L.INC LESBIAN HEALTH RESEARCH:

A study of the general health of the Lesbian community in Cork

Commissioned by: L. Inc (Lesbians in Cork) Ltd.
Funded by the Health Service Executive South

Conducted by Community Consultants Ltd. July 2006

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EXECUTIVE SUMMARY

Introduction

The aims of this research were to assess the health needs of the lesbian community served by L.Inc and to generate recommendations and options for L.Inc and its service providers to meet these needs.

The research utilised a combination of methodologies to optimise resources and maximise access to its sample population. This included planning meetings, focus groups, a quantitative survey, meetings with outside agencies, and a review of existing national and international literature. 44 lesbian women participated in the focus groups, divided into self-selected categories of younger lesbians, 25-40 year old lesbians, older lesbians, lesbian parents, and staff at L.Inc. 107 individual questionnaires were completed and returned.

Participation rates were excellent, and the researchers are confident that the experiences of the women who participated reliably reflect the concerns of the wider lesbian community.

Background

In a climate of apparently increasing toleration of and support for “alternative” lifestyles, it might be assumed that lesbian health needs can be adequately addressed within existing structures and without the need for modification of current services. This piece of research challenges these assumptions and shows that the area of health presents pressing issues within the lesbian community, issues which need to be addressed by changes in health policy, legislative change, direct provision of services tailored to the needs of the lesbian community, and a major shift in attitudes and education among health service providers.

Lesbians can face multiple discriminations as lesbians, as women, as ‘single’ parents, and may also experience discrimination under any of the other grounds covered by the Equal Status Act (2000), such as age, disability, membership of the Travelling Community, etc. Negative experiences of accessing health care arising from such discrimination can impact upon lesbians’ willingness to seek regular medical care, which in turn will have implications for their general health.

Research from around the world indicates that lesbians have specific health needs, particularly in terms of having access to a health care system that respects their difference and where health care providers are sympathetic and informed about lesbian concerns. It is therefore imperative that the findings from this piece of research are noted and appropriate responses are developed.

Findings

There was a marked preference for female health service providers among participants. This would appear to be due to lesbians experiencing a higher level of safety being and a more facilitative approach to listening.

Respondents indicated an endemic level of heterosexist assumptions facing lesbians across the health services, although some had experienced what they would describe as a model of good practice in the maternity services.

Over half of the questionnaires indicated that respondents were 'out' to their GPs, whereas in the focus groups, this figure stood at around three quarters. This would confirm the researchers' perception that the focus groups were attended by more 'visible' lesbians, i.e. those who were more confident about revealing their sexual orientation, and that the anonymous questionnaire accessed a more hidden cohort. L.Inc staff also indicated that their experience of those who attend meetings and take part in groups are generally more privileged than the majority of those who access L.Inc's services on a daily basis. Thus the combination of findings from the focus groups and the survey provide us with a fuller picture of the community's needs than either one alone.

Ranking in the top four supports lesbians use were friends, family, GP, and lesbian community worker. Focus groups were organised to coincide with existing support groups in L.Inc, indicating that for the women who took part in the focus groups, L.Inc was an important resource for them. Anecdotally, many of the women suggested that their main friendships were within the lesbian community, and that they would like supports to be in place in L.Inc, where they could feel safe and secure among people they could trust. The vast majority of the women in the focus groups expressed a desire for the provision of a 'directory' of lesbian-friendly health services to be available at L.Inc.

Findings from the survey indicate that the health of lesbians and bisexual women in L.Inc's catchment area is poorer than Irish women in general on all measures of health measured. Significantly, the impact that these levels of health have on the everyday functioning of lesbians in terms of their work, physical activities and social relationships is more significant than for the average Irish woman.

Research from around the world suggests that lesbians have a higher risk of ovarian cancer and polycystic ovarian syndrome, and that experiences of homophobia and social isolation leaves them at risk of psychological distress, damaged self-esteem and reluctance to access preventive care. Because women's preventive health care is almost exclusively modelled around reproduction and contraception, (concerns that are not always central for lesbian women), lesbians face additional difficulties accessing appropriately targeted preventive health care.

Mental health issues are of concern among the lesbian population internationally, and many of those seeking help from L.Inc display or report symptoms of mental health problems. Among those who completed the survey questionnaire, higher levels of depression, anxiety, and lower levels of self-esteem than average were reported. Suicide rates among lesbians in general are higher than in the general population, but even more alarmingly, results from this research show that lesbians who responded to the survey in Cork were twice as likely to have attempted suicide as their American *lesbian* counterparts.

Levels of current alcohol and drug use in the lesbian community were difficult to gauge but consistently appeared anecdotally to be of great concern to many of the research participants. This concern might correspond with international research that shows an increasing awareness, together with a decline in, substance dependency issues in lesbian communities in other countries.

Identified Needs of Key groups

Younger lesbians were concerned at the absence of alternative social venues to the pub, and alcohol and drug misuse were considered a serious issue among young lesbians.

Older lesbians and the 25-40 year old group were much more concerned and fearful about what will happen to them later in life. They would like to stay "out", be safe and have appropriate and

sensitive elder care. They voiced grave concerns about “disappearing” as lesbians as they get older.

The **parenting group and the 25-40** year old group urged that reproductive services need to be made available to all and that parenting options should positively include fostering and adoption for lesbians. It was felt that there needs to be provision for the social co- (non-biological) parent to be included on the birth certificate of children born to lesbian couples.

The **25-40** year old group argued that more counselling services needed to be available for a variety of issues, including relationship and marriage difficulties and break-ups.

Staff in the organisation believe that their current remit is too broad and that they are under-resourced to deliver the range of services demanded of them. A full-time counsellor on-site and a full-time outreach worker were seen as key needs, and that it was important to strengthen the policy work of L.Inc which would assist in many ways, such as in obtaining services appropriately, applying for funding, and working toward changes to national policy to allow for greater awareness and integration of lesbian needs into all health services e.g. mental health, health promotion, etc.

Provision of health information was seen as an urgent need across all groups: younger lesbians in particular voiced the need for material in relation to sexually transmitted diseases, alcohol and drug misuse; those in the parenting and general groups for information about assisted reproduction, fostering and adoption, and for schools to be provided with appropriate sex education materials for children of lesbians and young gay and lesbian students; and older lesbians for general health information and lesbian-appropriate data on menopause and aging.

Recommendations

Despite recommendations made in various government and NGO reports, substantial progress is still to be made to achieve greater equality for LGB people. The 2004 Power report, *Towards Objective 86*, included a review of existing reports such as GLEN and Nexus (1995), LOT (1998), LOT/LEA, (2000), LASI (2002), Equality Authority (2002), NESF (2003), and concluded that the recommendations included in these and other reports were in the vast majority of cases still undelivered. *Towards Objective 86* highlights the need for services to be designed and implemented to be inclusive, non-discriminatory and positive for lesbian users, and for those who deliver services to be trained and educated around the specific needs of this client group.

This current research recommends that **the HSE respond to the recommendations made in *Towards Objective 86***, developing a health strategy and action plan specifically tailored to the needs of the lesbian community, funding research in lesbian health areas identified by previous reports, and developing awareness-training for all staff within the HSE.

The second principal recommendation is for the **HSE to fund a Health Worker** for the lesbian community based at L.Inc. Given that most lesbian women seeking help and support will look to their community to provide it, basing the health worker in L.Inc at the heart of the lesbian community in Cork would enable access by hundreds of lesbian women in the area.

The third key recommendation made in this research is that the **HSE should train its staff** in anti-homophobia and heterosexism, and develop a model of good practice based on the maternity services where lesbians consistently report a warm, inclusive and sensitive approach on the part of the service providers.

1. INTRODUCTION

1.1 Commissioning the Research

This qualitative piece of research was commission by L.Inc in October 2005. The focus of the research was on lesbian health and was open to all members of the community to participate and have an input. The terms of reference for this research were determined by the L.Inc steering committee after consulting the community at an open public meeting held in May 2005. See appendix I for an outline of the issues and concerns raised at this meeting.

Community Consultants Ltd. were contracted to carry out this qualitative piece of research. The work was carried out by Angela O' Connell and Maria Power. Given the short time frame allocated to the work, the steering group overseeing the research agreed on a thematic and qualitative focus in order to maximise the Consultants' time on the findings around the key needs of the community which is accessible in Cork. This means that there was a significant reliance on the members, sub-groups and mailing lists of L.Inc. This is access to approximately 730 members of the community.

1.2 Accessing the Community

The context of accessing this particular minority community for research purposes is important. Like other minority communities they are marginalized, they have one core group attempting to represent a multitude of experiences and voices, and they are significantly under-resourced to respond to all the demands that are made of them collectively. For the lesbian community, their collective voice can be restricted because of their lack of visibility, hidden lives and the degree to which each individual feels safe to be "out" (open about one's lesbianism). There are many barriers to full participation by lesbians in mainstream activities and services. Many members of the lesbian community are hidden, not out, fearful, or simply living private lives and not engaging in community activities. Many others, perhaps those who are most vulnerable or socially excluded, are unable to access the community. It is likely that these lesbians would have other things to say that would broaden our understanding of lesbian lives and needs. This context must be borne in mind when reading and understanding the needs of the community. The experiences of the women who participated in this research reflect genuine key needs on behalf not only of themselves, but also of others in the wider lesbian community. If society becomes a safer place, if agencies positively and sensitively respond to the community – then it will be safer

for more lesbians to be out, articulate their needs and life circumstances, and partake of a fully human life in society.

In the longer term, and if resources were to permit, a more in depth study would be useful particularly in trying to access those lesbians who are not visible or immediately accessible. To do this successfully would require research among a wide population base in order to access women who are currently not availing of L.inc services.

1.3 Methodology

For this piece of work the mainly qualitative methodological approach was augmented by an independently administered quantitative survey. Meetings were held with the research steering group to define and agree how the work would be carried out; subsequently focus group meetings were held under the following themes:

Parenting & Health
Younger Lesbians & Health
Older Lesbians & Health
Lesbians & General Health

The focus groups were organised utilising existing service groups in L.Inc and opening up the meetings to the wider community via mailing lists and the distribution of public posters. In addition to exploring the thematic topics named above, other aspects, such as the health effects of "coming out" (publicly revealing one's lesbianism), drug misuse, violence, and assessment of the quality of mainstream health services, were also explored. Additionally, the specific needs of other minority communities e.g. refugees and asylum seekers, and people with a disability were also identified where they participated in the research.

Desk research of other reports, particularly those available in the UK and the US, helped to place this research in an international context. There is minimal, although increasing, research into the lesbian community in Ireland, so all pieces of research are significant in building and understanding this community's profile and needs.

Meetings were also held with relevant agency representatives to explore similar models in operation elsewhere, consider possible responses to the findings and to deepen the analysis where required.

A quantitative health questionnaire was administered independently by a sub-group of the L.Inc steering group. The results from this process are contained in section four of the report.

An analysis of the focus group discussions and findings from the questionnaires forms the basis of the conclusions and recommendations in section 5. The findings and recommendations are considered in light of the international research reviewed, lesbian health projects and services offered in other countries, and possible progression routes that should be supported in an Irish context.

2. LESBIAN HEALTH IN CONTEXT

2.1 Existing Research

The World Health Organisation defines health as:

> *"…a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity… a resource for everyday life, not the objective of living; it is a positive concept emphasising social and physical resources, as well as physical capacity."* (WHO cited in EA, 2002)

2.1.1 Lesbian Women's Health Needs and Experiences

There is a dearth of research into lesbian health needs and experiences especially in Ireland. One of the difficulties in accessing data about invisible groups such as lesbians is that unless research is targeted at such groups, their needs and experiences merge with those of the dominant group, and even targeted research faces the difficulty of accessing members of minority groups for information. However, what information we do have from other jurisdictions, such as North America and Australia, indicates that although they share many of their health needs with women in general, lesbian women do have specific health needs and experience the provision of health care from a different perspective, both because of these needs, and because of external factors such as prejudicial or uninformed attitudes from the health care providers.

