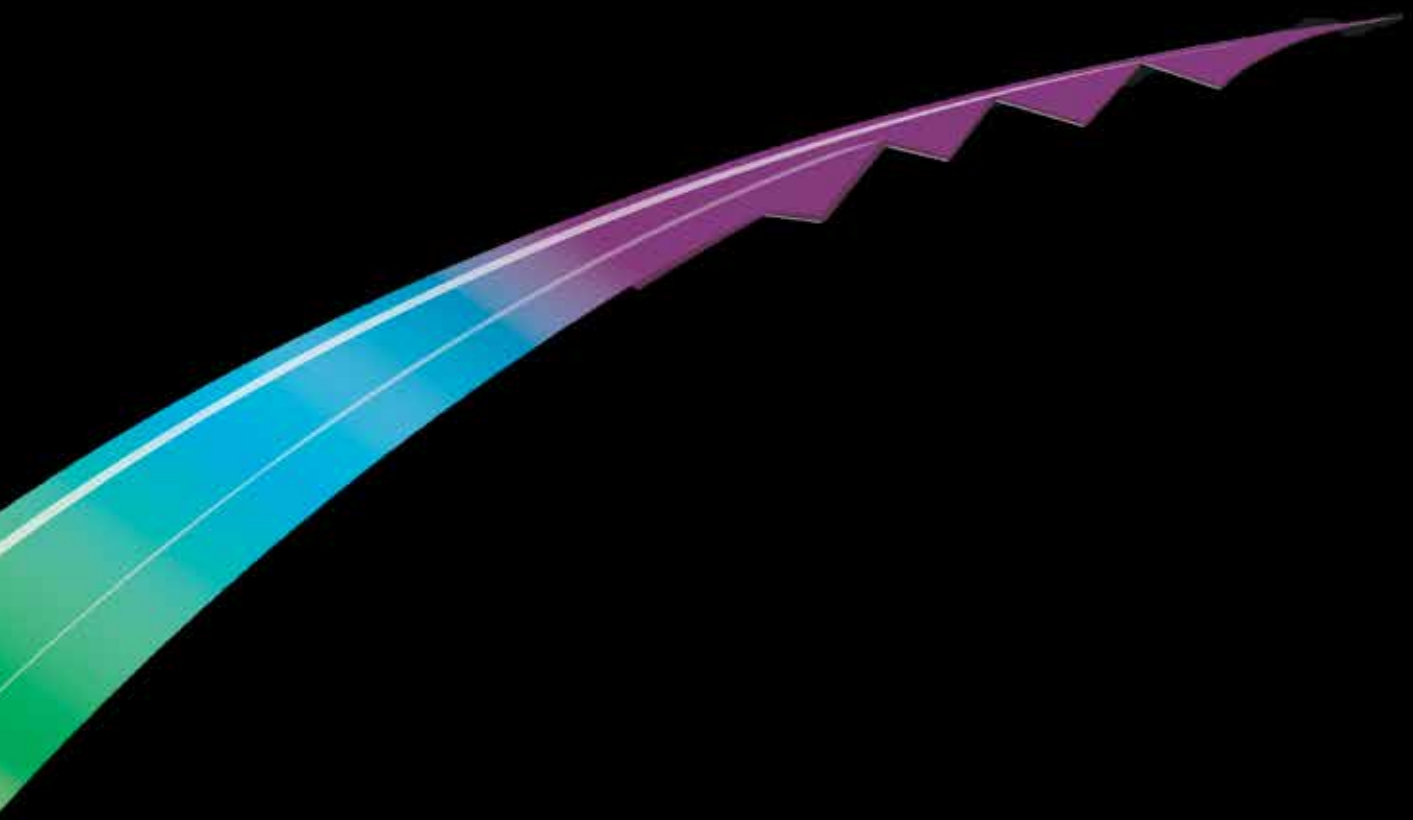
Rainbow Health

The Public Health Needs of LGBTTI Communities in Aotearoa New Zealand with Policy Recommendations.



M.W. Stevens

better together… affinity

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“All human beings are born equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”

Universal Declaration of Human Rights, Article 1, ratified by New Zealand in 1948

“The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

International Covenant on Economic, Social and Cultural Rights, Article 12, ratified by New Zealand 28th December, 1978

“Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.”

Yogyakarta Principles 2007

Introduction

"Rainbow communities are not so easy to see, and this may be one of the reasons our particular health needs have so often been overlooked, for so long."

Good health is not evenly spread across our population. When we go to 'map' the prevalence of individual diseases we find, time and time again, that they cluster in particular communities. This is not an accident. Poor health status is very largely determined by socioeconomic disadvantage, discrimination and other means by which particular population groups are marginalised in our society. Good health status, conversely, is largely a function of advantage, empowerment and a sense of control over life circumstances.

While some of the communities that face adverse health status are easily seen because they are geographic, or else determined by other readily observable characteristics such as ethnicity, the Rainbow communities are not so easy to see, and this may be one of the reasons our particular health needs have so often been overlooked, for so long.

This term 'Rainbow' is used to capture the wealth and breadth of what are in fact, many diverse communities and identities, with distinct needs. Yet as this report documents so well, one of the factors that draws all of them together is the shared experience of marginalisation and 'minority stress' which have driven the health problems that we face.

But our health needs do not end with addressing the marginalising factors that cause our ill health in the first place. The evidence is also strong that discrimination – both personal and structural - continues to feature in many treatment services. I well recall a survey of gay and bisexual men from the early 1990s which recorded a very high level of discrimination experienced in health services, often accompanied by heartbreaking descriptions of this experience. As the report acknowledges, for some of us, this has improved, but major problems remain. The very point of providing a culturally safe service, one of the central planks of service quality, is that the service needs to be respectful of and sensitive to the individual culture of every service user. That includes us – or should.

This report, and the seminar from which it was drawn, have been landmark events in our rainbow history. I offer my congratulations and thanks to all those involved, and especially to the leadership shown by the Auckland District Health Board. The report deserves to be read very widely, and its recommendations implemented not only in Auckland, but throughout New Zealand.

Kevin Hague

Member of Parliament

Former Executive Director, NZ AIDS Foundation, CEO West Coast DHB, Chair Public Health Advisory Committee, member National Health Committee, Quality Improvement Committee.

Foreword

"Alongside balanced budgets and national health targets we must have a more inclusive and community-led view of our success in meeting need."

