

AN OVERVIEW OF LESBIANS AND HEALTH ISSUES

A COAL Research Paper

by Helen Myers and Lavender

Coalition of Activist Lesbians Australia

This paper is dedicated to all lesbians who want and strive for a just and equitable society

COPYRIGHT COAL 1997

CONTENTS

1.0 INTRODUCTION

- 1.1 The Concept of Primary Health Care
- 1.2 Lesbian Health is a Women's Health Issue
- 1.3 The Social Context of Lesbian Health
- 1.4 The Present Brief

2.0 METHODOLOGY

3.0. LESBIAN SPECIFIC HEALTH ISSUES

Mental Health

- 3.1.1 Depression
- 3.1.2 Suicide
- 3.1.3 Drugs and Alcohol
- 3.1.4 "Coming Out"

Sexual Health

- 3.2.1 Sexually Transmitted Diseases (STDs)
- 3.2.2 Sexual practices

Reproductive Health

- 3.3.1 Donor insemination
- 3.3.2 Parenting

Special Life Cycle Issues

- 3.4.1 Adolescence
- 3.4.2 Adult Milestones and Life Cycle Issues
- 3.4.3 Mid-Life Issues
- 3.4.4 Menopause
- 3.4.5 Ageing and Old Lesbians
- 3.4.6 Dying and Death

4.0 HOMOPHOBIA, HETEROSEXISM AND DISCRIMINATION

- 4.1 Forms of Discrimination
- 4.2 Myths and Stereotypes
- 4.3 Attitudes of Health Practitioners
- 4.4 Solutions

5.0 ACCESS TO AND DELIVERY OF HEALTH SERVICES

- 5.1 Disclosure and Confidentiality
- 5.2 Fear of Disclosure and Avoidance of Services
- 5.3 Lack of Acceptance of Partner and Next of Kin Issues
- 5.4 Filtering and Gatekeeping
- 5.5 Use of Counselling
- 5.6 Rebates for Alternative Health Services
- 5.7 Health Insurance Costs
- 5.8 Issues Facing Rural and Isolated Lesbians
- 5.9 Access Issues for Lesbians with a Disability
- 5.10 Access Issues for Indigenous Lesbians and Lesbians from a Non-English Speaking Background
- 5.11 Values of Organisations Providing Services
- 5.12 Research
- 5.13 Lesbian Health Care Workers

6.0 CONCLUSION

7.0 RECOMMENDATIONS

- 7.1 Legislation
- 7.2 Health and Social Policy and Provisions
- 7.3 Education and Information
- 7.4 Lesbian Community

REFERENCES

ACKNOWLEDGEMENTS

1.0 INTRODUCTION

1.1 LESBIAN HEALTH IS A PRIMARY HEALTH CARE ISSUE

The concept of primary health care evolved from the recognition of major inequalities in health status between different groups of people within and between societies. In response to these concerns, in 1977, the World Health Organisation (WHO) created the goal of Health for All by the Year 2000. The 1978 WHO and UNICEF conference at Alma-Ata established primary health care as the strategy for achieving this global health equity, with Australia as a signatory (Collado, 1992; Glittenberg, 1988; World Health Organisation, 1978).

Primary health care incorporates the principles and strategies of social justice, cultural sensitivity, empowerment and broad social collaboration to promote health equity for all. These principles arise from the recognition that poor health is not evenly distributed amongst all members of society, and this uneven distribution is not random and can be attributed to social inequalities. Social inequalities arise from the uneven access to power and resources by some groups within society, as well as from discrimination based on social class, gender, race, ethnicity, disability, mental illness and geographical location (Peterson, 1994; McMurray, 1993; Short, Sharman and Speedy, 1993).

The principle of social justice within primary health care implies that an attempt is made to redress the imbalances in health status caused by social inequalities. A strategy for achieving this is positive discrimination. This involves the delivery of specific health programs tailored to meet the needs of socially disadvantaged groups within society (Peterson, 1994; Bates and Linder-Pelz, 1990; Palmer and Short, 1989). As this paper will show, a case can be made for including discrimination on the basis of lesbianism as a cause of social inequality in health care in Australian society. This implies that lesbians should be considered as a target group for positive discrimination in all health policies and strategies.

1.2 LESBIAN HEALTH IS A WOMEN'S HEALTH ISSUE

Women are more likely to be consumers of health services than men (Australian Bureau of Statistics (ABS), 1994), both consulting doctors and taking other health actions (eg. medications, reducing activities) more frequently. Women also are more likely than men to consult naturopaths, acupuncturists, dieticians, herbalists or osteopaths (ABS, 1994). No figures exist for lesbians' health actions so working on the estimation that 10% of women are lesbians (Bell and Weinberg, 1978), lesbian uptake of services must be considerable in Australia. Since 1974 when women's health centres were established first in Melbourne and Sydney and then in other locations (Hawthorne, 1992; Broom, 1991), the women's health movement has attracted lesbians as both clients and workers. On a level playing field one would expect lesbians' health needs to be well met. This is not the case. Lesbian specific programs, and general programs targeting lesbians are more the exception than the rule. Lesbians are often invisible or given sparse consideration in books on women's health (eg. Smith, 1992) or may be seen merely as political agitators rather than legitimate consumers of women's health services (eg. Broom, 1991).

The presumption that the presence of lesbian staff members within a service will mean lesbian needs are catered for, or even that the service will be welcoming to lesbians, cannot be sustained (Health Survey for Lesbians and Gay Women, (HSLGW), 1997; PS:6). Too often provision depends on the will and ability of aware individuals rather than policy and strategic intention. Lesbians have articulated the need for their physical and mental care to be catered for within women's health services with appropriate non-discriminatory service delivery (HSLGW, 1997; Oliver, 1996; COAL, 1995a; Davis, 1994a).

1.3 THE SOCIAL CONTEXT OF LESBIAN HEALTH

The social context of women's health care has been recognised as important for some decades (Ehrenreich and English, 1979; Boston Women's Health Collective, 1973). For lesbians, the impact of societal values and attitudes on service delivery was also recognised some time ago (Goodman, 1980; Klaich, 1974). This is consistent with a broader social analysis of health addressing issues of dominance, cultural relevance, marginalisation and social justice. For lesbians the issues of homophobia and heterosexism have been identified as central to this context (Horsley and Tremellen, 1996; Oliver, 1996; COAL, 1995a; Barnett, 1985).

Homophobia is the fear and loathing of those who have intimacy and/or sexual contact with another person of the same gender and is often accompanied by hostility (Pharr, 1988). Heterosexism refers to the belief that heterosexual relationships are inherently superior and hence should naturally be dominant (Lorde, 1984; Goodman et al., 1983). While homophobia and heterosexism are specific prejudicial, or bigoted attitudes, discrimination usually refers to actions.

1.4 THE PRESENT BRIEF

In 1995 the Coalition of Activist Lesbians Australia (COAL), the sole accredited lesbian-only organisation attending, sent a delegation to the Fourth World Conference and Forum on Women in Beijing. Issues of health, violence and human rights were emphasised for lesbians as debate raged over whether lesbians should be specifically included in the United Nations Platform document. Failure to achieve agreement between approximately 180 nation states attending meant that lesbians were excluded (Gayatri, 1996; COAL, 1995b). Three years ago, the WHO established the Global Commission on Women's Health with membership representing social, political and health interests. Despite the debate over lesbian inclusion at Beijing, "sexuality issues" are not yet on the agenda nor lifestyle issues developed (Giles, 1997). COAL considers the inclusion of lesbians as a named group in international, national, state and local health matters is a human rights issue. Difficulties arose during the Beijing debates over the connotation of the term "sexual orientation" as it was inexact, unclear and open to assumptions (eg. of paedophilia and bestiality!) COAL affirms the importance of lesbians naming themselves lesbian and encourages use of this specific name (Pittaway, 1997).

In a pilot study of lesbians, 27% of respondents identified health as the top priority requiring government action (COAL 1996b). Our brief has been to prepare an overview of the health issues facing Australian lesbians today. The task is an enormous one. The organisation of health care is complicated by a national picture of nine governments, public and private health sectors, and the very small amount of lesbian-focused and lesbian-inclusive research. Clinical reports and empirical studies that include lesbians tend to be from other countries. If reference is made to socio-cultural factors there will be a degree of uncertainty about applicability in Australian conditions. Additional considerations are the dominance of the heterosexual framework and a patina of negative attitudes towards lesbians which range from distaste to hostile. Access and rights imperatives for lesbians must be central to any service.

2.0 METHODOLOGY

Within the constraints of a very short time-frame and small budget, the methodological approach adopted was to survey the literature and to gather information for qualitative assessment. Qualitative research consisted of -

- * The Health Survey for Lesbians and Gay Women (HSLGW, 1997) distributed nationally through lesbian-only community groups and newsletters; some women's community groups and newsletters; women's health centres and services; and some gay and lesbian community organisations. The number of respondents was 168. (Note that this should not be referred to as a sample.)
- * Twenty nine personal submissions (PS) from lesbians, (the invitation being included in the covering letter to the survey).
- * A small survey of health practitioners (PrS) mostly obtained from advertisements in lesbian-only and some gay and lesbian newsletters/papers. The 27 responses included both medical and alternate practitioners as well as educators and administrators.
- * Interviews of 15 lesbian practitioners (PrI) drawn from the same sources.

It is clear the information gathered was for qualitative analysis, to substantiate indicators and to amplify issues, rather than be subjected to statistical analysis or considered a representative survey. This methodology is not about random sampling or meant to be interpreted as representative because there can be no true representative sample of a largely hidden population. Hence, there being no reliable statistically valid profile of Australian lesbians, we did not seek to gather demographic data.

Self-selected surveys are commonly used for qualitative research and for investigations such as this, and are valuable in that respondents exhibit a degree of commitment to the subject. In other words, if lesbians are not concerned about health issues they will be less inclined to respond.

3.0 LESBIAN SPECIFIC HEALTH ISSUES

What is a lesbian health issue? Is there such a thing? Obviously, lesbians are first and foremost people and are just as likely to suffer from any number of health problems troubling the general population. Bad backs, broken legs or pneumonia could not be said to be a lesbian health issue, even though lesbians suffer from them. However, how lesbians are treated when accessing services for these problems, could become an issue for them, if they are discriminated against, victimised, denied treatment, or if in any other way their care is compromised because they

are homosexual. A more general health issue may become a lesbian health issue when the incidence of that health problem is shown to be higher in a lesbian population than in the general population. This can be difficult to establish as there are few comparative figures on health status between lesbian and heterosexual women. However, some health issues have been indicated as having a significant incidence in lesbian populations and are in need of further study.

Lesbians are also women and could be thought to experience similar problems to heterosexual women. This is, however, where the issue becomes more contentious. Lesbian lifestyles and sexual practices may be different from their heterosexual counterparts leading to a different risk profile for health problems. For example, **cervical cancer**, for which there is a simple screening test, has as its main risk factors, early age at first coitus; intercourse with men; multiple male sexual partners; oral contraceptive use; genital warts and smoking (Price, et al., 1996; McCance and Heuther, 1990). This has led to an assumption that as lesbians do not have sex with men (not necessarily true), they are in a low risk category and are therefore not in need of Pap smears. Evidence from the HSLGW (1997) indicates some lesbians have been told they don't need a Pap smear and have in fact been denied them.

Pap smear refused because I was a lesbian - Dr. said there was no penetration so didn't need to worry. (HSLGW, 1997:3)

This shows a total lack of knowledge from health professionals about lesbian sexuality and obscures the fact many lesbians have had sex with men at some point in their life. In addition, many lesbians smoke, and the incidence of genital warts may be higher in the lesbian community, all leading to a risk of cervical cancer. Earlier research has found similarities in the incidence of abnormal Pap smears between lesbian and heterosexual women (Barnett, 1985), while other research shows an increased risk for late detection of cervical dysplasia (early sign of cervical cancer) amongst lesbians (cited in Horsley and Tremellen, 1996). Combine this with a perception among lesbians that they are less susceptible to cervical cancer (Price, et al, 1996) and therefore are less likely to seek Pap smears (Moran, 1996) and one can see that cervical cancer is a lesbian health issue and for different reasons than it is a women's health issue.

Similarly, **breast cancer** has become a contentious issue for lesbians. An American report cites the risk for lesbians of developing breast cancer as 1 in 3 (*Lesbiana*, 1993a), based on an estimation of risk factors (smoking, alcohol use, lack of childbearing) thought to be more common in lesbians. There does not appear to be any research to support this view. However, in view of the fact that lesbians may use breast self-examination less frequently than heterosexual women (Moran, 1996), it seems that this is an area which needs further comparative research and is again a lesbian issue which may differ in context from the way in which it is a women's health issue.

The following discussion contains information on other health issues which have been identified from the literature, the HSLGW (1997) and discussion with lesbian health practitioners, as being of importance to the lesbian community. It is not the intention of this discussion to pathologise lesbianism in any way (Rogers, 1994), rather to recognise areas where differences occur between lesbian and heterosexual populations in order to provide a basis for health promotion in these areas. It is always the case that these differences in health status arise from the impact of societal homophobia and heterosexism on individual lesbians or from differences in sexual and lifestyle practices. It is never the case that differences in health status arises from lesbianism itself, but rather from the context of being a lesbian in a heterosexual world.

