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IGLYO on...

Health

IGLYO 25 years 1984-2009
Dear member, reader, friends and partners of IGLYO

Welcome to this issue of IGLYO on...!

This issue focussed on the issues that LGBTQ young people face when it comes to accessing health services. For some, it might not be immediately obvious how being LGBTQ has an impact on an individual’s health, and would say that our health and well-being is utterly and completely a result of our own actions and behaviours. We hope that the articles in this publication go some way to demonstrating how far this is from the truth. Minority groups which experience oppression have poorer access to healthcare, and if they do eventually achieve access, often experience discrimination at the hands of healthcare professionals. This in itself presents a barrier to access. Furthermore, the stress associated with living in a culture that is oppressive toward you adds additional mental and physical stress that prevents wellbeing.

In this edition of IGLYO on ... we will begin by examining the main issues that LGBTQ young people face when approaching mainstream health providers, assessing whether they have the same access to healthcare as their peers. We will then move on to a special focus on the issues that transgender young people face in the area of health, covering both additional healthcare needs that they have, and issues related to accessing gender-reassignment therapies and more mainstream healthcare. This issue will then look at problems related to the attitudes and lack of knowledge of healthcare providers, issues related to lesbian healthcare, and finally the specifics of LGBTQ youth and HIV/AIDS prevention.

Happy reading!

On behalf of IGLYO board,
Claire and Simon

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LGBTQ young people at the doorstep of healthcare

By Simon Maljevac, IGLYO Board Member

When I think about health and the problems that young LGBTQ people face in that area, I always remember the story of a young Croatian girl. She was put in the psychiatric hospital by her parents at the age of sixteen when they found out that she had a girlfriend. She was held illegally in this hospital for five years, because of her parents' refusal to accept her sexual orientation, as well as of the negligence of duty by the former director of the institution. This violated her basic human rights: the right to freedom and the right to psychological and physical health. Sadly this is not an isolated event: stories like this are happening all around the world as you are reading this article.

But this story represents just one of the issues that the LGBTQ community faces when it comes to healthcare. As well as this, there are specific barriers to accessing health care that are manifested only for the LGBTQ community. Barriers experienced by others, like lack of resources, geographical and social isolation and lack of information may also affect LGBTQ people. However, those which are specific to LGBTQ people include the fear of discrimination and stigma, which affects their ability to seek care for themselves. Once they have accessed care, LGBTQ people are likely to withhold personal information that healthcare providers need in order to be able to give them appropriate care, due to a fear of a negative reaction, or discrimination. If a person experiences homophobia and/or discrimination coming from health providers it can result in them not going back for necessary further care. The reality is that young people who are open about their sexual orientation and identity are likely to experience homophobia and heterosexism from their friends, family and society at large and this may cause them to choose to keep their identity and sexual orientation secret, and to avoid seeking out services that they might need. Somjen Frazer and Ross Levi found in their research in which they interviewed 60 experts in health and human services and surveyed 3,500 LGBT New Yorkers about their health and human service needs that there are striking disparities between the LGBT experience and the experience of non-LGBT people: 40% of LGBT people said there are not enough health professionals who are adequately trained and competent to deliver healthcare to LGBT people. 27% feared that if medical personnel found out that they are LGBT they would be treated differently. This can result in people not giving their doctor the information he or she needs to provide effective care, or in LGBT people avoiding any medical care at all.
The review of the literature on the health concerns of LGBTQ youth by the Medical Foundation of Boston showed that a quarter of gay and lesbian youth drop out of school due to discomfort in the school environment, they account for 30% of all youth suicides and they are two or three times more likely to try to commit a suicide than their heterosexual peers. Studies in the UK into bullying and its impact on the mental health of gay and lesbian youth reveal that the bullying which they experienced in school was more severe in nature than general bullying.