One of the greatest barriers to lesbian participation in the health-care system is that women's preventive health care is exclusively organised around birth control and obstetrics, and usually the only place sexuality is recognised as a health issue is in Sexually Transmitted Disease (STD) clinics.

Some of the areas where lesbian health needs differ from those of heterosexual women include a preference for a more holistic approach to healthcare (Trippet, 1993; Buenting, 1993; Lukas, 1993); a marked preference for female health providers (Robertson, 1993; Trippet, 1993;) delays in seeking healthcare (Stevens, 1993; Buenting, 1993; Robertson, 1993; Trippet, 1993), a higher prevalence of polycystic ovarian syndrome (Hutchinson, 2003), a higher risk of heart disease (**www.bbc.co.uk** 13/9/03), a lack of information about sexually transmitted infections that can be

spread by woman-to-woman sex; and an absence of service provision for those seeking to become pregnant through assisted reproduction (O'Connell 2000; Flood, 2003).

As well as these measurable differences, differential risks may arise, for instance: more lesbians might be expected to never experience pregnancy, which is associated with higher risks of breast cancer; lesbians are reported to delay seeking healthcare due to fears of homophobia; and many lesbians experience the stress of homophobia in their daily lives, with its concomitant physical and mental health effects (Solarz, 1999).

There are currently no health services targeted specifically at lesbians in this country, and there appears to be little awareness among service providers that lesbian women are a group in need of special attention (Wetherall, 2001; Gibbons et al, forthcoming). A high level of prejudicial and stereotypical attitudes to lesbians was found in a U.S. study of attitudes carried out among 278 nursing students' *"the most prevalent stereotypes included lesbians' seduction of heterosexual women, lesbian "boasting," and the "masculine aura" of lesbians"* (Eliason, Donelan & Randall, 1993). In a few educational institutions around the country, steps to improve lesbian health provision are being taken on an ad hoc basis by individual teaching staff with an interest in lesbian health care. Mel Duffy, lecturer in Nursing Studies, Dublin City University, argues that teaching health care providers about the specific health requirements of various minority groups, such as lesbians, is the first step towards changing attitudes towards, and service provision for, those groups. Her experience of teaching nursing students about lesbian women's health care needs is often met with resistance, and with the response that *"All women are surely the same?"* even though they accept without question that they should study a module on the needs of other (ethnic) minority groups. Duffy indicates that Canada and Australia provide models of lesbian health care based primarily on nursing education, which is subsequently shown to impact positively on patient care.

2.1.2 'Coming Out'

> *"Inequalities of respect and recognition of those who fall outside of the accepted sexual norm, serve to legitimate discrimination and materially as well as socially further their marginalisation"* (Baker et al, 2004: 10).

Baker (2004) notes that gay sex is illegal in more than 80 countries, but even in Ireland, which prides itself on having introduced the most progressive equality measures in Europe with the introduction of the Employment Equality Act, 1998 and the Equal Status Act 2000, homosexuality is still experienced as problematic in many quarters. In the 1999/2000 European Values Survey over a quarter of Irish people said they would not like to have a homosexual as a neighbour – one of the highest figures in the E.U. (Halman, 2003). The EOS Gallup Survey 2003 shows that support for homosexual marriage and adoption is still relatively low among Irish people compared to many of our European counterparts (EOS Gallup, 2003). Research from the United States suggests that gay and lesbian people who are afraid to come out or who are otherwise unable to access the gay and lesbian community, are at risk for psychological distress and damaged self-esteem. (Garnets et al, 2002; CPA, 1995)

Negative experiences with health care providers can also directly impact on lesbian women's willingness to seek regular care, such as Pap smears, breast checks, and routine gynaecological care (Smith et al 1995, cited in Buenting, 1993). However, greater uptake of counselling services by lesbians is noted in the literature, accounted for by lesbians' greater experience of the stress of living in a homophobic society, or alternatively on their greater appreciation of introspection and the value of emotional well-being (Buenting, 1993)

2.1.3 Young Lesbians

A recent report in Gay Community News suggests that younger lesbians in Ireland are coming out at a younger age and in greater numbers (GCN August 2004: 3).

Health related issues of particular concern for this cohort include: sexually transmitted disease including allergic vaginitis, bacterial vaginosis, chlamyidia, gonorrhea, hepatitis, herpes (genital), HIV/AIDS, human papillomavirus (HPV)/genital warts, pelvic inflammatory disease, pubic lice, scabies, syphilis, trich, and yeast infections (candidiasis), and the absence of reliable information specific to lesbian sexual practices (Solarz, 1999; Buenting, 1993; www.gcn.ie;); coming out to health care providers, parents, family members, schools, employers and friends; and the fear of rejection, harassment and discrimination coming out might entail (Quiery, 2002); experiencing bullying and early school-leaving and the resulting susceptibility to poverty (GHS & Nexus,1999; CPA 1995; O'Carroll & Szalacha, 2000).

International research indicates that gay and lesbian young people comprise up to 30% of completed youth suicides – lesbian, gay and bisexual youth are two to three times more likely to attempt suicide than any other young people (EA, 2000). Although similar figures for the republic of Ireland are not available, a UK study of 416 gays and lesbians aged 15-20 years and living in London discovered that 19% of them had attempted suicide (Quiery, 2002). International figures (WHO 1991) would indicate that suicide could also be expected to be higher among gay and lesbians than in the general population in Ireland, and the NESF recently recommended that the National Suicide Review Group should research the relationship between sexual orientation and suicide in Ireland (NESF 27, 2003). A study conducted by the University of Ulster and Queens in Belfast found that *"young gay men are 30 times more likely to attempt suicide than their heterosexual counterparts"* (White, 1999), and the Women's Health Council of Ireland's recent submission to the Mental Health Policy noted that attempted suicide is *"particularly common among young lesbians"* (WHCI 2005).

A study conducted among lesbian and gay youth in New York (Paroski, 1987 cited in Stevens, 1993) indicated that young lesbians and gays fear judgemental care from health care providers, and another piece of research referred to by Stevens indicates that a third of lesbian women who were in therapy felt that their therapists were prejudiced against them on the basis of their sexual orientation (Saghir & Robins 1973 cited in Stevens 1993). On the basis of these findings, it is not surprising that young lesbians are less likely to seek help when they experience emotional difficulties directly related to dealing with issues relating to their sexual orientation.

2.1.4 Older Lesbians

Some of the problems facing older lesbians relate directly to health issues, such as menopause, increased risk of breast and other age-related cancers, while others arise as a result of lifestyle and relationship issues, such as lack of recognition of a partner/non-biological parent during sickness (where a partner might be excluded from hospital visits, or from decision-making around health-care) and bereavement, when particularly but not exclusively in the case of 'closeted' (undisclosed) lesbian relationships, little support is available to the grieving partner/parent. Other age-related issues arise from experiences of prejudicial experiences from the more conservative society of the past which have left lasting effects on the individual.

Financial access to health care is also hampered by the lack of legal recognition of lesbian relationships, meaning that social welfare health benefits, such as medical entitlements, cannot

be shared. The major private health insurance companies in Ireland do, however, allow same-sex couples and their families to avail of their schemes on an equal footing with married and heterosexual families. However, social insurance based on P.R.S.I. covering dental, optical and hearing aid benefits, do not extend to unmarried couples.

2.1.5 Abuse

Violence: Homophobic violence and harassment continue to feature prominently in many gay people's lives in Ireland. Figures from a recent report by the Equality Authority (2002) showed widespread violence against homosexuals, with one in four respondents reporting that they had been punched, beaten hit or kicked because they were assumed to be gay. Research in Northern Ireland among lesbian and bisexual women found that one in five had experienced violent assaults and none of them had reported these incidents to the police.

The Equality Authority report refers to research in the U.S. that concludes that anti-lesbian violence should be conceptualised *"as an extension of misogynistic violence"* (EA, 2002) Vulnerable as women and as lesbians, therefore, but under-reporting of violent incidents perpetuates the perception that violence is not an issue for this group. Domestic violence within lesbian relationships in Ireland is an area that has not received much attention to date, and international research shows that it is likely to be under-reported as is the case with other minority groups.

Substance Abuse: Little evidence is available to indicate whether levels of drug and alcohol abuse are higher among lesbians in Ireland than among the general population. International research provides mixed findings, with the majority of studies finding that alcohol problems are more prevalent and more severe among lesbians than among the general population, but with other studies urging caution in interpreting these findings in light of the methodological difficulties involved in sampling hidden and stigmatised communities (Hall, 1993). What is also noted in the international literature, however, is a cultural move away from substance abuse among lesbians, and a marked awareness within lesbian organisations that abuse and recovery are issues of central importance for their agendas (Room, 1998 cited in Hall, 1993).

2.1.6 Parenting, Reproduction, Fostering, Adoption

Lesbian parenting is an issue that has recently received a great deal of attention from the media, but which is still largely ignored at policy level, by the health, education, legal, social welfare and taxation services. Some of the problems that confront lesbian women, however, are a direct result of their specific position as both lesbians *and* women, and one of the more striking inequalities to affect them as lesbians is the lack of support and recognition of their family life. It is here that the combination of state apathy and antipathy towards non-traditional family forms serves to deny lesbian women and their children equal rights as citizens. Lesbians who want to parent either through assisted reproduction, co-parenting arrangements, fostering or adoption, often face medical, social and legal barriers which have emerged from a history of ignorance and prejudice about the issues of homosexuality and children's welfare.

Lesbians have always been a relatively invisible group in Irish public policy, and in spite of a mention in an occasional government publication (e.g. Daly, 2003) the interests of lesbian-headed families have been neglected in the vast majority of government sponsored research (see for example Ireland, 1998; Fahey & Russell, 2001; Daly & Clavero, 2002), and by the legislation and policies of successive governments.

It is suggested that potential and actual lesbian families form a small but significant minority in contemporary Ireland (see Appendix 2), but they are a group only in name – no outward signifiers identify them to each other or to enumerators. Even within the lesbian community, a largely urban singles scene provides the collective identity. Lesbian parents might not able to, or perhaps want to, access this lifestyle, thus risk being overlooked when needs are being assessed.

Some of the needs around parenting that arise in international literature apply even more forcefully in the Irish context. In Ireland, unmarried couples are not allowed to adopt a child jointly, even if the child is the biological child of one of the partners, nor is the non-biological partner currently facilitated in registering as the child's second parent on the birth certificate. Fostering has only recently become a practical possibility for lesbians in Ireland, and this mainly as the result of individual social workers implementing equality standards to their own practice. In Ireland, no fertility clinics currently allow lesbians to use donor insemination services to become pregnant. Despite having some of the most progressive equality laws in Europe on our statue books, because of Constitutional barriers to non-marital families, legal advice currently argues against taking a case against a clinic on this issue. However, this situation leaves lesbians

wishing to have children in Ireland with limited options. One of these options has been to travel to the U.K. where some clinics accept lesbian clients.[1]

For others who cannot or choose not to go this route, and instead make private arrangements for sperm donation, there are then other health risks arising from the already documented reticence of lesbians to approach the medical establishment for things such as health screening of the donor and adequate antenatal care, for fear of prejudicial reactions. A company set up in the U.K. which offered fresh donor sperm delivered to addresses in Ireland (from donors living in Ireland) has been criticised for the poor quality of its service: sperm has arrived cold, in broken flasks, and one client even found a piece of broken glass in the specimen. Aside from these problems, fresh sperm cannot be thoroughly tested so women using it to try to become pregnant risk their own, and their baby's health. This company has since folded. The lack of access to mainstream fertility clinics thus leaves lesbians who want to have children vulnerable to disappointment, or worse, to fatal diseases for them and their children (O'Connell, 2000; Flood, 2003).