3.1 MENTAL HEALTH

A discussion of the mental health needs of lesbians is problematic in the sense that for many people lesbianism itself is still seen as a mental health problem. It was less than twenty five years ago that homosexuality was removed as a sociopathic personality disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) of the American Psychiatric Association (1973). In many ways this view of lesbians as disordered still persists in the mental health field. For example, American research found that 11% of a sample of clinical psychologists used methods such as psychoanalytic techniques (where lesbianism is viewed as evidence of a disturbed or arrested psychological development and disorder femininity (Magee and Miller, 1996)) to change clients sexual orientation while 5.8% still supported the use of aversion therapy for this purpose (Jordan and Deluty, 1995). Some respondents from the HSLGW (1997) report that their lesbianism was viewed as an illness or that health professionals had told them they were sick because they were lesbians.

As a consumer of mental health services, my lesbianism has been regarded as part of my problem, illness, which is unbelievable in 1995. (HSLGW, 1997:107)

Change is occurring, however with emerging research focusing on the influence of internalised and externalised homophobia on the mental and emotional health of lesbians, as well as contributing to a greater understanding of the mental health implications of the coming out process (eg. Otis and Skinner, 1996; Downey and Friedman, 1995; Hershberger and D'Augelli, 1995; Meyer, 1995; Pilkington and D'Augelli, 1995; Savin-Williams, 1994; Erwin, 1993). Although this research has identified high incidence rates in various indicators of psychological distress, little research has focused on relationships between the context of lesbianism and dissociate or delusional disorders, or on issues surrounding lesbians with a dual diagnosis of mental illness and substance abuse. Information from the HSLGW (1997) identified mental health as a major area of concern for many respondents. Issues mentioned in this area were stress; self esteem; counselling, including relationship and sexuality counselling; coming out; mental health difficulties associated with not being out; depression; substance use; social isolation; safety; childhood sexual abuse; and maintaining emotional health in a homophobic world.

3.1.1 Depression

It is generally accepted that women have higher rates of depression than men and it appears that lesbians may have a higher risk and incidence of depression than heterosexual women. An American study by Bradford, Ryan and Rothblum (1994) indicated that one third of their sample in the National Lesbian Health Care Survey (with a total sample size of 1925) reported suffering from depression at some point in their lives. The reason for this depression was not indicated. Barbeler (1992) found very high levels of depression related to sexuality in her study of young Australian lesbians (total sample size was 200) while Otis and Skinner (1996) found a positive correlation between victimisation and depression in a lesbian and gay sample. Further research is needed in Australia to identify levels of depression in a wider lesbian population and also to report on the contributing factors and context in which this depression occurs.

3.1.2 Suicide

The issue of suicide, especially youth suicide, is a health issue of major importance to the lesbian community. The high incidence of suicide and suicide ideation amongst lesbians has been widely discussed and is supported by Australian research such as Barbeler (1992) which reports 46% of the sample's 14-18 year olds; 24% of 19-21 year olds and 33.5% of 22-25 year olds had contemplated suicide due to their sexuality, with 47.5% of the entire sample having attempted suicide at some point. Millard (1995) also identifies adolescence as a particular risk period for suicide as this is the time when many lesbians "come out". As they struggle with establishing a sexual identity which the majority of society disapproves of they may experience victimisation, discrimination and violence from family, friends and strangers, often resulting in total rejection, isolation from support systems and homelessness. These external factors combined with internal feelings of self doubt, self hatred and shame may lead to suicidal actions. Savin-Williams (1994) also identifies verbal and physical abuse as stressors in the lives of lesbian adolescents which may lead to suicidal behaviour, while Hershberger and D'Augelli (1995) note that family support may help to mediate the effects of victimisation, a resource which lesbian adolescents often lack due to family disapproval and rejection.

In adult lesbian populations the statistics show an equally high level of suicide and suicide ideation, with studies finding that suicide attempts amongst gays and lesbians are 2 - 7 times higher than amongst comparative heterosexual groups (cited in Saunders and Valente, 1987). Bradford, Ryan and Rothblum (1994) report that more than half of their lesbian sample had suicide ideation at some time while 18% had attempted suicide. Factors leading to these high rates include discrimination on the basis of sexuality; drug and alcohol use; interrupted social ties; breakup of relationships; childhood sexual abuse and limited support structures (Millard, 1995; Saunders and Valente, 1987). Lesbians from Aboriginal and non-English speaking backgrounds may be at increased risk for suicide as they may be isolated from their own ethnic support groups due to homophobia and discrimination whilst often being isolated from the "white" lesbian community as well (Millard, 1995).

3.1.3 Drugs and Alcohol

Studies have found that lesbians have a high rate of alcohol and drug use and that contrary to the pattern amongst heterosexual women this high rate of use does not decline with age (Moran, 1996; Bradford, Ryan and Rothblum, 1994; Barbeler, 1992; McKirnan and Peterson, 1989; Bennett, 1983). Some reasons suggested for this high incidence are the prominent use of gay and lesbian bars as places to socialise and meet other lesbians; internalised homophobia and societal homophobia; verbal and physical abuse; isolation; memories of childhood abuse and incest; tension reducing aspects of substances and general life stressors such as relationship breakdowns (Cabaj, 1996; Kominars, 1995; Hughes and Wilsnack, 1994; Savin-Williams, 1994; Shernoff and Finnegan, 1991; McKirnan and Peterson, 1989; Glaus, 1988). Considering the health problems which flow from the excessive use of alcohol and drugs and the link between suicide and substance use this data is disturbing. Even more disturbing is the fact that although women are a target group for Australia's National Drug Strategic Plan, 1993-1997 (1993) no

mention is made of lesbians as a target group with special needs in this area. Apart from the Alcohol - Go Easy postcards, using photographs of lesbians, produced by SLADE (Southern Lesbians Are Discussing Everything) in Adelaide, under a grant from the Drug and Alcohol Services Council of South Australia, little other health promotional material around drug and alcohol issues, aimed specifically at lesbians and using lesbian imagery is available in Australia.

SMOKING: American research has shown that lesbians tend to smoke more than their heterosexual counterparts and indeed are being targeted as a consumer group by the tobacco companies (Farrelly, 1996; Moran, 1996; Bradford, Ryan and Rothblum, 1994). Australian research conducted for QUIT Victoria supported this view and found that the number of lesbians who smoked was almost double that of heterosexual women (PrI:12; Tremellen, 1996). It would appear though that little has been done to target lesbians, using lesbian imagery in anti-smoking campaigns.

3.1.4 “Coming Out”

“Coming out” could be described as the process of recognising and acknowledging same sex attraction, and in many ways this can be a difficult, often destructive time of life. This is not to say that “coming out” is always a negative experience. For many lesbians it is a very positive experience leading to an increased sense of joy, freedom, empowerment and a sense of “coming home” to the “real self” (Cruikshank, 1992). For others, however it represents a time of great vulnerability and need, a “crisis”, which if not resolved successfully can lead to a number of health problems.

The first sense of awareness of same sex attraction may occur in childhood, with research showing the average age of awareness occurring between 13 and 18 years of age (Barbeler, 1992; Coleman, 1985) although many may not experience this awareness until much later. When this same sex attraction surfaces the individual knows that it is disapproved of by society and they will usually try to protect themselves by denying and repressing these feelings. This recognition of same sex attraction and concomitant sense of conflict with the “heterosexual norm” may lead to a strong feeling of “differentness”, decreased self esteem, a sense of personal failure, self disgust and self loathing, behavioural problems, psychosomatic illnesses and suicide attempts (Millard, 1995; Barbeler, 1992; Coleman, 1985). Obviously this is a critical time in terms of emotional, mental and physical wellbeing.

As the individual grows to accept their same sex attraction they often experience the need to tell others, especially significant others and therefore they run the risk of rejection in an attempt to seek validation for their homosexual feelings. This is another critical time as positive or negative responses may do much to shape the emotional and mental health of those identifying as lesbian (Coleman, 1985). Research shows that in fact most lesbians usually receive negative responses to their “coming out” and may experience rejection and victimisation from family, friends, school and society. Of particular importance for adolescent lesbians is telling parents that they are homosexual. This information is usually received in a negative manner by parents, with many young lesbians experiencing violence and victimisation at home. The effects of this rejection may include suicide, drug and alcohol abuse, depression, homelessness and prostitution (Cohen and Savin-Williams, 1996; Irwin, et al. 1995; Millard, 1995; Anderson, 1994; Savin-Williams, 1994; Barbeler, 1992; Coleman, 1985).

It can be seen that the process of “coming out” may be problematic especially for young lesbians who may be more reliant on the good opinion of others for their physical survival than older lesbians. The loss of support systems and the effects of violence, victimisation and rejection may lead to serious health issues for those who receive a negative response to their “coming out”. The serious issues associated with this process warrant the provision of support services for young women questioning their sexuality, including judgement-free counselling and family mediation services.

It should not be presumed that all lesbians “come out” while young. Older women's needs have a lower profile therefore research is necessary on the stressors and social support required. Personal narratives relate that some older lesbians who have been closeted for many years eventually decide to declare themselves (PS:6; Byrnes and Byrnes, 1987). Another common pattern is for a mid-life woman to “come out” after leaving a marriage, frequently this involves children and negotiating their care and custody (Charbonneay and Lander, 1991). Often the new lesbian who is older will have no idea of how or where to find support groups. In her confusion she may seek counselling or therapy for her needs which could otherwise be satisfied by finding other middle-aged or old lesbians for social contact and support (PrI:14). The sharing of coming out stories is a common aspect of support, especially for lesbians who may be, or may perceive themselves to be different to their peers and/or to the immediately visible lesbian community (Holmes, 1988). Similarly women from a non-English speaking background may be isolated if they are excluded from their own cultures and are wary of racism from the visible mostly white lesbian community (Pallotta-Chiaroli, 1996).

3.2 SEXUAL HEALTH

Sexual health is more than just preventing the spread of sexually transmitted diseases (STDs), it also encompasses the need for information to promote the enjoyment of sex and access to services for discussing sexual difficulties. For some lesbians this may mean access to information about lesbian sexual practices and safe sex; groups for learning assertiveness skills in negotiating sexual encounters; or information on creating safe spaces for exploring sexuality and sensuality. For other lesbians, there may be a need for counselling services to deal with issues of sexual dysfunction; past and present issues of incest, abuse or rape; or general sex or relationship difficulties. Information from the HSLGW (1997) indicated that sexual health was an issue of importance for the respondents, with appropriate safe sex information; information on lesbian transmission of STDs; access to free safe sex supplies; information on thrush and urinary tract infections; and the safety of diverse sexual practices, as mentioned.

3.2.1 Sexually Transmitted Diseases (STDs)

The issue of lesbians and STDs is characterised by two things; first, limited research on woman to woman transmission of STDs, thereby rendering the issue invisible; and secondly, by a perception amongst lesbians that they are immune from STDs. The combination of these factors has led to a high degree of sexual risk taking among some members of the lesbian community. For example, Barbeler (1992) found that only 41.5% of her adolescent lesbian sample practised safe sex. This issue of lesbian safe sex is, however, gaining greater prominence within the lesbian community with publications such as the booklet *Lesbian Sex* (ACON Women's Team, 1994), the launch of the lesbian safe sex pack in Perth in 1995, and numerous articles in *Lesbians on the Loose* in the last few years. The other component of safe sex practice is the availability of safe sex products such as dams, gloves and condoms. Anecdotal evidence suggests that safe sex products for lesbians may be becoming increasingly difficult to get due to the cost of funding free provision. Although condoms are freely available from many outlets there is a general lack of availability of gloves and dams.

HIV/AIDS: It needs to be acknowledged that there are lesbians who are HIV positive. It also needs to be acknowledged that there is a wide diversity of sexual practices amongst lesbians and that some of these practices carry a risk of HIV transmission. American studies have found a high prevalence of HIV risk behaviours amongst lesbians, including sexual experiences with men; injecting drug use and high risk (unprotected) sexual contacts with gay or bisexual men (Lemp, et al., 1995; Einhorn and Polgar, 1994). This is supported by Australian research which found that 40% of a (mostly) lesbian sample had sex with men in the previous five years. In addition 23% of respondents reported injecting drug use (Alley and Allwood, 1993). Other practices which may carry a risk of HIV transmission in lesbian populations include prostitution; insemination leading to pregnancy (Kennedy, et al., 1995; Alley and Allwood, 1993) and activities involving body fluid exchange between women including the sharing of sex toys and some sado masochistic practices. In addition to these risk practices there are also reported cases of woman to woman transmission of HIV where no other risk factors were present (*Lesbians on the Loose*, 1995b; *Grapevine*, 1994). In view of this research it is alarming that lesbians have been refused HIV tests because of an assumption of no risk.