Often LGBTQ young people have less control over their lives — in terms of where they live, who they live with, or the sense that they have the right to demand equality — LGBTQ youth are hit even harder by homelessness, mental health concerns and physical health concerns. It is very important, especially to youth who are in early stages of forming their identity (which includes gender and sexual orientation identities), to have health care and mental health care from providers who truly understand the issues they face. We all deserve doctors, nurses, therapists, and other providers who are not only "accepting" of us, but who really educate themselves on the issues we face — no matter who we are or who we love. Health care is not a special right.
Claire is an activist from the UK, with a background in campaigning with students for LGBTQ liberation. She has recently returned to university to pursue her other passion, medicine. Claire has been active in IGLYO since 2006 where her main areas of interest are working in education, and developing a strategic approach to tackling homophobia and transphobia.

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Access to health care for transgender people
By Claire Anderson and Simon Maljevac, IGLYO Board Members

I don't see the doctor if I don't really have to. I don't see the dentist, I haven't seen the gynaecologist for decades, and if I have an accident, I try not to go to the hospital... I think I have fewer experiences because I just don't go there, so I practise some kind of avoidance strategy.

This is just one of many similar stories that we find in a study into the lives of transgender people conducted by ILCA Europe and TGEU (Transgender Europe). The research clearly showed that experiences of transgender people with the healthcare system are often negative, with healthcare professionals being uninformed, biased and sometimes overtly rude with their clients, for example referring to the client in the non-preferred gender. The research also showed that only 30% of respondents, when seeking help or a referral for gender reassignment procedures, experienced what the survey defined as the minimum acceptable level of assistance – a practitioner wanting to help, but lacking information about transgender health care. One third reported that they were refused treatment because a medical practitioner did not approve of gender reassignment. It must be born in mind that when we are discussing health care for transgender persons, one of the main aspects is that trans people who wish to undergo gender reassignment have to gain access to medical treatment in order to begin the physical changes that are in line with their identities. This places them in an unequal position with healthcare providers – we are actually discussing a relationship of power and control; desire and need coupled with vulnerability; pathologisation and protocol which is clearly stated in a story from a transgender person from the Netherlands:

Everything went fine until I started to interfere with the policy of my psychologist. He wanted me to take part in some sort of research. I asked him what the scientific relevance was and questioned whether the research was relevant to me. He got angry and destroyed a letter in which he had just written down that I was eligible to start hormones. He tore the letter up in front of my eyes.
The study showed that 80% of transgender people in the EU are refused state funding for hormone treatments, and 86% of transgender people in the EU are refused state funding for surgery to change their physical sex. As a result, over 50% of transgender persons undergoing surgery to change their birth sex pay for the procedures entirely on their own. In addition, access to gender reassignment surgery is further complicated or conditioned by so-called "protocols" and conditions regarding childhood, sexual orientation, or clothing tastes, which are highly questionable. There are accounts of transgender people having to undergo genital examinations by psychiatrists, having to tell a set story of their childhood which is the only acceptable one; sometimes their claims are only considered genuine if they have at least one proven suicide attempt. Other transgender persons are being forced to stereotype themselves to the extreme in their preferred gender to fit eligibility criteria, leading to them experiencing ridicule in daily life.

It can be even more difficult for young transgender people to access gender reassignment therapy, as this is usually only available after a person has reached 18 years of age. However in some countries, like the Netherlands, transgender youth may begin treatment in puberty and receive counselling, so as to allow them to make informed decisions about their future gender identity. Then at the age of 18 they can proceed with gender reassignment treatments, if they still wish to. Recently, some other countries, such as Belgium and Germany, have started to provide similar treatment for youth under 18.
Marie Rousset is 22 and lives in Paris. She is vice-chair of MAG—an organisation working for LGBT Youth and studies the influence of Queer theory in the Trans political movement in France at the University Paris II.

The healthcare experience of young transgender people in France

By Marie Rousset

In order to increase the awareness and knowledge of the experiences of transgender youth aged 16 to 26 in France, the organisations Homosexualités & Socialisme (HES) and the Movement of Affirmation for young Gays, Lesbians, Bi and Trans (MAG-LGBT Youth) conducted a survey using an on-line questionnaire targeting this population. This survey provided extremely useful information in the areas of mental health and access to gender-related health care for transgender young people.

The first and most important information this survey reported was the high rate of suicide among transgender people in France. Of the 90 people who responded to the survey, 69% have considered suicide, and 34% have attempted to take their own life. It's therefore possible to consider the mental health of transgender young people together with that of the wider LGBT community and make comparisons with the suicide rates among the young lesbian and gay population, which are similar.