Twenty years on from the Human Rights Act 1993, equitable access to and use of publicly-funded health services regardless of sexual orientation or gender status seems a given. However is that really peoples' experience? The answer is sometimes and that is just not good enough. While the obligations health and disability providers have to ensure no unlawful discrimination are well-publicised in =the sector, we can do better to achieve the spirit of the law. In particular, we should be sure in as real time as is practicable that people do not feel they are being discriminated against so that issues can be addressed there and then.

Service funders and providers must therefore proactively seek to find out what the experience is and listen to patients and our community in a more sophisticated way than is the current norm. While we regularly assess our services or our commissioning of services against contractual or financial measures, we have work to do to get to this next stage. Alongside balanced budgets and national health targets we must have a more inclusive and community-led view of our success in meeting need. That includes a rainbow-community view of access, of effectiveness – or of whatever reasonable measure we can settle upon.

For that reason alone, I would find value in this Rainbow Health Report. In addition as the chief executive of an organization that serves the whole of New Zealand this gives us a rainbow community view given from around New Zealand. In addition we have a report where these views are carefully considered in a population-health context. We can see the seminar participants, the report author and the research sources all making cogent arguments for a population-based view of wellbeing.

That's as it should be. In the year I have been Auckland DHB's chief executive, I have seen many examples of co-design with patients and of supporting self-directed care. While it could be more systematic and integral to what we do, this is very promising. Our focus has to be on the outcomes people want for themselves, their whanu and their communities.

In that context I see this report as an important contribution to the field, contributing to a strategic direction and context set by our community; a greater focus on need and on community-based public health action. This is action that, while it seeks to reduce morbidity and mortality, also strives to enhance quality of life. I thank Affinity, the Mental Health Foundation, Rainbow Youth, OUTlineNZ and in particular, the report's author Michael Stevens for their efforts.

Ailsa Claire OBE

Chief Executive Auckland District Health Board

Foreword

Ensuring the provision to all of New Zealand society of the best possible standard of health is not just a basic human right, it is good policy and ultimately helps create a healthier society that places fewer demands on the health system."

It gives me real pleasure to introduce this report on the public health needs of Rainbow communities in Aotearoa/ New Zealand.

In February this year, Affinity worked with the ADHB, the Mental Health Foundation, Rainbow Youth and Outline to organise the symposium "LGBTTI Well-Being and Suicide", an event that attracted attention from Rainbow communities and others working in mental health across the country. Indeed the level of interest far surpassed what was expected. This showed that the Rainbow community is aware of the need for action, not just in mental health but in the wider areas of population health and public health as well.

This report follows on from that symposium, and paints a picture of the public health needs and underlying causes of the negative health outcomes that are disproportionately over-represented in Rainbow communities in this country. The policy recommendations that are included point to effective ways forward to change these negative outcomes.

Affinity is a mainstream organisation, but we are keenly aware of the diversity of the communities we serve and that make up the broader society we all live in, whether this is in terms of ethnicity, religion, gender, ability or sexuality. To create a healthier society, we must be aware of the needs of these communities and develop our abilities to provide services for them that are relevant, based in solid evidence and effective.

Ensuring the provision to all of New Zealand society of the best possible standard of health is not just a basic human right, it is good policy and ultimately helps create a healthier society that places fewer demands on the health system.

Affinity holds as central the value of working together to create and sustain healthy communities. As an organisation we are proud to have helped develop this report in partnership with the ADHB and to bring these important issues to the wider attention they deserve.

Barbara Browne

CEO Affinity Services Ltd

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Executive Summary

"New Zealand's health system needs to develop cultural competency in working with Rainbow communities to help alleviate the effects of minority stress and provide the healthcare that all New Zealand citizens are entitled to."

This report was commissioned by the Auckland District Health Board following the 2013 "LGBTTI Well-Being and Suicide Symposium" and analyses the physical and mental health needs of the Rainbow (Lesbian, Gay, Bisexual, Takatāpui, Transgender and Intersex) communities in New Zealand from a public health perspective.

While there have been many advances in the rights and legal status of people from Rainbow communities societal prejudices continue to exist and to exert a clearly negative effect on the health of Rainbow communities. These prejudices and their negative effects are captured in the term "minority stress".

Minority stress is a social determinant of health in the same way poverty or ethnicity is.

New Zealand's health system needs to develop cultural competency in working with Rainbow communities to help alleviate the effects of minority stress and provide the healthcare that all New Zealand citizens are entitled to.

The Rainbow communities, especially those of diverse gender identity (transgender) and diverse biological sex (Intersex) have a troubled history of interaction with the health system. This can lead to health problems becoming more complex and expensive to manage as people delay engaging with the health system out of fear.

Many health professionals are well-intentioned but ill-informed or unaware of the health needs of people from Rainbow communities.

Current health strategies and funding make no provision for the health needs of Rainbow communities, despite the high burden of negative health indicators they carry.

The current lack of targeted research means the health needs of the Rainbow community are hidden from and thus excluded from current public health policy.

Addressing these facts and including this population in relevant health research would in fact save money for the health system through preventative action and increase the overall efficiency of health service delivery.

Takatāpui (from the Māori Rainbow communities) have been doubly stigmatised and their Treaty rights ignored.

Local research shows that Rainbow communities in New Zealand are neglected by policy-makers despite data showing real and substantive health issues across this population. These issues include but are not limited to, greater levels of suicide, depression and substance abuse, as well as higher levels of obesity, and certain forms of cancer.

Taking a population health approach to the Rainbow communities is in line with the New Zealand Health Strategy. Adopting a targeted population health approach to various groups is already standard practice in New Zealand the utility of this for the efficient economic management of the health system is understood.

It became apparent at the 2013 Symposium that the general health needs of the Rainbow community were not being addressed effectively and the particular concerns of youth and the elderly were raised. As the baby-boomer generation ages, so Rainbow community members will need aged care provision that is inclusive and sensitive.

Policy Recommendations

1. Rainbow community service users will receive equitable and culturally safe access to general and mental health services across their lifespan.

2. The particular health needs of tangata takatāpui will be considered and addressed in line with the state's obligations and commitments under the Treaty of Waitangi and the principles of partnership, protection and participation.

3. All health services will be supported and resourced to deliver culturally sensitive and appropriate services for Rainbow communities

4. Rainbow communities will be actively involved with and consulted about the development and delivery and evaluation of appropriate policies, programmes and services.