HIV test was refused because I was a lesbian - 7 months after I had sex with a man. (HSLGW, 1997:3)

These may be isolated cases but they reveal a lack of awareness amongst health professionals about lesbian sexual practices and risk factors. This may also be due to the general lack of data on lesbians and HIV/AIDS, including the lack of reliable statistics on the incidence of HIV amongst lesbians (Farrelly, 1995d), thereby promoting lesbian invisibility in discussions of HIV/AIDS (Prineas, 1994).

OTHER STDs: There is very little information available on the incidence of other STDs amongst lesbians. A literature search of the major health indexes revealed little information on the transmission rates or general incidence of STDs within the lesbian community, apart from some emerging information about HIV/AIDS as described above. From anecdotal evidence it would seem that the incidence of Hepatitis C is quite high in the lesbian community. Barnett (1985) states that infections such as gardnerella, chlamydia and herpes are increasing in the lesbian community while other information suggests the herpes and wart virus may have a high incidence amongst lesbians with woman to woman transmission of warts, candida, chlamydia, gardnerella, trichomonas, Hepatitis B and bacterial vaginosis documented (cited in Horsley and Tremellen, 1996). Anecdotal evidence suggests that lesbians are also concerned about the transmission of thrush and urinary tract infections between women. Obviously the transmission of STDs between lesbians exists and more research is needed in this area.

3.2.2 Sexual Practices

There is a great deal of information on heterosexual sexual practices, wherever you look: on TV, in the movies, whatever you read, in ever more explicit ways, everyone knows what heterosexuals do in bed. But what do lesbians do in bed? The general lack of publicly acknowledged information on lesbian sex may affect lesbians' health status in a number of ways. First, the fact that no one talks about lesbian sex reinforces the notion that lesbian sex is deviant and therefore contributes to continued homophobia. Secondly, a lack of information about lesbian sexual practices can lead to assumptions about lesbian's health needs that are erroneous and often dangerous ie. lesbians do not need Pap smears or HIV tests; they do not need to practice safe sex as there is no risk of transmission of STDs from lesbian sex. It also contributes to the lack of research on lesbian health issues such as the transmission of STDs if lesbians are perceived to be in a low risk group due to misconceptions about sexual practices. Information on lesbian sexual practices (with no voyeuristic overtones) is needed by health professionals so that they may provide informed care with lesbian sensitive information.

3.3 REPRODUCTIVE HEALTH

Reproductive health involves the maintenance of positive health around issues such as pregnancy and parenting and may include both the physical and mental health dimensions. Widespread societal disapproval of lesbian mothers, as well as resistance from some members of the lesbian community toward other lesbians with children can make the job of lesbian parenting a difficult one.

3.3.1 Donor Insemination

he recent case in Brisbane of JM, a lesbian who was awarded \$7500 in damages on the grounds of discrimination and given the right to access sperm from a local fertility clinic after previously being denied access by the clinic because she was a lesbian (Dennis, 1997; Hammond, 1997) highlights the plight of many lesbians in Australia who wish to gain access to a safe source of sperm in order to conceive. The fact that this "win" is now being contested by the Queensland government, highlights the discrimination which exists within society against lesbian parenthood. Generally speaking, lesbians in Australia, are denied access to fertility services which are available to other women unless they do not reveal that they are lesbian. This lack of access for lesbians wishing to become parents may lead them to seek alternative methods of insemination including self administrated insemination from a known donor, often a bisexual or gay man, or sex with a man for the purposes of becoming pregnant. This immediately leads to an increase in risk of contracting HIV/AIDS or other sexually transmitted diseases as by definition to become pregnant you have to be exposed to seminal fluid (Kennedy, et al., 1995; Macaulay, et al., 1995). The other issue raised by this lack of access to fertility services is one of paternity. For heterosexual couples participating in these programs the sperm donor is anonymous, thereby guaranteeing them the rights of parenthood over the child. By denying access to lesbians and obliging them to use a known donor, lesbians are also then denied sole parentage rights and may be open to subsequent legal battles. The case of JM has done much to highlight these issues and it remains to be seen what will follow.

3.3.2 Parenting

Although historically lesbians may have had little opportunity or desire to become parents, it would appear that the number of lesbian parents is increasing. Barbler (1992) found that 5% of adolescent respondents already had children with 43% considering having children in the future. A 1995 readership survey conducted by *Lesbians on the Loose* (1996) found that 19% of the 732 respondents already had children with a further 12.4% contemplating becoming mothers in the future. With the acknowledgement that lesbian parents exist has come a discussion about the suitability of lesbians to be parents. This discussion usually takes the form of vehement opposition to lesbian parenthood as occurred when the CWA Riverina conference decided that lesbians should not be allowed to adopt children (Dunn, 1995).

Within the heterosexual world, lesbians who become mothers are almost universally vilified as a dangerous, unnatural aberration capable of irrevocably warping children's minds, while simultaneously contributing to the downfall of society as we know it (*Lesbiana*, 1996 - "Murderer better parent than lesbian"; McKenzie, 1996; Farrelly, 1995a). Lesbians often lose custody of their children because of these perceptions, despite research which shows that children raised in lesbian households function well in psychological and social terms and are no more likely to "end up gay" than children raised in heterosexual households (Tasker and Golombok, 1995; Shenfield, 1994).

For lesbian mothers parenting may be fraught with difficulty. They may experience disapproval, discrimination and abuse combined with a lack of support and affirmation from the heterosexual world. Lesbians may have difficulty accessing safe supplies of sperm; may lose custody of their children when the father is known and be shunned by usual support systems such as family groups (Wismont and Reame 1989). They face issues such as whether to 'come out' to school officials and children's' school friends; how to protect their children from experiencing homophobic reactions from other children (*Dykewise*, 1995); how to develop a positive sense of lesbian

motherhood; how to negotiate blended families where the partner has not been involved in the decision to have children (Counsellor's Corner, 1996) and how to deal with access and child support if a relationship breaks up. Lesbian co-parents (or non-biological parents) have few legal rights or recognition in relationship to the children they have raised. They live with the spectre of invisibility as a parent, often being denied access to their children in school and health settings (*Lesbians on the Loose*, 1994). Lesbian mothers, their co-parents and their children need social and legal recognition, positive affirmation; information and support (COAL, 1996a, 1995a).

3.4 SPECIAL LIFECYCLE ISSUES

It is generally accepted that age related changes in physical and mental development bring about certain challenges which the individual seeks to resolve or adapt to. The successful resolution of the challenges associated with these age related changes can lead to positive development and growth of the self. For those unable to resolve these challenges, a cycle of physical, mental, emotional and social problems may occur which can impact on the health status of the individual (Berger, 1994).

3.4.1 Adolescence

The period of adolescence is often seen as a critical time in human development as the person loses their focus on childhood interests and begins to establish an adult identity. It can be seen that in addition to the usual issues associated with this period, adolescence may represent a particularly difficult time for those who identify as lesbian. As already described above, the conflicts of establishing an identity disapproved of by others can be problematic and may lead to health risks, such as increased substance use, suicide, depression, self harm, homelessness, prostitution and abuse by family, friends and strangers.

These health risks may start in the 'pre coming out' phase, when homosexual feelings first arise and before an identity is established as lesbian. This represents a time when the appropriate supports can lead to the successful resolution of this stage of development and a positive lesbian identity. The appropriate level of support is difficult to achieve due to homophobia within society and the unwillingness of politicians and schools to tackle this problem. Any attempt to ease the burden placed on young lesbians and 'about to be lesbians' is seen as an attempt to promote homosexuality and is therefore forbidden (Hillier, 1996). This means that young women questioning their sexuality are denied assistance at the time they most need it.

It has been suggested (PrI:1) that there should be a funded counselling service, employing qualified psychological practitioners aimed at helping young women and men who are in the process of questioning their sexuality. This service would exist as a free standing enterprise and would not identify as primarily lesbian and gay as this may lead to a perception among young people that they will be encouraged only to be homosexual. The process would involve helping young people work through issues of sexual identity and support them in seeking a resolution, whether that resolution be homosexual, heterosexual or bisexual. No such service currently exists and it would do much to ease the pain of young people questioning their sexual identity and would support them in positive coping behaviours rather than detrimental ones.

3.4.2 Adult Milestones and Life Cycle Issues

The norm for women is to form a relationship with a man, marry or settle into a committed relationship, have children, have grandchildren, and celebrate wedding or similar anniversaries. Many women will leave their relationship and this may entail a divorce. As women age, younger members of the family leave home and adjustments are made. For a lesbian to enter a committed relationship, there are no traditional family gatherings and celebrations, no engagement parties, weddings or honeymoons. Her relationship may be denied by her parents and family of origin and, compared to her heterosexual siblings, she may be treated differently or even ignored.

When my sisters got married Mum did the whole wedding thing. When I told her we were moving in together she cried and said she hoped I could cope with all the difficulties. (PS:13)

It has been suggested by an experienced therapist (PrI:1) that this lack of recognition and personal validation is a continuing stress experienced by most lesbians.

Institutionalised homophobia and heterosexism are added stresses in the lives of lesbians as they interact with others in the workforce; in recreational and cultural pursuits; maintaining the basics of living (accommodation, income security, friendship and social networks) and mixing in the general community (Oikawa et al, 1994; Blumenfeld, 1992, Lavender, 1990). Unfortunately, being out and positive about oneself as a lesbian is no bar to experiencing prejudice, negative bias, ignorance, discrimination and anti-lesbian sexual harassment from others. Many lesbians, too, are aware of the legal bias which denies recognition of their committed relationships. Status and benefits enjoyed by married and de facto heterosexual couples are unobtainable (COAL, 1996a). The "closet"

alternative is no escape. So, either way, lesbians must deal with society's negativity about lesbianism. This stress is a lesbian-specific health issue (COAL, 1995a).

Sometimes the lesbian community is able to provide support groups, usually unfunded, which directly or indirectly address these stresses by assisting participants to learn life skills and to develop personal survival strategies. However, at best, even dealing with the stressors cannot guarantee lesbians stress-free lives as the root cause lies with wider societal attitudes.

3.4.3 Mid-life Issues

Cancer is the leading cause of death for Australian females aged 25-74 years. To put it another way over 23% of all female deaths are attributed to cancers of all sorts (ABS, 1992). Too few preventative health measures target lesbians. Currently the Victorian Anti-cancer Council is producing a booklet for lesbians about Pap smears, and there is a possibility this may later be available nationally.

Respondents to the HSLGW (1997) survey identified cancer as a specific concern, eg. provision of information about screening, clarification as to the necessity for lesbians not having penetrative sex to have Pap smears, and the various treatment options and procedures. Although cancer has been taken into the collective consciousness of various lesbian communities across this country, with groups being set up over the last few years for the support of lesbians with cancer and their partners, it is imperative that mainstream health services provide lesbian-specific health promotions.

For many years lesbians have been dealing with the premature deaths of their lesbian partners or other lesbians, their own mothers, sisters or women friends (Roberts, 1986). The gay male population has had less than two decades of experience of large numbers of premature deaths through disease. We have yet to see similar support from the gay male community for lesbians, dealing with and dying through cancers, that lesbians have given to men with HIV/AIDS. There is a case to be made for the two-way transferability of skills.

3.4.4 Menopause

For lesbians, as for other women, the predominant physical issue of mid-life is that change called menopause. Until the recent two decades, "the change" was seen as a negative experience, surrounded by silences or euphemistic references and notions of loss. It is highly unlikely the fact of a woman's lesbianism will alter her physiological changes, but it is realistically possible it can influence the quality and context of delivery of care (HSLGW, 1997:74; Copello, 1996; Sunlight, 1996).

In recent years, the health of ageing women has been one of the seven priority health issues identified in the National Women's Health (NWH) Policy and funded through the National Women's Health Program. This has enabled more services addressing menopause, continence and prevention of osteoporosis. Whilst these are areas of clinical concern, the social rather than medical model of health, as well as the attention of the women's health movement will give a broader context. Hence, it is reasonable to expect the needs of lesbians will be recognised, as well as those of Aboriginal and Islander women, rural women and other groups of women with special needs. However, as mentioned, lesbian women have not been identified as either a priority health issue or a target group in the NWH Policy or the NWH Program. Even so there is leeway for providers to acknowledge and respond to lesbians' needs.

Lesbian-specific needs are frequently narrated in anecdotal reports of experiences with medical practitioners and with support programs offering participatory groups.

At the community centre I went to a 'Changing Life' discussion group, the youngest woman was 42 and so we decided to focus on menopause. There was another lesbian who was very shy and closeted and myself among a dozen or so other women. Usually when it's relevant I'll mention I'm lesbian but there it didn't feel safe so I left the group. Where can I go to talk about my body changes and my directions without having to feel different or misunderstood because of my sexuality and emotional commitment? (PS:2)

My GP sent me to a gynaecologist . . . he asked me if my symptoms affected intercourse and if "he [meaning partner] minded [my] reduced libido". (PS:1)

(Note that research by Cole and Rothblum (1991) found sexual activity for menopausal lesbians to be as good as or better than ever!)