For all lesbian couples who embark on parenthood there are the stresses of the lack of legal connection with the child by one of the partners, and the consequent lack of recognition of that relationship by medical professionals, social policy and society at large. This can have emotional as well as practical implications for all concerned in the absence of any legal mechanism for sharing or transferring parental authority between lesbian couples. Problems can arise, for example, when children are ill, where only the biological mother is available to bring the child to seek medical attention, or when children are attending school and permission is sought for medical interventions.

The Parental Leave Act was recently updated to allow those acting *in loco parentis* to avail of parental leave, but this does not appear to apply to the non-biological mother of a child born to a lesbian couple, despite the fact that the Equality Authority report (2000) recommended that leave entitlements including parental leave should be provided for same-sex couples. In 2001, Canada extended parental leave to include same-sex couples, but it is yet to be seen if Ireland will follow through on the Equality Authority's recommendations.

[1] Of course, apart from the obvious expense which restricts access to the more affluent, the logistical difficulties involved in arranging travel, accommodation, and time off work are exacerbated by the sometimes impossible task of finding a sympathetic and qualified health-care provider locally to perform scans, re-write U.K. prescriptions, and monitor general health. It is well known among fertility experts that stress is a factor which mitigates against successful conception, so even for those who manage to arrange all of this, their chances of success are diminished from the outset.

All of these problems are of course enormously increased if a relationship breaks down, and there are currently no specifically targeted support services available to lesbian families in these difficult situations.

2.1.7 Services

A report compiled in 2004 on behalf of Cork City Development Board, *Towards Objective 86: A Service needs Analysis of the Cork City Lesbian, Gay and Bisexual Community* (Power, 2004) outlined the way in which service providers consistently fail to take account of the different needs of the lesbian and gay population in designing and implementing policy and in providing public services. This report finds that there is little understanding around the need for equality measures, positive interventions and existing differentials that existed in service provision. Some agencies are quoted as saying that since they treat everyone equally no discrimination exists, but it is a fact that equal treatment can frequently produce inequality of outcome.

A number of state agencies deliver services, in accordance with the requirements of legislation, strictly on an individual basis regardless of whether one has a same-sex partner, for example, the Health Service Executive and the Cork City centre for Social and Family Affairs, which each cited the fact that same-sex partnerships are not recognised under law. This applies equally from assessing cases for adoption to making welfare payments. An exception to this practice was found in housing needs assessment, where lesbian or gay families may apply for housing similar to heterosexual families and individuals. The criteria used for housing assessment are the same for all applicants. The Health Service Executive does, however, provide training for its staff around sexual orientation.

A sub-group in the Department of Community, Rural and Gaeltacht Affairs (CRAGA), which provided supports to other communities of interest, provided only *advice* in relation to Lesbian, Gay and Bisexual matters, providing no direct support to this community, despite applications for support by several LGB groups over a number of years.

This all takes place after a raft of recommendations by the Combat Poverty Agency (1995), the Equality Authority (2002), and the NESF (2003), including: the resourcing of community groups and the establishment of structures for participation; an anti-poverty programme which recognises the specific problems affecting the lesbian and gay community (GLEN, 1995: 93);

LGB awareness training amongst the judiciary and legal professionals (EA, 2002: 77); the mainstreaming of sexual orientation as an equality ground in policy design and monitoring; targeted funding of LGB groups with social inclusion and equality objectives; a central Government Department to oversee the implementation of equality policy for this group; and providing for positive action to be taken in relation to sexual orientation in the context of transposing the EU Employment Directive (NESF, 2003: 51, 56).

The needs of the lesbian and gay communities were assumed by the organisations included in the CCDB report to be no different from those of mainstream society. Little attention was paid to existing research highlighting the shortcomings of this approach, and not a single service provider collected its own data on the issue in order to inform policy and practice. What international and local research shows is that lesbian and gay people are more likely to suffer from homelessness, bullying and harassment, and as highlighted above, suicide among young gay males is significantly higher than in the general population (e.g. EA 2003; GLEN, 1995; ICCL 1990).

While the National Economic and Social Forum Report (2003) called on the Government to make a positive undertaking to implement equality for lesbians, gays and bisexuals, a recent survey showed that less than half (48%) of Public Sector organisations (excluding Government Departments) had made attempts to promote equality or avoid discrimination on the grounds of sexual orientation (Millward Brown, 2003). Lack of data and difficulties associated with data collection are cited as reasons why progress is slow in these areas, but the NESF report emphasises that *"lack of profile data and research…should not be a barrier to progress; action needs to be taken first by official bodies and the data will then follow"* (NESF, 2003:4). In other words, the invisibility of the lesbian and gay population is as a result of poor equality proofing, and their situation will improve with improved service provision.

One of the most striking findings of the CCDB research was the difference between what were often highly positive face-to-face interactions with those agency staff working on the ground and the level of apathy, resistance and even antipathy encountered at higher levels within the agencies surveyed. It is not clear whether this resistance is politically or economically motivated or is simply the result of ignorance of the issues, but the reality in practice is that agency staff members, no matter how well-motivated and informed they are as individuals, are often poorly supported at policy level in their efforts to address lesbian and gay issues.

The CSO National Household Survey 2004, shows that 0.8% of the population experienced discrimination in accessing health services on the basis of sexual orientation. While these figures are seen as statistically too small to be significant to the population as a whole, when translated into a percentage of the estimated proportion of the population that identifies as lesbian or gay, these figures take on statistical relevance. Interestingly, figures for discrimination in access to health care on the grounds of *gender* are 4.1%, *marital status* 3.1% and *family status* 9.7%. Lesbians might find themselves experiencing discrimination on any or all of these grounds arising from their sexual orientation, as well as on grounds not directly related to their sexual orientation, such as race, membership of the Traveller Community, age, etc.

This survey highlights other problems of discrimination, such as the low rates of those taking any action in relation to the discrimination they had experienced. This was especially notable among those categories of persons who are most likely to experience discrimination.
Taking the population as a whole, under the nine categories of discrimination examined, 48% of people who had experienced discrimination reported "some effect" on their lives, while 25% reported a "serious effect" on their lives. Just under 27% of people felt that the discrimination they had experienced had had little or no effect on their lives.

2.1.8 The Role of the HSE

The Health Service Executive (HSE) has two key strategies that lesbians have identified as key responses to their needs. These are the *Primary Care Strategy* and the *Focusing Minds Mental Health Strategy for Cork and Kerry*. Both of these strategies advocate closer relationships with the community, health promotion and well-being being holistic and integrated with other services and needs in life.

The HSE has the capacity and resources to respond to the needs of the lesbian community. What it also needs is a commitment at senior level to respond not only to the recommendations made in this report, but also to respond to City Development Board report *Toward Objective 86*. Both reports recommend the great need for awareness and anti-homophobia training among all health professionals, in addition to adjusting services to be more sensitive and inclusive of lesbian and gay people.

Health Board Departments are already dealing with lesbians throughout all their services: a good relationship with the community and a greater understanding of lesbian lives would go a long way towards a preventative approach to major health problems and long-term serious illnesses. In particular, much could be done by the Health Promotion Unit internally to bridge the gap between lesbians and the health services they access.

The NESF report, *Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues,* 2003, followed up on the implementation of the recommendations of the Equality Authority's 2002 report *Implementing Equality for Lesbians, Gays and Bisexuals* (2002) and found that although some of the recommendations made in the 2002 report had produced positive responses and commitments from some government departments, substantial progress was still to be made to achieve greater equality for LGB people. Three years later, at the time of this report, this still holds true. See Appendix III for a summary of this report's recommendations relating to health.

2.2 Key Findings from Existing Research

The findings below are taken directly from the research reports, which are referenced in the previous sections.

Health Matters

- ⇨ Lesbians have a higher level of polycystic ovarian syndrome
- ⇨ Lesbians have a higher risk of heart disease
- ⇨ There is a lack of information about woman-to-woman STDs – this is particularly important for young lesbians
- ⇨ Those who are afraid to "come out" or do not have access to an LGB community are at risk of psychological distress, damaged self-esteem and reluctance to access preventive care
- ⇨ There is a high uptake of counselling services by lesbians which could reflect the homophobic society which lesbians have to constantly live within and/or the value lesbians place on internal and emotional well-being
- ⇨ International research indicates that lesbian, gay and bisexual youth comprise up to 30% of completed youth suicides, and are up to 2-3 times more likely to attempt suicide
- ⇨ Drug and Alcohol abuse are significant concerns for the lesbian community

- ⇨ Lesbians with Mental Health issues frequently request help and referrals in the LGB community
- ⇨ Further specific research is required on these last three items in particular and has been recommended by previous reports as far back as 1995.

Health Services

- ⇨ Lesbians generally prefer a more holistic approach to healthcare
- ⇨ There is a preference for female service providers
- ⇨ A total lack of access to existing assisted reproduction services and official acknowledgement of lesbian family forms does not facilitate adequate and appropriate care of lesbians and their children
- ⇨ Negative experiences with health care providers can directly impact on women's willingness to seek regular care
- ⇨ Acknowledging same sex partners as next of kin, women as lesbians with different sexual preferences and life-styles are general concerns across the lesbian community when accessing all health services
- ⇨ Older lesbians experiencing lack of sensitive care around menopausal concerns, and lack of recognition of their partner or lifestyle can experience high levels of distress and isolation, particularly acute around a bereavement
- ⇨ The lack of appropriate elder care is of high concern among older lesbians
- ⇨ Violence exists within the lesbian community and it needs the full acknowledgement of all state services if it is to be reported and understood
- ⇨ There is a lack of equality measures in service provision, which takes account of the inequality and disadvantage being experienced at the outset by lesbians. This disadvantage can be compounded on other grounds of discrimination such as race, disability, ethnicity, family status and gender.

3. HEALTH SURVEY QUESTIONNAIRE

L.Inc decided to further examine the health of lesbians and bisexual women in Cork by reaching out to those women who may not have responded to the invitation to be part of the focus groups. There are 800 hundred women on L.Inc's membership list and it was felt that that we should also try to include the voices of this wider group. It was decided that this could best be done by a questionnaire study mailed to those who were on the L.Inc mailing list and by word of mouth. This was undertaken by a sub-group of the L.Inc steering group that included: Dr Julie Norris, Ms Cora O'Regan, Ms Gwen Kennedy and Ms Kate Moynihan. Together they undertook the development and promotion of this health questionnaire which tried to respond to the requests of the community for a piece of research which covered the issues of physical, emotional, sexual and social health. The survey was predominantly quantitative in nature i.e. produced numbers and percentages and used a number of different standard psychological questionnaires so they could be compared with other samples of the general population. These can be viewed in the appendix. Participants were given the opportunity to comment on some questions verbally also, which can also be viewed in the appendix.

Covered below are the summarised results of the questionnaires, including section on the sample group, general health including dependency, emotional health, including suicide and self harm, supports, social health, and the role of L.Inc.

3.1 The Sample Group

The questionnaire was posted on the L.Inc website, hundreds of questionnaires were sent out by post and a number were left in the L.Inc offices for anyone who wanted to fill one in. Of these 107 women who live in the Cork region returned the questionnaire and these have been analysed. The table below shows where the sample population heard of the research.

Table 1.

Mail out returned	85%
Word of mouth	12%
Downloaded	3%

Some respondents did not complete all sections of the survey. This was an option given with the instructions printed on the cover page of the survey to ensure everyone was happy to respond only to what they were comfortable with including. This means that there are slightly different

numbers of responses for each area. The specific numbers responding to each questionnaire are available in the appendix.

Table 2 below shows who responded, in terms of sexual identity, age, employment, where they live, who they live with and how many are parents of children.

