Lesbian, Bisexual+ and Queer (LBQ+) Cisgender Women's Health

Policy Position Statement

Key messages:

PHAA will work with key lesbian, bisexual+ and queer (LBQ+) cisgender women, communities, groups, organisations and peak bodies to advocate for federal and jurisdictional legislative reform which recognises the specific needs of these groups and addresses areas of systemic discrimination and inequity through meaningful research and health system reform and funding.

Key policy positions:

1. Compared to heterosexual cisgender women, LBQ+ cisgender women experience a disproportionate burden of mental health needs; higher levels of drug, alcohol and tobacco use; have lower rates of participation in health screening programs and considerable unmet needs for health care.

2. The observed health inequalities are related less with sexual orientation and more with the effects of discriminatory values that historically underpin and continue to pervade society. Discrimination and stigma on the basis of sexual orientation creates barriers to healthcare and further health, psychosocial and economic disparities for LBQ+ cisgender women particularly those who are poor, of colour, disabled, or ageing.

3. Those working in policy, research, healthcare and community sectors need to be knowledgeable about and prioritise addressing these inequities with meaningful stakeholder engagement and consultation, to improve the health and wellbeing of people whose identities are systemically marginalised, including LBQ+ cisgender women.

Audience: Federal, State and Territory Governments, policymakers and program managers.

Responsibility: PHAA Women's Health Special Interest Group (SIG)

Date adopted: September2023

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Citation: Lesbian, Bisexual+ and Queer (LBQ+) Cisgender Women's Health: Policy Position Statement [Internet]. Canberra: Public Health Association of Australia; 2017 [updated Sep 2023]. Available from: URL

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PHAA affirms the following principles:

1. The data reported in this policy highlight some key health inequalities observed among Lesbian, Bisexual+ (Bi+; i.e., bisexual, pansexual and other identities characterised by attraction to more than one gender) and Queer (LBQ+) cisgender women. Cautious of reinforcing harmful stereotypes or contributing to problematic discourse on diverse sexual identities, we recognise the following points.

2. While *LBQ+ cisgender women* are the focus of this policy, LBQ+ individuals have many intersecting identities related to their diverse bodies, sex characteristics, sexualities, and gender identities. Diverse sexual or romantic attraction includes monosexual identities (characterised by attraction to one gender), plurisexual identities (characterised by attraction to more than one gender or attraction to people irrespective of their sex assigned at birth or gender), asexual spectrum identities (characterised by little to no sexual attraction to any gender) and aromantic spectrum identities (characterised by little to no romantic attraction to any gender). The collective term 'LBQ+' is therefore not all-encompassing and many people use other and/or multiple identity labels to describe their diverse sexual and romantic identities.

3. Discrimination within and beyond healthcare contributes to particularly heightened health inequalities for trans and gender diverse people. Challenges to healthcare engagement among LBQ+ transwomen are likely to be distinct from those of LBQ+ cisgender women and need to be the subject of specific attention in future PHAA policy. Health services need to appropriately cater for all populations, regardless of gender.

4. The health, psychological and economic inequalities observed for LBQ+ cisgender women compared to their heterosexual counterparts are related less with sexual orientation and more with the impact of living in a society in which discriminatory values are systemically embedded (including government policy, healthcare, law, education and welfare systems)

5. At an interpersonal level, sexuality-based discrimination includes familial rejection, social exclusion or bullying, and harassment or violence perpetrated by peers, family members or the general public.

6. To address health inequalities for LBQ+ cisgender women, health initiatives should be underpinned by principles such as intersectionality, human rights, social justice, and person-centred and trauma-informed care.

PHAA notes the following evidence:

7. LBQ+ cisgender women are often omitted from or not meaningfully included in policy, clinical practice initiatives and population-based research, despite being a priority population of the National Women's Health Strategy of 2020-2030.[2]

8. Medical school curricula in Australia poorly address LGBTIQ+ health.[4]

9. Health care guidelines for sexual minority groups have traditionally failed to adequately include LBQ+ cis women's health issues and are often developed without stakeholder consultation.[3]

10. LGBTQ+ people report alarmingly high rates of sexual violence, but were omitted in the findings of the Australian Institute of Health and Welfare 2020 Sexual Assault Report due to a lack of national data.[5,6]

11. Past research has often grouped plurisexual and monosexual cisgender women together or excluded various Bi+ and queer identities. This approach overemphasises the commonalities between these groups and fails to portray their nuanced and at times disparate experiences.[7,8]

12. Health, psychosocial, and economic disparities exist among LBQ+ cisgender women (i.e., between sexual identity groups) and between LBQ+ and heterosexual cisgender women. There are considerable evidence gaps in relation to intersections of sexual orientation, identity, experience, and how these contribute to these disparities.

13. LBQ+ cisgender women report higher rates of using illegal drugs and tobacco, and earlier initiation of alcohol drinking, than do heterosexual cisgender women.[9] Among LBQ+ cisgender women, bisexual-identified and queer-identified individuals are more likely to report potentially risky alcohol consumption[10] and tobacco smoking,[7] respectively.