It is very difficult to know how many transgender people between 16 and 25 have completed suicide. When attempting to assess this, we face the same problems as those when assessing homosexual suicide rates. It may be that deaths are not recorded as suicide, or that the family of the deceased did not know about their transgender identity or that it was linked to their mental ill health and ultimately their completed suicide.

The survey reported that fewer than half of the respondents (48%) had started to meet with doctors in relation to their medical transition. An 'official route' of transitioning has been created, where services related to transition are undertaken by 'official teams', although no law or official document gives them this 'official' status. In France, transgender people can be reimbursed for health care related to their transition only if they follow this 'official' route. The route is long: a minimum of 2 years before any treatment occurs and very conservative doctors are in charge of it.

We found in our survey however that of those who have begun a medical transition, 74% stated that they were undertaking it outside of the self-proclaimed 'official' hospital teams. One option is to go to see doctors who are not in the 'official teams'. This means they can go to see the doctors they choose and get hormonal treatments quicker as well as some operations. But, because of the
existence of the 'official' system, if they choose this route they will not get reimbursed. This situation is both absurd and useless, and we aim to use the results of our survey to lobby for changes in the way that it works.

Download survey at: www.mag-paris.fr

Some statistics taken from the survey:

- 80% of transgender people aged 16–20 described their trans identity as 'a suffering'

- 39% of all respondents had financial problems

- A quarter of respondents under 20 had received offers of unprotected sex

- Around half of respondents said that they wanted to have children later in life

- More than three quarters of respondents are paying for their own medical transitions, despite the existence of a free government-approved service, because of the overwhelming problems with the system
Alex Müller has been involved in IGLYO since 2008. She has two passions: medicine and photography, with a strong activist twist to both. She has studied medicine at the University of Göttingen in Germany and works in clinical medicine and HIV research in Cape Town, South Africa.

Why we should advocate for LGBT inclusiveness in health care

By Alex Müller

During six years of medical school, I have encountered homophobia on numerous occasions and at many levels of the medical hierarchy. It has ranged from derogative comments from a medical student to the refusal of a professor to acknowledge the girlfriend of a lesbian patient as her partner. It also extended into patient care: from nurses who mock a gay patient’s boyfriend behind his back to surgeons who are disrespectfully boasting about a gender reassignment surgery over lunch.

There are only few studies on LGBT issues in health care – mainly because sexual orientation is seldom included as a variable. The few studies that do exist have shown that LGBT patients face more barriers to health care than heterosexual patients, based on the experience of stigma or on inadequate service for their specific needs. It is especially worrying that LGBT people are more likely to suffer from mental health conditions and engage in addictive behavior, which is thought to be closely linked to having experienced stigma and social exclusion.

So, really, there are three main issues here: one is the general attitude with which LGBT patients are met in health care facilities. Secondly, there is a lack of services, especially for the trans community. And thirdly, the invisibility of LGBT patients makes it difficult to conduct research – research whose findings are needed as an advocacy tool.

What is it then that young LGBT patients should ask from their health care provider? In my opinion, it comes down to the most fundamental issues. We have the right to be treated with respect, in a way that allows us to be open about our sexual orientation. We have the right to access information and services of sexual reproductive health. We have the right to report incidences of discrimination. We have the right to be treated by a health care professional that knows about LGBT and equality issues and uses appropriate language.

Certainly education for health care providers is needed. But what is needed even more are voices that demand our rights – our voices.
Claire is an activist from the UK, with a background in campaigning with students for LGBTQ liberation. She has recently returned to university to pursue her other passion, Medicine. Claire has been active in IGLYO since 2006 where her main areas of interest are working in education, and developing a strategic approach to tackling homophobia and transphobia.

Ten things lesbian and bisexual women should discuss with their healthcare provider – and some of the reasons why

By Claire Anderson

Source: The Gay and Lesbian Medical Association and ILGA "Lesbian and Bisexual Women's Health Report"

1. Breast Cancer
Lesbians have the richest concentration of risk factors for this cancer than any subset of women in the world. Combine this with the fact that many lesbians over 40 do not get routine mammograms, do breast self-exams, or have a clinical breast exam, and the cancer may not be diagnosed early when it is most curable.