Table 2. Demographics of respondents

		(%)
Sexual Identity:	Lesbian	85
	Bisexual	12
Age	Under 23	8.5
	23-49	45
	Over 49	44
Employment Status	Working full-time	52
	Working part-time	24
	Working CE scheme	2
	Not working	18
	Student full-time	14
	Student part-time	13
	In receipt of benefit	17
Living Environment	City	50
	Town	17
	Village	7
	Semi-rural	6
	Rural	19
Living with:	On own	26
	Female partner	33
	Male partner	7
	Parents	7
	Friends	16
	Children	17
	Other	6
Parenting:	Parents	27
	With children under 5	8
	With children 5-12	11
	With children 12-18	4
	With children over 18	11

The figures above show that the survey was completed by 85% of women who identified themselves as lesbian, with only 12% identifying as bisexual. In terms of age, 89% of the sample are over the age of 23 showing that young lesbians are not well represented within this sample. There is however, an equal number between those under and over the age of 50.

3.2 General Health

The general health of lesbians and bisexual women in Cork were compared to the general health of a random sample of Irish females (Blake et al. 2000). There were eight indicators of general health and the comparison between the two groups is shown below in Table 3. The numbers shown are the average scores and a higher score means better health. Each scale has a possible score range of 0 – 100.

Table 3. Descriptive statistics measured on the-SF 36, (with norms from Blake et al 2000).

	Average scores	
Eight different types of health covered	*Our sample*	*Irish women*
Physical Functioning	83.54	84.32
Bodily Pain	68.39	76.59
Personal evaluation of Health	69.61	73.99
Vitality – Perceived energy levels	60.39	63.16
Mental Health	72.04	76.45
Extent to which physical and emotional health is seen to interfere with social activities	77.71	84.02
Extent to which physical health is perceived to interfere with work or daily activities	73.82	79.32
Extent to which emotional health is seen to interfere with work and daily activities	73.33	81.73

It is evident from these results that the health of lesbians and bisexual women who answered this questionnaire is poorer on all eight measures of health than Irish women in general.
37% of the sample experience moderate to severe physical pain. Importantly the physical and emotional health of Lesbians and Bisexual women has a greater impact on their ability to work, maintain social relationships, and carry out basic physical activities than the average Irish

female. It is clear from these results that the lesbian and bisexual community in Cork requires services directed in these areas.

Interestingly, studies show that as age increases health decreases, but this was not the case in this sample. Basically younger people showed the same levels of health as older people.
59% of the sample are out to their GP and 93% of those who are out found it easy. However, for example, only 38% of the sample attends regularly for smear tests, indicating that the health needs of lesbians need to be targeted with a particular focus on prevention.

3.3 Emotional Health

The survey measured Stress, Anxiety, Depression and Self-esteem. The average score for those who answered this part of the questionnaire was compared to a UK sample as there are no published averages for an Irish Sample. (This comparison was thought to be relevant because there was no difference between the eight measures of general health between Irish and UK women as reported in the previous section).
In the Table below, a higher score indicates greater levels of Stress, Anxiety and Depression, (between 0 – 39) but for the self-esteem score a higher score means lower self-esteem (between 10 – 40).

Table 4. Mean scores of DASS-42 and Self-Esteem, with norms.

	Sample Average	UK Average
Stress	8.69	9.27
Anxiety	4.82	3.56
Depression	6.47	5.55
Self-Esteem	36.48	34.52

The sample who answered this part of the questionnaire show higher levels of depression, anxiety, and lower levels of self esteem than average. The sample reported themselves to be less stressed, which is interesting given the known relationship between health and stress.
For anxiety 83% of respondents demonstrated normal levels, 8% demonstrated mild to moderate levels and 9% recorded severe to extremely severe levels. For depression, 79% are experiencing normal levels, 12% mild to moderate levels, and 9% severe to extremely severe levels.

Scores on self-esteem were found to be higher than normal (for published norms, see appendix) indicating that this sample has lower self-esteem. Levels of self-esteem have a stronger correlation with levels of depression for this sample.

Suicide and Self Harm

Respondents were asked a series of questions relating to their history of suicide ideation (thoughts of wanting to kill oneself), actual suicide attempts and self-harm practices. The other measures of emotional health reflect a 'snap shot' of community well being. As the sample is representative of the community it would be expected, without intervention, that the levels reported above will remain stable but for different people at any given time. Historical data is cumulative and therefore cannot be compared with current annualised suicide or parasuicide rates. However comparisons can be made with data reported by Balsam et al (2005) who measured self-harm, suicide ideation and suicide attempts in a sample of American lesbians and their heterosexual siblings. The comparison between lesbians and their siblings controls for variance due to familial exposure to suicide. Therefore any differences identified between the current data and the data reported by Balsam et al (2005) should be due to cultural context, that is the difference between being a lesbian in the Southern region of the HSE as opposed to being a lesbian in America.

Table 5. Self-harm, suicide ideation and attempts of the current survey, American lesbians and their heterosexual siblings.

	% in Survey	% American Lesbians	% Heterosexual Siblings
Self Harm (now)	2.8	-	-
Self Harm (past)	23.8	24.5	13.2
Suicide Ideation	49.1	38.4	19.7
Suicide Attempt	14.2	7.9	4.4
Mean no of attempts	*1.92 (2.4)*		

It is clear from Table 5 that American lesbians have higher rates of self-harm, suicide ideation and suicide attempts than their heterosexual female siblings. Levels of reported self-harm are higher in American lesbians than in the current sample. However, of great concern is the comparison between levels of suicide ideation and suicide attempt. Percentage of respondents

reporting suicide attempts in this survey is nearly double the percentage of people who have attempted suicide in the American sample.

Supports

Respondents were asked what support networks they feel comfortable in using in the emotional health section of the survey. Participants could tick multiple responses to indicate all of their supports.

From Table 6 it is clear that family and friends are most relied upon for support, with friends being the most important. In order of preference these are followed by the individual's GP and lesbian community workers.

Table 6. Support that % of respondents feel comfortable using.

Support	%
Friends	88
Family	66
GP	28
Lesbian Community Workers	21
Internet	15
Straight Community Workers	14
Other	12

Summary of Emotional Health

Of primary concern within this section are the statistics in relation to suicide. That measures of depression, anxiety and self-esteem are above population norms is also of concern. The inter-relationship of suicide and depression would indicate a necessity for intervention. The high level of dependence for support from friends would support the notion of community intervention.

3.4 Social Health

As reported earlier the primary source of support for this sample is friends. It is therefore important that the community as a whole is supported so that individuals can fulfil the role required of them. There are issues relating to sexual orientation that impact across the health spectrum which require an understanding of the social context of lesbian and bisexual women in order to be addressed.

Within this there are specific social and relationship issues that can impact upon health. Whilst 89% of the sample are out, just under half of those found it very difficult to come out to their families. Even though the majority of the sample is out, a significant proportion of the sample manage or change their behaviour in public. 50% of the sample avoid showing affection in public mainly for fear of physical and verbal abuse.

70% of the sample reported they were currently in a relationship. It is acknowledged that all relationships can be difficult regardless of the gender of those in the relationship. So while 50% of respondents indicated that their relationships would be better if they spent more time together, 20% of the sample reported that they had experienced sexual abuse or violence from a female partner at some time in their lives. The difference between lesbian relationships and heterosexual relationships is the amount and accessibility of the support services to deal with such issues.

Information is also important for maintaining healthy relationships. 83% of the sample believed that they should practise safe sex but only 35% of respondents do and 23% of the sample didn't know what safer sex is.

Issues around Dependence

Alcohol

Respondents to the survey indicated that they drink an average of 8.4 units of alcohol a week. 1% of the sample indicated that they were dependent on alcohol. It would appear that dependence is not a significant problem for the community, However, it is worth noting where issues of dependency are concerned there is often a general tendency for people to not be aware of, or to report a problem, or simply to be in denial.

Therefore a more enlightening statistic is that 10% of the sample indicated former dependency issues for which help was sought with a further 3% currently seeking help with issues around dependency.

The role of L.Inc

52% of this sample indicated that they use L.Inc as a resource. For those who did not use L.inc the major reason stated was that the opening hours were not suitable for people who worked in places other than the city, respondents were particularly keen for more weekend and evening opening and for information, courses, support and social groups.

4. FOCUS GROUP DISCUSSIONS AND FINDINGS

In order to capture the personal and more direct experience of health services and needs, over 200 women were invited to participate in focus group discussions. The focus group sessions took account of 44 women's experiences: 34 of these participated directly in open forum discussions and 10 were accessed through the staff. All of the women reside in and around Cork city. The thematic headings chosen for focus group discussion were Young Lesbians and Health, Older Lesbians and Health, Parenting, and Lesbians and Health. While the topics were specific, general themes such as "coming out" experiences and "abuse" were explored across all groups. In addition, a fifth discussion was organised with the staff as L.Inc as they have direct experience of meeting women who come in to the resource centre often citing health concerns. It is these women, who are often not out and who are sometimes fearful, that frequently have the most urgent health needs.

The focus group discussion was structured by a number of key questions, at the end of which a brief information hand-out complied from Irish and international reports was given to participants, and a short personal questionnaire was completed by everyone in attendance.

The Context of Carrying out Lesbian Research Work

It is essential that we note at the very beginning the context in which we as researchers, and L.Inc as an "out" lesbian organisation, are working.

We all felt that we were privileged to have met so many lesbians in this research that were willing to participate and share their experiences with us. We were also highly conscious of the number of lesbians that we personally knew directly or indirectly who would not even cross the doorstep let alone share what we knew to be their difficult circumstances and health status.
The women who attended meetings are, by and large, confident, assertive and have good self-esteem, many own their own homes and live a middle class life-style. However, we know that there is another cohort of lesbians who do not fit into these more comfortable categories and who cannot or will not attend at this point in time in their lives. How can we ensure their inclusion?

We have tried to include their experiences, as we know of them through informal contact and word of mouth, under key community needs as they apply to the wider community. This is only

the tip of the iceberg and it is where very real needs exist. But until it is safe to be visible, until we have a society that is more accepting, tolerant and sensitive, it will continue to be difficult for those lesbians who are most vulnerable to come out, access services and get the health responses they need and deserve.

Qualitative research often includes lower numbers of participants, (than large scale quantitative data analysis), but as its name suggests it comprises high levels of experiential depth and quality in its approach and analysis. This research takes account of the input and discussion of real lesbians' lives and the interactions and experiences that they have with the world. This qualitative approach is commonly used in community work, where communities are small for geographic or minority reasons, but it is an approach which has the capacity to get closer to the real truths and needs in people's lives.

Community Consultants Ltd., has worked with many other minority communities, e.g. Travellers, Asylum Seekers and Refugees, Lone Parents and an average group size for input into qualitative research work would be an average of 20-25. All agencies working with these communities accept the findings as reflective of the general community experience.

From the good level of participation in the focus group discussions, the key findings are:

4.1 Young Lesbians & Health

Generally aimed at 18-25 year olds.

Seven women attended this session. 3 were aged 20, 2 aged 21, 1 aged 22, and 1 aged 23.

6 identified as lesbian and 1 as bisexual.

4.1.1 Experience of Health Services in General?

The main services that these young women accessed was GPs, Dentists and Gynaecologists. Most women stated that they also use alternative health care .e. homeopathy and herbalists etc., in addition to traditional mainstream services. Contact with the Health services was at a minimal level and was mostly concerned with routine check-ups - primarily due to age.

The main difficulties being experienced by these young women are the heterosexist (belief in the "naturalness" and superiority of heterosexuality) assumptions and remarks that they are subjected to when they visit health services.

"Most of the women are commonly asked about boyfriends," remarks are made about *"playing rugby not being suitable for girls,"* and one lesbian woman with a disability is almost ignored as a person, in addition to her sexual preference not being seen. Some women who are from rural areas said that their *"GP or Dentist do not even know what a lesbian is, there is not a scrap of information in their surgery to let you or anyone else know."*

One woman who had fertility problems was told she *"needn't worry as it wouldn't affect her because she is a lesbian."*

4.1.2 Experience of Coming Out to health professionals?

Only 2 out the 7 were out to their GP. For the two women who are out, one says it is fine and a non-event, the other found her GP to be very reassuring. The GP had obtained relevant information and facilitated her to be open about her sexuality at her clinics. Being out has enhanced the relationship both in terms of safety and disclosure of full medical needs.

