Policy Statement on Social Determinants of Lesbian, Gay, Bisexual, Trans, Queer, Intersex and Asexual Health

Adopted at MAW15, Proposer: Sexpression:UK

Summary

Medsin believes that violations of human rights in any form are unacceptable, and that this encompasses sexual orientation and gender identity. We believe that existing health inequities within and among nations are the results of political, social and economic forces, and are unjust and unacceptable. Furthermore, we affirm our belief that stigmatisation of, and discrimination against, people based on their sexual orientation or gender identity is a social determinant of health that affects an unacceptable health inequity.

Discriminatory policies and actions perpetuate stigmatisation of lesbian, gay, bisexual, trans, queer, intersex and asexual ("LGBTQIA") persons, resulting in negative health effects. Attitudes towards sexuality differ significantly both within and between countries. Whereas marriage equality has been a prominent topic of debate in some, others still enforce criminal sanctions, including capital punishment, for homosexual acts. The commonality across all countries is that any negative treatment of LGBTQIA persons reinforces stigma associated with sexual identity and undermines well-being for all LGBTQIA persons, with adolescents and young adults at greater risk. Medsin therefore calls for the government and health organisations to recognise sexual identity as a social determinant of health, and calls for legislative reform to grant marriage equality to all persons.

Introduction

LGBTQIA persons comprise a minority population that suffers poorer health than the heterosexual population. A meta-analysis drawing data from many countries concluded that lesbian, gay and bisexual people are 2.47 times more likely to attempt suicide (4.28 times for gay and bisexual men) and are 1.5 times more likely to suffer depression, anxiety disorders and alcohol and other substance dependence (King et al., 2008). Research on transgender individuals is woefully inadequate, and complicated by perceptions of de facto mental illness, but the prevalence appears to be similarly high, if not even more pronounced (Bockting, 2013; Clements-Nolle, Marx & Katz, 2006), particularly in the case of transgender people of colour (Grant et al. 2010). One survey showed that as many as 88% of trans people experience depression, 75% experience anxiety and 35% have attempted suicide (McNeil et al, 2012).

Much of this demonstrated health disadvantage in the developed world may be attributed to the phenomenon known as "minority stress", which LGBTQIA persons experience in their struggle for validation and societal acceptance (Buffie, 2011). Stigma and discrimination against sexual minorities has been extensively documented (Ritter, Matthew-Simmons and Carragher, 2012) and assessed as likely to be at least part of the reason for the higher rates of psychological morbidity observed (King et al., 2008 and Chakraborty, 2011). Emerging evidence suggests that discrimination and social stigma similarly contribute to mental health disparities in gender minority persons (Clements-Nolle et al., 2006; Grant et al. 2010) and that this goes beyond the psychological distress inherent to a conflict between gender assigned at birth and gender identity, also known as gender dysphoria (Bockting, 2013).

Transgender individuals are also uniquely vulnerable in that affirmative practices such as legal documentation consistent with self-identified gender and completing medical transition, both of which substantially reduce suicide risk, can be difficult to access due to structural stigma (Bauer, Scheim, Pyne, Travers, & Hammond, 2015). For example, the process of legally changing one's gender in the UK requires the applicant to prove that they have lived in their 'acquired gender' for two years, and there is no provision for the legal recognition of agendered or genderqueer identities (Gov.UK, 2015).

Transgender people also experience difficulties with access to healthcare in the UK, with up to 32% having to wait 1-3 years to attend a Gender Identity Clinic (McNeil et al, 2012). The World Professional

Association for Transgender Health produces the 'Standards of Care' for the health of trans and gender nonconforming people (Wpath.org., 2015), and these are referred too through the UK guidelines (Royal College of Psychiatrists London, 2013). Further research is needed into the applicability of alternative models in the UK, such as the popular 'informed consent' model that has been implemented in several US clinics, whereby accessing therapy is not restricted by the need to have mental health evaluations or undergo 'real life tests' (Reisner et al, 2015).

Perhaps even more neglected in terms of research are asexual individuals, or those who experience little or no sexual attraction. A single published study suggests that asexual individuals have higher rates of mental illness compared to heterosexual individuals (Yule, Brotto & Gorzalka, 2013), but research examining why this is the case is non-existent.

