARDS LGBTI PEOPLE IN HEALTH CARE SETTINGS

Submission on systemic barriers and stigma and discrimination experienced by LGBTI people in accessing health services for hepatitis B, hepatitis C and/or HIV prevention, care or treatment.

ACON

EXECUTIVE SUMMARY

We are experiencing increasing momentum towards ending stigma and discrimination against LGBTI people in the international human rights arena. With the United Nations and heads of state speaking out against discrimination and the need for protection there is both growing awareness and a burgeoning evidence base about the needs and experiences of LGBTI people.

This international push and comprehensive research, however, has not necessarily translated to improved practice for LGBTI people in health care settings. LGBTI people continue to report barriers to accessing safe and appropriate healthcare and experience discrimination and negative treatment from health providers that results in poor health outcomes.

LGBTI people report hiding sexual orientation, gender identity or intersex status when seeking healthcare; facing heterosexual bias, misunderstandings about sexual practices and assumptions of risk behavior; and lack of knowledge from staff (particularly for trans people, LBQ women and PLHIV) epitomised by invasive, irrelevant questions, judgmental comments or inability to provide appropriate referrals, particularly in regional and rural areas.

These experiences compound with systemic barriers such as the role of medical professionals as gate keepers to accessing medication, hormones and surgeries; association of the health care system with the criminal justice system; lack of general comprehensive sex education; funding cuts to essential services; and lack of routine data collection using gender and sexuality indicators. In comparison, sensitive and knowledgeable health professionals provided affirming experiences for LGBTI people within health care settings.

Health care providers can draw from existing initiatives to create more sensitive and inclusive work practices. Inclusivity and diversity training has been successfully delivered to frontline staff, management and supervisors and human services in areas of aged care, mental health, domestic and family violence.

Training resources, e-learning modules, videos, policy review services and strategy planning sessions to assist with organisational change. Change is possible within healthcare where interventions are driven by LGBTI people and PLHIV and HCV and involve meaningful engagement at all stages of program and policy design and implementation.

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ABOUT ACON

ACON is a health promotion organisation specialising in HIV and STI prevention, HIV support and lesbian, gay, bisexual, transgender and intersex (LGBTI) health. We support our communities to take control of their sexual health by providing educational resources and a range of support services including: screening for STIs through our a[TEST] facilities, sex, health and relationship workshops, distribution of free condoms and safe sex resources, substance support services and counselling.

From the onset of the HIV crisis, we played a key role in mobilising and embedding affected communities into the response, a pioneering approach to addressing a public health crisis. Our models of peer based education are great examples of this approach, as were the care and support that ACON staff and volunteers provided to the sick and the dying during the devastating early years of the epidemic.

Our education campaigns throughout the years have helped change the way that people in our communities engage with health issues, especially those related to their sexual health. The success of our approach has been through reflecting the lived experience of LGBTI people and people with HIV, and delivering information in a positive, evidence based and non-judgmental way.

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INTRODUCTION

Lesbian, gay, bisexual, transgender and intersex people are an increasingly open and visible part of the Australian community. Within these groups there is significant diversity and overlap and sexuality, gender identity and intersex status are all distinct concepts that require understanding. Legal definitions are provided in the *Sex Discrimination Act 1984* Cth and peer organisations have produced inclusive language guides (National LGBTI Health Alliance, 2013).

Stigma and discrimination towards LGBTI people has long been an area of significant concern and continues to be linked to poorer health outcomes. Over the last three decades there have been international shifts to recognise LGBTI rights to non-discrimination and equality before the law. The United Nations Human Rights Committee has found that the International Covenant on Civil and Political Rights (ICCPR) includes an obligation to prevent discrimination on the basis of sexual orientation (*Toonen v Australia* Communication No. 488/1992; *Young v Australia,* Communication No. 941/2000). The 2007 Yogyakarta Principles recognise that the international response to violations against people because of their sexual orientation "has been fragmented and inconsistent", even though those violations "constitute a global and entrenched pattern of serious concern" (2007, Introduction). In 2015 United Nations Secretary General Ban Ki Moon stated that LGBT people "suffer disproportionate discrimination and abuse" (UN, 2015) and in 2016 the UN Human rights Council voted to appoint an expert on LGBT human rights (UN, 2016).

Different populations will experience this stigma and discrimination in intersecting ways. Male homosexuality was illegal in Australia until recent times, with the process of decriminalisation beginning in South Australia in 1975 and not being completed until 1997 in Tasmania. Sex between women was never illegal, although lesbians and same-sex attracted women could be harassed through other statutes. There remain state and territory laws that criminalise people living with HIV if they are providing sexual services regardless of safer sex practice or risk of transmission (Jeffreys, Matthews and Thomas, 2010). Such laws affect a person's access to health provision for fear of arrest.

The law is also only just beginning to recognise diverse gender identities: In 2014 the High Court upheld the right to be registered as neither a man nor a woman (*NSW Registrar of Births, Deaths and Marriages v Norrie* [2014] HCA 11). The law is also beginning to protect people from discrimination on the basis of gender identity, sexual orientation and intersex status, with amendments to the *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* Cth. This was the first time intersex status was protected in Australian anti-discrimination laws. However anti-discrimination protection at the state and territory level remains inconsistent.

These legal changes have typically run behind changes in public opinion, whereby the increased acceptance in the general community was eventually reflected in changes that occurred through parliament. Since homosexuality was decriminalised, other discriminatory legislation has continued to be repealed, although full legal equality is yet to be achieved, for example in the case of marriage equality. Hospital staff refusing to recognise non-biological family or LGBTI partners in medical situations is an example of how this impacts upon quality of health care. The Australian Human Rights Commission reports that public support for marriage equality was at 72% in June 2014 (AHRC, 2015, 27). Further, changes in societal attitudes are never uniform and there remain many within the Australian community who are not yet comfortable living or working with LGBTI people. There are also a number of representatives in state and Commonwealth parliaments who actively sanction stigma and discrimination against LGBTI Australians.

In addition to the general stigma and discrimination that LGBTI people face, LGBTI people are also affected by stigma and discrimination associated with blood borne viruses, particularly HIV. When HIV first entered public consciousness it was associated with gay men, sex workers and injecting drug users, behaviours which carry their own stigma. Combined with the striking physical effects of AIDS, this meant that HIV became a highly stigmatised condition.

In the health care system, LGBTI people are often subject to a dual narrative. There were (and continue to be) excellent health care professionals who provide high quality, non-judgmental services to LGBTI communities, those with blood borne viruses and those who fit both categories. However, people who work in health care settings can sometimes also demonstrate the negative stereotypes associated with LGBTI communities and people with HIV, and can act in a way that stigmatises or discriminates against their patients. This threatens prevention, testing, treatment, support and care for HIV and hepatitis B and C, and undermines the public health goal of eliminating HIV and hepatitis B and C infection.

The published research and community findings cited in this submission reflect the urgency of completely eliminating stigma and discrimination against LGBTI people, especially those living with HIV and/or other blood-borne viruses, along with the practicable possibilities for doing so through the health care system.

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THE EXPERIENCE OF STIGMA AND DISCRIMINATION IN LGBTI COMMUNITIES

STIGMA

LGBTI people are already subject to well-documented stigma experienced in a society where heterosexuality and patriarchal gender identities remain powerful norms. As such, for LGBTI people the prevention, care and/or treatment of hepatitis B, hepatitis C and/or HIV is sought or experienced through a layered experience of stigma and discrimination. As with hepatitis B, hepatitis C and/or HIV, this stigma is due to prejudice in the dominant cultural imagination, of these infections as they intersect with sex work, homosexuality, poverty, migration, injecting drug use, and prison settings. This layering effect is intensified for LGBTI people who also experience sexism, racism or other forms of oppression. There are significantly deleterious health consequences of stigma for LGBTI people in relation to hepatitis B, hepatitis C and/or HIV. For ACON's constituency, stigma specifically impacts on people's vulnerability to violence and abuse, presents barriers to accessing employment and housing, and affects experiences accessing health care generally. For example:

Reluctance to disclose LGBTI, HIV or HCV status

- Risk of discrimination affects a person's decision to disclose their HIV or HCV status. PLHIV and PLHCV may "attempt to hide stigmatised behaviours such as drug use or their HIV or HCV positive status" (ASHM, 2012);

- Almost 50% of all LGBT people hide their sexual orientation or gender identity when accessing services for fear of violence or discrimination (Bernstein et al. 2008; Boehmer and Case 2004; Curmi et al, 2015; Douglas et al, 2015; Eliason and Schope 2001; Petroll and Mosack 2011; Rosentreich et al, 2011; Stein & Bonuck, 2001; Tracy et al, 2010);

- In *Private Lives 2*, the most recent national survey of GLBT Australians' health and wellbeing, "young people aged 16 to 24 years were more likely to hide their sexuality or gender identity" (Leonard et al, 2012).

Fear of discrimination

- Stigma affects testing for HIV and HVC, as "people who have experienced or who worry about experiencing discrimination or stigmatisation will be less likely to be tested for HIV or HCV" (ASHM, 2012);

- Discrimination creates barriers to people accessing general healthcare and treatment related to HIV and HCV, as "experiencing stigma and discrimination … has a major impact on the willingness to access general healthcare" (ASHM ,2012).

High rates of depression, anxiety and suicide

- LGBT people are at a higher risk for a range of mental diagnoses and significantly more likely to be diagnosed with depression or anxiety (Australian Human Rights Commission, 2015);

- The First Australian National Trans Mental Health Study found that 43.7% of trans respondents were currently experiencing clinically relevant depressive symptoms; 28.8 % met the criteria for a current major depressive syndrome; 5.4% for another depressive syndrome; 18.3% for a panic syndrome; and 16.9% for another anxiety syndrome. One in 5 participants (20.9%) reported thoughts of suicidal ideation or self-harm on at least half of the days in the 2 weeks preceding the survey (Hyde at al, 2014).

Poor treatment by health providers

- The fear of discrimination or stigmatisation may reflect the discomfort and negative attitudes many healthcare providers, including nurses, experience and convey when working with LGBT patients (Boehmer & Case, 2004; Dorsen, 2012; Institute of Medicine, 2011; Stein & Bonuck, 2001);

- Research on physician attitudes reveal levels of homophobia or heterosexual bias, including a reluctance to treat or negative comments during the treatment of LBQ women (Boehmer & Case, 2004; Matthews et al., 1986; Peterson & Bricker, 1996; Solarz, 2003);

- Women reported negative reactions to their disclosure from healthcare providers & therefore negative experiences throughout their treatment (Boehmer & Case, 2004; Gruskin, 1999; Solarz, 2003; Stevens, 1990; Stevens, 1992).