There were distinctly opposing opinions in the group as to whether it mattered whether you are out or not. Some felt that there is no need to say it, and others felt that it is essential to who you are in the world.

Being out is central to receiving appropriate services: most of the women experienced the service provider as *"judgemental, not approving of their level of sexual activity though most thought this would not be the case if they were sexually active were men".* Young lesbians stated that they often receive advice which is inappropriate or sometimes inaccurate. Many lesbians felt they were dismissed when it came to being given information on Sexually Transmitted Infections (STIs) and reproduction.

4.1.3 What are your (and the community's) specific health needs?

This group felt that there is a huge need for information about safe sexual activity, reproduction and health-related illnesses particularly around alcohol and drug misuse.

The issue of most concern for young lesbians was information, advice and services to respond to alcohol and drug addiction. The whole group felt that this was a serious issue for their community and had witnessed a significant level of engagement in both alcohol and drug use. Many in the group felt that a lot of binge drinking and drug use was as a result of being uncomfortable and feeling unsupported with being lesbian and not have the information, knowledge or confidence to access the community organisations that exist. Young people need safe places to socialise. They felt that most young people are unaware of the long-term effects of excessive drinking and drug abuse. This group also indicated that are not aware of anywhere in Cork where they could access safe-sex prophylactics such as dental dams or where they can receive non-judgemental advice in relation to safe-sex practices for lesbians.

4.1.4 How should L.Inc/other organisations respond? – what are the priorities?

- ⇨ Information leaflets on LGBs to be provided for distribution to all GPs, Dentist and other health service surgeries, clinics or service areas.
- ⇨ Health Professionals need to educate themselves, especially around lesbian lives, i.e. having same-sex partners, having children and living a normal life. This would contribute to a more inclusive and non-judgemental health-care setting.
- ⇨ Sex education in schools is almost exclusively about heterosexual sex, with no information on STDs (including issues of particular concern to lesbians, such as the use of gloves and dental dams), or reproductive issues that apply to lesbians.
- ⇨ L.Inc should run regular workshops on a variety of health topics to facilitate the education of the lesbian community, create a directory of lesbian-friendly services, develop awareness posters and materials for wide distribution e.g. services, pubs, clubs, etc., and stock safe-sex supplies such as latex gloves and dental dams.
- ⇨ L.Inc should liase with the Health Service Executive – all departments, and assist with designing and developing appropriate training and education modules for health professionals. The HSE in partnership with L.Inc should ensure the community know how to access services.
- ⇨ A specific youth health project is needed which will create a safe space for lesbians to learn about their bodies and their health, a project which provides a range of information of all topics of concern to young people and a project that takes a preventative and

responsive role in relation to young lesbians who are experiencing difficulties with alcohol and drug abuse.

4.2 Older Lesbians & Health

Generally aimed at women aged 40+ Ten women participated in this group session. 2 were between the age of 40-45, 4 between the age of 46 and 50, and 4 between the age of 51 and 55. 9 identified as lesbian and 1 as bisexual.

4.2.1 Experience of Health Services in General?

There was a mixed reaction to general health services, although there is a high level of frustration among older women at the manner in which they are treated by the medical profession in particular. The most common services accessed were GPs, Gynaecologists, some mental health services and occasional visits to A&E.

The key frustration agreed across the group is that medical professionals are *"not listening"*. Women are expected to be passive, not understand their bodies, and receive standard drug responses to any of their complaints – many women said they received this response particularly in relation to any menopausal complaints. One woman who described herself as working class felt that *"because of her class she is heard even less and often finds the services very judgemental: when she interacts with the professionals, they suggest she is neurotic and depressed"*. All participants felt that women do know their bodies even if they cannot articulate it medically. *"By and large, women know when something is wrong with their bodies and they are often right – but this is not valued"*.

On the other hand, some women found specific services to be a very positive experience e.g. one woman attending the breast clinic said it was *" an amazing service, easy, relaxed, informative and helpful"*. Many women said that when they had utilised hospital services, they were treated with dignity and respect though they found the use of medical jargon difficult.

At least 50% of the group use alternative health options regularly though it was noted that alternative therapies are expensive, not accessible to everyone and not everyone is aware of them as options. One woman stated that *"using alternative approaches starts from the assumption that you know best about your body and you are treated holistically".* Services accessed ranged from homeopathy, acupuncture, massage, reflexology, herbalists, reiki, osteopathy.

4.2.2 Experience of Coming Out to health professionals?

9 out of the 10 women were out to their GPs and other health professionals when they meet them, although they would not declare their sexuality if they felt that they might be diagnosed with depression as a result of this disclosure. Everyone in the group felt that being out is essential to your well being as a lesbian in the world.

"Lesbians have very valuable lesbian lives that they would like acknowledged and recorded".

As with younger lesbians, this group felt that medical professionals make many heterosexual assumptions about the women they meet, in addition to assuming that they are not sexually active because of their age.

In relation to health and well-being, the experience of "being" in a heterosexual environment or "being" in an accepted (usually lesbian) environment is experienced as totally different – like being on two different planets. This is why L.Inc is so important – a safe space to be ourselves.

4.2.3 What are your (and the community's) specific health needs?

The biggest concern for this group of lesbians is getting older and how will they be cared for *as lesbians*. Will they have to come out yet again? As they get older will they disappear as lesbians again? *"We are worried about getting older as lesbians".*

"As we get older we should have a choice about the type of care we want – we should be allowed appropriate care and conversation – to be ourselves and not have to disappear into straight models of care. We want responsive health care that sees us as who we are – lesbian – and not to be patronized and pathologised".

There was a strong belief that there is a high level of alcohol addiction within the lesbian community – it is how some women cope with personal problems and with the stresses of being different in a "straight" (heterosexual) society. Services that respond appropriately to this need but first understand the problems and context were seen as a priority.

4.2.4 How should L.Inc/other organisations respond? – what are the priorities?

- ⇨ Teach all health professionals not to make assumptions, to use inclusive language in conversation and in literature, and understand lesbian sexual practices. All staff need an understanding of homophobia (hatred/fear of homosexuality) and its negative impact.
- ⇨ Administrative paperwork of the HSE could include a tick-box for partner – male/female, and when taking a woman's medical history ask questions without heterosexist assumptions.
- ⇨ Provide information within the community e.g. about lesbian friendly services, getting older and related health issues e.g. menopause, osteoporosis, etc., that might arise and information about rights and entitlements. Encourage all lesbians to be out.
- ⇨ Increase counselling services in the community, ideally through L.Inc.
- ⇨ The development of lesbian-specific nursing homes – this would go a long way to caring for older lesbians and could probably be self-financing?
- ⇨ Build a partnership approach to addressing needs between services of the HSE and L.Inc, where women are referred to L.Inc for support and information, and where HSE staff undertake appropriate training and improve their in-house procedures, materials and administrative paperwork.
- ⇨ Areas needing further research in terms of providing appropriate responses are mental health, alcohol/drug addiction, and domestic violence.

4.3 Parenting & Health

10 women attended this meeting. Their age ranged from 1 under 35, 3 between 35-40, 4 between 41-45, and 2 between 46-50.
All 10 identified as lesbian with one woman using gay also.

This group focused on health from their perspective as parents requiring and interacting with the health services both for themselves and their children.
Women in the group have become parents through a variety of means i.e. donor insemination (known and anonymous), fostering, adoption, and children from a previous heterosexual relationship (married and not).

4.3.1 Experience of Health Services in General?

Almost all women in this group experienced GPs both for themselves and their families as very positive and open. While GPs can be naive about lifestyle and sexuality, they generally appear open to learning. This was not the case for one woman living in a small rural town.

In relation to other services – A&E was a good experience, and specialists such as Gynaecologists are becoming more open to lesbians having children – although this is the opposite of the experience of younger lesbians.

Women found that once they were out their experience of maternity services from ante-natal care, to birthing and after care was excellent. *“The staff in the maternity services were kind, sensitive, inclusive of their partners and they were all accepted as lesbian parents”.* This was felt as a great relief as anticipating the response of health professionals is often daunting.

For lesbians wishing to use donor insemination services in clinics in order to conceive a child, they are refused access in all of the clinics currently operating in Ireland, forcing them to travel abroad for this part of the service. This makes achieving pregnancy very problematic and expensive. However, one couple reported very good recent experience of a fertility clinic in Cork, where they received scans and back-up support while travelling back and forth to the U.K. for inseminations. Being in a couple made it easier to explore reproductive options, and using recommendations from other lesbians was found to be the best way to proceed in the absence of any official information.

There appears to be inconsistent treatment when it comes to obtaining birth certificates for children born to lesbians through assisted reproduction, where there is no birth father to record. Some women got them in the hospital soon after the baby was born and without any difficulty, other women could not get them even though it was the same hospital. Other women had to get an affidavit signed by a commissioner for oaths and subsequently attend the registration office to go through an interview process which was not a comfortable experience.

Almost all parents use alternative therapies both for themselves and their children. The therapies ranged from Homeopathy, Herbalists, Acupuncture, Massage and Cranio-Sacral Therapy. The general experience of using alternative therapies is positive, and women feel it easier to be out in these situations.

General comments in relation to other health services such as mental health, psychiatry, counselling, etc., appears to be that these health professionals are not generally well-informed and seem somewhat uncomfortable with lesbians and their lifestyle.

Finally, family mediation services were mentioned and were criticised for being “very heterosexual” and not readily available to lesbian couples needing support.

4.3.2 Experience of Coming Out to health professionals?

Nine out of the ten participants are out to their GP and other health professionals. These participants claimed that being out does make a difference in your interaction with health professionals – it helps services to be more sensitive, acts as an education lesson and the service can be more helpful to you.

However, having to come out all the time is experienced as painful and the constant level of assumed heterosexuality is exhausting.

4.3.3 What are your (and the community’s) specific health needs?

Reproductive services are highest on the list for these individual women and for the community as a whole. In addition, and across all groups, the need to be treated with sensitivity, understanding and without prejudice ranks equally high.

While it was acknowledged that the HSE are very supportive of fostering by lesbians, the level of "outness" among the extended parties can vary considerably. Adoption, including second-parent adoption, by lesbian couples is currently not allowed in law, although in theory a lesbian can adopt as a single person. This was felt to be discriminatory and not in the best interests of children who it was felt needed the security of a continuing relationship and support of two parents where this already existed in a *de facto* lesbian family. There is no provision for the non-biological mother to register as a second parent on the birth certificate. Similarly, there was some confusion and it was felt that there is a lack of information around guardianship for those who would wish to choose this route (as the law currently stands in Ireland, a guardian can only be appointed by the mother in her will). It was strongly felt that this leaves all children born to lesbian couples in a very vulnerable situation vis-à-vis their family status, maintenance, custody and access and inheritance rights over their non-biological parent.

Lesbians in this group would like access and more information about all health issues affecting women, regular screening, and appropriate sex education for our children. In particular, it was felt that an information or referral point within the community which is safe and where lesbians can get referred on to other suitable services that are reliable and lesbian friendly is a priority. Many parents expressed a wish for greater counselling supports within the community both as a regular service and for crisis situations.

4.3.4 How should L.Inc/other organisation respond? – what are the priorities?

- ⇨ Request the HSE to provide reproductive services in a non-discriminatory manner, from screening to fertility treatments and information on insemination options. This should be affordable and available in Cork.
- ⇨ Provide for the inclusion of the non-biological mother's name as second parent on birth certificates.
- ⇨ Introduce legislation to allow joint adoption by unmarried and same-sex partners.
- ⇨ All health professionals should be appropriately trained (including awareness of co-parents' roles) to use anti-discriminatory practices in their work, to listen sensitively to people and to avoid making heterosexist assumptions.