Lesbians have been a mostly silent and invisible minority both in specialist literature and in policy and service areas while general lesbian and feminist writings tend to ignore older women and lesbians (Davis, 1994a, Anike

and Ariel, 1987). Although there are some lesbian-specific books on social and personal perspectives of midlife (Lynch and Woods, 1996; Sang et al, 1991; Almvig, 1982), two prominent feminist writers have recently published books on midlife and age issues for women which all but ignore lesbians (Freidan, 1993; Greer, 1991).

3.4.5 Ageing and Old Lesbians

Relevant literature, policy and provisions identifying special needs of old lesbians is similar to that concerning midlife lesbians - sparse. Davis (1994b) points out current cohorts of older homosexuals have experienced a more homophobic environment than younger ones and that the "closeted" life entails fears and suppression. Despite this some have "thrived" and she refers to the 1978 Bell and Weinberg research which dispelled the myth of the discontented, lonely and lone homosexual. Lesbians who "came out" before the feminist and gay rights movements had little public support for addressing their marginalisation because concepts such as homophobia, heterosexism and rights for same-sex partnerships were non-existent. Despite the then contemporary images of homosexuality as sick, sinful, sorry or weird (Wills, 1994; Thompson, 1985; Ettore, 1980) they developed individual strategies for dealing with personal and societal hostility (Webster, 1990; Monte, 1987; Adelman, 1986; Gidlow, 1986).

Today these old lesbians, as actual or potential consumers of health services, are often ignored and have to deal with homophobia as well as ageism. Horsley and Tremellen (1996) tell of a national Women's Health Program funded project for older women which included lesbians as one of several target groups and which received extensive criticism from bureaucrats and others.

Copper (1988), Anike and Ariel (1987) and Macdonald (1984) are among those exploring the bias of ageism and its impact on old lesbians. Health care providers as well as the lesbian communities reflect mainstream institutionalised ageism (Cruikshank, 1992). General awareness of old people may have broadened through activities such as seniors' week, adopt a "granny" schemes, or pandemic advertising of pensioners' bus trips, but where are the images of old lesbians? Almvig (1982) suggests not only is information from studies necessary for service providers, but also to inform the lesbian communities because it is often difficult for those younger to find older role models.

An American study of lesbians aged 60-80 revealed that 72% reported good or excellent physical health and 82% good or excellent mental health (Kehoe, 1989). Another study in the same country of health-seeking behaviours of lesbians aged 51-82 revealed potential health problems such as infrequent breast self-examination, high use of alcohol, being overweight, and scepticism about traditional health care and preventative approaches (Deevy, 1990). An Australian qualitative study conducted by Day (1984) of 23 people (sexual orientation not recorded) noted a high degree of emotional and mental well-being and strong independence. What is missing is some lesbian-specific data.

Specific information on how lesbian identity - whether acknowledged or "closeted" - impacts on the clinical particulars of lesbians is of much more than mere academic interest. Extrapolating from reports on lesbians of all ages (eg. Horsley and Tremellan; 1996, Barnett, 1985) it could be safely postulated that the impact of attitudinal aspects of health carers and the culture of health organisations on the lesbian patient is a crucial. Sometimes it is not outright prejudice, rather the denial of a woman's intimate life, that affects the quality of care.

After I came home from hospital the doctor suggested getting someone in to help, yet he's treated us both for years and must know about us. [Meaning that no suggestion was made of her partner's existence and availability to assist her.] (PS:7)

A major social issue relating to the health of old women is accommodation, including nursing homes. Nurses who are lesbians working in nursing homes report the complete denial of lesbian patients and homophobic jokes about female residents who are close friends. One told of an eighty four year old woman crying on her birthday because her "friend" of forty years, with whom she'd shared a home for over thirty, was in another nursing home some distance across the city (PrI:14). Popular culture retold this situation in the movie *The Sum of Us* (Farrelly, 1995b).

Current policy changes concerning large payment for nursing home entry should be closely monitored for the possibility of disadvantaging lesbians of sparse or no means and/or those with no children. The shift in the organisation of aged services from public to private funded by superannuation is another development which could disadvantage lesbians (Waite, H., 1995). In recent years lesbians in at least three states have formed the Matrix Guild organisations with a view to providing aged accommodation. Their research has shown lesbians prioritise autonomy, privacy, the avoidance of discrimination and living with and being cared for by other women, preferably

women only (Farrelly, 1995b; Allbrook Cattalini, 1990). It is important that these organisations are accorded the public support and financial advantages which accrue to the established age care providers like the churches and long standing charities.

3.4.6 Dying and Death

Traditions and the social organisation of dying and death usually mean the person's family is involved to some extent. However, when the dying/dead person is a lesbian, their biological family and their lesbian family (construed variously) may contest for ownership of the event and/or person. Lesbians have been excluded from their partner's hospital ward, death bed and funeral by health personnel and/or by the biological family (PS:3). There is an obvious need for recognition and respect or at the least, restraint of hostilities, in such a critical and charged time. Health providers, too, need to be aware of their role. Rights and respect for lesbians should be underpinned by both educational and far-reaching policy provisions rather than mere arrangements. For example, arrangements made between an equal opportunity commissioner and chief executive officers of various hospitals caring for AIDS patients, allowing partners at the bedside, is no substitute for definitive policy.

Regarding treatment, anecdotes relate how terminally-ill lesbians have dealt with their illness and treatments within a heterosexist system (George, 1990; Lorde, 1980). It was affirming for lesbians to be recognised by Petrea King (of Cancer Support Society) in her address about women and cancer to the National Press Club (12 December 1996). Unfortunately, too often lesbians with life threatening illnesses, and their partners and friends, have to deal with homophobia in its many guises (Martindale, 1994).

Lesbians have sometimes organised their own circles to give home care and to tend their dying sister (George, 1990; PS:9). Others have extended this to taking total responsibility for the funeral up to the point of burial or cremation (PS:9; PS:14). Although, not exclusive to lesbian circles there is much to commend in self-organising funerals. For lesbians it could afford the privacy and particular respect which may not be forthcoming using conventional services. Some lesbians state their preference for women run undertakers (PS:25). Grief counselling for lesbians - whether their loss be of a partner or another lesbian or of a biological family member - is an area where professional's attitudes are crucial to client satisfaction.

4.0 HOMOPHOBIA, HETEROSEXISM & DISCRIMINATION

4.1 FORMS OF DISCRIMINATION

Discrimination may be direct and clearly recognisable eg. exclusion from a service because the woman is a lesbian. It may take the form of denial or invisibility of lesbians eg. if a service gives no recognition of the fact that a proportion of their clients are lesbians. Some doctors state they have never treated a lesbian or do not know how to recognise a lesbian or that lesbians do not live in their locality (Horsley and Tremellen 1996). These are examples of indirect discrimination, which despite a situation seeming fair or equal, say a women's health service, the effect is inequality because of the assumption that "woman" means heterosexual woman (Bell, 1990). Discrimination may be deliberate or unwitting. Sometimes it may be expressed through humour, eg. jokes about masculine looking women. All forms stem from homophobic and heterosexist attitudes (Pharr, 1988).

When a lesbian experiences discrimination, it may not be easy to locate the actual cause as perpetrators do not necessarily articulate reasons for their behaviours. Pharr (1988) considers heterosexism to be the basis of homophobia, while the NSW Anti-Discrimination Board has acknowledged that sexism and homophobia are intertwined and often difficult to differentiate (Lavender, 1990). A small proportion of HSLGW (1997) respondents considered the discrimination experienced resulted from anti-woman attitudes rather than homophobia or heterosexism. The point is, that for a woman who is also a lesbian, discrimination may come from more than one basis. For those lesbians from an ethnic or cultural minority or who have a disability, then mainstream prejudices and discrimination become triple burdens (Pallotta-Chiarolli, 1996; Cochran and Mays, 1988; Lorde, 1984).

Discrimination in health services was identified by the majority of HSLGW (1997) respondents and over half related negative personal experiences. These included rudeness, refusal of treatment, bad treatment, disregard for partners, assumption of heterosexuality and lack of lesbian-specific information and images.

The woman doctor at the women's health centre avoided touching me when I consulted her about warts on my heel. I gained the impression she thought I was suffering from a "sexuality". (HSLGW, 1997:168)

The majority of HSLGW (1997) respondents considered homophobia and heterosexism as underpinning discrimination in health services. Alternatively some lesbians stated they were not 'out' to health providers or only

'out' to selected ones and so felt they had not been discriminated against. However, it could be argued that such personal protective strategies are indicative of structural discrimination.

Discrimination may take the form of exclusion of lesbians from services for which health professionals will often articulate cogent reasons. An example would be the offering of clinical or scientific justification for the denial of Pap smears, as discussed earlier. Another response by lesbians suffering discrimination is self-exclusion.

Discrimination is so rotten that these days I'd have to be on death's door before I'd use a health service. (HSLGW, 1997:100)

Silences, and the presumed invisibility of lesbians are further examples of discrimination. Lesbian writers and activists have for many years claimed the power of naming themselves and of identifying discrimination. "Lesbian visibility" has become shorthand for strategies for change (Cruikshank, 1992; Lavender, 1990). Specifically within the health context, lesbians seeking medical, paramedical or alternative services frequently will be presumed to be heterosexual. Commonly consultations with a general practitioner will entail, if the woman is of child bearing age, questions about birth control and suggestions about child bearing.

4.2 MYTHS AND STEREOTYPES

Myths and stereotypes about lesbians contribute to homophobic and heterosexist attitudes (Eliason et al., 1992; Goodman, 1980). A pilot study by *Lesbian Network* (1988) for the preparation of that national organisation's submission to the discussion paper on the draft National Women's Health Policy, revealed similar attitudes to those noted in HSLGW (1997).

- * The practise of writing "Lesbian" on lesbians' medical records.
- * The exclusion of lesbian partners from hospital visiting on the grounds they are not next of kin.
- * Questions based on the presumption all women are heterosexual, eg. "Do you take the pill?"; "Do you have painful intercourse?"
- * Differential unfavourable responses to lesbians from health carers, eg. remarks about "strangeness", weird friends etc. such as would not be experienced by other women accompanied by their husbands/boyfriends and/or who appear conventional.
- * The presumption a lesbian's lifestyle is the source of her physical and/or mental disorder and/or substance abuse.
- * The presumption women are lesbians because they "couldn't make it with a man".
- * The presumption lesbians are unhappy.
- * The presumption lesbian relationships, lifestyles and sexual activities are the same or similar to gay men's.
- * The presumption lesbian relationships, lifestyles and sexual activities are the same or similar to heterosexual women's.
- * The equating of lesbians and man-hating.
- * The notion that if a lesbian asks to see woman practitioner it's because she can't cope with men.
- * The assumption lesbians are highly sexually active and/or "always on the make".
- * The assumption lesbians are frigid, sexually inactive and "frosty old maids".
- * The assumption that because some lesbians are users of health services, all lesbians must be sick, stressed, anxious etc.

4.3 ATTITUDES OF HEALTH PRACTITIONERS

The gynaecologist said: "This is a bit unusual - 39 years old, not married, no children" . . . when I complained to the Medical Board, he denied everything. (HSLGW, 1997:46)

Questions about sexual practices were clumsy and I suspect voyeuristic. (HSLGW, 1997:157)

"What sort of sex do you have" - from a new practitioner when I had the flu. (HSLGW, 1997:169)

Attitudes of health professionals were among the most prevalent concerns of respondents to the HSLGW (1997), particularly those of acceptance/rejection of lesbians and the need for the lack of assumption of heterosexuality. Lesbians' reports of encounters with professionals reveal homophobic and heterosexist attitudes are plentiful (McKenzie, 1993; Sneddon, 1993). Mental health practitioners have been found to exhibit a significant bias against homosexual patients, particularly those with serious psychopathologies (Lilling and Friedman, 1995; Perkins, 1995; Smith, 1993). Investigations into other practitioners and other settings have revealed prejudice, homophobia and heterosexism (Oliver, 1996; McColl, 1993; Parkes, 1993; Rose, 1993; Kelly, 1992). This prejudice may occur at all levels. It is important to avoid the presumption that higher levels of education and responsibility necessarily

lead to non-homophobic attitudes. Studies have shown that at undergraduate stage attitudes are unfavourable to homosexuals and this continues into professional practice (Crock and Kleeman, 1995; Holt, 1994; Eliason and Randall, 1991).

4.4 SOLUTIONS

What remedies do lesbians have? There are two options - individual personal solutions or social change. Personal solutions such as self-exclusion or being "closeted" or some other adjustment do nothing to change the overall situation. Obviously individual lesbians use such solutions because of isolation or traditional survival tactics. However, from a human rights perspective the situation is indicative of a group dispossessed of the right to equal participation and a dominant culture which condones or even encourages this inequity. Social justice should not be seen as the sole responsibility of the group affected by the lack of it, nor that for some reason members of the group have brought the situation on themselves. For instance lesbians have been told that if they appear less unconventional or they refrain from disclosing their lesbianism or avoid contentious matters (like being a lesbian!) they will be treated well (Penelope, 1996). Blaming the victim is not applicable, it is necessary to take a broader social view.