Misunderstanding of health issues

- Health professionals make assumptions about health issues, risks and needs of trans and gender diverse people. Medical professionals do not always ask the right questions (for example, whether a woman needs a prostate check or whether a man needs a pap smear) or have up-to-date and relevant information (for example, about the long-term impact of synthetic hormones on the body or fertility);

- LBQ women face misunderstandings of their sexual practices and risks by health professionals. Women reported negative reactions to their disclosure from healthcare providers & therefore negative experiences throughout their treatment (Boehmer & Case, 2004; Gruskin, 1999; Solarz, 2003; Stevens, 1990; Stevens, 1992);

- It is not only overt discrimination that causes harm to LBQ patients: assumptions of heterosexuality can cause harm, reduce patient satisfaction with care, create feelings of invisibilty and is linked to a lack of re-attendance, avoidance of health care, and less routine health care (Barrett & Conneely, 2012; Bowen et al., 2007; Brown & Mayer, 2015; DeHart, 2008; Dorsen, 2012; Lauver et al., 1999; Powers, et al., 2001);

- Studies on disclosure have revealed that LBQ women may not disclose their sexuality when providers do not ask; that they dislike providers assuming they are heterosexual; that they have poorer perceptions of their medical care than their heterosexual counterparts; and that patients report a desire for their healthcare providers to know their sexuality (Boehmer & Case, 2004; Fobair et al., 2001; Kamen et al., 2015).

DISCRIMINATION

Discrimination is a manifestation of stigma towards LGBTI people. The Australian Human Rights Commission reported in 2015 that “experiences of interpersonal and institutional discrimination in settings such as schools, healthcare facilities, and structural barriers to informed and appropriate healthcare” were intrinsically linked to the rate of suicide for LGBT people (i.e. 3.5 to 14 times higher than the general population) and LGBT people’s higher risk of depression, anxiety, and other mental illnesses. Nearly 25% of respondents to the Commission’s online consultation reported being refused a service of some kind on the basis of their sexual orientation or gender identity (Australian Human Rights Commission, 2015). Access to health is impacted by broader social issues affecting LGBTI people, including vilification in media, targeted policing, homelessness, unemployment, and domestic and family violence. Discrimination can thus also be experienced as heavily layered for LGBTI people living with HIV, hepatitis C or hepatitis B. For ACON's PLHIV and PLHCV constituency in particular, discrimination includes:

- Health care workers "making decisions about infection control on the basis of perception of infectious risk rather than the risk inherent in the procedure' (ASHM, 2012) and otherwise 'reinterpreting universal (standard) precautions… making practice decisions based on rationales like … we need to clean more, disinfect more thoroughly, and sterilise the equipment for longer periods of time" (Gagnon, 2014);

- Discrimination through the use of formal and informal policies e.g. 'using forms with questions specific to HIV to screen patients, scheduling appointments last or later in the day, systematically refusing services to patients living with HIV on the basis that they are considered to pose a risk to other patients' (Gagnon, 2014);

- Breaching confidentiality, e.g. "disclosing the serological status of a patient to 'warn' colleagues, 'flagging' a patient who is HIV-positive by indicating the serological status on the chart (using a sticker or a red pen) and/or in other work-related documents (e.g. care plan)" (Gagnon, 2014).

SYSTEMIC BARRIERS IN THE HEALTH SYSTEM

LGBTI people's relationship to the health is informed by a history of pathologisation and medicalisation. The historical inclusion of homosexuality, 'transsexuality' and BDSM as mental 'disorders' in the United States Diagnostic and Statistical Manual and the International Classification of Diseases has informed the treatment of LGBTI people in health care settings. Medical professionals (in addition to psychiatrists and judges) have played a role of gatekeepers for trans people to access hormones and surgeries and require trans and gender diverse people to meet narrow models of gender dysphoria to access support and treatment. Trans people rely on authorisation from health professionals to change sex on official documents, trans people in prison or corrective services cannot always access hormones or medication, and people with intersex variations continue to face coercive medical treatment and surgeries from infancy. Genetic screening for intersex variation and elimination intersex traits continues. This history affects LGBTI people's relationship to health professionals and has left a legacy of distrust in the medical profession. Narratives of disease, disorder and abnormality continue to affect cultural attitudes and practices.

Barriers to accessing health care that is free of stigma and discrimination for LGBTI people include:

- Uninformed, or actively discriminatory beliefs about LGBTI people in health care service personnel across the system (ACON, 2016);

- Lax or non-enforcement of anti-discrimination laws and policies (ASHM, 2012);

- Lack of LGBTI-specific quality assurance monitoring and mechanisms for LGBTI health care clients (ASHM, 2012);

- Lack of knowledge production on LGBTI clients' service needs and patterns of engagement (SWASH, 2013);

- The association (perceived or otherwise) of the health care system with the criminal justice system (ACON, 2016);

- Lack of gender and sexuality indicators in population-level data collection for policy and planning in areas such as mental health and lifestyle-related illness (SWASH 2013);

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- Changing funding environment for women’s health organisations and a flow on impact for LBQ women. In September 2016 the Australian Women’s Health Network announced that Federal government health funding cuts had led to drastic rationalisation of Australia’s only women’s health promotion peak body. From the start of 2016, this peak body, which has traditionally advocated for and supported LBQ women as part of its work, will function as a volunteer based organisation only. In its place the organisation Jean Hailes received $8.25 million in government funding until 2019 to become the national digital gateway for women's health and wellbeing. The Jean Hailes website contains no content at all for LBQ women, or for women who are transgender.

- Limited opportunities for trans and gender diverse people to speak to their experiences of discrimination in health care and be heard and validated.

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ANNOTATED BIBLIOGRAPHY – PUBLISHED ARTICLES

1.

TITLE

HIV Stigma and Discrimination: Enduring Issues [Introduction to journal issue on stigma and discrimination]

AUTHOR

Helen Land, PhD, LCSW, Nathan Linsk PhD.

PUBLICATION DETAILS

Journal of HIV/AIDS & Social Services, 12:1, 3-8, 2013.

HYPERLINK IF AVAILABLE

http://dx.doi.org/10.1080/15381501.2013.765717

KEY FINDINGS

- Stigma due to HIV/AIDS is often layered over previous manifestations of stigma. Therefore, stigma toward PLHA is built over stigma toward sex workers, homosexuals, the economically impoverished, people of color, and injection drug users. Stigma associated with these social and structural factors has the effect of extending and deepening AIDS stigma. Sources of AIDS stigma often include fear of disease, contagion, and death.

- Stigma has a deep and deleterious impact on health. AIDS stigma has adverse consequences for preventive behaviors, such as condom use, HIV test–seeking behaviors, willingness to disclose serostatus, care-seeking behaviors, adherence to treatment, the quality of care provided to PLHA, and social support received. Silence and denial generate barriers to treatment and expand poor health outcomes for the infected.

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2.

TITLE

Strange bedfellows: HIV-related stigma among gay men in Australia

AUTHOR

John B.F. de Wit, Dean A. Murphy, Philippe C.G. Adam and Simon Donohoe

PUBLICATION DETAILS

Chapter 17 in P. Liamputtong (ed.), Stigma, discrimination, and living with HIV/AIDS: A cross-cultural perspective, Springer, 2013.

HYPERLINK IF AVAILABLE

http://link.springer.com/chapter/10.1007%2F978-94-007-6324-1_17

KEY FINDINGS

The chapter reports on the HIV Stigma Barometer study conducted in Australia to investigate HIV-related stigma in the gay community as experienced by HIV-positive men and expressed by non-HIV-positive men. Key findings included:

- Experiences of stigma overall are low among HIV-positive gay men in Australia;
- Negative emotional reactions and sexual exclusion were the most common manifestations of stigma for participants;
- Participants were most likely to disclose HIV status to healthcare workers and to sexual partners, and, HIV-positive men's overall experiences of HIV-related stigma were significantly associated with disclosure to their sexual partners and healthcare workers;
- Overall experienced stigma was significantly higher in men who had any sex partners of unknown HIV status;
- The more non-HIV positive men engaged with the gay or HIV-positive communities, the less likely they were to express HIV-related stigma; (also suggesting that "the HIV-positive community is an important refuge for gay men who experience HIV-related stigma");
- Older gay men experienced and expressed less stigma, as did men who had serodiscordant sex partners;
- The findings overall suggest strongly that "if perceptions of risk [of HIV infection in health care and sexual contexts] decrease, including as a result of accumulating evidence that HIV transmission is substantially reduced if PLHIV are effectively treated,.. stigma will decrease. However, as risk is subjectively experienced, additional approaches may be required to address underlying social and psychological processes";

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- Traditional venues and media for HIV prevention and stigma reduction may be eroding and may not yet be fully replaced by appropriate new channels of communication and education (i.e. as LGBTI communities increasingly express themselves online).

3.

TITLE

Tranznation: A report on the health and wellbeing of transgendered people in Australia and New Zealand

AUTHOR

Murray Couch, Marian Pitts, Hunter Mulcare, Samantha Croy, Anne Mitchell, Sunil Patel

PUBLICATION DETAILS

Australian Research Centre in Sex, Health, and Society, La Trobe University, Melbourne, 2007

HYPERLINK IF AVAILABLE

http://www.glhv.org.au/files/Tranznation_Report.pdf

KEY FINDINGS

- A central concern for transgender communities in accessing health services is recognition (including formal documentation) of their preferred gender.

- Positive interaction with the medical community could be a profoundly legitimating experience for transgender people.

- Participants described their best and worst experiences with a health practitioner or health service in relation to being transgender. For many respondents, the best experiences in the health system involved encounters where they felt accepted and supported by their practitioners. Respondents' worst experiences with health services usually involved encounters where they were met with hostility and not treated respectfully.

- Practitioners were greatly appreciated if they were knowledgeable and experienced in transgender issues, and if they were sensitive to gender diversity and to the difficulties that transgender people face in health care settings.

- Most participants, (87.4%) had experienced at least one form of stigma or discrimination on the basis of gender. Social forms of stigma such as verbal abuse, social exclusion and having rumours spread about them were reported by half the participants. A third had been threatened with violence. A similar number had received lesser treatment due to their name or sex on documents, as well as been refused employment or promotion. Almost a quarter had been refused services and 19% physically attacked. Many participants generally kept their gender identity to themselves, or said they would only express it in private, and in safe spaces. Discrimination from family members (who could also be victims of discrimination themselves) and in the workplace were commonly discussed. Participants expressed strong fears for their safety based on their experiences of discrimination. Respondents who had experienced a greater number of different types of discrimination were more likely to report being currently depressed and almost two-thirds (64.4%) of participants reported modifying their activities due to fear of stigma or discrimination.

ACON

4.