- ⇨ Provide more appropriate information to GPs, Dentists, other health services that can be publicly available in waiting rooms, clinics etc., demonstrating some openness to lesbian clients and to the existence of lesbian families.
- ⇨ Information should be available to the community to access easily e.g. a directory of lesbian friendly services.
- ⇨ The Health Promotion Unit should produce suitable information and proof all materials for heterosexism and homophobia.
- ⇨ L.Inc should be funded to work in partnership with the HSE.
- ⇨ L.Inc should provide more counselling services and act as a referral point to other mainstream services in the HSE.
- ⇨ Specialised addiction services and responses are required but there needs to be further investigation as to how this could happen.

4.4 Lesbians 25-40 year olds & Health

7 women attended this final focus group meeting. The meeting was aimed at 25-40 year olds who may not have been captured in the other focus group meetings.
7 identified as lesbian.

4.4.1 Experience of Health Services in General?

Most women talked about accessing General Practitioners, Dentists and Gynaecologists.
While overall service provision appears good, the level of heterosexist assumptions is totally exhausting for everyone. Judging by these experiences, the lack of understanding, sensitivity and education among health professionals around being lesbian in the world, is extremely bad. The following are examples:

" You don't need a smear test if you're not sleeping with men – lesbians are not at risk of STIs"

"When I was going down to theatre for an operation, my gender was being questioned"

"When I did come out, there was an uncomfortable silence, and I was already feeling vulnerable"

In general, everyone in this group said they would prefer to use women doctors. 5 out of the 7 women use alternative therapies, and are out to all those practitioners.

All women in the group said that getting referrals, especially to services that are lesbian friendly is best. They are then more comfortable even before going to the service and know that they can expect a more friendly and open service to them as a lesbian.

4.4.2 Experience of Coming Out to health professionals?

Most of this group said that they do not come out to Health Professionals unless they have to. Coming out is experienced as very stressful and pressurising. Everyone agreed that being out is critical to your health and well-being, though there were mixed reactions as to whether one would come out or not due to fear.

4.4.3 What are your (and the community's) specific health needs?

The key item identified at the top of the list is for health professionals to be more aware and sensitive to their lesbian clients. They should be more open to other lifestyles and sexual preferences.

A crucial need identified by this group was the need to respond appropriately to single lesbians. *"Maybe you're not a lesbian if you don't have a partner – how do you know?"* There needs to be a greater awareness and acceptance by health professionals of single lesbians.

There is a huge need to provide general health and STI information in relation to lesbian sex.

Forming families was reported to be fraught with difficulties for lesbians. For most lesbians there is no information and no access to reproductive services. Those that are available in the UK are very difficult to access and expensive. Similarly, with Adoption, there is a lack of information

and it too is expensive. This puts having a family out of the reach of many lesbian women who would otherwise choose to have children.

Anecdotally, there is a high level of alcohol/drug misuse within the community. There needs to be more information available in addition to access to a sensitive referral system. Many women (as with other focus groups) cited examples of women over-drinking due to not being comfortable with their sexuality, or not being out. This cultural response of drinking was noted by all groups as being a prevalent aspect of the community. Within our community, there is a need for mental health supports and referrals – many women are stressed, not coping and have multiple negative experiences in their lives.

In relation to abuse of all kinds, including sexual abuse and domestic violence, it was felt that this is the silent issue in the lesbian community. It was suggested that the community does not have the safety, the language or the skills to deal with abuse situations currently. There are fears around acknowledging its existence, fears that it will undermine the community or the credibility of being lesbian resulting in damage to the whole community. *"People push it away and don't want to know".*

Getting old is also of concern to this group, particularly if they are on their own – what will happen to them? Financial concerns were expressed in relation to women earning less than men and living longer – how are they to manage?

Finally, there is a huge need in schools to have sex education that includes lesbian and gay sexuality. There is a greater need to support children of lesbians in school and to support children who are themselves lesbian. They need recognition of who they are in their own right.

4.4.4 How should L.Inc/other organisation respond? – what are the priorities?

- ⇨ Health Professionals need to treat us better and support us to be fully ourselves
- ⇨ Health administration forms could be changed to at least include lesbians
- ⇨ People should be able to designate next of kin, so that female partners can be recognised and clients/hospital patients feel supported to be out and feel comfortable

- ⇨ Breast screening should be easily available to lesbians and we should not be made to feel uncomfortable about who we are
- ⇨ Giving blood donations as lesbians should be acceptable
- ⇨ Information and reproduction services should be available in Cork to all lesbians
- ⇨ More health information should be available at L.Inc and information about appropriate health services and professionals e.g. database
- ⇨ L.Inc could have an advocacy/information worker to support women to access appropriate services
- ⇨ Full-time counselling service is needed for the community
- ⇨ Development of an education pack for professionals and other organisations in relation to lesbian lives and homophobia

4.5 L.Inc staff experience of Lesbians using the resource centre

During the course of this research, it became clear that the women who were prepared to turn up to focus group meetings and participate in discussions were generally confident, out for the most part (98%), experienced at being out generally and politicised to varying degrees. Additionally, it was noted that the focus groups tended to attract more middle-class lesbians who are already somewhat privileged in their lives including their ability to be out confidently and comfortably.

The research through focus groups does not capture the experience of those women who are not able to be out for a variety of reasons, do not have access to the community or who not confident to attend a meeting and speak out. However, it was noted that many women who come into the resource centre are those who are shy, often not out and need a higher level of support and information than those captured by the focus groups.

To attempt to capture this information, a meeting was held with the staff at L.Inc who expressed their experience of what women were looking for, in relation to health matters, when they came into L.Inc. The following is a brief synopsis:

4.5.1 Women accessing the L.Inc Resource Centre

Women seek support from L.Inc by dropping in to the centre, telephoning and via email. For many women, it is easier to turn up in the hope of getting a listening ear than attending support groups especially when they are not ready. Most of the women who drop into the centre are in

the age bracket of 30+ and are looking for emotional support on a range of issues. The key issues are:

- **Accommodation needs**: House prices and rents have skyrocketed in the past few years, especially in cities. This has left many lesbians seeking accommodation that they cannot afford, that is, acceptable living conditions suitable to them living as a lesbian in the world. For many non-Corkonians this has become a highly stressful and demanding need in their lives. Women seeking accommodation are often in the age bracket 30-40, are away from their families, wish to have contact with the lesbian community and do not wish to live in poor quality accommodation far outside the city centre. Given the booming economy and level of housing prices, this is a serious and growing concern for many women and for L.Inc. For many of the women who drop in, there is a high risk of homelessness, isolation, transitory and unstable day-to-day living.

- **Support around the break-up of relationships**: For many women, breaking up from a relationship can be very traumatic especially if there is nowhere you can talk about it. For some women it is the break up with their female partner and for many others it is the break-up of their marriage/relationship with a male partner. *"One woman who called in was being physically threatened by her male partner who held a gun to her."* There is huge fear for women coming out of marriages: *"they fear losing their children, surviving in the world independently and financially. These times for the women who come in to L.Inc are highly stressful."*

- **Mental health:** Many women come into L.Inc and present with an initial opening line for discussion. Sometimes they progress on to other real issues that they are faced with but sometimes are unable to do so. For example, some women will look for social information, others who arrive just want to talk and be listened to, having more visible presenting symptoms although they are not discussing these e.g. obviously depressed, stressed, displaying a more nervous disposition, or signs of drinking or drug use. In all these cases, these women's self esteem and confidence is low and a majority come from a working class background or area of the city.

For the women who enter the centre with health concerns or difficulties, many of them find a listening ear and get appropriate information but find it is above all a safe place to chat and have

a cup of tea. The staff tries to integrate women who drop in into one of the support groups and where this happens the outcome in general has been very successful in terms of increased well being and finding support. However, many women who drop in are very vulnerable and are not ready to attend a structured group meeting.

In some situations, women present with issues of domestic violence. L.Inc wishes to refer them to specialist organisations but they in turn do not have the training to understand lesbian relationships and violence. Some refuges e.g. Tralee, have requested training from L.Inc but L.Inc does not have the resources to provide such training. Another opportunity goes a begging. Domestic violence is a difficult issue for the community, there is a sense of "community shame," and currently it is being met with silence.

For staff and the organisation of L.Inc, this type of drop-in service is demanding, disruptive to their core work responsibilities and many times the staff themselves feel that they do not have the skills, training[2] or qualifications to respond well to the person dropping in. But it remains the only place for lesbians who need support to go.

"Many women see L.Inc, its support groups and resource centre like a surrogate family. We need therefore to take care of each other in all our needs from emotional and general health to housing and as we get older – it's a lot".

Key Needs:

- ⇨ L.Inc urgently needs more trained staff to respond the number of women who walk through the door and need an appropriate response. All agree that a full-time counsellor, who could also provide information, is probably the best choice of person and most suitable to respond.
- ⇨ L.Inc could consider applying for a family resource centre programme with a view to moving many of its support services and drop in requirements to this part of the organisational strategy.
- ⇨ A directory of health information and lesbian friendly services is urgently needed.
- ⇨ A full time Outreach Worker is required to train the other organisations and agencies out there who provide a service to the lesbian community.

[2] All staff are trained in appropriate listening skills through Lesbian Line training.

- ⇨ Some of the work is policy work. Other service providers should respond to some of the needs of the lesbian community – this requires pursuing regional and national agencies and strategising. For example Housing needs – City Council, Specific Health Departments – HSE, Domestic Violence – Women's Refuges, Homelessness, Alcohol and Drug misuse by other specialist organisations.
- ⇨ Many of these needs and appropriate responses are identified in the HSE Mental Health Strategy *Focusing Minds*. Counselling and community supports would go a long way to ensuring a better quality of life and improved mental health status for the women who come into L.Inc.

5. CONCLUSIONS & RECOMMENDATIONS

5.1 INTRODUCTION

This research is very significant in that it one of the few pieces of work undertaken with the lesbian community in Ireland which has been comprehensive in terms of a review of existing research nationally and internationally, detailed design and analysis of questionnaire data using SPSS, and qualitative research, where participation levels for this particular community, which is frequently hidden and inaccessible, is high. Similar to other minority communities e.g. Travellers, Refugees & Asylum Seekers, Lone Parents, qualitative research is often the best methodology for accessing information about people's real life experiences in a holistic manner. Until it is safe for all lesbians to be out in mainstream society, it will always be difficult to collate hard-core data.

From Community Consultants' perspective, we are very confident in the level of data and information received; therefore one can place a high level of reliance on the findings. The conclusions and recommendations are well founded and are specific enough for the Health Services Executive and other agencies to be able to respond efficiently and with direct impact.

- 500 women were invited to participate in this health research either by attending directly or by completing questionnaires and returning them to L.Inc.
- 50 women turned up to the first meeting to scope out the terms of reference for the research.
- 34 women took part in focus group discussions and information was provided by about 10 more.
- 17 national and16 international research reports relating to lesbian health were examined.
- 107 women completed comprehensive questionnaires.

Identity: of the women taking part in focus group discussions 95.5% identified as lesbian, and 4.5% as bi-sexual.

In general, the community are very aware of their health needs and almost all participants in this research said that they use a wide rang of alterative therapies, (homeopathy, reiki, massage, reflexology, herbalists, etc), and many also used counselling services. The main reason cited for this was that they felt alternative therapies offered a more holistic approach to health, the whole person including their sexual preferences were taken into account, and coming out in general was easier and more acceptable as an alternative legitimate lifestyle. Counselling was generally seen as a mechanism for dealing with emotional stresses and resolving issues to facilitate moving on in life.

The accounts of the experiences of the 44 women who were willing to share their stories, the 107 women who filled out questionnaires, and the reports of L.Inc staff working continuously with women who drop into the resource centre, reliably reflect the experiences of lesbians in Cork City.