5. Research and data collection on the physical and mental health needs of Rainbow communities will be a priority for health research.

Introduction

This report on the public health needs of the Rainbow communities[1] was commissioned by the Auckland District Health Board following the "LGBTTI Well-Being and Suicide Symposium" held in February 2013. This symposium was organised to consider the mental health needs of the Rainbow community and consider what could be done to improve this, but it became apparent over the course of the symposium that while mental health issues for our communities are of great importance there is a need to engage with all aspects of health.

This report is intended to provide an evidence-based argument that this population has real physical and mental health needs that need to be addressed within a population health framework both as a matter of public health and also as a matter of equity, and in compliance with New Zealand's obligations to all its citizens as stated above .

This report is designed to lay out the reality of these issues, to display the local and international evidence that supports this public health approach and to recommend strategies and policies that can address these problems and improve the health of this group of citizens.

1 The term "Rainbow Community" or "Rainbow Communities" is used along with LGBTTI(Lesbian, Gay, Bisexual, Transgender, Takatāpui, Intersex) in this report as umbrella terms to capture people from diverse sexual and gender minorities. The factors that both bind and separate these groups will be explored further in this report.

Context

"The Rainbow Communities in Aotearoa New Zealand constitute a distinct population that have clear public health needs that currently are not being met."

While there have been many important advances in the rights and legal status of most people from the Rainbow Communities over the last decades, societal attitudes and prejudices continue to exist and to exert a negative effect on the overall physical and mental wellbeing of this population. Until recently there has been almost no examination or inclusion in a public health sense of this population of people of diverse gender identity (transgender, transsexual or trans*), of diverse sexual orientation (lesbian, gay, bisexual) or diverse biological sex (intersex). And while the rights of those who are same-sex attracted have advanced the most in recent years, all members of Rainbow Communities and particularly people of diverse gender identity or diverse biological sex still face legal and social obstacles that impede their ability to lead their lives fully, safely and openly (Human Rights Commission/Te Kahui Tika Tangata, 2008)

An increasing body of international and local research demonstrates that this population is over-represented in negative health indicators, in both their general and mental health, and that the underlying causal factor for this is "minority stress".

Meyer explains minority stress thus: 'the concept is based on the premise that LGBT people, like members of other minority groups, are subjected to chronic stress related to their stigmatization' (Meyer I. , Minority stress and mental health in gay men, 1995)

Minority stress should be viewed in the same light as other social determinants of health.

The Rainbow Communities in Aotearoa New Zealand constitute a distinct population that have clear public health needs that currently are not being met. It is incumbent on the government, the Ministry of Health, District Health Boards, and other health funders and health providers in the public, NGO and private sectors to take steps to address and engage with this situation. Appropriate resourcing and research are needed, just as has been done with other identifiable populations exhibiting clear evidence of a disproportionate burden of negative health indicators.

A public health approach towards these communities is increasingly being seen as necessary and beneficial overseas (Meyer I., 2001) (Leonard, et al., 2012) (Irlam, 2012) (Makadon, Mayer, Potter, & Goldhammer, 2008), and there is no reason to doubt this also applies to Rainbow communities in New Zealand. Researchers in New Zealand have pointed to the invisibility of these groups in policy terms and the need for change. (Adams, Braun, & McCreanor, 2007)

As the Rainbow Communities are increasing in confidence and visibility they are making their own needs more obvious and taking a role in demanding equity in all levels of health care. This was clearly expressed at the February 2013 LGBTTI Well-Being and Suicide Symposium referred to earlier and data and core ideas from that symposium are reflected throughout the content of this report.

The Rainbow Community and Healthcare Provision

"In short, many people within Rainbow Communities continue to be pathologised, being viewed as sets of medical and psychiatric conditions that need to be remedied, or as something broken in need of repair."

For many people who belong to the Rainbow communities the medicalisation of our difference has been no improvement on the criminalisation with which we have been treated for centuries. With the goal of 'normalisation' medicine and the health system has been used as a tool to inflict unwanted surgeries and unjustified, spurious psychiatric interventions and so-called 'reparative therapies', and at times in New Zealand's past as a place to lock up and dump people because of their non-conformity in these areas of gender and sexuality. In partnership with the police and the justice system, medicine has been used to coerce, to deny and to marginalise Rainbow Communities.

While these practices are thankfully becoming rare today, there are people alive who have been treated in this way and there are still reports of malevolent or ignorant interventions by healthcare professionals. These stories inform aspects of the general understanding of health and illness in the wider Rainbow world.

People who are gender diverse or transgender are still pathologised, and were until recently described in the DSM as suffering from a psychological "condition" (Gender Identity Dysphoria) although the latest version of the DSM has somewhat modified this by shifting its emphasis to the problems arising from the dysphoria itself rather than assuming a shift in gender identity is necessarily a problem. However this pathologising tendency continues in the International Classification of Diseases within the category "Transsexualism."

The pathologising of gender diversity forces this population to interact with mental health services, usually to obtain a diagnosis of being disordered, as part of accessing medical support for transitioning to their correct gender.

Primary care, specifically General Practitioners (GPs), is another fraught area for people who are transgender or transsexual, or who want to transition to a different gender with medical means. GPs are usually the first point of contact for this population, yet there are few resources and little research or education available to equip GPs for these interactions and thus many transgender or gender diverse people are met with ignorance and ineffective care when seeking medical support.

Intersex babies born with ambiguous or unusual genitalia are routinely subjected to cosmetic surgery without their consent at a very early age purely to satisfy social anxieties of medical personnel and families, a practice that has resulted in deep and lasting distress and trauma for many. Intersex activists have been increasingly vocal in their demands that any non-urgent surgeries on Intersex children be postponed until they are able to decide for themselves if this is needed or not.[2]

2 The UNHCR Special Rapporteur on torture and other cruel and inhumane or degrading treatment or punishment, Juan Mendez, talks specifically about the unethical use of medicine as a coercive tool for intersex and transgender people in his February 2013 report. (Mendez, J. , 2013)

In short, many people within Rainbow Communities continue to be pathologised, being viewed as sets of medical and psychiatric conditions that need to be remedied, or as something broken in need of repair. In the past, homosexuality was viewed as a mental illness, as was refusing to accept a gender role defined by one's biological sex at birth. Being intersex continues to be seen as a birth defect that needs to be surgically corrected in order to conform to socially constructed norms.

