THE HEALTH & WELLBEING OF LGBTIQA+ PEOPLE IN RURAL AUSTRALIA

A DETAILED REVIEW AND RECOMMENDATIONS FOR CHANGE

Pride foundation australia

AUTHORS

Ian Gould
Community Researcher

Ian worked professionally in agri-food research and research management, with the Dept of Agriculture, Victoria, the Australian Food Industry Science Centre and the CSIRO. For over 40 years he has volunteered with many Melbourne based LGBTIQ+ community organisations and government advisory committees. He is a Life Member of Thorne Harbour Health and the Mid Summa Festival and was a board member of Pride Foundation Australia for over 10 years. Now living near Castlemaine his current volunteer roles include Community Member, Dhelkaya Health 'Health Equity & Community Wellbeing Committee'; Community Member, Mt Alexander Shire LGBTIQA+ Steering Group and Community Member of the Central Victorian Community Advisory Committee of the Murray Primary Health Network.

Ruth McNair AM
Chairperson Pride Foundation Australia

Ruth is a practicing GP and owner at an inner-Melbourne general practice. She is also an Honorary Associate Professor at the University of Melbourne. She has clinical and research interests in lesbian and bisexual women's health, trans and gender diverse affirmation, LGBTQ health care and homelessness. She is a life member of the Victorian Gay and Lesbian Rights Lobby, Thorne Harbour Health and was inducted into the Victorian Honour Roll of Women in 2017 for her academic, clinical and advocacy work. She became a Member of the Order of Australia in 2019 for significant service to medicine and as an advocate for the LGBTI community.

Pride Foundation Australia

Pride Foundation Australia (PFA) is a national philanthropic foundation run by and for the LGBTQIA+ community in Australia. PFA enables advocacy for systemic change to advance LGBTQIA+ equity and inclusion and provides support to affected communities and individuals. They raise awareness of LGBTQIA+ disadvantage and work to increase philanthropic support for the LGBTQIA+ communities in Australia through fundraising, grant giving, collaboration and commissioning projects.

Pride Foundation Australia website - https://pridefoundation.org.au

Author Contact details:

Ian Gould
PO Box 179, Castlemaine, Vic 3450
E: ian.gould@iosphere.net.au

Authors acknowledgement:

The authors thank Matthew Parsons of Maropa Production and Consultancy (www.maropa.com.au) for their valued feedback on this manuscript.

Suggested Citation:

Gould, I. and McNair, R. (June 2025) The Health and Wellbeing of LGBTIQA+ People in Rural Australia - a detailed review and recommendations for change. Melbourne, Australia: Pride Foundation Australia

This report can be downloaded from the Pride Foundation Australia at:
https://pridefoundation.org.au

ISBN: 978-1-7641025-1-3

CONTENTS

EXECUTIVE SUMMARY

Background

Lesbian, gay, bisexual, trans & gender diverse, intersex, queer and asexual (LGBTIQA+) people are often challenged by significant levels of minority stress, structural stigma and discrimination, which impact their health and wellbeing in many negative ways. Research reviewed here shows these challenges are greater for the approximately 340,000 LGBTQA+ people living in regional, rural and remote Australia[01] than their counterparts in Australia's capital cities. In recent years, a small number of regional and rural health services have initiated LGBTQA+ specialist services or adapted mainstream services to be LGBTQA+ inclusive, however most have not, and none have included people with intersex variations. One reason for this lack of action is that data sources currently used in evidence-based planning by rural health services do not include data on LGBTIQA+ health.

This report fills this gap by reviewing recent Australian literature on the health status of LGBTIQA+ people living in rural areas compared with their urban counterparts and with non-LGBTIQA+ people in their local areas. The review should be used by rural health services to inform their strategic, operational and budgetary planning to improve their LGBTIQA+ inclusion. It is hoped such inclusion will reduce the health disadvantages experienced by many LGBTIQA+ people in rural Australia.

Data sources

The report presents secondary data analysis from a range of Australian primary data sources:

- Private Lives 3[02] (PL3)
  This national study was conducted by a team at La Trobe University from July to October 2019. The survey is Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people to date. It provides a comprehensive snapshot of the LGBTIQ Australians' everyday lives, based on data covering a wide range of topics including households, mental health, use of health services, intimate partner and family violence, experiences of stigma and discrimination. The findings summarised here relate to health differences found between LGBTIQA+ people living in urban or regional and rural areas.
- Writing Themselves In 4[03] (WTI4)
  Conducted by a team at La Trobe University between September and October 2019. This national study is a survey of health and wellbeing among self-identifying LGBTQA+ young people (ages 14 to 21 years. Findings relating to area of residence in regional, rural or remote Australia are summarised here.