Wider social change approaches promoting equitable health services for lesbians is a social justice imperative for Australia. A model for Aboriginal and Islander health prominently articulated in the early 1980s was 'land rights is a health issue'. So too for lesbians homophobia and heterosexism are health issues. To take a stand against discrimination means dismantling the institutionalised, pervasive and prevalent homophobia and heterosexism in all forms and areas - not just in the delivery of health care.

5.0 ACCESS TO AND DELIVERY OF HEALTH SERVICES

I think most lesbian health issues are probably social issues, including access. (PrS:3)

Ideally unfettered access to health services should be promoted through both stated policy and actual practice that achieves universal availability and provision. However despite the language of democratic liberalism, the bare fact is our society's provisions fall short of equal recognition, access and provision for some groups. Lesbians are one such group. Heterosexist assumptions and homophobic attitudes, whether intentional or inadvertent, create structural barriers (Eliason, 1996; Horsley and Tremellen, 1996).

Alternatively, if recognition is made that equal treatment does not result in equal outcomes for all, then groups with special needs should be identified and accorded special treatment. In many aspects lesbians have not been accorded even baseline access - recognition of marginalisation and special needs. Lesbians are not a homogeneous population, they intersect with other population groups such as Aboriginal and Islander women, women with a disability, old women, isolated and rural women, women from a non-English speaking background and young women. When attention is given to access to services for women who are, for example, Aboriginal or who have a disability and are lesbians, consideration should be made of all their needs (Stewart, 1990; Wilde, 1990). Access is an issue of social power and exclusion or reduced access is a complex rather than a simple unidirectional relationship (Winter, 1995). Some of the aspects influencing this power relationship are discussed separately below.

When women from various target groups are considered it should not be presumed they are all heterosexual. This presumption influences lesbian access to reproductive health and sexuality services. These services invariably focus on heterosexual women's needs as sexuality is taken to be within the context of women's sexual activities and relationships to males. Occasionally lesbians are included as a group, but only in reference to sexually transmissible diseases and/or HIV infection (Australian Health Ministers Advisory Council, 1993 - Goal 1.8.3 reproductive health). This limits understanding of lesbians and their health concerns to being merely a minority sexuality and in fact the term "sexual minorities" has entered social service jargon, eg. Crossroads Tolerance Report (1996).

The heterosexual assumptions of relationships, marriage, family with my health and life being viewed and treated according to these assumptions. (HSLGW, 1997:25)

Program descriptions, including the National Women's Health Policy and Program, do not refer to the needs of lesbians (James, 1996; PS:9). Indeed the astute researcher learns to assess such documents by their omissions rather than just their stated content! Although the health effects of sex role stereotyping on women and gender differences have been identified in policy, planning and epidemiological material (Tilley, 1996; Australian Health Minister's

Advisory Council [AHMAC], 1993) there is no mention of lesbians or the heterosexist framework of the stereotyping.

The problems of [sex role] stereotyping are two-fold. In the first instance, stereotyping is reductionist and does not allow for full range of individual, cultural, ethnic and age differences. In the second and most harmful instance, sex role stereotyping promotes negative, limiting and degrading images of women and undermines women's self-confidence. (AHMAC, 1993:49)

Similarly, references to “culturally appropriate” programs according respect and meaningful services usually relate to race and ethnicity and omit any reference to lesbian consumers (Pallotta-Chiarolli, 1996). Yet lesbians could well claim grounds for inclusion and a case can be made for the broadening of this concept and strategy.

It is important to note lesbians will not always have satisfactory experiences at women's health centres, at HIV/AIDS services, with women practitioners, or with lesbian or gay male health workers (HSLGW, 1997; Oliver, 1996). It cannot be presumed where these services are available that they are lesbian-affirming or have reliable knowledge of the range of lesbian health needs (HSLGW, 1997). Sometimes lesbian practitioners are reluctant to be seen as lesbian specialists and some are “closeted”; if the culture of the service is such that lesbian staff feel threatened, so must it be for lesbian clients/patients. Within AIDS/HIV services lesbians are frequently seen as the female equivalent of gay males or merely considered for their sexuality concerns.

There may be a tendency for providers to confuse the client's identity with her clinical needs. The HSLGW (1997) revealed lesbians being treated as if lesbianism was the presenting problem (PS:168). This has also been reported in the literature (Stacey, 1993). As well as lesbians being denied access to services explicitly on account of their lesbianism (Oliver, 1996), frequently they encounter covert or subtle but definite barriers due to homophobia and heterosexism. These are obvious restrictions of access to quality service and are discussed below.

5.1 DISCLOSURE AND CONFIDENTIALITY

Lesbians who disclose are unsure of their reception. (PrS:20)

Many lesbians are wary of disclosing their lesbianism as this has been recorded in clinical notes and led to negative and inappropriate responses from professionals (PS:28). This information is then available to other professionals, having access to the records at a later time, who may have less favourable attitudes about homosexuality, and with whom the lesbian may have a different, or less positive relationship. Another negative aspect is the concentration by staff on the fact of a woman's lesbianism to the detriment of the quality of care received (Oliver, 1996).

5.2 FEAR OF DISCLOSURE AND AVOIDANCE OF SERVICES

My biggest problem is my own fear of being rejected/discriminated against if I am "out" to health care workers. (HSLGW, 1997:48)

Some research is emerging which suggests lesbians tend to avoid mainstream health care services such as doctors and hospitals (Ramsay, 1996). It is suggested this avoidance occurs because of the fear of disclosing their sexuality to health providers. This is often based on the fear of stigmatisation and experiences of rough treatment, voyeuristic questioning, discrimination and inappropriate diagnoses (Harrison, 1996; Horsley and Tremellen, 1996). Lesbians may have high safety needs within health care institutions and may employ a number of protective strategies to combat their feelings of vulnerability in these settings (HSLGW, 1997; Stevens, 1994).

Fear of disclosing lesbian sexuality, the assumptions of health care providers that everyone is heterosexual, and the fear of homophobia and discrimination, limit lesbian access to the health care system (COAL, 1995a). A suggestion made by several respondents in the HSLGW (1997) was that there should be either a list of lesbian knowledgeable and affirming health providers or some visible sign within health care settings to let lesbians know they are in a safe space. Other suggestions included lesbian posters and pamphlets in surgeries and official forms whose questions were inclusive of heterosexuals and homosexuals.

5.3 LACK OF ACCEPTANCE OF PARTNER AND NEXT OF KIN ISSUES

Legal definitions of next of kin do not include same sex partners (COAL, 1996a, 1995a; Lesbian and Gay Rights Legal Service, 1994). Respondents in the HSLGW (1997) made frequent mention of this and felt their partners should be included on forms as their next of kin and in discussions and decisions around their health care. Personal solutions available to lesbians include referring to their partners/lovers as their sisters and in some states creating an enduring power of attorney, however this may not cover all eventualities (Grapevine, 1996).

One of the most cruel aspects of homophobic denial is the exclusion from the bedside of partners of seriously ill and dying lesbians. As mentioned, informal arrangements between executive personnel of different organisations are no substitute for legislative provision coupled with appropriate policy and service directives.

5.4 FILTERING AND GATEKEEPING

Filtering or gatekeeping has been reported by lesbians wanting referrals to lesbian practitioners (PS:10; PrI:8). As receptionists and non-treating assistants are usually the first people encountered in the health care setting, lesbians often experience gatekeeping before even seeing the health practitioner. Responses to women perceived as lesbian, or unconventional, or too assertive include coldness, disapproval and distancing. Filtering or gatekeeping may be either by lesbian or non-lesbian health care workers and could be attributed to their internalised homophobia and presumption of a lesbian practitioner's need for privacy. This occurred during one of the professional interviews for this paper (PrI:6). The informant talked of a lesbian health practitioner within a publicly funded service who had prioritised lesbians for her client outreach. Although this was accepted and known, the response to an enquiry, by one of the authors, for contact was met with a refusal on the grounds it may infringe the particular health practitioner's privacy!

5.5 USE OF COUNSELLING

Bradford, Ryan and Rothblum (1994) in their national survey of American lesbians revealed 73% of their sample had received counselling at some point. Of these, 50% had sought counselling because they felt sad or depressed. Other reasons given were anxiety, loneliness, relationship problems, being lesbian, alcohol and drugs, work problems, racism and loss of significant other. This represents a very high use of counselling services amongst those lesbians who participated in this survey. It is unclear how these figures translate to the Australian situation, however a review of the HSLGW (1997) revealed the need for counselling and access to free counselling services was a common theme amongst respondents. It is also important that counsellors' attitudes and understanding of lesbians are realistic and bias free (Ray, 1995; Hewson, 1993). Seeking counselling is obviously an important health promoting behaviour which lesbians wish to utilise or do utilise. This is an important health issue in the Australian context as access to cheap, longer term, in-depth, quality counselling is limited.

Last year I was unable to access a mental health counsellor because I could not afford to pay private fees, and because I did not have an active drug addiction or was (not) suicidal I did not qualify for community services. (HSLGW, 1997:121)

In view of the possible mental health problems which may be experienced by lesbians and which arise from the effects of living as a marginalised group in a homophobic world, this lack of access to counselling represents a health issue which should be addressed.

5.6 REBATES FOR ALTERNATIVE HEALTH SERVICES

Anecdotal evidence in conjunction with information from the HSLGW (1997) suggests many lesbians seek health care from alternative (or complementary) health providers. It is unclear what the reasons for this may be, although comments included dissatisfaction with biomedical views of health, the lack of control experienced by lesbians within mainstream health settings, the lack of information received from doctors, and general homophobia and discrimination within the mainstream systems. For many lesbians alternative practitioners provide a valuable source of support in maintaining a healthy lifestyle and the view has been expressed that these services should be available under Medicare or private health insurance. Again, this is an access issue as lesbians on low incomes may not be able to afford these services.

5.7 HEALTH INSURANCE COSTS

In 1995 Bill Brown and Andrew Whitbread-Brown, a gay couple with a son, were found, by the NSW Equal Opportunity Tribunal, to have been discriminated against by the NIB after being refused family membership and therefore their entitlement to the lower family rate for health insurance costs (*Lesbians on the Loose*, 1995a). This case occurred around the same time as a lesbian couple with a young son were also preparing a legal challenge after being refused family cover by another insurance fund, Medibank Private (Farrelly, 1995c). At this point only some health insurance companies such as MBF and Manchester Unity were offering family cover for gay and lesbian families (Farrelly, 1995c; *Lesbiana*, 1993b). Since the Brown and Whitbread-Brown finding, which was later challenged by the NIB but subsequently upheld by the Supreme Court of NSW (Widdicombe, 1996), it would seem that health insurance companies have changed their viewpoints and their regulations. A recent (1997) phone call, by one of the writers, to five major health insurance companies (HBF, HCF, MBF, Medibank Private and NIB) received an affirmative when asked whether a lesbian couple could join under the family rate.

5.8 ISSUES FACING RURAL AND ISOLATED LESBIANS

Anxious (about) disclosing my sexual identity to health care workers, particularly to the male GPs in my rural area, there are no female GPs. (HSLGW, 1997:48)

At least some culturally appropriate services for lesbians may be available in capital cities, where there are a number of lesbian and lesbian affirming practitioners of medicine and alternative therapies advertising in community media and otherwise known to lesbians. This is rare in rural areas. Respondents to HSLGW (1997) report a lack of access to lesbian affirming health providers in rural areas and often do not feel safe to 'come out' in this environment. In Dempsey's study of inequality between women and men in rural Australia (1992) the strength of male domination and the emphasis on women's role in the family were viewed as inevitable because "men play a key role in transmitting an ideology which helps to subordinate women . . ." (p1). While he did not mention the effect of this on lesbians it could be postulated women perceived as lesbians would be subjected to greater stress compounded by the absence of lesbian affirming services. This is supported by anecdotal evidence (HSLGW, 1997:167, 168; PS:1). Adolescent lesbians are also isolated in rural areas within an environment of hostility and homophobia (Hillier, 1996). There is an urgent need for secure funding for phone information and support services for rural and isolated lesbians and women questioning heterosexuality.

5.9 ACCESS ISSUES FOR LESBIANS WITH A DISABILITY

No interpreter for a deaf lesbian to communicate with the doctor or nurse. (HSLGW, 1997:132)

There is little research available on issues affecting lesbians who have a disability. O'Toole and Bregante (1993) suggest that lesbians with a disability are extremely isolated as they belong to so many communities but are seldomly given acceptance in any. Like women from non-English speaking backgrounds, they face a triple stigma by virtue of their womanhood, their sexual orientation and their disability (Wilde, 1990). For lesbians, who traditionally value their autonomy and independence, to acquire a disability or chronic illness raises issues of dependency, self-esteem and isolation (Waite, R., 1996). Other issues lesbians with a disability face include gaining lesbian-specific information about sexual activity, dealing with negative reactions from others, venue access and the need to be independent (Cullen, 1993). Although Matrix Guild Victoria is currently conducting a needs assessment of older lesbians, particularly those with a disability or chronic illness (*Lesbiana*, 1997; Taylor, 1997), much more research is needed to clarify health issues for this group of lesbians.