'90% of breast cancers are caused by environmental factors.'
Rina Nissim, naturopath and co-founder of the women’s health Centre in Geneva.

2. Depression/Anxiety
Lesbians have been shown to experience chronic stress from homophobic discrimination. This stress is compounded by the need that some still have to hide their orientation from work colleagues, and by the fact that many lesbians have lost the important emotional support others get from their families due to alienation stemming from their sexual orientation.

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'
Preamble to the Constitution of the World Health Organization, 7 April 1948

3. Gynaecological Cancer
Lesbians have higher risks for some of the gynaecologic cancers. What they may not know is that having a yearly exam by a gynaecologist can significantly facilitate early diagnosis associated with higher rates of curability if they ever develop.

4. Fitness
Research confirms that lesbians have higher body mass than heterosexual women. Obesity is associated with higher rates of heart disease, cancers, and premature death. What lesbians need is competent advice about healthy living and healthy eating, as well as healthy exercise.

'A major concern is that lesbians do not access the health care system in the same way as heterosexual women, because birth control and family planning services are not priority issues for lesbians.'  ILGA–Europe 2004
5. Substance Use
Research indicates that illicit drugs may be used more often among lesbians than heterosexual women. There may be added stressors in lesbian lives from homophobic discrimination, and lesbians need support from each other and from health care providers to find healthy releases, quality recreation, stress reduction, and coping techniques.

6. Tobacco
Research also indicates that tobacco and smoking products may be used more often by lesbians than by heterosexual women. Whether smoking is used as a tension reducer or for social interactions, addiction often follows and is associated with higher rates of cancers, heart disease, and emphysema — the three major causes of death among all women.

7. Alcohol
Alcohol use and abuse may be higher among lesbians. While one drink daily may be good for the heart and not increase cancer or osteoporosis risks, more than that can be a risk factor for disease.

‘In South Africa, 10% of black lesbian women and 4% of white lesbian women had experienced sexual abuse in the period 2002-03.’ www.out.org.za

8. Domestic Violence
Domestic violence is reported to occur in about 11 percent of lesbian homes, about half the rate of 20 percent reported by heterosexual women. But the question is where do lesbians go when they are battered? Shelters need to welcome and include battered lesbians and to offer counseling to the offending partners.

Women comprise about half of all people living with HIV worldwide. In sub-Saharan Africa, where the epidemic is worst, they make up 57% of people living with HIV; and three quarters of young people infected on the continent are young women aged 15-24.’ Unaids 2004 – www.unaids.org

9. Osteoporosis
The rates and risks of osteoporosis among lesbians have not been well characterized yet. Calcium and weight-bearing exercise as well as the avoidance of tobacco and alcohol are the mainstays of prevention. Getting bone density tests every few years to see if medication is needed to prevent fracture is also important.

10. Heart Health
Smoking and obesity are the most prevalent risk factors for heart disease among lesbians, but all lesbians need to also get an annual clinical exam, because this is when blood pressure is checked, cholesterol is measured, diabetes is diagnosed, and exercise is discussed. Preventing heart disease, which kills 45 percent of women, should be paramount to every clinical visit.
Lydia has been Education Officer at Stonewall since August 2008. She manages a range of projects like Stonewall’s annual Education for All Conference and the Anti-Homophobic Film Clip Competition for young people. Lydia also works with other equality organisations and national youth and education agencies to help influence policy relating to homophobic bullying.

Loving your inner lesbian: a best-practice example
By Lydia Malmedie

In 2008, Stonewall, a UK charity lobbying for the rights of lesbian, gay and bisexual people, commissioned a survey on lesbian and bisexual women’s health. The survey response with over 6,000 women choosing to take part was overwhelming and made it the biggest survey on gay women’s health in Europe.

The results however, are deeply worrying. The responses show that lesbians and bisexual women in Britain are less likely to have had smear tests and more likely to have had breast cancer than other women, while the levels of self harm and suicide are significantly higher, especially amongst young women, than in the wider population. Half have had negative experience of healthcare and 50% say they aren’t out to their doctor. Gay women are more likely to have smoked and to drink more heavily than women in general.