TITLE

Experiences of HIV stigma: The role of visible symptoms, HIV centrality and community attachment for people living with HIV

AUTHOR

Loren Brener, Denton Callader, Sean Slavin, and John de Wit

PUBLICATION DETAILS

AIDS Care: Psychological and Socio-medical aspects of AIDS/HIV, 25:9, 1166-1173.

HYPERLINK IF AVAILABLE

https://www.ncbi.nlm.nih.gov/pubmed/23311451

KEY FINDINGS

- Those with visible symptoms experienced more HIV-related stigma and had poorer outcomes on a range of psychological and mental health measures than those who were able to conceal their stigma;
- These effects remained after controlling for length of time since diagnosis, time on HIV treatment, perceived health satisfaction and age;
- PLHIV reported that HIV was more central to their identity and reported greater attachment to an HIV-positive community;
- While HIV centrality appears to increase the negative effects of having visible symptoms associated with HIV, greater community attachment seems to ameliorate these effects.

5.

TITLE

Global Commission on HIV and the law: Risks, rights and health

AUTHOR

Global Commission on HIV and the Law, UNDP, HIV/AIDS Group, Bureau for Development Policy,

PUBLICATION DETAILS

UNDP 2012.

HYPERLINK IF AVAILABLE

http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf

KEY FINDINGS

- Laws to prevent HIV discrimination exist in 123 countries, but they are often ignored, laxly enforced, or aggressively flouted;

- Women and girls make up half of the global population of people living with HIV and gender inequality affects infection rates and treatment;

- Globally, men who have sex with men (MSM) are nineteen times more likely to be infected than other adult men and stigma (from social stigma to active criminalisation of homosexuality) both causes and boosts those numbers. As many (MSM) also have sex with women, criminalisation of same-sex relations endangers not just MSM but women too. By contrast, evidence shows that in a range of epidemic settings, universal access to HIV services for MSM together with anti-discrimination efforts can significantly reduce infections both among these men and the wider community;

- Where sex education, harm reduction and comprehensive reproductive and HIV services are accessible to youth, young people's rates of HIV and other sexually transmitted infections (STIs) drop. These interventions are rare, however, and in both developed and developing nations, the denial of the realities of young people's lives is reflected in the high physical, emotional and social toll of HIV among the young;

- Where the police cooperate with community workers, condom use can increase and violence and HIV infection among sex workers can decrease. Where governments promulgate harm reduction, such as clean needle distribution programmes and safe injection sites, HIV infection rates among people who use drugs can drop significantly.

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6.

TITLE

Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010 and 2012

AUTHOR

Julie Mooney-Somers, Rachel M. Deacon, Jude Comfort, Juliet Richters, Nicolas Parkhill.

PUBLICATION DETAILS

ACON and Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney, 2013

HYPERLINK IF AVAILABLE

http://www.acon.org.au/wp-content/uploads/2015/12/SWASH-Report_2014.pdf

KEY FINDINGS

- 9% of LGBTQ women in the sample reported high psychological distress (17% of 16-24 year olds); 51% had accessed psychological services and 34% had received a mental health diagnosis in the past 5 years;

- While most women rated their physical health as good/very good/excellent, 12% said their health was poor or fair;

- 33% had experienced some kind of anti-LGBTQ behaviour in the past year.

7.

TITLE

The HIV Stigma Audit Community Report

AUTHOR

Sean Slavin, Loren Brener, Denton Callander, John de Wit.

PUBLICATION DETAILS

National Association of People Living with HIV/AIDS and National Centre in HIV Social Research, 2012.

HYPERLINK IF AVAILABLE

http://napwha.org.au/files/napwa_stigma_audit_report.pdf

KEY FINDINGS

- The entire sample reported higher levels of felt stigma than enacted stigma;
- Gay community and gay sex partners can be significant sites of stigma;
- People with HIV have two key ways in which they mitigate the effects of stigma:
  - Control of the process of HIV disclosure where people with HIV choose the circumstances in which they disclose.
  - Developing skills and characteristics that offer resilience in the face of stigma and other setbacks in life. These include: seeking social support when needed, including from the HIV community; minimising the extent to which HIV is regarded as a key aspect of identity; and cultivating the capacity to bounce back from, or not take to heart perceived slights.

Both the above strategies show that people with HIV(PLHIV) are not passive receptors of stigma. Rather, PLHIV are overwhelmingly resilient in the face of what remains a significant life challenge.

8.

TITLE

Resilient individuals: Sexual orientation, gender identity and intersex rights: National Consultation Report

AUTHOR

Australian Human Rights Commission

PUBLICATION DETAILS

Australian Human Rights Commission, 2015.

HYPERLINK IF AVAILABLE

https://www.humanrights.gov.au/our-work/sexual-orientation-sex-gender-identity/publications/resilient-individuals-sexual

KEY FINDINGS

- LGBT Australians report lower health outcomes in the areas of cancer, sexual health and cardio vascular disease, and from health impacting behaviours such as alcohol and tobacco consumption and illicit substance use. successive studies in Australia have demonstrated poorer health outcomes experienced by bisexual people compared to lesbian and gay people. These include higher levels of documented anxiety and depression;

- The limited information available on the health and wellbeing of trans and gender diverse people suggests that they also experience higher morbidities and lower life expectancy;

- Information on the health and wellbeing of intersex people remains almost non-existent and hence it is not possible to draw clear conclusions about any health consequences resulting from unjust discrimination that they face;

- Research suggests that the rate of suicide for LGBT people is 3.5 to 14 times higher than the general population.LGBT people are also at a higher risk for a range of mental diagnoses and significantly more likely to be diagnosed with depression or anxiety. Experiences of interpersonal and institutional discrimination in settings such as schools, healthcare facilities, and structural barriers to informed and appropriate healthcare are amongst the key factors that contribute to this risk profile. Disturbingly, nearly 25% of respondents in the online consultation reported being refused a service (of some kind) on the basis of their sexual orientation, gender identity or intersex (SOGII) status;

- The absence of inclusion of LGBTI people in mental health strategies was highlighted in the National Mental Health Commission’s Report on the National Review of Mental Health Programmes and Services. The report also included a recommendation that relevant contracts for service providers require expertise and cultural sensitivity for LGBTI people.

ACON

9. TITLE

Writing Themselves In 3 (WTi3): The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people.

AUTHOR

Lynne Hillier, Tiffany Jones, Marisa Monagle, Naomi Overton, Luke Gahan, Jennifer Blackman, Anne Mitchell.

PUBLICATION DETAILS

Hillier, L. Jones, T. Monagle, M. Overton, N. Gahan, L. Blackman, J. Mitchell, A. (2010) Writing Themselves In 3: The Third National Study of the Sexual Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People. Monograph Series No 78. Melbourne, Australian Research Centre in Sex, Health and Society.

HYPERLINK IF AVAILABLE

http://www.glhv.org.au/files/wti3_web_sml.pdf

KEY FINDINGS

- 61% of young people reported verbal abuse because of homophobia;
- 18% of young people reported physical abuse because of homophobia;
- School was the most likely place of abuse – 80% of those who were abused;
- 69% reported other forms of homophobia including exclusion and rumours;
- Young men and GQ young people reported more abuse than young women;
- Homophobic abuse was associated with feeling unsafe, excessive drug use, self-harm and suicide in young people;
- For more than half of the participants, homophobic abuse impacted on a range of aspects of schooling.

ACON

10. TITLE

Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians

AUTHOR

William Leonard, Marian Pitts, Anne Mitchell, Anthony Lyons, Sunil Patel, Murray Couch, Anna Barrett.

PUBLICATION DETAILS

Willian Leonard, Marian Pitts, Anne Mitchell, Anthony Lyons, Anthony Smith, Sunil Patel, Murray Couch and Anna Barrett (2012). Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians. Monograph Series Number 86. Melbourne, The Australian Research Centre in Sex, Health and Society, La Trobe University.

HYPERLINK IF AVAILABLE

http://www.glhv.org.au/files/PrivateLives2Report.pdf

KEY FINDINGS

- The most common types of heterosexist violence reported by participants were non-physical, from verbal abuse (25.5 per cent), to harassment (15.5 per cent), to threats of physical violence (8.7 per cent) and written abuse (6.6 per cent). A significant percentage of respondents reported Occasionally or Usually hiding their sexuality or gender identity in a range of situations for fear of heterosexist violence or discrimination: 44 per cent in public and 33.6 per cent when accessing services. Young people aged 16 to 24 years were more likely than any other age group to hide their sexuality or gender identity at the nine locations listed;

- The percentages of lesbians and gay men reporting sexual assault were similar (2.6 per cent and 2.2 per cent respectively). However, rates of almost all types of physical and non-physical abuse were higher for trans males and females, with 6.8 per cent of trans females reporting having been sexually assaulted in the past year;

- While a majority of both lesbians and gay men reported being out at home and with family, this was not the case for bisexuals, and in particular for bisexual men. For example, 71.4 per cent of lesbians and 65.6 per cent of gay men report that they have never hid their sexuality or gender identity with family members. This percentage drops to 45.7 per cent for bisexual women and to 28.9 per cent for bisexual men.

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RECOMMENDATIONS

Intervention training and communication with the health care sector

- The education and training of health care workers is crucial to the delivery of appropriate and best practice healthcare for trans and gender diverse people. In addition to general LGBTI diversity training for health workers, specific training on gender identity and gender affirmation processes is also lacking. (Australian Human Rights Commission, 2015);

- Work with local services to reduce self-stigma as they have a particular role to play in reducing self-stigma (NAT);

- Develop key messages targeted at health care providers on the risk of HIV exposure and transmission to ensure that practice is informed by scientific evidence and up-to-date information on this topic (Gagnon, 2014);

- Develop a campaign for health care providers to reiterate the principles underlying the use of universal (standard) precautions in clinical practice. This campaign should be focused on the underuse, inconsistent use, and overuse of standard (universal) precautions. (Gagnon, 2014).

Intervention trainings with the broader community sector

- Conduct interventions on HIV stigma in cross-sector (HIV, faith, media, social justice, health) and cross-cultural (e.g. African/Carribean, Asian, Latino) settings. These interventions should combine the use of intrapersonal/psychological strategies and interpersonal/collective empowerment strategies (Committee for Accessible AIDS Treatment).

Design of interventions

- Meaningful engagement with PLHIV and partnership approach with LGBTI communities and inclusion of people with lived experience at all stages of program and policy design and implementation.