5.2 CONCLUSIONS

There are very real concerns specific to each category of lesbian interviewed and sampled as part of this research but there are some key identified needs that run across all age groups and status. In particular, almost all lesbians who participated in the research talked about:

⇨ **Endemic level of heterosexist assumptions facing lesbians are faced with across health services**

There is an urgent need for health professionals to stop making heterosexist assumptions, a practice which appears to be widespread. Additionally, there is a great need for health professionals across all disciplines to do some awareness training and anti-homophobic work in delivering their service and interacting with their clients. All sectors of the health professions need training about lesbian lives and issues and around anti-homophobic practices.

⇨ **Need for health information across the spectrum of health needs and for a directory of lesbian friendly services**

All groups mentioned the need for information – health specific information e.g. menopause, sex education, in addition to obtaining information about lesbian friendly services and referrals to the appropriate health service. Lesbians would prefer to utilise L.Inc for information, for referrals and link to the HSE mainstream services. This is a very modest and achievable aspiration.

Additionally, the HSE should produce lesbian friendly materials[3] for use by health professionals whether in hospital settings, general practitioner clinics or dentists' waiting rooms.

[3] There are examples available through the Gay Men's Health Projects and an Garda Siochana who produced their own relevant literature.

⇨ **Coming out to be encouraged and supported**

Most of the lesbians who participated in this research are very out, confident and politicised. This did not happen overnight and has taken years of effort, courage and skill to constantly identify as a minority group member, risk adverse responses, and be proud of who you are. The requirement for lesbians to come out is constant, exhausting and often stressful. While everyone agreed that coming out is essential to your own and others quality of life, much more could be done by Health Professionals to make coming out an easier, safer and supported experience.

⇨ **Model of Good Practice in the Maternity services**

The maternity services across various hospitals in Cork offer a model of good practice where all participants in the research who had experience of these services found them to be excellent, sensitive and inclusive. There is no doubt that if the practices utilised in these services could be replicated and learned from, that all other health services could respond more appropriately to lesbian needs. The model should be documented by the HSE for learning purposes.

⇨ **Need for non-discriminatory reproductive services and parenting supports**

Amongst particular age groupings of women, 20-40 year olds, the need for reproductive services that were accessible, affordable and user friendly was seen as "a right" of all women, and that needs responding to urgently. While this research was not specifically in relation to maternity or reproductive services per se, it is commonly known in the community that, in accordance with international trends, there has been a significant increase in the number of children born to lesbian parents by choice in the past few years. In general, many of these women fall into the "middle class" category i.e. in employment, reasonable level of disposable income, many own their own homes and car and a have a good level of education. Many of these women carry out a significant level of research into their options, some travel abroad and pay for expensive fertility and ante-natal services, while others are genius at home insemination and liasing with the wider community and health professionals.

Reproductive services and support to have children through fostering and adoption should be available to all women regardless of background, status, or any of the grounds listed in the Equal

Status Act 2000. Adoption services and fertility clinics already have screening mechanisms in place to ensure that children are brought into safe and loving families and they could apply the same criteria to lesbian couples. Birth registration legislation needs to be updated to reflect the reality of families created through donor gametes.

⇨ **Lesbians fear of becoming invisible as they get older**

Most women who participated in this research feared becoming invisible again as lesbians in the health system and particularly in later life when their care needs increased.

⇨ **Need to respond to Mental Health issues**

The need to respond to mental health issues was cited by several groups and particularly by the staff as a growing concern for the community. Some of the services required are very specific to mental health specialists and others could be responded to through a lesbian-friendly counselling service. A counselling service based at L.Inc would be safe, would facilitate many women to rehabilitate and improve their quality of life by being integrated into the community.

⇨ **L.Inc's remit too broad**

When carrying out the research, one of the concerns observed by the researchers was that L.Inc was attempting at times, and generally felt it had to, respond to *all* the needs of the community. The demands on the organisation are high, the needs of the community are diverse but L.Inc is a voluntary community organisation with a steering group made up of 10 members and 3 paid staff (1 full-time co-ordinator, one administrator and one outreach worker under the Equality for Women Measure), who are totally stretched capacity-wise. There are four support groups that meet on a regular basis, made up totally of volunteers. While L.Inc has done tremendous work and achieved a huge amount to date, long-term planning and resourcing needs to be a serious consideration before attempting to respond to all the lesbian community needs. Expectations in the community need to be managed and other models of organising and delivering should be considered when engaging in long-term planning. Time and funding should be expended by L.Inc on its staff and management members exploring options and successful models of operating into the medium to long term, in order to ensure its sustainability and continued success.

A summary of the are key specific needs of particular groupings are:

Youth	Lots of health information particularly in relation to STIs, alcohol and drug misuse. Alternative social venues to the pub. Alcohol and drug misuse is considered a serious issue for young lesbians.
Older Lesbians **40+**	General health information including information on the menopause, osteoporosis, etc., This age grouping plus the 25-40 year old group, were much more concerned and fearful about what will happen to them later in life. They would like to stay “out”, be safe and have appropriate and sensitive elder care.
Parents	Reproductive services need to be made available to all. Parenting options should include fostering and adoption for lesbians. Social parent should be included on birth cert. Appropriate sex education for children at school both in relation to children being lesbian/gay or their parents/guardians.
25-40 year olds	This group also cited reproductive information and services as being essential to their options and choices in life. Additionally, this age grouping felt that more counselling services needed to be available for a variety of issues not least of which is relationship and marriage difficulties and break-up.
Staff	Staff working on the front-line of delivering services have significant needs in terms of additional support and resources to cope and deliver what is being demanded of them. In particular, there is a need for a full-time counsellor to be available on site: one who can provide support, advice and information. There also needs to be a full-time outreach worker to adequately respond to other organisations and agencies that require training to better deliver their own services. Additionally, strengthening the policy work of L.Inc would assist in obtaining much needed services appropriately, applying for funding and working toward changes to national policy to allow for greater awareness and integration of lesbian needs into all health services e.g. mental health, health promotion, etc.

There is a felt need for further research into specific health issues affecting the community, in particular, lesbian-specific research into the link between suicide and being lesbian, and also the link between substance abuse and being lesbian. Both of these issues were noted as a concern by all focus groups in this research. These areas have also been mentioned several times in other key reports[4] in the last few years and require an urgent response.

Finally, but very importantly, the HSE sits on the City Development Board and participated in the research which led to the publication of *Towards Objective 86*, a service needs analysis of the LGB community in Cork City.

[4] GLEN& NEXUS (1995), EA (2002) and NESF (2003).

5.3 RECOMMENDATIONS

5.3.1 HSE to respond to the recommendations made in the report "Towards Objective 86".

Objective 86 of the City Development Board's Integrated Strategy states that Lesbian, Gay and Bisexual communities will be enabled to fully participate in the social, cultural and economic life of Cork City. A report entitled *Towards Objective 86*: A Service Needs Analysis of the Cork City Lesbian, Gay and Bisexual Community (Power) was published in March 2004. This report outlined the way in which service providers consistently fail to take account of the different needs of the lesbian and gay population in designing and implementing policy and in providing public services. This service needs analysis and the lesbian health research makes some very clear recommendations to service providers around inclusive equality policies and practices. It recommends that the HSE develop a health strategy and action plan specifically for the LGB community. It also recommends the development of an awareness-training programme for all departments and areas within the HSE in addition to funding specific LGB research identified as needed by many research reports.

5.3.2 HSE to fund a Community Health Worker for the Community

Given the number and level of needs being identified in this lesbian health research, the most useful way of responding and co-ordinating responses to the community would be through the employment of a community health worker. This worker could be based at L.Inc and have an overall brief of supporting the community while at the same time building relationships with the HSE to encourage responses by the HSE that are appropriate to the community. See key actions below that require implementation.

5.3.3 HSE to carry out training for all health professionals

The HSE should urgently carry out anti-homophobic training with all staff, develop a model of practice based on the maternity department services[5] and advocate to reduce the level of heterosexism that prevails across all HSE services.

[5] The HSE's Community Department relationship and role with the Lesbian Community has also been noted as a positive model of interaction and development.

The following are the key actions required under a health strategy to be implemented with the Lesbian Community. A Community Health Worker would be key to co-ordinating implementation.

- ⇨ **HSE to develop appropriate and sensitive materials for health professionals**

  HSE should develop materials and information that are sensitive to the lesbian community, increases awareness among all health professionals, hospital services and general public services and clinics.

- ⇨ **Counselling services to be more available to the community from L.Inc**

  The need for a full-time counsellor was evident across all the research into health needs. The staff at L.Inc cannot cope with the amount of inquiries and requests for support. Lesbians have a variety of issues ranging from mental health problems, relationship difficulties and or alcohol/drug concerns. A full-time counselling service could respond to a significant level of needs within the community. A counsellor could provide one-to-one support, health information and literature, or refer people to the appropriate service if adequately trained and linked to the HSE.

- ⇨ **Lesbian youth health project needed in Cork**

  Given the concerns of young lesbians about the apparent use of alcohol and drugs in their social scene, allocating resources to educate this group around these issues would appear to be a cost-efficient exercise. The project could act as a strong preventative measure in current and potential abuse levels, in addition to providing counselling support and health information appropriate to young women. Ideally, this project should be linked to other mainstream youth projects/organisations.

- ⇨ **Further lesbian specific research**

  While this has been a recommendation of past reports, it still needs addressing. In particular, the link between suicide, mental health status and being lesbian, and the link between being lesbian and the level of alcohol and drug misuse, needs further investigation. There is a perception in the Irish lesbian and gay community that there is a very strong link but the research needs to be Cork specific. This perception is backed up by international research – see page 10 – where this link has also been noted. Cork

specific research would support L.Inc and other organisations including the HSE to respond appropriately and in a targeted manner to their own local communities.

⇨ **HSE to promote the provision of reproductive services, which are inclusive of the lesbian community**

Full reproductive services should be delivered in a non-discriminatory way in Cork City. The services should be accessible, lesbian friendly, affordable and offer a wide variety of options and choices.

⇨ **Increase the level of Health information available to the community**

There is a wide range of information available through HSE sources. The HSE needs to co-ordinate the collation of this information, supply L.Inc with the furniture to display it, and deliver the quantities that are needed to the resource centre and the community.

⇨ **Develop a Mental Health pilot project with L.Inc similar to the Glen project**

Similar to the pilot project being co-ordinated in the Glen area, L.Inc should be included as a target group for piloting an outreach mental health service.

⇨ **Address Accommodation issues**

This is clearly emerging as a critical issue of concern for the lesbian community. Staff at the Resource Centre who deal with most of the enquiries, are very concerned about the consequences that the lack of accommodation options potentially pose for lesbians. Further work is needed in this area and perhaps a joint initiative could be considered between L.Inc and City Council Housing Department.

⇨ **Greater level of Outreach Work with external organisations and agencies**

This is a well-documented need, both by lesbian and gay groups nationally but also by the number of organisations that contact L.Inc requesting assistance. More outreach is needed but needs resourcing. As the EWM are responding at some small level to this need (part-time worker in place), an innovative enterprise option supported by interagency funding could also be considered with support from L.Inc.

⇨ **Commission research into Lesbian Centre for Eldercare**

This need has arisen very strongly in Cork but it has also been raised by many other lesbian/gay groups in the past. It is timely, given the tax incentives relating to this area, that L.Inc commission a Needs Analysis and a Feasibility Study into this option. Responding to this need should not be part of the core work of L.Inc but be contracted out to assess the possibility of providing responses objectively and independently – with and without private investment. L.Inc needs to be funded to carry out this work.

⇨ **Compile a directory of lesbian friendly services**

This is a priority for all lesbians who participated in this research. The HSE should fund this work immediately and make the production widely available.

⇨ **L.Inc to develop its policy work with all agencies in the city**

This aspect of L.Inc's work needs to be strengthened. Taking a stronger policy role would put more pressure on agencies to honour their commitments, have others take the lesbian community more seriously within their work, and lobby for changes in policy at national level in addition to promoting lesbian equality and rights.