These results aren’t as surprising when taking the experiences of lesbian, gay, and bisexual young people in Britain into account. Seven in ten lesbian, gay and bisexual pupils say they have never been taught about lesbian and gay people or issues in class and two in three have experienced homophobic bullying. This lack of visibility and acknowledgement in education of LGB issues in general and of lesbian sexuality specifically has serious effects on their health and well-being.

As a result of this survey, Stonewall has launched the Love Your Inner Lesbian campaign: A series of posters which health care practitioners and schools are encouraged to display to show they are aware of and welcoming to lesbian and bisexual women and their health needs. Furthermore, Stonewall’s Education for All campaign works to ensure that LGB issues become an integral part of the curriculum and that education and youth settings prevent and tackle homophobic bullying. Only by doing so can wider issues affecting the LGB community be tackled.

For more information visit: www.stonewall.org.uk
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How to stop AIDS epidemic?
By Simon Maljevac

Statistics for the end of 2007 indicate that around 33 million people are living with HIV. Each year around 2.7 million become infected. The epidemic is spreading most rapidly in Eastern Europe and Central Asia, where the number of people living with HIV increased 150% between 2001 and 2007. But in recent years we have been more successful in finding treatments for AIDS. Those who have access to these endure a fairly arduous treatment, but are still able to live a relatively normal everyday life.

So how to stop the transmission of HIV? Medicine alone cannot prevent new infections. It cannot solve the problem of stigmatisation and discrimination against those infected with HIV. As Brian Gazzard, an expert in the field of HIV/aids said in a World Health Organization conference, HIV in Europe 2007, “We must join forces and expertise in the fight against HIV. Testing and administration of medicines is not high science, but we are talking about rocket science when we are thinking about how to change high-risk sexual behaviour.”

Current preventative measures against HIV infections are clearly not effective enough, and we are not investing enough resources in them. Human behaviour is unpredictable and every part of the new generation demands new approaches. So the need for a constant research and new innovative approaches, adapted to the microenvironment is always present. It is therefore necessary that we take a multidisciplinary approach involving all actors and institutions in prevention. The complexity of the HIV epidemic is far more than the capacity of a single sector. We need to build partnerships, we need more coordination, continuity, consistency and coherence. Transparency, critical thinking, learning and sharing our knowledge with others are essential elements of this cross-sector working. And this is what is often lacking when we are talking about HIV/AIDS prevention. We need to change our attitude towards HIV and AIDS, embrace those who are positive and take it as another fact of life – but one which can be prevented.
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How to Negotiate with a Partner for Condom Use

First you have to decide what you want to do and what makes you happy. If you decide that you will have sex only with a condom, you must then strictly adhere to this. You need to repeat and practice this in your mind. Here are a couple of tips that can help you.

1. Always have condoms with you: either in a bag or in a jacket. Have them at your disposal all the time.

2. If you decide to bring someone home, always be sure that you have condoms available on site.

3. You must be strong. You have to be ready and also able to say NO. If someone does not agree to use condom, it should be easy for you to say: "Well, then I ask you to go." And you need to be firm when you are saying this. It's good to practice a situation like this in your mind. Try repeating a sentence like "I don't want to have sex without a condom". When you are in a situation like this you should not negotiate or argue, you should just simply say "I like you, but not without a condom".

4. One option is to choose to have another form of safe sex where you don't need to be protected.

5. If you are not able to follow your decisions, don't be ashamed to seek help. If you are in a relationship where your partner makes you do things which you do not want, it might be time to finish it. You should ask yourself: "Is this really the best relationship for me?" And if you need help and support don't be afraid to look for it.

6. In emergency cases, it is good to know also about Post-exposure prophylaxis (PEP). This means taking antiretroviral medications (ARVs) as soon as possible after exposure to HIV, to reduce the likelihood that the exposure will result in HIV infection. PEP should begin as soon as possible after exposure to HIV. But this is just a lifeline in an emergency if you are convinced that you were in contact with the HIV virus. This is not the next morning pill for HIV; it is an aggressive therapy with many side effects.

And don't forget, consistent and correct condom use is still the best form of protection.
Life never comes to a full stop