- Designing interventions in stigma and discrimination for the health sector requires strategic care:

    - "A substantial number of studies have designed interventions for increased tolerance of PLHA, but a many of these studies have methodological shortcomings. The use of proxies, such as case scenarios, videos, and hypothetical encounters with PLWAs, has been common procedure in lieu of direct contact with persons with HIVAIDS. Such methods have yielded less attitudinal tolerance (Brown et al., 2001). Other study designs have not tested actual stigma reduction in the field, relying primarily on participant self-report. As a result, the validity of findings remains questionable. In addition, reliability and validity of stigma measures vary considerably from one investigation to another. While some studies have used validated instruments, others rely on a single question to measure the complex construct of stigma. Finally, few studies have reported a longterm effect of antistigma interventions beyond 6 months post intervention (Brown et al., 2001)." (Land and Linsk);

- Designing a strategy for stigma reduction should consider: Where and with whom are we trying to have an effect? What are we trying to affect to achieve change? How are we going to achieve this? (NAT).

Healthcare practice

- Ensure that all health care providers have the necessary knowledge and competencies to provide safe, competent, and ethical care to people living with HIV. Hold the educational and health care sectors accountable for meeting current standards of practice in HIV care.

Healthcare programming

- Provide accompaniment services in moments of heightened vulnerability especially when the person is unwell, in pain, or hospitalised. Encourage people living with HIV to bring someone along for support when they go to medical appointments, clinic visits, and so forth (Gagnon 2014);

- Develop a practical guide on the rights of people living with HIV in health care settings. This guide should be specific enough to address the rights of people living with HIV with respect to disclosure, confidentiality, and discrimination in health care settings (Gagnon 2014);

- Further develop the HIV Support Program in NSW which has already developed significant improvements in the capability of diagnosing doctors to educate patients, offer referrals and retain individuals in care; and includes an approach which focuses on strengthening the doctor-patient relationship rather than introducing an additional party (e.g. a public health officer) into that relationship.

Healthcare program reach

- There are likely to be many LBQ women who are not connected to LGBTQ communities either by choice or because they are not comfortable identifying with this group, and program reach to this group needs additional consideration. (SWASH)

- Conduct needs assessments among trans, gender diverse and intersex people about health needs.

Broader community sector practice guidelines

- Anti-stigma work, including campaigns and events, should avoid the idea that people with HIV are passive receptors of stigma or require sympathy. Such work should promote strong and positive responses that work to enhance wellbeing (Slavin et al).

Awareness-raising in the LGBTI communities

- Targeted campaigns addressing the effects of heterosexist discrimination on marginal and vulnerable populations within LGBTI communities, including campaigns addressing transphobic discrimination and abuse (PL2);

- As HIV prevention evolves to include a range of risk-reduction strategies that may or may not include condom use, all such efforts should be reviewed to assess their effects on PLHIV. This includes strategies that encourage disclosure of HIV status and which may reinforce the sero-divide. Consideration should also be given to the different effects on PLHIV of such prevention efforts in settings outside large gay cities such as Sydney and Melbourne, where sizeable PLHIV communities reside (Slavin et al).

- Develop a quick reference guide for people living with HIV that details the principles of universal (standard) precautions and what is considered "good practices" in clinical settings with respect to the use of gloves, masks, gowns, and isolation precautions. (Gagnon 2014)

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Research

- Further research into protective and resilience-building factors for people living with HIV/HCV;

- We need to know more about the patterns of engagement among LBQ women and with the wider LGBTQ communities (SWASH);

- As 'E-health' gains more prominence, it is important to know more about how LBQ women access information online, particularly in regions that do have the population to sustain dedicated physical spaces for LBQ women. This information will improve the future effectiveness of health promotion, prevention messages or early interventions to this group (SWASH).

Quality assurance

- Document current practices in health care settings by conducting surveys and reporting the findings to professional regulatory bodies. The survey of dental offices completed by COCQ-sida throughout the province of Quebec could serve as a model for future initiatives (Gagnon 2014);

- Produce report cards for health care institutions, departments, clinics, and so forth based on a set of criteria including, but not limited to, adherence to standard (universal) precautions, adherence to transmission-based precautions, confidentiality, and record-keeping (Gagnon 2014);

- Develop a statement of principles that set out the responsibility of all individuals to take reasonable precautions to ensure infections are not transmitted (cf. Victorian model) (ACON, 2016).

Law/Reporting and sanctions/systemic measures

- Encourage people living with HIV to file complaints against providers and institutions in cases of stigma and discrimination. Provide the necessary support (i.e. informational, practical, psychological, and financial) for complaints to be filled and followed through (Gagnon 2014);

- Advocate for the development of internal policies in health care to ensure that current standards of practice in HIV care are clearly delineated and applied in day-to-day operations. Include these policies in the production of report cards as previously described (Gagnon 2014).

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ANNOTATED BIBLIOGRAPHY – UNPUBLISHED RESEARCH OR ARTICLES

1.

TITLE

ACON Health Outcome Strategies 2013-2018: Community Safety and Social Inclusion; Smoking; Alcohol and Other Drugs; Mental Health and Wellbeing; Domestic and Family Violence

PUBLICATION DETAILS

ACON, Sydney, 2013.

AUTHOR

ACON

HYPERLINK IF AVAILABLE

http://www.acon.org.au/wp-content/uploads/2015/04/HOS-COMMUNITY-SAFETY-AND-SOCIAL-INCLUSION.pdf

http://www.acon.org.au/wp-content/uploads/2015/04/HOS-Smoking-webres.pdf

http://www.acon.org.au/wp-content/uploads/2015/04/HOS-Alcohol-and-other-drugs_web-res.pdf

http://www.acon.org.au/wp-content/uploads/2015/04/HOS-Mental-Health_web-res.pdf

https://issuu.com/aconhealth/docs/acon_hos_-_dfv_2015_web_res

- Prejudice, violence and abuse have shadowed our communities' history and development, and continue to have a disproportionate impact on LGBTI communities to this day. They continue to have significant impacts on the health and wellbeing of our communities. The criminalisation and pathologisation of sexual and gender diversity, moral condemnation from religious authorities, and a patriarchal social structure that judges expressions of gender and sexuality outside of social norms have provided justification for violence, extortion, detention and compulsory medical treatment, as well as verbal abuse, social exclusion and discrimination.

- Risky alcohol use is higher among lesbian, gay, and bisexual (LGB) people than heterosexuals (*AIHW 2011, p.61*). Lesbian and bisexual women show higher levels of risky alcohol consumption and problematic drinking than heterosexual women (*Ritter,Matthew-Simons, and Carragher 2012, p.67*).
- The 2010 NDSHS also showed significantly higher rates of cannabis, ecstasy, methamphetamine, and cocaine use among LGB people (*AIHW, 2011*).

- LGBTI people are as likely as non-LGBTI women to experience DFV, but are less likely to find support services that meet their specific needs (ABS 1996; ICLC 2011, p. 24; Little 2008; Pitts et al. 2006, p. 51).

- They are also less likely to identify DFV in relationships, report it to police or seek support from mainstream DFV services (Farrell & Cerise 2006, p. 18; Pitts et al. 2006, pp. 51-52).

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- It is now well documented in the literature that LGBT people experience higher levels of psycho social distress than heterosexual, cisgender people, and that LGBTI people are at increased risk of a range of preventable mental health problems, including depression, anxiety disorders, self harm, suicidal ideationand suicide, much of which has been attributed to experiences or fears of social exclusion, discrimination and abuse (*Carman, Corboz, and Dowsett 2012; Couch et al. 2007; Hillier, Edwards, and Riggs 2008; Hillier et al. 2010; Leonard et al. 2012; Ritter, Matthew Simons, and Carragher 2012; Suicide Prevention Australia 2009*).

- Figures from the National Drug Strategy Household Survey (NDSHS) show smoking rates for the general population at 18.9%, while the smoking rate for those identifying as homosexual/ bisexual is 39.5% (*AIHW 2011, p. 28*). In 2010, rates fell respectively to 17.5% for the general population and 34.2% for homosexual/bisexual populations (*Ibid*.).

- Descriptive and small studies of transgender health also suggest high rates of smoking. 44.1% of trans men and 35.4% of trans women surveyed in the Private Lives study smoked on more than five occasions in the preceding month (*Pitts et al. 2006, p. 35*).

2.

TITLE

Stigma and discrimination around HIV and HCV in Healthcare Settings: Research Report

AUTHOR

Australian Society for HIV Medicine (ASHM)

HYPERLINK IF AVAILABLE

http://www.ashm.org.au/resources/Pages/1976963391.aspx

KEY FINDINGS

Stigma and discrimination can have a negative influence on both mental and physical health.

In Australia, the groups most commonly associated with HIV are: men who have sex with men; people who inject drugs; immigrants and ethnic minority groups; and sex workers. Each group already experiences stigma due to the perception that they engage in behaviours viewed as deviant or different. In interaction between health care workers and patients, there are four areas where stigma and discrimination could occur:

- standard precautions, where health care workers may make decisions about infection control on the basis of perception of infectious risk rather than the risk inherent in the procedure;
- disclosure, where PLHIV and PLHCV attempt to hide stigmatised behaviours such as drug use or their HIV or HCV positive status;
- testing for HIV and HCV: people who have experienced or who worry about experiencing discrimination or stigmatisation will be less likely to be tested for HIV or HCV;
- general healthcare and HIV-and HCV-related treatment: experiencing stigma and discrimination has been found to lead to a variety of negative health outcomes and has a major impact on the willingness to access general healthcare.

3. TITLE

Rethinking HIV-related stigma in health care settings: A research brief

AUTHOR

Dr Marilou Gagnon, RN, ACRN, PhD, Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa, Canada

PUBLICATION DETAILS

University of Ottawa, Canada, 2014

HYPERLINK IF AVAILABLE

http://www.ohtn.on.ca/wp-content/uploads/2015/05/RR94-healthcare-stigma.pdf

KEY FINDINGS

HIV-related stigma presents in 3 key modes: episodic, symbolic, and structural stigma.

1. Episodic stigma: Participants considered that HIV-related stigma in health care settings is episodic rather than present at all times. E.g.: when requiring urgent care, diagnostic tests, surgical interventions, dental procedures, and medical consultations; seeking reproductive, health promotion, and mental health services; being incarcerated, hospitalised, and diagnosed;

2. Symbolic stigma: is the most frequently reported and studied manifestation of HIV-related stigma. Symbolic stigma starts with the experience of being labeled and stereotyped for being HIV-positive. For example, participants described how they were automatically categorized as “drug seeking patients” by health care providers for being HIV-positive;

This is followed by status loss and discrimination. As such, participants who were stigmatized reported being treated like they had fewer rights than other patients and being treated differently by health care providers because of their serological status;

3. Structural stigma: The experiences described by participants revealed another manifestation of HIV-related stigma called structural stigma. It presented itself as the exact opposite of symbolic stigma. This particular dimension of stigma has not been studied in great details in the field of HIV;

Structural stigma refers to the strategic use of labeling for “risk management”. It relies on the assumption that people living with HIV pose a risk to health care providers and that is necessary to identify patients who are HIV-positive to properly “manage” this perceived risk;

The important attributed to disclosure in health care settings was highlighted by participants. They also provided numerous examples of unethical, arbitrary, and discriminatory strategies that were explained or presented to them as “risk management” strategies.