14. Compared to heterosexual cisgender women, LBQ+ cisgender women more frequently report having arthritis, asthma, cardiovascular disease, disability, subjective cognitive decline, a higher number of chronic conditions, and poorer general, physical and mental health.[14]

15. LBQ+ cisgender women report lower incomes and levels of education than their heterosexual counterparts.[14]

16. Sexual minority cisgender groups (particularly, bisexual identified individuals) report higher rates of lifetime homelessness than heterosexual cisgender individuals.[13]

17. LBQ+ and 'mostly heterosexual' cisgender women report higher rates of physical abuse, severe physical abuse, emotional abuse, harassment, sexual abuse, and partner violence than exclusively heterosexual cisgender women.[11]

18. Experiences of interpersonal violence more strongly predicts poorer mental health for lesbian and bisexual than exclusively heterosexual cisgender women,[11] with rates being particularly high among bisexual-identified cisgender women.[11] Queer-identified individuals most frequently experience anti-LGBTQ discrimination.[12]

19. Systemic and interpersonal discrimination compromise LBQ+ cisgender women's access to healthcare. For example, LBQ+ cisgender women desiring children are often unnecessarily directed towards costly and invasive in-vitro fertilisation (IVF) despite not having a medical infertility diagnosis.[20] This is in part because this population is a considerable source of profitability for IVF services.[21]

20. LBQ+ cisgender women have been found to be proactive about their health.[12] However, report negative experiences of healthcare including discriminatory responses from doctors ranging from identity erasure or assumptions of heterosexuality/monosexuality, to overt forms of discrimination.[17,22]

21. Bisexual+ and queer cisgender women face more discrimination in healthcare than do lesbian-identifying cisgender women, which can lead to foregone care.[17,23,24]

22. Living in areas characterised by high levels of anti-LGBTQ+ stigma is a predictor of low levels of engagement with primary care and high prevalence of self-reported disability among cisgender women in same-sex relationships.[26]

23. LBQ+ cisgender women access mental health services more frequently than heterosexual cisgender women and sexual minority cisgender men,[15,16] but experience greater unmet mental health needs as a consequence of heightened barriers to care.[17–19]

24. LBQ+ cisgender women have low uptake cervical screening compared to heterosexual cisgender women.[12] Lesbian-identifying cisgender women are the most under-screened for human papillomavirus and sexually transmissible infection.[12,25] Mistakenly, doctors and LBQ+ cisgender women alike often perceive they are at low risk.[17]

25. LBQ+ cisgender women are less likely than heterosexual cisgender women to have a regular GP and be satisfied with their GP care.[15] Previous research strongly indicates that inclusive provider practices that allow for minoritized sexual orientations to be disclosed and discussed openly are a necessary precursor of GP care satisfaction and continuity, as well as accurate clinical assessment and referral to specialist services in this population.[23]

26. Structural inequalities exacerbate older LBQ+ cisgender women's barriers to health care, aged care and programs for healthy ageing.[17,27]

27. LBQ+ cisgender women who identify as belonging to multiple stigmatised or marginalised groups experience multiple forms of discrimination and barriers to access.[22,28,29] Providers may lack awareness of intersectionality (e.g., the experience of being both LBQ+ and Indigenous) or have limited capacity to adopt inclusive care models in their workplaces.[30]

PHAA seeks the following actions:

28. The Federal government's 10-year National LGBTIQ+ Health and Wellbeing Action Plan should identify LBQ+ cisgender women as a priority population. Specific programs and funding streams should be developed and monitored to address health, psychosocial and economic inequalities, in addition to stigma and discrimination in the general population.

29. All health and human services organisations should commit to attaining formal accreditation in LGBTQA+ inclusivity at an organisational level and integrating routine training in culturally safe practice for all staff (e.g., Rainbow Tick Accreditation, Rainbow Network Training or the How2 program via Rainbow Health Australia).

30. University Heads of School and Deans of Medical Education need to ensure that LGBTQA+ health issues are addressed in health professional education at all levels and underpinned by an understanding of intersectionality and marginalisation.

31. Relevant professional guidelines for health and human services providers should be developed in consultation with relevant stakeholders to ensure these providers can competently respond to LBQ+ cisgender women's unique needs.

32. Research should seek to meaningfully understand the positive lived experiences, health and wellbeing challenges and healthcare needs of LBQ+ cisgender women populations, and findings should be reported in ways that avoid reinforcing harmful stereotypes.

PHAA resolves to:

33. Advocate for the above steps to be taken based on the principles in this position statement.

34. Incorporate sexual-orientation-related health issues into PHAA policy development, recognising the unique needs of people belonging to different sexual identity groups and using evidence-based principles of equity, diversity, access, consultation and participation, health promotion and partnership with the community.

35. Work with key LGBTIQ+ groups and organisations to develop guidelines for LGBTIQ-inclusive health practice.

REVISED 2023
(First adopted 2008, revised 2011, 2014, 2017 and 2023)

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