More recently the effects of HIV/AIDS were viewed by some in the health system as some sort of just consequence for same-sex activity, although in other ways HIV/AIDS forced many medical professionals to re-consider their assumptions and prejudices at least when it came to the world of same-sex attracted men. With this background it is not surprising that some degree of ambivalence to the medical system continues within Rainbow Communities to this day.

The situation today is, in general terms, much better than it was 20 or 30 years ago, but where once there was outright prejudice and bigotry masked as medical science today the health system fails to see or acknowledge any special health needs of this population. Where once the medical gaze would bring down condemnation and intervention, today it claims to be impartial but is in fact oblivious, and this blindness to the particular needs of this population has a different but still deleterious effect on the overall health of the Rainbow Community and its members.

Until all areas of the health system understand and acknowledge that this population has a distinct set of needs that must be engaged with, the general health for those from the Rainbow communities will not improve. In fact it will continue to deteriorate and be a burden on scarce resources, where an appropriate degree of preventative action and targeted programmes would lessen the toll on the health system in costs, staff and resources.

Issues

"The overwhelming majority of all health research carried out in New Zealand has not included either gender diversity or sexuality as factors in data collection, and this has only served to continue the invisibility of this population and neglect of its health needs."

The strategic planning and delivery of health services across New Zealand has involved almost no consideration of the needs of Rainbow Community members. The only notable exception to this has been the ongoing resourcing to address the HIV epidemic which is mainly provided to the New Zealand AIDS Foundation in its work with men-who-have-sex-with-men (MSM). It is fair to say that the health system typically assumes that all service users are heterosexual and gender-conforming, just as in the recent past the underlying assumption was that all service users were Pakeha and monocultural. (Neville & Henrickson, 2006) The overwhelming majority of all health research carried out in New Zealand has not included either gender diversity or sexuality as factors in data collection, and this has only served to continue the invisibility of this population and neglect of its health needs.

This approach has led to the marginalisation at best and more typically the invisibility of Rainbow Communities within the general health system, and the false assumption that there are no special areas of either physical or mental healthcare that burden this population, when evidence clearly demonstrates this is not the case. A growing body of evidence both nationally and internationally demonstrates that members of Rainbow Communities face a significantly higher burden of health disorders than the general population. This is particularly clear in matters of mental health but these populations have specific needs in the area of general physical health as well that are not being acknowledged or engaged with from a public health perspective.

Just as reports such as Te Puawaitanga o Te Oranga Hinengaro (2003) and Whakatataka Tuarua (2006) have demonstrated that Māori communities carry an excess burden of mental health disorders, and Te Rau Hinengaro, the New Zealand Mental Health Survey (2006) also showed a level of over-representation of Pacific Island populations with mental health disorders, we can state with authority that the same situation exists for Rainbow communities.

It must be remembered that Rainbow communities transcend ethnic boundaries, and people from Rainbow communities will also figure in research such as the reports mentioned above, however they are not specifically recorded and thus this group is silenced and marginalised once again.

Te Tiriti O Waitangi, Rainbow Communities, and Tangata Takatāpui

There is strong body of research led by the work of Professor Ngahuia Te Awekotuku that demonstrates pre-colonial Māori society viewed variety in gender and sexual expression in an accepting and encompassing manner when compared with the colonising powers (Te Awekotuku, 2001) (Te Awekotuku, 1991). It is from her work and research that the traditional term 'takatāpui' has been reclaimed and revived. It is now accepted that traditional Māori society, as with other Polynesian cultures, did not merely tolerate but included and valued people of diverse gender and sexuality, and that these social and cultural settings were distorted or destroyed through the impact of colonisation and the work of missionaries. (Hutchings & Aspin, 2007). Indeed one of the more perverse outcomes of colonisation was the manner in which many Māori adopted a form of Christianity that is inimical to the welfare of takatāpui, removing them from a traditional place of acceptance to one of stigmatisation and shame.

The term takatāpui has been used in health research and reports in New Zealand since at least 1994 (Herewini & Sheridan, 1994) and is widely known and particularly employed in work by the New Zealand AIDS Foundation in its programmes on men's sexual health. While originally meaning 'an intimate companion of the same sex' today it is used in a more fluid way than its nearest English equivalents such as gay, lesbian or transgender, and is often used in a way that covers aspects of both sexuality and gender identity.

The intersections of ethnicity, gender and sexuality are complex, especially when the effects of colonisation are added. Through breaches of the Treaty of Waitangi by the State tangata takatāpui have lost a world that viewed them as part of the normal range of human expression, a world and a culture that had an established and respected place for them. As well as sharing in the general negative health outcomes that colonisation has brought to Māori they carry the double burden that goes along with living in a society that can stigmatise them twice, both on the grounds of ethnicity and gender or sexual expression. (Aspin, 2005) (Henrickson, 2006)

In short, takatāpui moved from a social and cultural situation where minority stress was simply not a factor in the pre-colonial world of Māori, to one where it has become a key force in the negative health outcomes they experience.

Identifying and addressing the specific public health needs of tangata takatāpui is a duty of the Government in fulfilment of its Treaty obligations, especially in line with Article Three, guaranteeing the same rights and privileges to Māori as to British subjects. The starkly disproportionate representation of Māori in negative health indicators demonstrates that Māori do not enjoy these rights and privileges in relation to health. Given the burden of belonging to a doubly stigmatised population, the ability to enjoy these rights and privileges in relation to health are even more diminished for tangata takatāpui.

The accepted principles of the Treaty of Waitangi are phrased as partnership, protection and participation. The government does not act in accordance with these principles with regard to tangata takatāpui.

The government has an obligation to this population under the terms of the Treaty of Waitangi that it is failing to consider or meet.

Pasifika Populations - MVPFAFF

“many terms and concepts based in a Western view of sexuality and gender identity such as gay or transgender do not map easily or exactly onto existing Pasifika cultural norms, and there is an obligation for our services to be aware this..”

The complexity and richness of just how identities and ethnicities intersect in the New Zealand context also deserves attention. New Zealand has a large Pasifika population and these cultures already have their own terms and cultural frameworks for understanding gender diversity and sexual orientation, and while these are known and obvious to those from these cultures mainstream New Zealand, including the mainstream of Rainbow communities, are often blind to their existence. This extra layer of marginalisation too acts as a contributory factor to negative health outcomes.