Examples of “risk management” strategies:

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• Using formal and informal policies

Examples: using forms with questions specific to HIV to screen patients, scheduling appointments last or later in the day, systematically refusing services to patients living with HIV on the basis that they are considered to pose a risk to other patients.

• Breaching confidentiality

Examples: disclosing the serological status of a patient to “warn” colleagues, “flagging” a patient who is HIV-positive by indicating the serological status on the chart (using a sticker or a red pen) and/or in other work-related documents (ex: care plan).

• Reinterpreting universal (standard) precautions

Examples: creating new rules for patients who are HIV-positive and making practice decisions based on rationales like “we need to take extra precautions”, “we need to be more careful” or “we need to clean more, disinfect more thoroughly, and sterilize the equipment for longer periods of time”.

ACON

4.

TITLE

Community Grants to Tackle Discrimination and Prejudice for IDAHOT 2016.

PUBLICATION DETAILS

ACON Media Release, 11 April 2014

AUTHOR

ACON

HYPERLINK IF AVAILABLE

http://www.acon.org.au/about-acon/latest-news/media-releases/page/3/#community-grants-to-tackle-discrimination-and-prejudice-for-idahot-2016

KEY FINDINGS

- ACON will support 10 groups and organisations throughout NSW for IDAHOT through the provision of a small grants scheme that aims to focus attention on the impact that homophobia, transphobia and biphobia has on the health and wellbeing of young people.
- In its fourth year of providing support, 5 metro and 5 regional events will receive a $500 grant to go towards recognising the important day and promoting the message that young LGBTI people need to be protected from homophobic and transphobic-motivated prejudice, harassment, violence and discrimination.

5.

TITLE

Report reveals lesbian health gaps

PUBLICATION DETAILS

ACON Media Release, 6 May 2015

AUTHOR

ACON

HYPERLINK IF AVAILABLE

http://www.acon.org.au/about-acon/latest-news/media-releases/page/7/#new-report-reveals-lesbian-health-gaps

KEY FINDINGS

A world leading study shows that lesbian, bisexual and queer women experience a range of poor health outcomes including high rates of mental health issues, and rates of smoking and risky alcohol use much higher than those of women in general population.

The data is contained in the latest report of the Sydney Women and Sexual Health (SWASH) Survey, a biennial study of lesbian, bisexual and queer (LBQ) women. 1100 women participated in the latest round of the survey which was conducted during the 2014 Sydney Gay and Lesbian Mardi Gras.

Key Findings Of 2014 SWASH Report:

- LBQ women smoke at much higher rates than the general community. 30% of respondents were smokers compared with 17% of women in the general population. Also, 48% of respondents aged 16 to 24 were smokers.
- LBQ women experience high rates of mental distress. 22% of respondents aged 16 to 24 reported recently experiencing high levels of psychological distress, while half of all women surveyed (49%) reported they had received a mental health diagnosis in their lifetime.
- Many young LBQ women consume alcohol in a problematic way. While alcohol consumption across all respondents was similar to levels in the mainstream community, 82% of respondents aged 16 – 24 drank alcohol at a level that put them at risk of alcohol related disease or injury over their lifetime.

SWASH 2014 also revealed some good news about LBQ women’s experience:

- Over time a diminishing proportion of women have reported experiencing LBQ-related verbal abuse or harassment in the past year (40% in 2006 compared to 27% in 2014).
- Women who had a regular GP were more likely to be out to their doctor about their sexuality.
- Women who were open about their sexuality were more likely to be very satisfied with their regular doctor.
- LBQ women are proactive about their health and seek screening for cervical cancer at similar rates to the general population.

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6.

TITLE

ACON's LGBTI Workplace Inclusion Program Signs its 100th Member

PUBLICATION DETAILS

ACON Media Release, 26 August 2015

AUTHOR

HYPERLINK IF AVAILABLE

http://www.acon.org.au/about-acon/latest-news/media-releases/page/5/#acons-lgbti-workplace-inclusion-program-signs-its-100th-member

KEY FINDINGS

- Pride in Diversity, Australia's first and only national not-for-profit employer support program for all aspects of LGBTI workplace inclusion, today announced that it had signed the International Convention Centre Sydney (ICC Sydney) as its 100th member.
- Pride in Diversity is a social inclusion program of ACON, NSW's leading HIV prevention, HIV support and LGBTI organisation, and counts some of the nation's top companies as its members.

7.

TITLE

The national needs assessment of sex workers who live with HIV

AUTHOR

Kane Matthews, Scarlet Alliance

PUBLICATION DETAILS

Scarlet Alliance, 2008.

HYPERLINK IF AVAILABLE

http://www.scarletalliance.org.au/library/hiv-needsassessment08

KEY FINDINGS

- Training and education for health professionals who interact with people with HIV and/or sex workers to reduce stigma and be more supportive of behaviour and choices. All people who review case files should also be included;
- Improved public health policies to reduce stigma, including measures to encourage compliance by health professionals;

- State and Territory Governments need to decriminalise commercial sex for people with HIV in ACT, VIC, WA, QLD; develop nationally consistent state-based legislation for HIV positive sex workers; ensure legislation around sex work for people with HIV reflects those relating to private sex;

- State and Territory Governments need to remove disclosure requirements from state laws in NSW and TAS; introduce Anti -Discrimination laws for sex workers in all jurisdictions;

- Various Government departments need to provide a trained liaison officer to provide advice and support for sex workers with HIV; ensure that disclosure of both HIV and sex work is not a requirement, but is promoted as acceptable, when accessing a liaison officer; ensure there is an adequate education program within government agencies to address stigma and discrimination, including privacy issues.

ACON

8.

TITLE

Submission to the statutory review of the Public Health Act 2010 [in which a number of changes to the laws around privacy and disclosure of STI status have been mooted by the NSW Government]

AUTHOR

ACON

PUBLICATION DETAILS

June 2016

HYPERLINK IF AVAILABLE

http://www.acon.org.au/wp-content/uploads/2016/06/ACON-submission-to-Statutory-Review-of-the-Public-Health-Act-Final.pdf

KEY FINDINGS

- Fear of stigma and discrimination is a pressing and ongoing issue for people with HIV, particularly those from more vulnerable sub-populations;

- The ongoing reality of stigma and discrimination against people with HIV both in the general community and in health care settings means that the prospect of any dilution of their privacy creates high levels of fearfulness and anxiety among people with HIV;

- Vulnerable sub-populations inlclude people from culturally and linguistically diverse backgrounds (especially recent migrants, people on student visas and people who have arrived as refugees, people from high prevalence countries in Africa), Aboriginal people, highly sexually active men with multiple STIs, sex workers (especially male sex workers), non-gay identifying men who have sex with men, and people residing outside the inner-city;

- A number of studies have shown that a significant amount of HIV-related stigma is experienced in healthcare settings;

- HIV-related stigma is frequently reported as a major barrier to access to mainstream health services among people with HIV in outer-metropolitan, rural and regional areas;

- It is imperative to protect the right of people with HIV to make informed decisions about which health care providers are able to access their information;

- It is possible that some health care professionals interpret the current rules about disclosure and non-disclosure of HIV status too narrowly and improving understanding of these provisions may preclude the need to change the law;

ACON

- The health care sector has an important role to play in resisting stigma and discrimination by maintaining confidentiality of clients living with HIV and/or other blood-borne viruses.

9.

TITLE

Restricting gay men from donating blood is discriminatory

AUTHOR

Jennifer Power, Research Fellow at Australian Research Centre in Sex, Health and Society, La Trobe University

PUBLICATION DETAILS

The Conversation

HYPERLINK IF AVAILABLE

https://theconversation.com/restricting-gay-men-from-donating-blood-is-discriminatory-61021

KEY FINDINGS

- "In Australia, men are only able to donate blood if they have abstained from sexual contact with another man for 12 months. This effectively places a ban on most gay and bisexual men."

- "In Australia, a lifetime ban on blood donation by any man who had ever had homosexual sex was introduced in 1983. At this time, Australian states and territories also put in place legislation that made it a criminal offence not to disclose to the blood bank a history of male homosexual contact or injecting drug use."

- "Technology has significantly improved since the 1980s. Today the "window period" for blood testing is conservatively estimated to be around six to 12 weeks. Multiple testing methods are used to comprehensively screen for HIV and other blood-borne infections, meaning the risk of HIV being transmitted via donated blood is less than one in a million."

- "In 2012, a study commissioned by the Australian Red Cross concluded that, as the vast majority of blood donors are compliant with safety regulations, there would be minimal risks associated with reducing the deferral period for homosexually active men to six months."

- "However, in 2014 the Therapeutic Good Administration (TGA) rejected a Red Cross submission to reduce the deferral period citing it would increase the risk of HIV being transmitted through the blood supply without a related increase in donors."

ACON

RECOMMENDATIONS

Training

- Review of 'risk management' strategies, including assumptions that PLHIV pose risk to health care providers, decision-making about infection control and perception of risk, and practices of red-flagging PLHIV or enforcing special rules/requirements on those patients/clients;
- Develop a quick reference guide for people living with HIV that details the principles of universal (standard) precautions and what is considered "good practices" in clinical settings with respect to the use of gloves, masks, gowns, and isolation precautions (Gagnon, 2014);
- In-house provision of accompanier to support/advocate for the patient in the event of diagnosis, as gay men newly diagnosed with HIV report doctors being highly upset when delivering HIV diagnosis which reduces their ability to support the patient;
- Education and exchange (e.g. between HIV positive and negative people, as demonstrated in deWit et al) to combat stigma.

Law and policy reform

- Removal of deferral period for homosexually active men to donate blood, and base blood donations based on individual risk rather than membership of a particular group;
- Removal of laws criminalising sex work for people living with HIV in ACT, VIC, WA and QLD.

Funding for initiatives

- Funding for campaigns to address health issues among LBQ women (such as smoking, alcohol consumption, and breast and cervical cancer);
- Funding for initiatives to address HIV-related stigma as well as homophobia and transphobia motivated prejudice, harassment, discrimination and violence to reduce barriers to LGBTI people accessing healthcare.

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PERSONAL ACCOUNTS OR RESULTS OF YOUR ENQUIRIES

In this section please provide a list of unpublished accounts of stigma and discrimination as experienced among your constituents. These might be complaints made to your agency or information provided through surveys and the like

Please provide the following for each account – Please provide no more then ten accounts

1.