5.10 ACCESS ISSUES FOR INDIGENOUS LESBIANS AND LESBIANS FROM A NON-ENGLISH SPEAKING BACKGROUND

Despite changing attitudes favouring multiculturalism, racism and discrimination are still part of the social milieu of Australia. Lesbians who are indigenous or from a non-English speaking background experience racial prejudice and differential treatment (Cohen, 1990; Johnson, 1990).

They look at me as being a Koori before anything else, they ask if you are Aboriginal or Torres Strait Islander. So I wonder if I'll get special treatment or not. If you're black and really sick the first thing they ask is if you've been drinking. They don't seem to want to know if you're a lesbian. (PS:29)

Health policies recognise the notion of culturally appropriate delivery of services, (Australian Health Ministers' Advisory Council, 1993; Commonwealth Department of Community Services and Health, 1989) if and how this actually translates into service delivery may be another matter. Cultural sensitivity should take difference of sexual orientation as a factor in conjunction with ethnicity, religion, colour and related attributes (Pallotta-Chiarolli, 1996). Not only should service providers ensure information and programs on women's health be lesbian inclusive, but consultations should be undertaken to allow indigenous lesbians and lesbians from non-English speaking background to speak for themselves.

5.11 VALUES OF ORGANISATIONS PROVIDING SERVICES

Values and attitudes of religious or other private health providers may be heterosexist and homophobic and be perceived by lesbians as antagonistic or at the least unsupportive. Lack of recognition of lesbians as actual or potential or excluded health consumers may be deliberate or it may be unconscious. As well, the possibility of non-government services not having anti-discrimination policies and/or escaping the net of legislative protection (eg. equal opportunity provisions) is of concern (Crossroads Community Care Centre, 1996). With current political and policy driven moves towards privatisation of services (Waite, H., 1995; Cox and Leonard, 1991) lesbian access may be further hindered.

5.12 RESEARCH

The paucity of either lesbian-specific research, or lesbian-inclusive research presents a definite access barrier, as does the need to incorporate existing research information into mainstream health knowledge and resources (Dennenberg, 1995). All types of research are necessary although the problem of generalising data to a largely hidden population

should be acknowledged. Consideration also should be given to encouraging methodologies which attempt to understand the perspective of lesbians. O'Leary (1995) notes too much research has been done *on* women, not *for* women. Researchers should be mindful of including lesbians in their general surveys and collating and analysing data so to not hide lesbian-specific information under nebulous topics such as "sexuality" or "other".

Lesbians are often ignored as a subgroup within larger population studies, as occurred in the heterosexist framework of the National Longitudinal Women's Health Study presently being conducted through Newcastle University. It would have been a simple matter to include a question asking for sexual orientation, however this was not done, thus losing a valuable opportunity to collect comparative data on health status between heterosexual and lesbian women (PrI:8; PrI:12; Horsley and Tremellen, 1996). If funding is provided for a parallel study of lesbians then Australian empirical data will become available. In the meantime, for some direction it is necessary to extrapolate from other less specific data and generalise from narrative descriptions. Academics should encourage students at every level to choose lesbian topics whenever possible. The lack of research on lesbian health issues contributes to lesbian invisibility and serves to justify the omission of lesbians as a valid target group within Australian health promotion policies and strategies.

5.13 LESBIAN HEALTH CARE WORKERS

The HSLGW (1997) and practitioner survey revealed that due to the stress of homophobia and personal need for privacy, numbers of lesbian health practitioners do not feel safe or comfortable to disclose their lesbianism within their employment. One stated that longstanding heterosexual women clients had ceased to attend after her disclosure. Additionally, due to prevailing attitudes, should she be open she would fear for her consultancy (PrS:3). Lesbian health care initiatives may be seen as not legitimate concerns for heterosexual practitioners (Horsley and Tremellen, 1996). Likewise, it is often assumed that lesbian practitioners will be repositories of specialist lesbian health knowledge (although some may be). Expectations from the practitioner's institution and peers, from lesbian clients and from the lesbian community amount to considerable stress (PrS:22). These and other pressures on lesbian practitioners, including disapproval, distancing, criticism of unrelated trivial matters and isolation, within a prevailing heterosexist framework (PrI:15) must be seen as an occupational health issue.

6.0 CONCLUSION

From a social justice perspective it can be seen that lesbians constitute a disadvantaged group within society, and are in need of targeted health strategies and promotions. This need arises from the stresses of homophobia, heterosexism and discrimination which can (and often do) have a detrimental impact on lesbian health status. Wider social change is advocated as is change within the health system to make health services more affirming and accessible to lesbians. This should be seen as the responsibility of all health providers.

7.0 RECOMMENDATIONS

7.1 LEGISLATION

7.1.1 Federal, state and territory governments should **enact legislation**, where absent or incomplete, to **fully protect against discrimination on the basis of sexual orientation** within human rights, anti-discrimination, equal opportunity and relevant provisions. These should cover both public and private sectors, should include removal of extant homophobic exemptions and provide for relevant community education programs.

7.1.2 Federal, state and territory governments should legislate to **outlaw discrimination against lesbians obtaining access to fertility programs**.

7.1.3 Federal, state and territory governments should provide legislation, where absent or incomplete, to **fully recognise the rights and responsibilities of lesbian partners, intimate associates and next of kin, on the same standing as heterosexual couples, for those lesbians who wish to come under such provisions**.

7.2 HEALTH AND SOCIAL POLICY AND PROVISIONS

7.2.1 Federal, state and territory governments should **develop policies on lesbian health** in consultation with lesbian groups. (See also 7.2.4 and 7.2.5 below)

- 7.2.2 Federal, state and territory governments should **include lesbians as a group within health strategic plans, policy statements and program directions** and fund and maintain **lesbian specific services within existing programs.**
- 7.2.3 Health service providers in both public and private sectors should develop and deliver **equity programs for all staff aimed at eliminating homophobic and heterosexist practices.**
- 7.2.4 **Funding should be provided for a consultative body** to be established to overview and advise governments and health systems in general about **lesbian health needs and provisions**; this body to be managed by the Australian Centre for Lesbian and Gay Research or a similar established organisation with some expertise/focus on lesbian issues.
- 7.2.5 Federal, state and territory governments should **provide funding** for COAL and other relevant organisations focusing on social justice and human rights to develop **programs, research and consultations relevant to the social context of the health of lesbians.** (See Section 7.4 below)
- 7.2.6 Federal government should provide a system of **rebates for counselling and alternative health services** under the Medicare scheme.
- 7.2.7 Health insurance companies should provide **wider health cover for counselling and alternative health services.**
- 7.2.8 Federal, state and territory governments should **allocate funds for research** into lesbian health issues and ensure that lesbians are included as an identified group in general health studies.
- 7.2.9 Federal, state and territory governments should provide funding for **health education/ promotion** programs targeting identified lesbian health issues and utilising positive and diverse lesbian images and information. Issues to be targeted should include: equity in health care to ensure non-homophobic and non-heterosexist delivery, ageing lesbians, lesbians in midlife, lesbians and cervical cancer, lesbians and breast cancer, lesbians and safe sex, lesbians and smoking, lesbians and drug/alcohol use, lesbians and “coming out”, lesbian relationships, and the social context of lesbian health.
- 7.2.10 Federal, state and territory governments should provide a **lesbian/gay health advocate** in major hospitals with access for lesbians and gay men in regional and rural areas.
- 7.2.11 Federal, state and territory governments should establish a **free standing sexuality support service** which is non-judgmental and non-discriminatory, and staffed by professionals, specifically to assist lesbians in the process of “coming out”.
- 7.2.12 Federal, state and territory governments should establish a **lesbian health line - a telephone information service**, similar to that provided by Women's Health Statewide in South Australia, to be staffed by health professionals who are non-judgmental and non-discriminatory and who understand and respect lesbian relationships, lifestyles and health needs.
- 7.2.13 Health services/providers should **develop admission and data collection forms which are inclusive of lesbian lifestyles and relationships.**
- 7.2.14 Health and social service providers should **include non-discrimination on the basis of sexual orientation in Quality Assurance (QA) programs, practice standards and the like.**
- 7.2.15 **Funding should be provided for a conference about lesbians and health** and other services, and which would be community driven. (See 7.4.5 below)
- 7.3 EDUCATION AND INFORMATION**
- 7.3.1 Educational institutions with responsibility for health professional education (basic or entry level) **should include issues of homophobia, heterosexism and discrimination, as well as values clarification around these issues in their courses.**

- 7.3.2 Health professionals' organisations, institutions with responsibility for supervising training allowance schemes and continuing education of health professionals should include issues of **homophobia, heterosexism and discrimination, as well as values clarification around these issues in their courses.**
- 7.3.3 Health professionals' organisations should educate members about both the **social and clinical aspects of lesbian health** issues.
- 7.3.4 School education and TAFE colleges should include **issues of homophobia, heterosexism and discrimination, as well as values clarification around these issues** in their human relations, personal development, social studies, welfare and related courses.
- 7.3.5 Schools, universities and other providers should ensure that **homophobic and heterosexist material is withdrawn from all courses** and students are encouraged to approach the topic of homosexuality without bias.
- 7.4 LESBIAN COMMUNITY**
- 7.4.1 COAL should initiate and supervise the development of a **program to inform lesbians of their basic human rights**, remedies for any breach, and related aspects pertaining to use of services.
- 7.4.2 COAL should initiate and supervise the development of a **national register of lesbian affirming and knowledgeable health services** and providers.
- 7.4.3 COAL should initiate and supervise the development of a **symbol**, (eg. a rainbow sticker), to be displayed by **health professionals who are non-homophobic, non-heterosexist** and who have a knowledge of lesbian health issues.
- 7.4.4 COAL or another lesbian organisation should initiate, develop and promote a **support and information network for lesbian health practitioners and lesbians interested in health matters.**
- 7.4.5 COAL or another lesbian organisation should initiate, develop and supervise a **conference for lesbians, providers, and researchers, on lesbians, health and other services.**

REFERENCES

- ACON Women's Team. 1994. *Lesbian Sex*. Sydney: AIDS Council of NSW.
- Adelman, M. (Ed) 1986. *Long Time Passing: Lives of Older Lesbians*. Boston: Alyson.
- Allbrook Cattalini Research Ltd. Ltd. 1990. *Report on the Proposed Women's Home for the Aged and Differently Aabled*. Perth: Women's Community Centre Collective.
- Alley, J. and Allwood, K. 1993. *The LIP Report - Lesbians and HIV/AIDS*. Sydney: The Lesbian Information Project.
- Almwig, C. 1982. *The Invisible Minority: Ageing and Lesbianism*. Philadelphia: Tower.
- Anderson, DA. 1994. Lesbian and gay adolescents: Social and developmental considerations. *High School Journal* 77(1-2): Special issue 13-19.
- Anike, L. and Ariel, L. 1987. *Older Women - Ready or Not*. Bexley NSW: Anike and Ariel.
- Australian Bureau of Statistics 1994. *Women's Health*. Canberra: Australian Government Publishing Service.
- Australian Bureau of Statistics 1992. *Social Indicators Number 5: A National Social Report for Australia*. Canberra: Australian Government Publishing Service.
- Australian Health Ministers' Advisory Council, Subcommittee on Women and Health 1993. *Health Goals and Targets for Australian Women*. Canberra: Australian Government Publishing Service.
- Barbeler, V. 1992. *The Young Lesbian Report: A Study of the Attitudes and Behaviours of Adolescent Lesbians Today*. Sydney: Young Lesbian Support Group.
- Barnett, R. 1985. Examining lesbian health *HealthSharing* Spring: 7-10.
- Bates, E. and Linder-Pelz, S. 1990. *Health Care Issues* (2nd ed). Sydney: Allen and Unwin.
- Bell, N. 1990. The Anti-Discrimination Act - what it means for lesbians. pp23-25 in *What is Lesbian Discrimination?: Proceedings of Forum 1987* edited by Lavender, Sydney: Anti-Discrimination Board.
- Bell, AP. and Weinberg, MS. 1978. *Homosexualities: A Study of Diversity Among Men and Women*. New York: Simon and Schuster.
- Bennett, G. 1983. *Young and Gay: A Study of Gay Youth in Sydney*. Sydney: NSW Drug and Alcohol Authority.
- Berger, KS. 1994. *The Developing Person Through the Life Span* (3rd ed). New York: Worth Publishers.
- Blumenfeld, W. (Ed) 1992. *Homophobia: How We All Pay the Price*. Boston: Beacon.
- Boston Women's Health Collective 1973. *Our Bodies, Ourselves*. (1st ed). New York: Simon & Schuster.
- Bradford, J., Ryan, C. and Rothblum, ED. 1994. National lesbian health care survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology* 62(2):228-242.
- Broom, DH. 1991. *Damned if we do: Contradictions in women's health care*. Sydney: Allen and Unwin.
- Byrnes, P. and Byrnes, R. 1987. 'La Vie en rose' 1956. In Bradstock, M. and Wakeling, L. (Eds) *Words From the Same Heart* Sydney: Hale and Iremonger: 23-32.
- Cabaj, RP. 1996. Substance abuse in gay men, lesbians, and bisexuals. pp 783-799 in Cabaj, RP. and Stein, TS. (Eds) *Textbook of Homosexuality and Mental Health*. Washington: American Psychiatric Press.
- Charbonneay, C. and Lander, PS. 1991. Redefining sexuality: Women becoming lesbians in midlife. pp 34-43 in Sang, B., Warshow, J. and Smith, AJ. (Eds) *Lesbians at Midlife: The Creative Transition*. San Francisco: Spinsters.
- Coalition of Activist Lesbians Australia (COAL), 1996a. Submission to Australian Senate Sexuality Discrimination Inquiry. Sydney: COAL.
- Coalition of Activist Lesbians Australia (COAL), 1996b. Lesbians' self-identification of issues for government attention. Unpublished, Sydney: COAL.
- Coalition of Activist Lesbians Australia (COAL), 1995a. Position papers for Fourth World Conference on Women, Beijing China, 30 August-8 September. Sydney: COAL.
- Coalition of Activist Lesbians Australia (COAL), 1995b. Beijing Report. Sydney: COAL.
- Cochran, SD. and Mays, VM. 1988. Disclosure of sexual preference to physicians by black lesbians and bisexual women. *Western Journal of Medicine* 149:616-9.
- Cohen, D. 1990. pp 19-22. in *What is Lesbian Discrimination?: Proceedings of Forum 1987* edited by Lavender, Sydney: Anti-Discrimination Board.
- Cohen, KM. and Savin-Williams, RC. 1996. Developmental perspectives on coming out to self and others. In Savin-Williams, RC. and Cohen, KM. *The Lives of Lesbians Gays and Bisexuals: Children to Adults*. Fort Worth: Harcourt Brace College Publishers: 113-151.
- Cole, E and Rothblum, ED. 1991. Lesbian sex at menopause: as good or better than ever pp 184-193 in Sang, B., Warshow, J. and Smith, AJ. (Eds) *Lesbians at Midlife: The Creative Transition*. San Francisco: Spinsters.
- Coleman, E. 1985. Developmental stages of the coming out process. In Gonsiorek, JC. (Ed) *A Guide to Psychotherapy with Gay and Lesbian Clients*. New York: Harrington Park Press: pp31-43.
- Collado, CB. 1992. Primary health care: A continuing challenge. *Nursing and Health Care* 13(8): 408-413.