[01] In this report regional, rural and remote is abbreviated to 'rural'.

[02] https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

[03] https://www.latrobe.edu.au/arcshs/work/writing-themselves-in-4 Hill AO, Lyons A, Jones J, McGowan I, Carman M, Parsons M, Power J, Bourne A (2021) Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia. National report, monograph series number 124. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne. ARCSHS.

- The Rainbow Realities report[04]
  This was completed in 2023 for the Commonwealth Department of Health and Aged Care to inform development of the Australian government's 10-year LGBTIQA+ Health and Wellbeing Action Plan. Rainbow Realities provides a synthesis of pre-existing mainly national research plus more than 50 new analyses derived from the data of six surveys of LGBTQA+ populations in Australia: Private Lives 3, Writing Themselves In 4, SWASH (Sydney women's health report 2020); Trans Pathways (2017); Walkern Katatdjin (Reports 1 & 2; Rainbow Knowledge) and Pride and Pandemic (2022). This report summarises new data comparing health and wellbeing outcomes of LGBTIQA+ people living in Australian inner capital city, outer capital city, regional, rural and remote areas.

- The health and wellbeing of the LGBTIQA+ populations in Victoria, findings from the 2017 Victorian Population Health Survey (VPHS)[05]
  A secondary analysis of the health and socio-economic status of LGBTIQA+ people living in rural Victoria compared with non-LGBTIQA+ rural dwellers is presented.

- A study by Thorne Harbour Health and Cobaw Community Health [06] in ~2019
  Explored barriers to better physical and mental health for the lesbian, gay, bisexual, transgender, intersex, queer, asexual, and people with other gender and sexuality identities (LGBTIQA+) across the Loddon Mallee region, Victoria.

- The Pathways to Pride report, Victoria [07]
  This examined systemic barriers for LGBTI+ young people in accessing appropriate, safe, and current evidence-based health and wellbeing services through General Practitioners (GPs) across the Loddon sub-region, the southern half of the Loddon Malle Region of northwest Victoria.

Data are also presented from a West Australian LGBTIQA+ health care priorities report, an LGBTIQA+ AOD (alcohol and other drugs) study, studies on the health impact of natural disaster and disaster recovery on LGBTI people and LGBTIQA+ resources published by three rural Primary Health Networks (PHN's).

[04] Amos, N., Lim, G., Buckingham, P., Lin, A., Liddelow-Hunt, S., Mooney-Somers, J., Bourne, A., on behalf of the Private Lives 3, Writing Themselves In 4, SWASH, Trans Pathways, Walkern Katatdjin, and Pride and Pandemic teams (2023). Rainbow Realities: In-depth analyses of large-scale LGBTQA+ health and wellbeing data in Australia. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. ISBN: 978-0-6458786-0-8 https://www.latrobe.edu.au/arcshs/work/rainbow-realities

[05] https://vahi.vic.gov.au/reports/population-health/health-and-wellbeing-lgbtiq-population-victoria . Citation: Victorian Agency for Health Information 2020, The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017, State of Victoria, Melbourne

[06] GP Medical Clinics and the provision of equitable LGBTIQA+ healthcare across the Loddon Mallee Region, Claudia Validum, Program Coordinator, Thorne Harbour Country and Belinda Brain Country LGBTIQA+ Inclusion Program Cobaw Community Health. Occasional publication, Sunbury Cobaw Community Health, 12-28 Macedon Street, Kyneton, Vic, 3444, Australia.

[07] 'Pathways to Pride' Author: Kate Phillips, Project Lead, Thorne Harbour Country, Published: May 2022. Available from Thorne Harbour Country, 58 Mundy St, Bendigo VIC 3550; E: thcountry@thorneharbour.org. NB: The participants involved in this report gave permission to include their views or opinions for the purpose of system improvement. This report is to be used for this purpose and this purpose ONLY.

Key findings

LGBTIQA+ people in rural Australia experience significant disadvantage and have poorer health and wellbeing when compared to (i) non-LGBTQA+ rural community members, and (ii) LGBTQA+ people living in metropolitan areas. In rural areas LGBTQA+ people are significantly more likely to experience health inequalities including:

- two or more chronic illnesses
- poorer life satisfaction
- lower acceptance rates in the community and at health care services, particularly when visiting a GP
- mental health conditions (including anxiety or depression)
- higher psychological stress (including youth and during the COVID pandemic)
- greater difficulty accessing inclusive mental health services
- higher suicide risk, with both LGBTQA+ adults and youth experiencing significantly higher suicide ideation and suicide attempts
- higher tobacco smoking, alcohol and illicit drug consumption rates, and alcohol and other drug (AOD) harm reduction campaigns are less likely to be LGBTQA+ inclusive
- poorer dental health.