Other subgroups that are particularly vulnerable are bisexual persons and youth. Bisexual individuals appear to have higher rates of mental illness than lesbians and gay men (Dodge & Sandfort, 2007), which may be potentially attributable to the additional stigma experienced from within LGBTQIA communities. The youth sub-group experiences more frequent and more serious suicide attempts than their heterosexual counterparts. Heterosexism may also lead to isolation, family rejection, and lack of access to culturally competent care. (Suicide Prevention Resource Center, 2008).

A clear need exists for further research into how heterosexism, homophobia, biphobia, acephobia, transphobia, inter*phobia, and minority stress can be reduced, particularly for aforementioned vulnerable subgroups. Such research is hampered, however, by the physical and psychological risks faced by these very persons when they identify as LGBTQIA in an unsupportive environment. (Takacs, 2006 and Ryan & Rivers, 2003) Research is particularly lacking from non- Western countries, where the risks of both hate crimes and prosecution may be greater. As of 2012, homosexuality was punishable by death in five countries and in 78 countries, homosexual acts were illegal. The vast majority of countries have at least now legalised homosexual acts. (Itaborahy, 2012)

Similarly, stigma has been argued to prevent access to sexual health services, with homophobia cited as a major barrier to ending the global HIV/AIDS epidemic (AVERT, 2013). The Eminent Persons Group has called on the Heads of Commonwealth Governments to repeal discriminatory laws and commit to programmes of education that would aid this process (Eminent Persons Group, 2011).

"Marriage equality" is defined here as providing legal permission for any two persons, regardless of sex, sexuality and gender identity, to marry one another. This is not to impose an obligation on an authorised celebrant, being a minister of religion, to solemnise any marriage.

Discriminatory policies relative specifically to marriage equality have been shown to have negative health effects, with significant increases in psychiatric disorders amongst lesbian, gay and bisexual persons living in states that banned gay marriage (Hatzenbuehler, 2010).
Legislation in countries like Australia, where the *Marriage Act 1961* currently defines marriage as a legal union solely between a man and a woman, discriminates institutionally on the basis of sexual orientation. Marriage denial reinforces stigma associated with sexual identity and undermines well-being for all LGBTQIA persons, with adolescents and young adults again particularly sensitive. Conversely, marriage equality would confer broadened developmental options for lesbian and gay adolescents and young adults, who could then envision marriage as a key element of their adulthood. (Herdt and Kertzner, 2006)

Many health associations also support marriage equality on health grounds, or have recognised the major health care disparities that exist as a result of denying marriage equality, including the American Medical Association, Indiana State Medical Association, American Psychiatric Association, American Academy of Paediatrics, American College of
Obstetricians and Gynaecologists, American Psychological Association and Australian Psychological Society and the National Drug and Alcohol Research Centre (University of New South Wales).

Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies. Because their bodies are seen as different, intersex children and adults are often stigmatized and subjected to multiple human rights violations, including violations of their rights to health and physical integrity, to be free from torture and ill-treatment, and to equality and non-discrimination. This means there is no generic 'intersex body' and encompasses a wide variety of body types that are not dysfunctional, but are often deemed 'abnormal' by society (Officer of the High Commissioner for Human Rights, 2015).

Some intersex people are seen as a medical issue: they don't produce a certain protein, have a missing receptor, or another genetic/biological explanation. But there are many others for whom there is no identifiable cause that can explain their intersex status. Clinicians are too often left with a best guess as to which sex to designate (Carpenter, 2015). There are also those who are subjected to genital surgery where the only reason is to assign them as male or (more commonly) female just so they conform to societal stereotypes. These (often multiple) surgeries can lead to an intersex person being sterilised as a 'condition' of their surgical assignment. Surgical intervention has improved over the years and decisions about surgery are more commonly being deferred until pubertal age in order to respect the autonomy of the person in the UK. This is not the truth for all intersex people but certainly is more so in the past, therefore still affecting people living nowadays, and in other parts of the world (Officer of the high commissioner for Human Rights, 2015). Bodily autonomy should be respected and surgery limited only to matters that are life threatening or affecting physical function. If someone wants to change their genital anatomy, it should at least be done at an age where they can give informed consent, yet that is not the case at present (Liao et al., 2015)