The point was raised in the symposium that many terms and concepts based in a Western view of sexuality and gender identity such as gay or transgender do not map easily or exactly onto existing Pasifika cultural norms, and there is an obligation for our services to be aware this.

The abbreviation MVPFAFF[1] is gaining increasing use to signify the existence of this population, representing identities from different Pacific cultures that have a strong presence in New Zealand. While these terms are unfamiliar to many, they are understood and used as identifiers and cultural signifiers within these communities.

As the ethnic profile of New Zealand alters with changes in immigration patterns the implications of this need to be borne in mind in all areas of public health as well as specifically within the areas of gender identity and sexual orientation.

1 Mahu (Hawai’i and Tahiti, Vakasalewalewa (Fiji) Palopa (Papua New Guinea) Fa’afafine (Samoa) Akava’ine (Rarotonga), Fakaleiti (Tonga) Fakafifine (Niue)

Local Research

The report “Let’s Talk About Sex” (Birkenhead & Rands, 2012) shows that 26% of mental health service users attending Auckland Community Mental Health Centres identified themselves as falling somewhere under the general category of Rainbow but typically not making themselves visible in this setting due to fear of or prior experience of homo/transphobic responses from service deliverers. Research carried out by Dr David Semp has also highlighted the invisibility of MSM within mental health services and the negative effects on their health and therapeutic outcome that follow from this (Semp D. , 2006) (Semp D. , 2011). If MSM, the group that is arguably the most privileged and well-tolerated portion of the Rainbow community in society reports these experiences it is reasonable to assume that this is the case or that it is worse for those Rainbow community members in less socially powerful positions.

Likewise the needs assessment report commissioned by Te Pou for these communities showed a lack of leadership or appropriate programmes to help the mental health system engage with clients from Rainbow communities in a sensitive and productive way.

“This needs assessment confirmed that there is minimal policy specifically focused on mental health of GLBTI people. Very few mental health promotion or prevention services directed at GLBTI populations in New Zealand were identified. While the impact of current programmes and services could not be determined, several of the GLBTI-focused services appeared to be well-utilised. Government-funded mainstream mental health promotion and prevention services were reported as not responding appropriately to the needs of these groups.” (Adams, Dickinson, & Asiasiga, 2012)

The findings of these local researchers are congruent with data from international sources (Huygen, 2006) and this demonstrates that Rainbow communities across the developed world share in similar patterns of health and sickness.

These data represent a grossly disproportionate over-representation of people from Rainbow communities. This is a health issue that needs to be taken seriously and a population that deserves the support and attention of planners, funders, educators and service-deliverers in the mental health system.

The Rainbow Communities

"The Rainbow Communities do not form one clear and obvious homogenous group, instead they constitute a mosaic of people from all ages, classes, ethnicities and cultural backgrounds."

The Rainbow Communities do not form one clear and obvious homogeneous group, instead they constitute a mosaic of people from all ages, classes, ethnicities and cultural backgrounds.

As New Zealand has become more richly multi-ethnic so the composition of the Rainbow Communities has changed, bringing with it added layers of complexity.

While the distinctions of gender identity, sexual difference and attraction within this overarching group are apparent to insiders this may not be so clear to outsiders. There are areas where issues intersect or overlap, so a transwoman might also identify as a lesbian, but the groups which form this overall population each have a range of social, cultural and health needs, some of which are shared and some of which are not. For example the health needs and interests of Intersex people will not automatically align with those of gay men. However all share in one defining feature and that is they are members of a minority population and highly likely to have experienced social exclusion and rejection, outright discrimination and stigma simply due to the fact they do not fit into standard social categories of male and female or expected patterns of romantic and sexual attachment.

Many LGBTTI people avoid or delay accessing health care because of the real or anticipated fear of encountering homo/transphobic staff and transgender people can face stigma, discrimination and even ridicule at times from those health professionals entrusted with their care.

The population health of Rainbow Communities is characterised by the social conditions of stigma, rejection, and discrimination.

There is broad consensus today that the cause of this over-representation in negative health indicators arises from the way mainstream society constructs and treats Rainbow Communities. There is nothing inherently pathological or debilitating about being born Intersex, or about being born same-sex attracted or being transgendered. It is how this difference is viewed through the eyes of the wider world that creates an environment in which LGBTTI people struggle to thrive, and this experience of shared stigma that unites the various strands of the Rainbow Communities. As noted earlier this phenomenon is typically referred to as minority stress, and has been shown to be a core social determinant in negative health outcomes for other minority populations.

The fact that communities and social structures affect the health and well-being of individuals and populations is one of the basic assumptions of any public health intervention. For example the role of poverty as a social determinant of health has been widely analysed and this understanding today is commonplace. Likewise the disproportionate burdens that stigmatised minority populations experience can be viewed in this manner. The pressure of belonging to a group that is seen as socially outside the norm of dominant social understandings, whether that perception is based on ethnicity, religious beliefs, or how sexuality or gender is expressed, all result in some degree of negative health outcome which can be explained at least in part by the mechanism of minority stress.

One of the first things many individuals from sexual and gender minorities learn to do is to hide the elements of their lives that they believe will bring them any unwanted scrutiny or turn them into the victims of prejudice or even violent physical assault. Thus learning to conceal core aspects of the self and to be vigilant in this regard are experiences that are commonly shared by members of these groups. Not surprisingly such behaviour affects the degree of trust and openness individuals from Rainbow communities view the world and informs how they interact with others, especially those in positions of authority such as health care providers.

The institutional invisibility of Rainbow communities is acknowledged by data from the USA "Although mainstream American culture has come to better accept LGBT persons, stigma and discrimination persist. Thus many LGBT persons remain "invisible " citizens even today, making it difficult to obtain representative samples…" (Makadon, Mayer, Potter, & Goldhammer, 2008, p. 210) and also from New Zealand research. (Adams, Braun, & McCreanor, 2011)

In a medical setting this has the effect that many avoid or delay care or treatment because of real or anticipated transphobic or homophobic responses from health professionals. New Zealand evidence from the study "Lavender Islands" shows that heterosexuality is usually assumed by healthcare providers unless the person concerned comes out to them (Henrickson, Neville, Jordan, & Donaghy, 2007).

This group deserves to be viewed as a distinct population in public health terms. There is in fact an identifiable Rainbow sub-culture that needs to be understood and engaged with by all health service providers in the same way that minority ethnic cultures are in New Zealand.