- Copello, B. 1996. Life with Irene, the menopause and the pink tablets. pp109-116 in Lynch, L, and Woods, A. (Eds) *Off The Rag: Lesbians Writing on the Menopause* Norwich VT: New Victoria.
- Copper, B. 1988. *Over The Hill: Reflections on Ageism Between Women*. Freedom CA: Crossing Press.
- Counsellor's Corner. 1996. Dear CC. *Lesbiana* 44:10.
- Cox, E. and Leonard, H. 1991. Superfudge: Sweetening the pill of privatising old age. Paper presented at Superwoman conference. Sydney: 16th August.
- Crock, E. and Kleeman, M. 1995. Changing attitudes. *Contemporary Nurse* 4(4):178-9.
- Crossroads Community Care Centre 1996. *Needs Assessment: Community Services and Sexual Minorities in the Sutherland Shire*. Miranda: Crossroads Community Care Centre.
- Cruikshank, M. 1992. *The Gay and Lesbian Liberation Movement* New York: Routledge.
- Cullen, I. 1993. Don't fence me in. *Lesbians on the Loose* 4(9):20.
- Darty, T. and Potter, S. (Eds) 1984. *Women-Identified Women* Palo Alto: Mayfield.
- Davis, J. 1994a. The construction of family and social networks by old Lesbians. *Journal of Australian Lesbian Feminist Studies* 4:85-92.
- Davis, J. 1994b. *Older Australians: A Positive View of Ageing*. Sydney: Saunders.
- Day, A. (1984). *We can manage: Expectations about care and varieties of family support among people 75 years and over* Melbourne: Institute of Family Studies Monograph No 5.
- Deevy, S. 1990. Older lesbian women: An invisible minority *Journal of Gerontological Nursing* 16(5):35-39.
- Dempsey, K. 1992. *A Man's Town: Inequality Between Women and Men in Rural Australia*. Melbourne: Oxford University Press.
- Denenberg, R. 1995. Report on Lesbian Health. *Women's Health International* 5(2):1-11.
- Dennis, R. 1997. Fertility win under threat. *Brother Sister (Queensland)* 90:3.
- Dunn, S. 1995. Lesbian couples should not adopt: CWA branch, CWA (Country Women's Association) Riverina Group Conference. *Daily Advertiser*, Wagga NSW. 12 October.
- Downey, JI. and Friedman, RC. 1995. Internalised homophobia in lesbian relationships. *Journal of the American Academy of Psychoanalysis* 23(3):435-447.
- Dykewise 1995. Children of lesbian couples. *Dykewise* September/October: 11.
- Ehrenreich, B. and English, D. 1979. *For Her Own Good: 150 Years of the Experts' Advice to Women*. London: Pluto.
- Einhorn, L. and Polgar, M. 1994. HIV-risk behaviour among lesbians and bisexual women. *AIDS Education and Prevention*, 6(6):514-523.
- Eliason, MJ. 1996 Who cares? Institutional barriers to health care for lesbians, gay and bisexual persons *National League for Nursing* 14-6762:273.
- Eliason, M., Donelan, C. and Randall, C. 1992. Lesbian stereotypes. *Health Care for Women International* 13(2):131-144.
- Eliason, MJ. and Randall, CE. 1991. Lesbian phobia in nursing students. *Western Journal of Nursing Research* 13(3):363-74.
- Erwin, K. 1993. Interpreting the evidence: Competing paradigms and the emergence of lesbian and gay suicide as a 'social fact'. *International Journal of Health Services* 23(3):437-453.
- Ettorre, EM, 1980. *Lesbians, Women and Society*. London: Routledge & Kegan Paul.
- Farrelly, B. 1996. The fag end of the market. *Lesbians on the Loose* 7(3):10-11.
- Farrelly, B. 1995a. Government told to act on lesbian mum smear. *Lesbians on the Loose* 6(12):3.
- Farrelly, B. 1995b. A lavender twilight. *Lesbians on the Loose* 6(8):9.
- Farrelly, B. 1995c. Medibank dishonours cover note: Maltons, not the Waltons. *Lesbians on the Loose* 6(7):3.
- Farrelly, B. 1995d. Lesbians don't count in HIV data. *Lesbians on the Loose* 6(3):4.
- Friedan, B. 1993. *The Fountain of Age* London: Vintage.
- Gayatri, BID. 1996. Indonesian lesbians writing their own script: Issues of feminism and sexuality. pp86-97 in Reinfelder, M. (Ed) *Amazon to Zami: Towards a Global Lesbian Feminism*. London: Cassel.
- George, E. *If Anyone's Friend be Dead*. Melbourne: Dykebooks.
- Gidlow, E. 1986. *Elsa: I Come with My Songs, The Autobiography of Elsa Gidlow*. San Francisco: Bootlegger.
- Giles, P. 1997. Personal Communication.
- Glaus, KO. 1988. Alcoholism, chemical dependency and the lesbian client. Special issue: Lesbianism: Affirming non-traditional roles. *Women and Therapy* 8(1-2):131-144.
- Glittenberg, J. 1988. World Health Organisation: 1948-1988. *Journal of Professional Nursing* 4(4): 235,308.
- Goodman, B. 1980. *Where Will You Be? The Professional Oppression of Gay People: A Lesbian/Feminist Perspective*. W. Hempstead, NY: Womomade.
- Goodman, G., Lakey, G., Lashof, J. and Thorne, E. 1983. *No Turning Back: Lesbian and Gay Liberation for the '80s*. Philadelphia: New Society.
- Grapevine 1996. Protecting our rights. *Grapevine* 188:12-13
- Grapevine 1994. Lesbian transmission of HIV reported. *Grapevine* 163:11.

- Greer, G. 1991. *The Change: Women, Ageing and the Menopause* London: Hamilton.
- Hammond, P. 1997. Lesbian mother wins \$7,500 landmark decision. *The Courier Mail* Feb 1: 1.
- Harrison, AE. 1996. Primary care of lesbian and gay patients: Educating ourselves and our students. *Family Medicine* 28(1):10-23.
- Hawthorne, S. 1992. A history of the contemporary women's movement. *Journal of Australian Lesbian Feminist Studies* 3:71-79.
- Hershberger, SL. and D'Augelli, AR. 1995. The impact of victimisation on the mental health and suicidality of lesbian, gay, and bisexual youths. Special issue: Sexual orientation and human development. *Developmental Psychology* 31(1):65-74.
- Hewson, D. 1993. Heterosexual dominance in the world of therapy? *Dulwich Centre Newsletter* 2:14-20.
- Hillier, L. 1996. *Lesbian, gay, bisexual, unsure: The rural eleven percent*. Melbourne: National Centre in HIV Social Research: Centre for the Study of Sexually Transmissible Diseases.
- Holmes, S. (Ed) 1988. *Testimonies: A Collection of Lesbian Coming Out Stories*. Boston: Alyson.
- Horsley, P. and Tremellen, S. 1996. Legitimising lesbian health - challenging the lack of demonstrated need argument. In *Changing Society for Women's Health: Proceedings of the Third National Women's Health Conference*. Canberra: Australian Government Publishing Service.
- Holt, VJ. 1994. Doctors and homosexuality . . . and should be taught as medical students. *British Medical Journal* 308(6932):854.
- Hughes, LT. and Wilsnack, SC. 1994. Research on lesbians and alcohol: Gaps and implications. Special focus: Women and alcohol. *Alcohol Health and Research World* 18(3):202-205.
- Irwin, J., Winter, B., Gregoric, M. and Watts, S. 1995. *As Long as I've Got My Doona: A Report on Lesbian and Gay Youth Homelessness* Sydney: Twenty Ten Association.
- James, C. 1996. Models of practice - Queensland women's health pp 51-54 in *Changing Society for Women's Health: Proceedings of the Third National Women's Health Conference*, Canberra, November 1995 edited by Davis, J., Andrews, S., Brooom, DH., Gray, G. and Renwick, M. Canberra: Australian Government Publishing Service.
- Johnson, E. 1990. *What Do They Call Me?* Written and performed at National Lesbian Festival and Conference, January 1990, Melbourne.
- Jordan, KM. and Deluty, RH. 1995. Clinical interventions by psychologists with lesbians and gay men. *Journal of Clinical Psychology* 51(3): 448-456.
- Kehoe, M. 1989. *Lesbians Over 60 Speak for Themselves*. New York: Harrington Park.
- Kelly, CE. 1992. Bringing homophobia out of the closet: antigay bias within the patient-physician relationship. *Pharos of Alpha Omega Honor medical Society* 55(1):2-8.
- Kennedy, MB., Scarlett, MI., Duerr, AC. and Chu, SY. 1995. Assessing HIV risk among women who have sex with women: Scientific and communication issues. *Journal of the American Medical Women's Association* 50(3-4):103-107.
- Klaich, D. 1974. *Woman Plus Woman: Attitudes Towards Lesbianism*. New York: Simon & Schuster.
- Kominars, SB. 1995. Homophobia: The heart of darkness. *Journal of Gay and Lesbian Social Services* 2(1):29-39.
- Lavender (Ed) 1990. *What is Lesbian Discrimination?: Proceedings of Forum 1987*. Sydney: Anti-Discrimination Board.
- Lemp, GF., Jones, M., Kellogg, TA., Nieri, GN., Anderson, L., Withum, D. and Katz, M. 1995. HIV seroprevalence and risk behaviours among lesbians and bisexual women in San Francisco and Berkeley, California. *American Journal of Public Health* 85(11):1549-1552.
- Lesbian and Gay Rights Legal Service, 1994. *The Bride Wore Pink: Legal Recognition of Our Relationships*. Sydney: Gay and Lesbian Rights Lobby:.
- Lesbian Network Collective 1988. Response to National Women's Health Policy Discussion Paper. (Unpublished.)
- Lesbiana, 1997. Lesbian Health Survey. *Lesbiana* 55:13.
- Lesbiana, 1996. Murderer better parent than lesbian. *Lesbiana* 51:7.
- Lesbiana 1993a. Cancer risk for lesbians. *Lesbiana* 13:6.
- Lesbiana 1993b. Girlcott Medibank Private. *Lesbiana* 13:5.
- Lesbians on the Loose 1996. 1995 readership survey. *Lesbians on the Loose* 7(3):9.
- Lesbians on the Loose 1995a. Victory: We belong, too. *Lesbians on the Loose* 6(8):4.
- Lesbians on the Loose 1995b. Lesbians do get AIDS. I did. *Lesbians on the Loose* 6(3):20.
- Lesbians on the Loose. 1994. Significant mothers. *Lesbians on the Loose*, 5(5): 18-19.
- Lilling, AH. and Freidman, RC. 1995. Bias towards gay patients by psychoanalytic clinicians: an empirical investigation. *Archives of Sexual Behaviour* 24(5):563-70.
- Lorde, A. 1984. *Sister Outsider: Essays and Speeches*. Trumansburg, NY: Crossing.
- Lorde, A. 1980. *The Cancer Journals*. San Francisco: Aunt Lute.
- Lynch, L. and Woods, A. (Eds) 1996. *Off The Rag: Lesbians Writing on the Menopause* Norwich VT: New Victoria.
- Macaulay, L., Kitzinger, J., Green, G. and Wright, D. 1995. Unconventional conceptions and HIV. *AIDS Care* 7(3):261-276.