TITLE

Gay Men Newly Diagnosed with HIV

AUTHOR OR SOURCE OF INFORMATION

Reflections of facilitators of the Genesis program for gay men newly diagnosed with HIV in NSW.

COLLECTING AGENCY

Genesis is a joint project of ACON and Positive Life NSW.

DATE

This was reported in October 2016, based on the previous two years of workshops.

HYPERLINK IF AVAILABLE

NA

KEY FINDINGS

- Clients continue to report that Doctors and nurses have low level of knowledge of HIV and sexual health, outside of specialist services. There are examples of doctors being extremely upset when delivering diagnoses, which reduces their ability to be able to support the patient.

- Stigmatising attitudes are still prevalent. For example, a doctor telling a man with HIV that “only gay men and drugs addicts get HIV”. The doctor was not the normal doctor of this man and unaware of this man’s status.

- Hospital disclosing PLHIV’s status in the waiting room, without consideration for the sensitivity of being HIV positive for some people.

- There are numerous examples of health care professionals taking excessive precautions, such as double gloving.

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2.

TITLE

Additional precautions in acute mental health settings

AUTHOR OR SOURCE OF INFORMATION

Mental health staff at ACON

COLLECTING AGENCY

ACON

DATE

This was reported in October 2016, based on the previous three years of enquiries.

HYPERLINK IF AVAILABLE

NA

KEY FINDINGS

- My unit hasn't seen anyone reporting discrimination within healthcare settings, but our local clinical services are pretty informed.
- I have in the past had inquiries from acute mental health services concerned as to what precautions they should be taking with a client they suspect or have learnt through medical records is HIV positive.
- The concern was around risk of transmission to other clients through accidental exposure to blood and bodily fluids (self-harming or injuries) and sex (worried around disinhibition of clients not necessarily the person with HIV but others who may have diminished capacity to provide consent).

3.

TITLE

LBQ Women's experiences of stigma and discrimination

AUTHOR OR SOURCE OF INFORMATION

Collected by Lesbian and Same Sex Attracted Women Project and Claude

COLLECTING AGENCY

ACON

DATE

2016

HYPERLINK IF AVAILABLE

KEY FINDINGS

- "I recently had to have emergency surgery to repair a hernia. At the hospital I realised staff were looking at us strangely, and it was because we were two lesbian women. Nurses and Doctors also kept insisting I should have a pregnancy test before my surgery. I continued to tell them that I was in a lesbian relationship, so I would not be pregnant. However this caused great confusion as they were also aware that I had a 1 and a half year old baby – so to the minds of staff there it was not possible to be a lesbian with children. A doctor and I had a long conversation about how we managed to achieve this. He said "It's just that I've never met anyone like you." At 3am after my surgery, I was awake reading. The only nurse on duty came by and inquired, how did I manage to have a baby when I was obviously partnered with a woman? I decided all these moments were moments were "visibility work" – which is what I term the work I do just by being visible. I patiently spoke to everyone who asked me about my family and how it had come to be. But I did feel like I was in a fishbowl with fascinated people coming by all the time."

  "My partner and I have both put off accessing GPs because of the fact that we have to "come out" in the process. When I am already feeling vulnerable it is hard to have to explain myself over and over. I am compelled to be constantly polite about my own difference, and it becomes exhausting. Because it is hard to find "safe" GPs who are lesbian friendly, it also means that it is hard to have a family GP that you stick with. This means you have to tell your family history and background to every new GP you see. This means details are lost and relevant information is not passed on. At present we have found an excellent male GP who is of African background, and came to this country as a refugee. I believe that because of his own experiences of discrimination, he understands more about our own experiences. He never asks my partner "Where is your son's father? Who is the real mother?" or any of those regular questions we often have from other health providers. He is always welcoming and friendly. For that reason, now that my partner is experiencing peri-menopause, she will actually be seeing a male GP for this rather than searching for a woman GP. But we know he will be supportive and kind."

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- "I remember the day I got my first ever STI test. I had recently split from my girlfriend of five years and wanted to be tested before wandering into the queer wildnerness. I will never forget the humiliation of having to convince a male doctor why I, a queer woman with no STI symptoms, was presenting myself in his office. He eventually swabbed me but refused to give me a blood test, saying I was only at risk "if I'd been having sex with gay men"."

- "Researchers in 2013 described us as "preventative healthcare's forgotten women." We don't test as often as we should for STIs, and nor do our communities have access to accurate, inclusive sexual health information. Anecdotal evidence from our clients and networks suggest that LBQ women, especially those who do not report having sex with cis men, are invisible in sexual health settings. Many women have reported to us that their healthcare providers tell them they are not at risk of STIs, do not have to get pap smears, or that the sex they are having doesn't constitute "real sex" (quote from a client). Personally, I have been told that I don't need to get tested for HIV (or have any kind of screening for BBVs in general) because HIV "only affects gay men." This was without any knowledge of my sexual history or practices, only a notation on my file that said "lesbian". The issue for many of us is invisibility and a complete disregard for the nuances and complexities of our sexual lives and identities. We can see this lack of knowledge and dismissive attitudes from healthcare providers reflected in research, some of which shows that 40% of LBQ women in the Sydney area have never had an STI test, despite being sexually active (and being sexually active in a range of ways, both with women and with bi and gay-identified men)."

- "Systemic discriminations exist that limit choices for trans-women where the same choices are not limited for cis-women or cis-men. HRT for cis-women and anti-baldness treatments accessible to cis-men were not available to me without significant effort on my part and a great deal of wasted time and money. Medical professionals in general, even those that claim to be experts in trans health, lack experience and knowledge. Knowledge that is possessed by the trans community, they limit access to appropriate treatments by their lack of knowledge."

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4.

TITLE

HIV and Sexual Health

AUTHOR OR SOURCE OF INFORMATION

COLLECTING AGENCY

ACON

DATE

2016

KEY FINDINGS

- “I went in to the hospital for follow up post-surgery. I needed to have the stiches removed from the procedure that had been done a week earlier. I was waiting for a nurse in a small room. I spoke briefly with the nurse who went through my file. I noted in my file as it was open on the desk that it had HIV+ in big letters and circled. I felt slightly uneasy about the way this was recorded, but knew it was better for anyone who would be caring for me that they knew, so I decided to leave it be. As I was moved onto a bench to have the stiches removed, I heard another nurse walk into the room. The nurse must have been reading my file. The next thing I heard was this second nurse call over the first nurse who was removing my stiches. She must have pointed to the open file. All I heard from that point was;

  Nurse 2 – Have you seen this?
  Nurse 1 – yeah I know.
  Nurse 2 – Better double glove.

  Personally, I feel resilient enough to not let this get to me. I didn’t speak up, although I wish I did. In that moment I felt like I was being treated differently because of my HIV status and all for having stiches removed.”

- “He explained that he is sexually active and hasn’t had a test in over a year because he had such a bad experience the last time he was tested. He went to a GP to get tested and the GP was extremely uncomfortable chatting to him and was judgmental about his sexual behaviour. He was then passed onto the nurse to perform the tests, however, she wasn’t in and he had to wait four days for an appointment. He came back and had the tests and then he had to book another appointment with the GP that he had previously seen to get his results. The whole process took about two weeks and made him very uncomfortable. To the point that he hasn’t had a test since.”

- I attended a training conference for Doctor’s around HIV and I thought the training protocol was lacking in terms sensitivity and understanding the impact of a diagnosis. Doctor’s would instruct clients to tell everyone they had sex with they were HIV positive. This message delivered without support and context I thought would be really difficult for a newly diagnosed person. I did mention this to the Doctor’s at this conference. I would add that services especially regional should have updated knowledge around TASP as well as the favourable health benefits of treatment. They should be aware of the importance of meeting peers to share their experiences/ diagnosis with. Referral to ACON and/or Positive Life to provide ‘support’ is essential. As one counsellor explained to me often with ‘coming out’ there is often shame/ rejection from our families. The community often becomes our family. There is added shame with a diagnosis as well as prospect of rejection from the ‘family’. A Dr telling you that you need to tell every person you HIV+ that you have sex thrown into a diagnosis conversation is therefore harsh.

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5.

TITLE

Experiences of discrimination in healthcare for trans and gender diverse people

AUTHOR OR SOURCE OF INFORMATION

Regional Outreach Service

COLLECTING AGENCY

ACON

DATE

November 2016

KEY FINDINGS

- "One month after my 2014 genital reconstruction surgery in Thailand, I returned home to my regional town to find I had a post-op complication. I had a suspected vagino-rectal fistula with faecal material entering the vagina near the entrance. I presented to the local hospital where all staff, bar one, were very accepting and professional. Sadly, all relevant surgeons were away at a conference and a locum was called in to examine me. His prejudice simply would not allow him to listen or understand the nature of my surgery. He eventually took a swab sample to test for faeces. The results never appeared. My partner and I were very distressed through this whole process and were not in a mind frame to respond as assertively as we should. We did make progress with other hospital staff, however, my case was considered so new, radical and out of the ordinary, no one seemed to know how to manage me. I was sent for scans but we were expected to find specialists and coordinate everything ourselves. Finally we saw a GP who took our case in hand and through to a good outcome."

  Trans woman, regional town

- "…it is the continually small acts of discrimination that really get to me. I have never walked into a health service and seen my gender on the forms, I have always had to circle 'female' and have never had to chance to let the service provider know my gender or my preferred pronouns. This doesnt give me much confidence walking into these appointments."

  Non-binary person, regional area

- "I had to see a respiratory specialist and I decided that I would actually disclose my previous surgeries when she asked for my surgical history. It is incredibly rare for me to do that, for good reason. Once I told her I had had chest surgery and a hysterectomy she asked me a barrage of invasive questions about my genitals, how I have sex, who I have sex with and if I had 'always felt like a boy. I had just been diagnosed with tuberculosis (latent) and made the mistake of telling her that I was both a trans man and gay, I had read that having TB and being at risk of HIV meant I should be treated so figured it was important…she didn't believe that I have sex with gay cisgender men and told me I wouldn't need to be treated for TB because I wasn't at sufficient risk. I still haven't been treated because the specialist doesn't believe I am at risk even though I am now also on PrEP"

  Trans man, Sydney

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- “Back in 2007 I had just come out to a few close friends and family, but I had know idea what to do or who to turn to for advice on how to go about getting the help I needed. I thought seeing a doctor about it would get me the answers I needed, (I couldn't have been more wrong). My local GP showed no compassion or empathy to what I was saying and pretty much just shrugged his shoulders and said nothing. The silence in the room made me feel even more uncomfortable then I already was. I finally I said "so can you help me”, his reply was just to tell me to look up the Gender Centre in Sydney and they might help. Because of the lack of help, I ended up back in the closet for another 9 years. When I decided it was time to transition, I decided to go straight to the city for my doctor because I have no confidence in the country system.”