A Public Health Approach

Internationally the value and necessity of considering Rainbow communities from a public health standpoint is becoming more widely accepted as the evidence in support of this approach grows. This approach is not limited to mental health but considers the overall health of this population and research has uncovered specific needs within the Rainbow community that demand attention. (Meyer I. , 2001) (Makadon, Mayer, Potter, & Goldhammer, 2008) (Sylvestre, 2001) (Wolitski, Stall, & Valdisseri, 2008) (Leonard, et al., 2012)

A core aspect of this is the application of population health principles to focus on improving the health of a specific population.

"A population health approach is aimed at improving the health and well-being of the entire population and at reducing health inequities among population groups. In order to reach these objectives, it recognizes the importance and acts upon the broad range of individual and collective conditions that determine health, including social, economic, and environmental factors... This broader perspective emphasizes political and community determinants, for example living and employment conditions, income, housing, environment, culture, social inclusion and social capital." (Ivibijaro, 2012, p. 141)

Taking such an approach is in alignment with the seven stated fundamental principles that underpin the New Zealand Health Strategy (Ministry of Health, 2000, p. 7) . The critical importance of implementing such an approach in order to meet overall national health goals has also been highlighted by commentators on the New Zealand Primary Health Care Strategy (Winnard, et al., 2008) and this emphasis applies just as much to the health of Rainbow Communities as to any other.

Demography

"Both local and international research shows that more respondents indicate same-sex behaviour and attraction than choose to identify as lesbian, bisexual or gay."

The demographics of gender and sexual minorities are challenging to establish as these communities do not present in an obvious and coherent manner in the way that many ethnic populations do. The New Zealand census, the chief source of demographic data in this country does not directly measure either sexuality or gender identity and this is common in similar datasets internationally. This means that what data there are for New Zealand has mainly been collected by cohort-based research including longitudinal studies such as the Christchurch Health and Development Study. Recent research by Dr Frank Pega at Otago University explores this topic in the New Zealand and international settings and offers a useful framework for definitions and concepts that should be seriously considered. (Pega F. , Gray, Veale, Binson, & Sell, 2013)

Another complicating factor is that typically members of the Rainbow communities choose whether or not to identify themselves as such and there are strong social, cultural and personal barriers to doing this in many places even in contemporary New Zealand. While various surveys have taken place around the world to try and capture the size of the same-sex attracted population the reliance on self-reporting in these has been criticised as leading to under-reporting of the true figures.

For example, some people may experience same-sex desire or romantic feelings but never act on them. Some people may have frequent sexual encounters with someone of the same sex but not take on an identity as bisexual or gay. Both local and international research shows that more respondents indicate same-sex behaviour and attraction than choose to identify as lesbian, bisexual or gay (Wells, McGee, & Beautrais, 2011) (Pedersen & Kristiansen, 2008). Some

people may clearly identify as gay but choose to remain celibate. The differences between attraction, activity and identity need to be borne in mind, and lead to complexity in determining an accurate population size.

Getting accurate data on the size of the transgender and intersex populations has been even more challenging owing to the even more marginalised status of these groups. The difficulties in gathering accurate data on the size of the intersex population is highlighted in the Australian report “Private Lives 2” (Leonard, et al., 2012).

The recent Australian “National LGBTI Ageing and Aged Care Strategy” released by the Federal Department of Health and Ageing assumes that 11% of the population fall within the Rainbow grouping (Australian Government Department of Health and Ageing, 2012) and this appears consistent with meta-analyses carried out by other researchers (Wolitski, Stall, & Valdisseri, 2008) The majority of this number is made up of same-sex attracted men and women, with bisexuals, transgender and intersex people forming a smaller proportion of the total.

This represents a significant segment of the wider population whose health needs are generally invisible or ignored by the health system.

There are obvious advantages for the health system in being aware of the health needs of this group and in being able to intervene in such a way as to lessen the burdens on this group and thereby lessen the costs they incur within the health system. Effective targeted public health programmes and interventions will actually reduce costs overall and add to the efficient and equitable provision of health services to this group of citizens.

New Zealand currently adopts a targeted approach to specific populations based in public health principles towards many groups. The clearest examples are programmes dedicated to specific ethnic groups and the most obvious of these is the delivery of certain health services to Māori , but this approach is also used with Pasifika populations as well.

This method is not solely confined to ethnic groups, with public health programmes targeting certain populations defined by age or gender as

well.

In short, the New Zealand health system is already used to adopting a population health approach where evidence demonstrates both the need of the population and the utility for the health system in developing programmes that improve the health of these groups and thereby reduce costs and burdens on the health system.

Meyer outlines three categories for consideration of Rainbow communities in public health thus:

“(1) Areas in which LGBT people are at an increased risk for disease because of unique exposures, (2) areas in which they have high prevalence of diseases or problems that are not caused by unique exposures and (3) areas in which they are not at increased risk for disease but which nevertheless require specialized culturally competent approaches. Clearly these categories cover the whole spectrum of health and illness.” (Meyer I. , 2001)

We argue that the Rainbow Community needs to be viewed in the same way as any other minority population with distinct and demonstrable health needs that require a set of targeted interventions, and that the government and health boards have a clear responsibility to engage with this community as citizens and taxpayers and ensure that their health needs are considered and met.

The Symposium

"There was a consistent call that all health service providers become culturally competent in working with clients from Rainbow communities."

The LGBTTI Well-Being and Suicide Symposium held in Auckland, February 2013 provided a catalyst for this work and a forum for community concerns to be aired. It was originally planned to be a small local event, but it soon became apparent that interest in the opportunity to discuss all aspects of health was widespread and attendance far outstripped organisers' initial projections, with a wide range of individuals and organisations from around the country participating. This in itself demonstrated that the Rainbow community is strongly aware of the issues that have been raised in this report, and the need for effective engagement to bring about improvements in Rainbow community health.

The 2013 Symposium raised a number of broad concerns that deserve attention.

There was a consistent call that all health service providers become culturally competent in working with clients from Rainbow communities. This demand for cultural competency in healthcare provision is also echoed and in fact being implemented overseas (Byne, 2013).

Support was strong for a single umbrella body for the Rainbow community that can efficiently represent our communities and work with the health system in the same way as overseas groups do, such as the National LGBTI Health Alliance Australia.