Main text

Medsin-UK believes that:

1. Embracing diversity and countering discrimination against LGBTQIA persons is a necessary and important step towards health equality for all members of society;
2. Marriage equality would reduce the discrimination and thus minority stress that LGBTQIA persons suffer, leading to improved health.;
3. All members of the LGBTQIA communities have the right to equitable healthcare and legal recognition

Medsin-UK therefore supports marriage equality and efforts to achieve it for all persons and encourages and supports educational and service activities pertaining to LGBTQIA health issues by its branches, activities and National Working Groups.

Medsin-UK calls upon the government and health service providers to:

1. Increase awareness and implementation of the 'Reducing Health Inequalities for Lesbian, Gay, Bisexual, and trans people' document produced by the Department of Health in 2007. (DoH, UK; 2007)
2. Support research into the negative health effects of stigma and discrimination on LGBTQIA persons; and
3. Where they have jurisdiction over marriage, remove all discriminatory references from their relevant legislation to allow any two persons, regardless of sex, sexuality and gender identity, to marry one another; noting that this is not to impose an obligation on an authorised celebrant, being a minister of religion, to solemnise any marriage.
4. Develop and implement (or support implementation of) a medical curriculum that takes into account and emphasises gender-specific presentations and treatment options;
5. Implement policies that actively promote educational and leadership opportunities within medical workplaces and recognise and remove barriers that prevent this from being achieved for those of all genders;

6. Develop policy to recognise and actively prevent sexual harassment, sexist attitudes and sexist or inappropriately gendered language for both patients and staff;
7. Work in partnership with LGBTQIA individuals, community groups, NGOs and service providers to increase population-based research into the health outcomes and experiences of the LGBTQIA population.
8. Ban the practice of attempts to convert a person's sexuality by therapeutic sessions such as 'gay conversion therapy'
9. Ensure that every person has the right to request to change the legally recorded gender and/or first name, if the person so wishes to change the first name, in order to reflect that person's self-determined gender identity and that a re-issue of legal documents is given
10. Make it unlawful for medical practitioners or other professionals to conduct any sex assignment treatment and/or surgical intervention on the sex characteristics of a minor whose genitalia are not perceived to conform with society's view of normal which treatment and/or intervention can be deferred until the person to be treated can provide informed consent as set out in the Fraser Guidelines and passing of Gillick Competence
11. Ensure that all persons seeking psychosocial counselling, support and medical interventions relating to sex or gender are given expert sensitive and individually tailored support by psychologists and medical practitioners or peer counselling. Such support should extend from the date of diagnosis or self-referral for as long as necessary.
12. Ensure that in the context of legal gender recognition, medical and juridical processes should be distinguished so that no treatment (surgeries, sterilisation, hormones) is made compulsory by law.
13. Ensure that all treatments that are deemed necessary by trans and intersex users on a case by-case basis should be, as much as possible, accessible, affordable and included in the national basket of benefits.
14. Make amendments to the Equality Act 2010 to:
    1. Include gender identity and gender expression as a protected characteristic
    2. Remove the exception that allows single sex services to discriminate against trans people
15. Make efforts to ensure data collection and analysis should be transgender inclusive and engage with trans organisations and researchers with trans-specific expertise to design research questions
16. Make reforms to The Gender Recognition Act 2004 to become a simple, cheap administrative procedure based on self-determination of gender and without any requirement for medical or psychiatric evidence
17. Open the standard Gender Recognition Certificate process to 16 and 17 year olds and create a process for those under 16 years old with the additional requirement of parental agreement
18. Allow people to opt out of being legally a man or a woman and have passports with unspecified gender available to support this
19. Provide automatic UK recognition of overseas gender recognition
20. Prohibit discrimination on the basis of intersex traits, characteristics or status, including in education, healthcare, employment, sports and access to public services, and address such discrimination through relevant anti-discrimination initiatives

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