  Trans woman, regional town

- “When I had my hysto (approx. 5 years ago) in a regional city, I was made to stay in the maternity ward overnight despite me having full facial hair and being a man. This not only made women in the ward uncomfortable, but made the nurses feel the same way. I had negative interactions on a daily basis as I was constantly told "You're in the wrong place!" and "WHY are you here?" from not only staff, but other patients. I had to out myself time and time again. For someone who tends not to do that other than for medical professionals, outing myself to total strangers was horrible. I felt sub-par, like I was invading (I kinda was!) and like I totally shouldn't have been there. Hospital staff definitely treated me differently after they were aware of my procedure and why I had it done.”

  Trans man, regional town

- “My experience around healthcare professionals and transition has been largely good as I've taken great care in choosing who've I gone to and have been able (mental health wise) to wait for months when necessary for these appointments. However when I have seen GPs without vetting them first my experience has been that despite being well intentioned there is often ignorance on trans issues. For example I went to see a GP at my university for a referral to see a mental health professional in order to start testosterone. The experience wasn't necessarily bad, but the fact that he then proceeded to ask me about "wanting a sex change to become a woman" (I'm a trans man), couldn't get his head around preferred and legal names and worded my referral letter as "seeking permission" to start testosterone does suggest a lack of training and exposure. Additionally I've seen well meaning GPs repeatedly misgender their patient and seemingly not recognise the impact they're having. Despite having several trans patients and believing that they are quite versed on the issue, this GP had some fairly rigid views which was impacting his willingness to refer patients to further help [can't transition while there are other mental health concerns etc].”

  Trans man, regional town

- “When I was first starting my transition and seeking health services, I saw a child psychiatrist that was a specialist on transgender and gender questioning youth. At that time I was very confident in knowing that I was transgender, and was taking legal steps to follow a medical direction in my transition. I was young, and felt intimidated and worried about accessing health services - and put my trust in someone that was meant to specialise in this area. Unfortunately not all that specialise in very sensitive areas are particularly sensitive or considerate at all. I was asked a lot of questions which would be fairly standard in being diagnosed with gender identity disorder and then I was asked questions that were incredibly invasive. I was asked about my sexuality- which is irrelevant to my gender. Then I was asked if I had sex, if I had penetrative sex, what my sexual partners were like, if I roleplayed as the gender I identified and how I had sex. Being young and really not having anyone else of trans experience in my life, I didn't realise that feeling uncomfortable and distressed with the questions was completely valid so I beared through it. I felt like I had to tell a stranger- a 'professional' very intimate details about my personal life, and that if I didn't I would somehow not be considered trans enough and would not get the medical treatment that I personally needed. I was scared.”

  Trans man, regional city

- "I had already been taking hormones for a few years and it had drastically improved my quality of life, but I still felt tremendous dysphoria and knew that pursuing surgery, in this case a bi-lateral mastectomy, was an important and needed step in my personal journey. Not having many people in my age group that I knew to be of trans experience put me in a position where I felt legal information was often confusing and had a lot of grey areas, and the need for surgery for me was at a very important point to my wellbeing. I decided to seek out a psychiatrist that specialised in transgender and gender questioning youth and when asking about the options that were available to me I was met with very strong and rude opposition from the psychiatrist who expressed to me that I would simply have to wait and that I was not ready despite being on hormone replacement therapy and feeling confident as man for years. I later learned that he had provided me with misinformation and when confronted about this he laughed it off and said that I and my family must know more than him- a supposed 'specialist'. Not only had he provided me with misinformation, he had gone out of his way to send a letter to a surgeon I had approached without mine or my family's consent expressing that I should not be operated on under any circumstances. Luckily the surgeon disregarded this letter and expressed that the psychiatrist was not very professional. But I didn't know anyone else to go to because resources were so limited. This experience had an incredible impact on my self-esteem and trust in health services."

  Trans man, regional city

- "When I first started to seek out medical options in my transition after having all the legal and signed paperwork and permissions, I was completely refused to be seen or even spoken to by a local endocrinologist in the NSW area. They expressed to me and my family that under no circumstances would I receive any hormonal treatments for my medical transition unless I was critically suicidal. It took a lot of searching before I could find a reliable endocrinologist whose professional practice was not clouded by bigoted bias. The experience left an impact on both my self esteem and trust in health services. Experiences like this left me feeling scared and alone in seeking health care services, and often dampened my hope of being able to make the steps that I knew I needed to undertake to be my true, healthy and authentic self."

  Trans man, regional city

- "I needed to see a GP but my family GP was not available and I was left without much choice but to access another health services. A GP was made aware of my transgender experience and he left me feeling humiliated after asking me incredibly invasive and irrelevant questions that had nothing to do with my presenting issue. The GP also asked me if I had, or had planned on having any 'genital reassignment'/'sex change' surgery. I was young and felt intimidated by the GP's professional presence, and also very uncomfortable with disclosing very personal, intimate information that was completely irrelevant to my reasons for seeing the GP. But still he persisted, and seemed to refuse to see why it was unprofessional and invasive to ask. I am terrified of seeking out new GP's and in general health services due to encounters like this, where I feel I am being interrogated and prodded at as if I'm an interesting 'project' or seen as unable to think and make informed decisions for myself and my health."

  Trans man, regional city

- "I identify as a non-binary trans masculine person. To receive affirming medical treatment and access testosterone and chest surgery I have had to conform to the medical model of transgender as binary MTF or FTM: Identifying as a man and wanting all gender affirming procedures/treatment. Any time my presentation, expression or preferred ways of being affirmed have different from this binary expectation I have been told I need psych help, that I am not really trans and that I cannot receive treatment. The last time this happened in a medical context I was denied continued access to the andrology clinic. I had been receiving treatment there for over 10 years when the head of the clinic challenged me on why I chose to go on and off testosterone. I said I didn't wish to completely masculinise. She asked why and I said I do not identify as a man but as transgender. She informed me that I should see a psychologist and that I could no longer attend the clinic. I felt invalidated. It also meant financial hardship as I couldn't receive subsidized testosterone or have my hormone levels and bone density monitored for free. I had to find a GP who would help me. I couldn't afford the testosterone offered by the clinic as it wasn't available to me on the PBS as I was registered F on Medicare. The testosterone I could afford and access was not a slow release form and gave me headaches for two days every fortnight. Thankfully the PBS rules have now changed and gender doesn't determine your access to prescriptions."

Trans man, regional town

- "I was about to have bowel surgery. After a recent experience with a doctor who, while investigating the problem, inappropriately touched and focused on my testosterone-enlarged clitoris I was concerned about how the surgeons might respond to my 'non-conforming' genitalia. In fear, I said to the surgeons that my clitoris was not a typical size and pleaded that they do not try to surgically adjust it. It sounds paranoid but I just didn't trust them especially because of how the medical profession 'treat' intersex people."

  Trans man, regional town

- "As a trans man I know it is important to look after my 'reproductive' health. Almost all of my trans men friends and those in my community do not have any pap smears or STI checks out of fear. I go to a sexual health clinic who prioritise trans people and sex workers. I do not have to explain to anyone there why as a man I need to have a pap smear or have vaginal discharge that needs checking out. The clinic is experienced enough to know that testosterone affects the pap smear test and often leads to a false positive result and they have a solution for it. This information, specific to trans men, is not widely known by other trans people or medical professionals."

  Trans man, regional town

- "I injured my arm and had to stay in hospital and had surgery. My medical chart and discharge papers stated that being transgender ('gender dysphoric') was a co-morbidity. Being trans had nothing to do with my injury or treatment. Why did it have to be noted on all the paperwork that I was trans?"

  Trans man, regional town

- "I live in a small village in a regional area. I fear being exposed as transgender to my local community by a worker at a local medical centre or by getting a hormone prescription filled at the local chemist (most chemists do not have testosterone in stock and it must be specially ordered in). I fear being ill and having to deal with a transphobic or ignorant doctor. I travel 2hrs one way on public transport to see a GP in Sydney's inner west who I know to be supportive and respectful of trans people. I see this GP for all my health needs, not just ones related to being trans. She has an average 2 week waiting list. If I am ill and cannot get an appointment with my doctor then I go without medical help."

  Trans man, regional town

- "To receive access to subsidized hormones at an andrology clinic in a hospital, I was required to supply a psych evaluation (a requirement not required of cis men receiving treatment). I had already given my psych evaluation to a surgeon (as a requirement to have chest surgery). Without a copy of that report I had to be evaluated by a psych at the hospital, who informed me that I was the first trans man he had seen and that he normally only sees trans women. He then laughed and said to me that he couldn't understand why anyone would want to cut their dick off. I was horrified by this but felt too vulnerable to say anything or to leave. I needed this insensitive, ignorant man's approval to proceed with the treatment."

  Trans man, regional town

- "In 15 years as a trans masculine person I have never been asked by any of the GPs I have seen if I have had a pap smear or whether I check what's left of my breast tissue after chest surgery for lumps/breast cancer. None have been able to tell me what the long term health impacts may be with taking testosterone. My trans feminine friends don't get asked if they have had a prostate exam. And they haven't been told how to check their breasts for lumps. Doctors assume trans people are not at risk of developing these diseases. Or maybe they don't want to know?"

Trans man, regional town

- "I present as male but my Medicare gender is female. I changed my name to a male name. When I got admitted to hospital for an accident they put me in women's ward and put a female title next to my name. The other patients kept demanding to know why I, a man, was in the ward with them. They were very upset and angry. I was embarrassed and anxious. I didn't want to have to explain I was transgender. I didn't want staff do to this either. I just wanted to recover from my accident without any grief. It made my stay very stressful."

  Trans man, regional town

- "Waiting for a doctor in a busy family medical centre. It's full of people. I have facial hair and present as male although my Medicare card says female. My name on my card is male. The receptionist calls out my name and uses a female title – Miss – in front of everyone. I have to respond to her misgendering me and people stare as I walk up to the desk. She justifies calling me 'miss' because of the gender on my Medicare card. I am embarrassed. There was no need to use a gendered title. Calling my name would have been sufficient."

  Trans man, regional town

- "Each time I go to a hospital I get assigned a gender according to the hospital and which parts of my medical records and history the person admitting me prioritises. At one hospital it has been male because I went to the andrology clinic there. At another hospital it has been female as once I had breast screens there for cancer. This is despite presenting as male. At another hospital it was male – I'm not sure why but they put me in a mixed ward. I never know what will be assumed about me. No-one ever asks what I would prefer."