Greater support for community development for Rainbow Communities across the entire country was also identified as a priority.

The section below highlights age-specific concerns that were raised.

Health Over the Life-Course

One of the clear concerns expressed at the 2013 Symposium was that Rainbow Community health issues are not confined to a particular phase of a person's life, and that at different stages different health burdens become more apparent. Most recent work has understandably been focussed on the health and well-being of our youth. The particular and intense burdens that our youth experience are something that Rainbow community members are personally familiar with and therefore keen to address for others as they go through this period of their lives.

The needs of an ageing population were raised as a core concern as well, and the issues that face middle-aged people were also highlighted in a way that surprised some, with particular mental health concerns and anecdotal reports of disproportionate suicidality being observed especially in middle aged gay men.

Youth

The problems and pressures that affect young people from Rainbow communities have received the most attention from researchers, reflecting at least in part the awareness and need for action in supporting our youth coming from Rainbow people's own lived experience. Local and international research demonstrates the same issues arising for youth who are gender or sexually non-conforming. These cover but are not limited to increased rates of depression, psychosis, drug and alcohol abuse, greater suicidality and higher rates of STIs. (Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008) (Mustanski, Garofolo, & Emerson, 2010). Local research also demonstrates lower levels of academic achievement for young people who come out early in life. (Henrickson, 2008).

New Zealand research from the Christchurch Health and Development Study shows that youth who are predominantly homosexual had rates of mental disorder and suicidal behaviours that were between 1.5 and 12 times higher than for those who identified as exclusively heterosexual (Fergusson, Horwood, Ridder, & Beautrais, 2005). There is a lack of similar local research into the needs of transgender and intersex youth in New Zealand and this only serves to emphasise their invisibility in the data. The report "Youth '12" (Clark, et al., 2013) explores some of these issues but is very much a lone voice in this field.

As transgender and intersex youth represent the margins within the margins it is fair to assume that these groups are likewise over-represented in these areas in New Zealand.

Middle Age

This group has received very little attention so far from health researchers, but there are signs that for many people at this stage of life mental health issues continue and intensify. Increased depression, problems with drug and alcohol use and reports of increased levels of suicide are some of the factors mentioned. Physical health issues are also identified in this age-range, with reports of higher than population average obesity, respiratory illnesses (often linked to tobacco use) and health concerns related to long-term HIV infection and higher rates of anal cancer among MSM being mentioned. However, in New Zealand as appears to be the case internationally this age group has attracted little attention from researchers to date.

Ageing

"Don't send us back into the closet as we get old!"

One of the topics that arose as a central concern during the 2013 Symposium was that of LGBTTI people and ageing. Little local research has been carried out on the needs of this group although there has been work on the attitudes of staff in aged care towards people from Rainbow

“Don’t send us back to the closet as we get old!”

Communities (Bellamy, et al., 2012).

As the baby-boom generation has aged there has been a surge in demand for services that provide care for senior populations and a growing awareness of the specific health needs of the aged and how their health has been affected by stigma and minority stress (de Vries, 2013). Most research around the health needs of Rainbow Communities has focused on youth, but there are specific issues for the ageing Rainbow population that need to be addressed but have so far received almost no attention in New Zealand. The School of Nursing at the University of Auckland has recently developed a set of guidelines and training resources for staff in aged-care facilities to help make them aware of the needs of this population, and this is a move to be applauded. (University of Auckland School of Nursing, 2013)

The historical background to the lives of this population needs to be remembered. Many Rainbow Community elders still feel the need to hide their identity. These are people who have grown up in an era where simply being themselves could be a criminal offence and discovery could result in a diagnosis of being mentally unwell resulting in forced medical treatment, imprisonment, public shame and family rejection. Others will have been involved in fighting for change and acceptance. Some will have married and raised families or attempted to “pass” for large sections of their lives.

Many gay men of this generation will have lived through the worst years of the AIDS epidemic and watched their friends and loved ones get sick and die. Some of those in need of aged care will be gay men living with HIV. Many gender diverse elders will have lived through periods where they either had to completely suppress this core aspect of their identities or they had to find ways outside society’s norms to survive. Many lesbians from this generation will have been married and had children and been forcibly separated from them simply due to being lesbian. Many intersex people will have been subjected to unwanted surgical interventions and medical surveillance through much of their lives. Many from this entire community will still be hesitant about the degree of openness they can express, especially as they come to feel more vulnerable through being dependent upon others for care as they age.

Some will have experienced rejection by their biological families to a greater or lesser degree and have created alternative families of choice instead, and these should be acknowledged and included in the same way a biological family is where this is indicated.

Some people who use aged care services will wish to do so without ever being public about this aspect of their life, and others will insist that this is a central part of who they are that must be acknowledged and included in their care. Transgender and intersex people may be placed in a position where they have no choice but to be public about this aspect of their lives.

LGBTI elders will share the same issues as the rest of the aged population, including concerns about their mental and physical health as they age, the necessary preparations for death, having the ability and power to make choices about their care, whether they can stay involved with their communities and how they can make the most of their lives. The need for and issues that arise in finding safe and accepting accommodation for the LGBTTI elderly are also of concern to this population. (Neville & Henrickson, 2010).

Evidence demonstrates that along with these factors there are mental and physical health issues specific to this population, including but not limited to, increased rates of depression and substance use, sexually transmitted infections including HIV, obesity, a higher incidence of certain cancers and increased risk of coronary heart disease (Makadon, Mayer, Potter, & Goldhammer, 2008, pp. 140-152)

How aged care service providers deal with this population is a topic that deserves attention and support. For optimal care staff need to be aware of and sensitive to the needs of this group, and for those in residential settings to be aware of the reality and needs of this group. This might also include managing other residents in the same care setting who express homo or transphobic views.

The specific mental and physical health issues that arise from this population's gender identity or sexual orientation need to be acknowledged and engaged with, and services at all levels involved with aged care need to be made inclusive and welcoming to Rainbow Community elders.

Challenges and Opportunities

"This complexity however is no reason for inaction or a dismissal of the health needs of these groups. These are challenges that need to be met and addressed as a matter of equity, a matter of human rights, of Treaty of Waitangi obligations, and of good public health policy.