⇨ **L.Inc should apply for a Family Resource Centre (FRC)**

Applying for an FRC would facilitate L.Inc to respond to many of its community needs. In particular, the needs of parents, children, and youth using a community development approach which is already part of L.Inc's core ethos. Many FRCs, adhering to community development principles, provide the structure that is needed to respond to the wider needs of the community. L.Inc is carrying out all of this type of work, but without the clearly defined structure or budget that an FRC would give them.

⇨ **L.Inc to explore its current and optimum operating and organisation structures**

Following on from this research and alongside other pieces of work that L.Inc is currently focused on e.g. EWM, Support Services & Groups, L.Inc should consider the development of a long term strategic plan and appropriate structures to carry out the work needed on behalf of the community into the future. For example strategies and structures could be considered under the following headings: Outreach & Training, Family services, Well-Being & Support, Policy & Research e.g. eldercare, suicide and mental health.

L.Inc's Potential Structure[6] is outlined on the next page. The organisation and work of L.Inc must be supported and funded if L.Inc and the HSE are to ensue successful impact and positive health outcomes for the community over the longer term.

Appendix I

Outline of issues raised at the initial public meeting

L.Inc Meeting Minutes
Thursday 19th May 2005 –
Community Discussion on Lesbian Health with Research in mind

22 Community members attended

Areas discussed:
Physical Health
Mental Health
Sexual Health
Social Health/ Impact
Spiritual Health
Methodology - How to do the research?

Physical Health	**Mental Health**	**Sexual Health**
Drinking Smoking Drugs Addiction Accidents/ Illness Stress Exercise Domestic violence Disability - visibility / invisibility Alternative health care - Cost GP access Hospital Long- term illness Availability of E45 cream on the medical card Developmental life stages - Young Lesbian/ Older Lesbians/ Menopause Coming Out Fertility Issues - Insemination Dentistry Death/ Dying/ Bereavement	Supports - Family/ Friends/ Community work Support for families Suicide and attempted suicide Depression Fear of rejection/ being outed Bullying Eating Disorders Identity - Group Dynamics/ Self image/ Group image/ Role Models/ Social conformity / Living and coping with Homophobia/ Social attitudes - what helps? Panic disorders Depression What gives you a lift? Visibility/ consciousness raising Life stages / experiences Individuals' experience of health care providers Where your mental health is at	STDs Smear test Doctors' attitudes Well being Vulnerability Lesbian Death bed - the stopping of sex in long- term relationships Addiction Issues **Sexual Activity** Therapy / Eroticism/ Porn/ Celibacy / Support/ Sexual aides/ Promiscuity Misconception that Lesbians are a safe group Safer Sex Practices - Safer / potential dangers/Consequences Perceptions - Quality of sex/ Happiness with sex Sexual violence

[6] Taken from a strategic review of work-in-progress at l.Inc currently.

Health Screening - Smear tests/Breast check/ STDs Diseases Sexual Abuse Sex How Lesbians are perceived	right now - self perception Stress Access to counselling services - individual / group / couple	Ability to enjoy / Hang ups/ Post Abuse Where do you get information? Information you would like to have access t Have you slept with men?

Coming Out	**Spiritual Health**	**Relationships**
To self / From Where? How? When? Why? / Being out/ Homophobia - Internal and external- effects on self / family- Parents/ Siblings/ Children/ Partners/ relationships with wider community of choice and origin Self Esteem Isolation Communication	Positively embrace day to day Religious groupings and other spiritual groupings **Church and Religion** Loss of religion/church to live as a Lesbian due to condemnation and lack of recognition of lesbian sexual relationships by same and therefore loss of familiar support structures Impact on Quality of Life Ability to participate in religious practices Creativity Meditation Identity Practices / Belief systems Alternative	Having/ Not having/ Breaking up/ Bereavement - Acknowledgement of family members/ work / life Anxiety Sleep - How much/ How Long Survivor of abuse support

Methodology

Questionnaires - Distribution of with Linc Magazine/ Downloadable form on website/ In person
One to one
Focus groups - group discussion
Short term worker- Researcher/ Health worker together with Linc sub group
Access - Literacy
Prioritise Health Service Executive - Southern Region but distribute Questionnaires Nationwide/
Ask Where respondents live and whether its Rural/ Urban/ Suburban Big town / Small town
Quantitative and Qualitative space
Also ask How do you Identify? Lesbian or Bisexual or Transgender and Lesbian or Bisexual

Appendix II

Numbers of children in lesbian headed households in Ireland

The 2002 Census indicated that the number of same-sex cohabiting couples increased from around 150 to almost 1,300 (two thirds of these were male couples)[7]. The census figures give no indication of the numbers of children born to or living with lesbian parents, however they do give numbers of people under the age of 19 years who ordinarily reside with lesbian couples. The total number of persons in this category is 33, less the 10 who are described as part of a couple, making, according to census figures, a total of 23 children currently living in lesbian-headed households in the whole of Ireland. This vastly undercounts the numbers of children known to be living in lesbian headed households - L.inc's membership alone counts a great many more than that number in the immediate Cork City area alone. The U.S., which has a population (very roughly) seventy times that of Ireland, has recently been estimated to have, depending on criteria used to quantify, between 800,000 and 7 million gay or lesbian parents with between 1.6 million and 14 million children between them[8]. Loosely based on the most conservative end of these figures, Ireland could be expected to find about 10,000 gay and lesbian parents with 20,000 children, approximately 0.24% of the general population.[9]

[7] Although the introduction of the category 'partner' on the 2002 census form is thought to account for much of the apparent increase in cohabiting heterosexual and same-sex couples, it is not known what proportions of same-sex couples did *not* adopt this description of their relationship and were thus excluded from the census figures. Multi-adult households would increase the possibility of a same-sex relationship within that household being obscured as no provision is made for descriptions of relationships other than those to the nominated head of household. Fear of exposure to the enumerator also, who checks the details of the form on the doorstep, could certainly act as a deterrent to revealing the nature of the relationships of many same-sex couples.

[8] Patterson and Freil, 2000, cited in Flood, 2003.

[9] These figures would concur more closely with the findings of the Avon Longitudinal Study of Parents and Children (ALSPAC), a geographic population study of almost 14,000 mothers and their children in the U.K. which put the figure of lesbian mothers at a little above 0.22% as a proportion of all mothers in their sample. A small-scale survey conducted among 35 service users at L.inc indicated that around 50% of lesbian women currently using that service are parents (Morley, 2004). This figure seems rather higher than would be predicted according to international standards. One possible explanation for this might be that the centre offers support to lesbian parents, thus attracting them to the service. Or it might be the case that the older lesbians who are involved with the centre are more likely to have been married and have children from those marriages. Younger lesbians, who are "coming out" at a younger age and in greater numbers GCN August 2004: 3), no longer feel the same pressures that their older counterparts would have, to conform to the heterosexual models of marriage and children.

Appendix III

Health-Related Recommendations of Equality Authority Report (2002)

Community Development and Empowerment

⇨ The Department should ensure that LGB people are a named and resourced target group in programmes and structures designed to support community development and to combat social exclusion and inequality, in particular, the Community Development Programme

Equality Proofing

⇨ All Government Departments and Agencies should put in place programmes for equality proofing of policy and provision.

Partnership Rights

⇨ The legal and policy codes should be systematically reformed to ensure that references to the family recognise the diversity of family forms, households and couple relationships

⇨ The Department of Justice, Equality and Law Reform should ensure that same-sex couples are treated in an equal manner by extending the right to nominate a partner with legal rights to same-sex couples, comparable with those recognised for a spouse. The outcome of which would recognise the right of same-sex couples to: a) nominate a partner or successor; b) designate a next of kin for medical issues; c) nominate a beneficiary of pensions and inheritance; d) nominate a partner as a co-parent or guardian of a child.

⇨ Legislation governing violence in intimate relationships should operate on an equal basis towards same-sex relationships as towards married relationships.

⇨ The Department of Justice, Equality and Law Reform and the Department of Enterprise, Trade and Employment should ensure that leave entitlements (for example, parental leave) should be provided for same-sex couples, non-married heterosexual couples and married heterosexual couples on an equal basis.

- ⇨ Rights in relation to parenting, fostering and adoption should operate on an equal basis for same-sex couples, individuals, married and non-married heterosexual couples and should be based on the core principle of attaching rights to children and responsibilities to parents and carers.
- ⇨ Employers should ensure that workplace entitlements such as pensions and healthcare benefits that are extended to employees' "spouses" are changed to be a "nominated person" as designated by the employee.

Health

- ⇨ The Department of Health and Children and the Health Boards should ensure that LGB people's needs are mainstreamed into the design, delivery and impact assessment of services with LGB interest represented in all consultative fora and structures that inform policy and service delivery.
- ⇨ In order to encourage best practice amongst professional healthcare service deliverers, the Department of Health and Children, with the support of he Equality Authority and in conjunction with the relevant professional bodies, agencies and institutions, should develop a training strategy for health professionals. This should involve a survey of the role of professional health training in sexual orientation, and the production and piloting of a training module on sexual orientation and health designed in partnership with the relevant LGB interests, with a view to mainstreaming the training strategy across all professional healthcare courses.
- ⇨ Each Health Board should examine the health needs of LGB people and LGB community services in their areas, and develop appropriate responses. The Health Boards should support and develop effective partnership interventions with LGB people, such as that established between the Eastern Regional Health Authority and community groups in Dublin.
- ⇨ Lesbian, gay and bisexual people should be a named service user group identified within mainstream programmes and services and the subject of specifically targeted initiatives within future national health strategies.
- ⇨ In developing a mental health strategy, specific attention should be given to the needs of LGB people. Appropriate consultation with LGB interests should take place in the planning of the strategy and resources and services should be identified for the LGB community within any future comprehensive mental health strategy.

⇨ Methods of research and monitoring of the relationship between sexual orientation and suicide in Ireland should be developed. The National Suicide Review group should establish the most appropriate mechanisms through which data, analysis and action can be developed.

⇨ To address the specific needs and gaps in health provision that currently affect lesbian women, there should be lesbian representation on the Regional Women's Health Committees.

⇨ The Health Promotion Unit of the Department of Health and Children should develop information materials for health workers and health professionals working with the LGB community.

⇨ The Health Promotion Unit should develop health promotion materials and initiatives for young LGB people and youth workers in liaison with LGB interest groups.

⇨ The Commission on Assisted Human Reproduction should ensure that assisted reproduction services provided by either public or private agencies are provided and delivered in a non-discriminatory manner to all, thus recognising the provisions of the Equal Status Act.

⇨ The Women's Health Advisory Council should liase with lesbian groups to develop specific initiatives in relation to lesbian health research and promotion.

Education

⇨ The current attitude to bullying and harassment should be reviewed with a view to eradicating homophobic bullying and providing for practical developments at school level with an emphasis on training staff and information for students in order to comply with the provisions of the Equal Status Act.

⇨ All training course for service providers such as teachers, doctors, lawyers and social workers should include equality and diversity issues, including issues in relation to sexual orientation.

Youth Services

⇨ Addressing the needs of LGB youth should be an integral component of all policy design and service delivery by VECs, and the Departments of Education and Science; Justice, Equality and Law Reform and Health and Children.

⇨ All existing and future youth service facilities and centres should visibly promote an anti-homophobic environment, for example, through posters, leaflets and projects.

⇨ Lesbian, gay and bisexual community organisations and resource centres should be resourced by youth work organisations to provide alternative social venues for young LGB people.

Services

- ⇨ All service providers should mainstream equality and diversity into the decision-making, design, delivery and implementation of their service provision.

Violence and Harassment

- ⇨ A new Hate Crimes Act should be introduced, covering harassment and violence aggravated by prejudice against specific categories of people, including LGB people.
- ⇨ The Department of Justice, Equality and Law Reform should ensure representation of lesbian interests on the National Steering Committee on Violence Against Women.
- ⇨ The Department of Justice, Equality and Law Reform should make available resources to lesbian and gay support groups such as gay helplines and lesbian lines to develop their provision of victim support services within the LGB community.

Appendix IV

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