  Trans man, regional town

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RECOMMENDATIONS

Adjustment of forms and processes

- Review and re-writing of standard medical forms to include people of diverse gender identities, experiences and histories as well as diverse family and relationship structures;

- Implementation of processes in health care settings that invite people to nominate their preferred gender and preferred pronouns, including options for non-binary people, instead of making assumptions based on medical history or presentation;

- Review of confidentiality procedures in health care settings, including processes for communicating HIV status or trans experience in waiting rooms or places within earshot of the public;

- Providing access to hormones and surgeries for trans and gender diverse people who do not seek to transition to a binary gender;

- Ensure that in practice (not only in policy) LGBTI people can access Medicare subsidies regardless of gender;

- End coercive treatments on intersex people and screening for intersex variations in pregnancies.

Referral pathways and connections to communities

- Ensure health professionals know to provide appropriate referral pathways for people newly diagnosed with HIV, including specialised and tailored counselling services and links to community organisations;
- Ensure health professionals in regional and rural areas have access to information, resources and contacts to specialised and appropriate services.

Training

- Comprehensive training on diversity of bodies, genders and sexualities for health providers;
- Ensure health providers understand specific confidentiality impacts for LGBTI people and the consequences of being outed in health settings, particularly for trans people or those living with HIV.
- Legal training for health care professionals of their responsibilities under federal and NSW anti-discrimination laws, and latest updates in NSW laws on changing identity documents and accessing surgeries or hormones;
- Awareness and sensitivity training for health care professionals about the experiences of stigma and discrimination of LGBTI people in health care settings to deter intrusive and inappropriate questions from health staff;
- Training implemented across all levels of organisation from high level medical staff to professional and administrative staff.

Research

- Research on LBQ women’s sexual behaviour and risks of STI and HIV transmission
- Research into long term impacts of hormones on health (e.g. on bone density, fertility, cancer)

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INITIATIVES TO ADDRESS STIGMA AND DISCRIMINATION

In this section please provide details of any training or other initiatives your agency has in place to address stigma and /or discrimination in health services. This may be internal training or external <repeats the sections below if more than one initiative>.

TITLE

Pride in Diversity

ACON Training & Consulting

DATES/TIMES

Pride in Diversity started out with eight foundation members seven years ago, to more than 165 member organisations currently. Members exist across a range of industries and sectors including health care, community services, banking, financial services, law firms, tertiary education, mining and resources, and more. A range of training sessions and consultation services are delivered to member organisations across the year.

ACON Training & Consulting's genesis began three years ago following initial funding provided by the Australian Government Department of Social Services through the National LGBTI Health Alliance. ACON developed a training package, "Lesbian, Gay, Bisexual, Transgender and Intersex Training for the Aged Care Sector with assistance from GLHV, Queensland Healthy Communities, The National LGBTI Health Alliance and A Gender Agenda. ACON was contracted to deliver this training throughout NSW. ACON also developed and administers an online e-learning module for the Aged Care sector. ACON began to face increasing demand to deliver other forms of face to face, fee-for service training which resulted in the formation of ACON Training and Consulting. It now sits within the broader suite of services in ACON Pride Inclusion Programs.

HYPERLINK IF AVAILABLE

Website: http://www.prideindiversity.com.au/

Resources: http://www.prideindiversity.com.au/resources/publications/

Website: http://www.acontraining.org.au/

e-learning Module: http://lgbtihealth.org.au/resources/lgbti-aged-care-training-e-learning-module/

DESCRIPTION/EVALUATION OF THE RESOURCE/TRAINING PROGRAM

Pride in Diversity is Australia's first and only national not-for-profit employer support program for all aspects of LGBTI workplace inclusion. Specialists in HR, organisational change and workplace diversity, Pride in Diversity has established itself as an internationally recognised program and a partner to many LGBTI employer support organisations across the globe. Pride in Diversity are also the publishers of the Australian Workplace Equality Index (AWEI), Australia's national benchmarking instrument for all aspects of LGBTI workplace inclusion from which the Top 20 Employers for LGBTI employers is determined.

Pride in Diversity is social inclusion initiative of ACON, who is New South Wales' leading health promotion organisation specialising in HIV and lesbian, gay, bisexual, transgender and intersex (LGBTI) health. ACON's

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mission is to enhance the health and wellbeing of LGBTI communities by ending HIV transmission and promoting the lifelong health of LGBTI people and people with HIV.

ACON Training & Consulting provide fee for service training

Interventions to combat stigma include LGBTI-specific training and consultation services across all levels of the organisation, training videos and resources available to all members, policy review services, strategy planning sessions, and support to setup sustainable employee networks.

Training and Consulting provides a wide range of training and consultancy services to assist with all aspects of LGBTI inclusion particularly for service providers, aged care and health. We are Australia's largest and most recognised national provider for LGBTI inclusion, operating across all states. We have a range of solutions to suit organisations of any size, spanning government, healthcare and service providers. With subject matter expertise in LGBTI inclusion across a range of industries and businesses, ACON Training and Consulting provides short or long term consulting advice.

A key part of ACON Training as Consulting's successes depends heavily on engaging with potential clients, funding sources, health care providers, disability services and the LGBTI community.

Training and Consulting has delivered:

- Training in LGBTI Inclusive Service Provision for Aged Care Front Line Staff
- Training in LGBTI Inclusive Service Provision for Aged Care Management and Supervisors
- HIV Awareness for Front Line Staff, in an Aged Care Setting.
- Training in LGBTI Inclusive Service tailored specifically to the needs of health and human services other than aged care. Eg. Mental health, domestic violence victim support services etc.
- Training: HOW2 Create an LGBTI Inclusive Service- under license from GLHV
- Consultation: Rainbow Tick Accreditation

We have also been engaged to speak on:

- Transgender Awareness and Support for Pride in Diversity members
- Privilege, diversity and Inclusion generally, for a range of organisations.

COULD THIS RESOURCE BE FURTHER DEVELOPED OR ROLLED OUT?

We are currently in the process of developing a Pride Inclusion program model (i.e., Pride In Diversity, Pride In Sport) with a focus on inclusive service provision to LGBTI community members accessing health and wellbeing services.

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CONCLUSIONS

STIGMA

As this report illustrates, stigma affects every level of health provision. Stigma relating to HIV, HCV and other BBVs as well as general stigma and misunderstandings about LGBTI practices, sexualities, identities, experiences and bodies affects the quality of health care provided.

HEALTH SERVICE IN WHICH THIS IS EXPERIENCED

Stigma impacts on decision-making, communications and risk assessments from administrative to high level health provision and occurs in health care settings from general practice, hospitals, clinics, mental health services and specialists.

YOUR RECOMMENDED REMEDIATION

The comprehensive recommendations listed in the sections above provide steps to reduce stigma through both awareness and sensitivity training and revision of formal and informal structural policies and practices in workplaces.

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DISCRIMINATION

LGBTI people experience discrimination in a range of health care settings, such as health care workers are making practice decisions like ‘double gloving’ for HIV positive patients based on perceptions of infectious risk (rather than the actual risk of the procedure).

HEALTH SERVICE IN WHICH THIS IS EXPERIENCED

General practice (as reported by Gay Men Newly Diagnosed with HIV), mental health services (as reported by mental health staff at ACON)

Your recommended remediation

In addition to the recommendations listed in the sections above, which include legal training for health providers about obligations and responsibilities under anti-discrimination laws:

- Develop a campaign for health care providers to reiterate the principles underlying the use of universal (standard) precautions in clinical practice. This campaign should be focused on the underuse, inconsistent use, and overuse of standard (universal) precautions (Gagnon 2014);
- Produce report cards for health care institutions, departments, clinics, and so forth based on a set of criteria including, but not limited to, adherence to standard (universal) precautions, adherence to transmission-based precautions, confidentiality, and record-keeping (Gagnon 2014).
- Develop a statement of principles that set out the responsibility of all individuals to take reasonable precautions to ensure infections are not transmitted (cf. Victorian model) (ACON, 2016), and to encourage the reporting of discrimination.

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SYSTEMIC HEALTH SYSTEM BARRIERS

UNINFORMED OR ACTIVELY DISCRIMINATORY BELIEFS ABOUT LGBTI PEOPLE IN HEALTH CARE SERVICE PERSONNEL

LGBTI people regularly report discriminatory attitudes or actions from health care service personnel. Nearly 25% of respondents to the Australian Human Rights Commission's online consultation on SOGII reported being refused a service of some kind on the basis of their sexual orientation or gender identity, which included health services (Australian Human Rights Commission, 2015). An example is reported above, where an HIV positive man was told by a doctor that "only gay men and drug addicts get HIV".

HEALTH SERVICE IN WHICH THIS IS EXPERIENCED

General practice, other health services

YOUR RECOMMENDED REMEDIATION

The education and training of health care workers is crucial to the delivery of appropriate and best practice healthcare for LGBTI people. In addition to general SOGII diversity training for health workers, specific training on gender identity and gender affirmation processes is also lacking. (Australian Human Rights Commission). See recommendations above for specific guidance on designing such interventions with health care workers.

LAX OR NON-ENFORCEMENT OF ANTI-DISCRIMINATION LAWS AND POLICIES

The personal accounts listed above reveal that discrimination is rife in health care settings and suggest that health providers do not always have a sense of appropriate protocol or best-practice care for LGBTI people.

HEALTH SERVICE IN WHICH THIS IS EXPERIENCED

General practice, other health services.

YOUR RECOMMENDED REMEDIATION

Document current practices in health care settings by conducting surveys and reporting the findings to professional regulatory bodies. The survey of dental offices completed by COCQ-sida throughout the province of Quebec could serve as a model for future initiatives (Gagnon 2014).

LACK OF RESEARCH/KNOWLEDGE PRODUCTION ON LGBTI CLIENT NEEDS AND PATTERNS OF ENGAGEMENT

Personal accounts from clients from ACON's outreach and support services demonstrate that trans people, PLHIV and LBQ women are all too aware of the barriers for these communities in accessing appropriate healthcare. LGBTI people are experts on their own experiences, including reasons for engagement/non-engagement, risks of engaging, and specific needs when dealing with health services. More work needs to be done to learn from the deep knowledge of these communities and translate this expertise for health providers to amend policy and practice.

HEALTH SERVICE IN WHICH THIS IS EXPERIENCED

General practice, other health services.

YOUR RECOMMENDED REMEDIATION

Encourage and support services to collect data on their patients/clients and potential patients/clients to build a profile of needs (in a way that is not intrusive or discriminatory). This includes uptake of sexuality and gender indicators in routine data collection.

Training for health providers by peer-led community organisations that recognises LGBTI people as experts on their own lives, needs and experiences.

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