Public and population health problems are often classified as 'wicked problems' (Rittel & Webber, 1973), that is they do not have one clear and obvious solution, and resolving some aspects of the problem is likely to result in unintended consequences elsewhere. The various complex commonalities and divergences that exist and intersect within the Rainbow Communities and the responses required to this in public health terms, present such a wicked problem. This complexity however is no reason for inaction or a dismissal of the health needs of these groups. These are challenges that need to be met and addressed as a matter of equity, a matter of human rights, of Treaty of Waitangi obligations, and of good public health policy.

As Meyer states in the American Journal of Public Health "Finally, all public health areas, even those in which LGBT populations do not have a unique or increased risk for disease, may require a specialized focus for these populations. For example, provision of adequate care requires that care providers be sensitive to the needs of these populations. Insensitive or hostile care may lead to inappropriate interventions, fail to effect change, and add to alienation and mistrust of the authority of public health recommendations." (Meyer I. , 2001)

The New Zealand Health system is already well-accustomed to the idea that social factors and cultural competency matter in delivering the most therapeutically beneficial health services, and that operating in this way in facts assists the health system in reducing overall costs and increasing efficiency, as well as providing better health outcomes for its citizens.

The critical importance of taking a population health approach in implementing the New Zealand Health Strategy and the New Zealand Primary Health Strategy has been noted by local experts (Winnard, et al., 2008).

The Rainbow communities form part of the general population of the New Zealand.

We call for this same approach to be employed and developed with regard to the health of Rainbow communities.

Policy Recommendations and Action Points

1: Rainbow community service users will receive equitable and culturally safe access to general and mental health services across their lifespan.

Action Points:

- The Ministry of Health will support the development and implementation of a standard for Rainbow Cultural Competency for the entire health sector in partnership with the Rainbow communities.
- The principle of client-centred care will be promoted to empower Rainbow community health-service users and their whanau and carers to ensure they receive culturally sensitive services.
- In order to empower transgender, transsexual, and gender diverse people to access an appropriate and consistent national standard of healthcare without being pathologised, a model based on informed consent will be established.

2: The particular health needs of tangata takatāpui will be considered and addressed in line with the state's obligations and commitments under the Treaty of Waitangi and the principles of partnership, protection and participation.

Action Points:

- The government and its agencies will ensure that organisations and researchers in the health sector are aware of this Treaty obligation.
- The government and its agencies will fund and assist in the establishment of appropriate services to address the health needs of tangata takatāpui.

Policy Recommendations and Action Points (cont'd)

3: All health services will be supported and resourced to deliver culturally sensitive and appropriate services for Rainbow communities

Action Points:

- Training in awareness of the physical and mental health needs of Rainbow Communities will become a mandatory part of all health and ancillary health qualifications.
- Appropriate funding will be made available to provide and maintain a consistent and culturally sensitive standard of service delivery throughout the health sector.

4: Rainbow communities will be actively involved with and consulted about the development and delivery and evaluation of appropriate policies, programmes and services.

Action Points:

- Rainbow community representatives, researchers, service users and community organisations will be included in all relevant health consultation processes.
- Consumer advocate teams will seek to actively recruit Rainbow community members.

5: Research and data collection on the physical and mental health needs of Rainbow communities will be a priority for health research.

Action Points:

- Any future iterations of national research projects such as the New Zealand Health Survey or similar will specifically include data on the Rainbow communities.
- Statistics New Zealand/Tatauranga Aotearoa will identify and act on opportunities to include Rainbow Communities in appropriate datasets.
- The Health Research Council will actively support research in this area.

Glossary

Bisexual A person who is emotionally and sexually attracted to both men and women

Gay A person who is emotionally and sexually attracted to the same gender. This is more widely used as a personal identity by men than women. This is used as both a personal and community identity

Gender The attributes and behaviours that society expects and ascribes to people based on their biological sex. NB: “male” and “female” describe biological sex, where “woman” and “man” describe socially constructed gender roles

Gender Diverse People who do not perform their gender roles in conformity with social expectations attached to their biological sex. Gender diverse people are found across all human societies across history, thus they are a naturally occurring part of the human experience

Gender Identity The sense of personal identity held in relation to social expectations of what it is to be a woman or a man. For most people gender identity and biological sex as assigned at birth are congruent, but for some people this is not the case

Intersex The physical presentation of intermediate or atypical characteristics that are normally used to distinguish male from female. This can range from variety in chromosomes, hormones, genitalia, and other physical features. Intersex variations are found in all mammals and are part of the natural order. The term hermaphrodite is today seen as inaccurate and offensive. Likewise the clinical term “Disorders of sexual development” (DSD) is seen as pathologising and oppressive

LGBTI Lesbian, Gay, Bisexual, Transgender, Intersex, also seen as GLBTI

LGBTTIF Lesbian, Gay, Bisexual, Transgender, Takatāpui, Intersex, Fa’afafine. NB this combination is only found in New Zealand and reflects New Zealand’s ethnic makeup.

Lesbian A woman who is primarily emotionally and sexually attracted to other women. This is used as both a personal and community identity

MSM	Men-who-have-sex-with-men: This is a term used mainly in sexual health research to describe activity, not identity. This reflects that many more men have sex with other men than identify as gay or bisexual. This is not used as a personal identity.
MVPFAFF	An acronym to describe Pasifika identities; Mahu (Hawai'i and Tahiti, Vakasalewalewa (Fiji) Palopa (Papua New Guinea) Fa'afafine (Samoa) Akava'ine (Rarotonga), Fakaleiti (Tonga) Fakafifine (Niue)
Rainbow	An umbrella term used to cover all forms of sexual and gender minorities. This is not used as a personal identity.
Sex	The biologically identified characteristics associated with female and male. These range from chromosomes and hormones to the physical presentation of genitalia and secondary sex characteristics such as body hair distribution and breasts.
Sexuality	This term describes the direction of one's attraction, whether emotional, sexual or romantic, to other humans. Heterosexuality and Homosexuality represent two ends of the spectrum of desire rather than the only two options.
Takatāpui	The Māori term used to describe same-sex romantic and physical attraction and identity
Transgender	A word that describes a wide variety of people whose gender identity is different to the sex they were assigned at birth.
Trans*	This word is used to strategically describe gender diversity without using particular terms like transgender or transsexual. The asterisk signals that these terms are always evolving and incomplete. We use trans* because we need to work with and beyond the limitations of language and identity categories.
Transsexual	This term is typically used for a person who has changed, or is in the process of changing, their physical sex to conform to their gender identity.

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