- Macdonald, B. and Rich, C. 1984. *Look Me in the Eye: Old Women, Aging and Ageism*. San Francisco: Spinster, Ink.
- Magee, M. and Miller, DC. 1996. Psychoanalytic views of female homosexuality. In Cabaj, RP. and Stein, TS. (Eds) *Textbook of Homosexuality and Mental Health* Washington: American Psychiatric Press: 191-206.
- Martindale, K. 1994. My (lesbian) breast cancer story: Can I get a witness? In Oikawa, M., Falconer, D., Elwin, R., and Decter, A. *Outrage: Dykes and Bis Resist Homophobia* (Eds). Toronto: Women's Press: 137-150
- McCance, KL. and Heuther, SE. 1990. *Pathophysiology: The Biologic Basis for Disease in Adults and Children*. St Louis: CV Mosby.
- McColl, P. 1994. Homosexuality and mental health services. *British Medical Journal* 308(6928):550-551.
- McKenzie, C. 1996. Lesgos. *Queensland Pride* 66: 25.
- McKenzie, C. 1993. Dyke refused therapy. *Lesbians on the Loose* 4(9):3
- McKirnan, DJ. and Peterson, PL. 1989. Psychosocial and cultural factors in alcohol and drug abuse: An analysis of a homosexual community. *Addictive Behaviours*, 14(5): 555-563.
- McMurray, A. 1993. *Community health nursing: primary health care in practice*. Melbourne: Churchill Livingstone.
- Meyer, IH. 1995. Minority stress and mental health in gay men. *Journal of Health and Social Behaviour* 36(1):38-56.
- Millard, J. 1995. Suicide and suicide attempts in the lesbian and gay community *Australian and New Zealand Journal of Mental Health Nursing* 4:181-189.
- Monte, 1987. In love with a memory. pp 17-22 in Bradstock, M. and Wakeling, L. (Eds) 1987 *Words From the Same Heart*. Sydney: Hale and Iremonger.
- Moran, N. 1996. Lesbian health care needs. *Canadian Family Physician* 42:879-884.
- National Drug Strategic Plan 1993-97*. 1993. Canberra: Australian Government Publishing Service.
- Oikawa, M., Falconer, R. and Decter, A. (Eds) 1994. *Resist: Essays Against a Homophobic Culture*. Toronto: Women's Press.
- Oikawa, M., Falconer, D., Elwin, R. and Decter, A. (Eds) 1993. *Outrage: Dykes and Bis Resist Homophobia*. Toronto: Women's Press.
- O'Leary, C. 1996. Creating a methodology: Lesbian feminist research. *Journal of Australian Lesbian Feminist Studies* 5:51-58.
- O'Toole, CJ. and Bregante, JL. 1993. Disabled lesbians: Multicultural realities. In Nagler, M. (Ed) *Perspectives on Disability: Text and Readings on Disability*. (2nd ed) Palo Alto: Health Markets Research: 261-271.
- Oliver, L. 1996. Lesbian health - is there anyone there? pp154-158 in *Changing Society for Women's Health: Proceedings of the Third National Women's Health Conference*, Canberra, November 1995. Canberra: Australian Government Publishing Service.
- Otis, MD. and Skinner, WF. 1996. The prevalence of victimisation and its effects on mental well-being among lesbian and gay people. *Journal of Homosexuality* 30(3):93-121.
- Pallotta-Chiarolli, M. 1996. Landscapes of conflict and integration: mental and emotional health issues for second generation women of non-English speaking background. In Spongberg, M., Larbalestler, J. and Winn, M. (Eds) *Women Sexuality Culture: Cross Cultural Perspectives on Sexuality*. Sydney: Women's Studies Centre, University of Sydney: 80-95.
- Palmer, GR. and Short, SD. 1989. *Health Care and Public Policy: An Australian analysis*. Melbourne: Macmillan.
- Parkes, R. 1993. Nurses attitudes affect health care. *Australian Nursing Journal* 1(4):16.
- Penelope, J. 1996. Passing Lesbians: The high cost of femininity pp 118-152 in L. Mohin (Ed) *An Intimacy of Equals: Lesbian Feminist Ethics*. London: Onlywomen.
- Perkins, R. 1995. Meeting the needs of lesbian service users. *Mental Health Nursing* 15(6):18-21.
- Peterson. 1994. *In a Critical Condition: Health and Power Relations in Australia*. St Leonards: Unwin and Allen.
- Pharr, S. 1988. *Homophobia: A Weapon of Sexism*. Inverness: Chardon.
- Pilkington, NW. and D'Augelli, AR. 1995. Victimisation of lesbian, gay and bisexual youth in community settings. *Journal of Community Psychology* 23(1):34-56.
- Pittaway, E. 1997. Personal communication.
- Price, JH., Easton, AN., Telljohan, SK., and Wallace, PB. 1996. Perceptions of cervical cancer and Pap smear screening behaviour by women's sexual orientation. *Journal of Community Health* 21(2):89-105.
- Prineas, E. 1994. Fatal attraction. *Lesbians on the Loose* 4(9):16-17.
- Ramsay, H. 1996. Lesbian health: The challenge for population health promotion. Presented at Teaching to Promote Women's Health International Conference, June 13-15, Toronto, Canada.
- Ray, V. 1995. Lesbians and their counsellors *Journal of Australian Lesbian Feminist Studies* 5:59-68.
- Rich, A. 1980. Compulsory heterosexuality and lesbian existence. *Signs: Journal of Women in Culture and Society* 5(4):631-660.

- Roberts, N. 1986. A gift to share pp 94-108 in Adelman, M. (Ed) *Long Time Passing: Lives of Older Lesbians*. Boston: Alyson.
- Rogers, L. 1994. Not in our genes or hormones: A critique of the latest theories for the biological causation of Lesbian and homosexual behaviour *Journal of Australian Lesbian Feminist Studies* 4:23-34.
- Rose, L. 1994. Homophobia among doctors. *British Medical Journal* 308(699928):586-587.
- Sang, B., Warshow, J. and Smith, AJ. (Eds) 1991. *Lesbians at Midlife: The Creative Transition*. San Francisco: Spinsters.
- Saunders, JM. and Valente, SM. 1987. Suicide risk among gay men and lesbians: A review. *Death Studies* 11:1-23.
- Savin-Williams, RC. 1994. Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution and suicide. *Journal of Consulting and Clinical Psychology* 62(2):261-269.
- Shenfield, F. 1994. Particular requests in donor insemination: comments on the medical duty of care and the welfare of the child. *Human Reproduction* 9(11):1976-1977.
- Shernoff, M. and Finnegan, D. 1991. Family treatment with chemically dependent gay men and lesbians. Special issue: Chemical dependency: Theoretical approaches and strategies working with individuals and families. *Journal of Chemical Dependency* 4(1):121-135.
- Short, SD., Sharman, E. and Speedy, S. 1993. *Sociology for Nurses: An Australian Introduction*. Melbourne: Macmillan.
- Smith, A. (Ed.) 1992. *Women's Health in Australia*. Armidale: University of New England.
- Smith, B. 1993. Homophobia: Why bring it up? In Abelove, H., Barale, MA. and Halperin, D. (Eds) *The Lesbian and Gay Studies Reader* New York: Routledge: 99-102.
- Smith, GB. 1993. Homophobia and attitudes towards gay men and lesbians by psychiatric nurses. *Archives of Psychiatric Nursing* 7(6):377-384.
- Sneddon, Y. 1993. Nurses' attitudes to lesbian health - could health care be affected? *Lilac* 1(2):10-12.
- Stacey, K. 1993. Exploring stories of lesbian experience in therapy: Implications for therapists in a postmodern world *Dulwich Centre Newsletter* 2:3-13.
- Stewart, B. 1990. I am a woman, I am a Koori and I am a lesbian. In Lavender (Ed). *What is Lesbian Discrimination?: Proceedings of Forum 1987*. Sydney: Anti-Discrimination Board: 11-13
- Stevens, PE. 1994. Protective strategies of lesbian clients in health care environments. *Research in Nursing and Health* 17(3):217-229.
- Sunlight 1996. Change of life. In Lynch, L. and Woods, A. (Eds) *Off The Rag: Lesbians Writing on the Menopause*. Norwich VT: New Victoria: 212-213.
- Tasker, F. and Golombok, S. 1995. Adults raised as children in lesbian families. *American Journal of Orthopsychiatry* 65(2):203-215.
- Taylor, J. 1997. Personal Communication.
- Taylor, J. 1995. A portrait of a lesbian as a middle-aged radical feminist. *Journal of Australian Lesbian Feminist Studies* 5:83-92.
- Thompson, D. 1985. *Flaws in the Social Fabric: Homosexuals and Society in Sydney*. Sydney: Allen and Unwin.
- Tremellen, S. 1996. What do we need to quit? Lesbians and smoking. *Healthsharing Women* 7(3): 12-14.
- Waite, H. 1995. Lesbians leaping out of the intergenerational contract: Issues of ageing in Australia. *Journal of Gay and Lesbian Social Services* 3(3):109-127.
- Waite, R. 1996. They don't know what to say to me. In Mohin, L. (Ed) *An Intimacy of Equals: Lesbian Feminist Ethics*. London: Onlywomen: 43-15.
- Webster, L. 1990. A lesbian growing up in the Sullivans' era. In Lavender (Ed). *What is Lesbian Discrimination?: Proceedings of Forum 1987*. Sydney: Anti-Discrimination Board: 14-15.
- Widdicombe, B. 1996. Three are family. *Sydney Star Observer* Nov 21:1.
- Wilde, K. 1990. Experiences of disability and lesbian discrimination. In Lavender (Ed). *What is Lesbian Discrimination?: Proceedings of Forum 1987*. Sydney: Anti-Discrimination Board: 17-19.
- Wills, S. 1994. Inside the CWA: The other one. *Journal of Australian Lesbian Feminist Studies* 4:6-22.
- Winter, B. 1995. Identity, choice and power: The politics of difference in context. *Journal of Australian Lesbian Feminist Studies* 5:30-42.
- Wismont, JM. and Reame, NE. 1989. The lesbian childbearing experience: Assessing developmental tasks. *Image - the Journal of Nursing Scholarship* 21(3):137-141.
- World Health Organisation. 1978. *Primary Health Care. Report of the International Conference on Primary Health Care*, Alma-Ata, USSR 6-12 Sept 1978. Geneva.

ACKNOWLEDGEMENTS

Lavender and Helen wish to thank the following individuals and organisations for their assistance, support and information for this project.

Individuals

Christine; Chris Sitka; Claire Rankin; Erica Bremner Kneipp; Jean Taylor; Judith Haggard; Jude Irwin; Pat Giles - Chair World Health Organisation's Global Commission on Women's Health; Ros Mills.

Community

- **All** the lesbians who completed the questionnaire and sent submissions and the health practitioners, administrators and educators who supplied interviews and information.
- The many lesbian groups, women's groups, gay and lesbian groups, women's health centres, refuges, other service centres, AIDS councils and other organisations who distributed our questionnaire.
- Allstate Printery Brisbane; *Capital Women*, Canberra; Coalition of Activist Lesbians Australia committee members; Crossroads Community Centre, Sydney; *Dykewise*, Brisbane, Feminist Bookshop, Sydney; Gay and Lesbian Solidarity, Sydney; *Grapevine*, Perth; *Hecate Interdisciplinary Journal of Women's Liberation*, Brisbane; Lavender Music, Coffs Harbour; *Lesbian Network*, Adelaide; *Lesbiana*, Melbourne; *Lesbians on the Loose*, Sydney; *Mountain Lesbian News*, Murphy Sisters/ Sisters by the Sea Bookshops, Adelaide; *Peace and Freedom*, Adelaide.

Public Sector

Australian Centre for Lesbian and Gay Research, Sydney University; Centre for Women's Studies, Australian National University; Flinders Medical Centre Adelaide, Child and Adolescent Mental Health Service; Department of Community and Health Services Tasmania, Women's Health Unit; Department of Human Services Victoria, Women's Health and Sexual Assault Services; Department of Health and Family Services Australian Capital Territory, Women's Health Service; Health Department of Western Australia, Program Planning and Purchasing; Office of Status of Women Australian Government; Queensland Health, Women's Health Unit; South Australian Health Commission, Strategic Policy and Planning Branch; Student Representative Council of Southern Cross University Lismore, Services Division; Territory Health Services, Women's Health Policy Office; Women's Studies Resource Centre, Adelaide.

ENDS -----