Socio-economic status of LGBTQA+ people in rural areas is also more likely to be poorer when compared to their non-LGBTQA+ counterparts, a factor known to be associated with health inequalities. LGBTIQA+ people in rural areas generally experience:

- greater feelings of isolation
- being unsafe
- feel less valued
- have less trust
- feel greater isolation from friends and neighbours
- higher levels of verbal or physical discrimination or harassment and assault
- higher levels of family and intimate partner violence
- lower levels of support in educational institutions for LGBTQA+ young people
- lower household incomes and higher unemployment
- a greater likelihood of experiencing homelessness
- twice the likelihood of experiencing food insecurity.

During a natural disaster and recovery LGBTIQA+ people feel greater marginalisation and exclusion due to heteronormative assumptions by government agencies. The involvement of faith-based organisations can lead to fears of or actual discrimination and trigger past traumas. LGBTIQA+ people also feel invisible due to lack of inclusion in official and media reporting.

Recommendations

A series of recommendations arise from this analysis for key health service stakeholders: rural health service providers; rural Shire Councils; State and national LGBTIQA+ led health and wellbeing organisations; State governments; Commonwealth government; arts and culture, and philanthropy. There are also areas suggested for further research.

For Rural Health Service Providers (including Shire Council health and aged care services)

1. Acknowledge the problem is real, and in your catchment. LGBTIQA+ health data at the LGA or SA3 is not needed for local health care planning, given the well documented, consistent and significant LGBTIQA+ health disparities found in this review.
2. LGBTIQA+ inclusion in strategic and operational/project planning.
3. Create an LGBTIQA+ welcoming environment.
4. Act on the priority health issues shown for LGBTIQA+ people: mental health; self-harm / suicide; AOD (alcohol, cigarette, vaping and other drug use); needle exchange; family violence; housing; and social connection.
5. Initiate novel ways to provide specialist LGBTIQA+ services.
6. Ensure data collection is inclusive of LGBTIQA+ people.
7. Adopt LGBTIQA+ inclusive governance.
8. Convene a specialist LGBTIQA+ advisory committee / reference group.
9. Share experiences amongst other regional, rural and remote healthcare providers.
10. Participate in Regional Pride activities.

For LGBTIQA+ Community led health & wellbeing organisations

11. Be visible leaders of LGBTIQA+ health and wellbeing in rural areas
12. Include rural LGBTIQA+ people in governance and senior management.
13. LGBTIQA+ Health Australia provide a national voice for LGBTIQA+ regional rural and remote people.

For State Governments

14. Include people with rural lived experience / expertise on State government LGBTIQA+ advisory committees.
15. Health datasets be 'fit-for-purpose' by including LGBTIQA+ rural health and wellbeing data.
16. Improve LGBTIQA+ health practitioner training for rural practitioners
17. Establish State based LGBTIQA+ rural Communities of Practice
18. Fund State based natural disaster support and recovery organisations to become LGBTIQA+ inclusive

For Commonwealth Government

19. Ensure the voice of rural LGBTIQA Australians is heard in the implementation of the 'National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025-35'
20. Establish and fund a National Regional, Rural and Remote LGBTIQA+ Health Advisory Council

21. Direct the Australian Institute of Health and Welfare (AIHW) to include rural LGBTIQA+ health and wellbeing indicators in their 'Australian Burden of Disease' reports.
22. Initiate and fund development and delivery of rural LGBTIQA+ health assessment, regional LGBTIQA+ referral guides and training packages by rural Primary Health Networks

For Arts and Culture

23. Recognize and fund the positive health benefits from mainstream cultural and specialist Pride events in regional, rural and remote communities.

For Philanthropy

24. Continue and grow LGBTIQA+ led philanthropy granting to rural LGBTIQA+ health.
25. Grow reach of mainstream philanthropy to be inclusive of LGBTIQA+ health and wellbeing in their rural granting programs.

Further research

26. Further research is needed to better understand the lived experiences and health needs of trans, bi, asexual and people with intersex variation, and LGBTIQA+ people of Aboriginal and Torres Strait Islander heritage, living with disability and cultural/religious diversity living in rural settings.
27. A review is needed of Australian and international literature of effective LGBTIQA+ targeted rural health promotion initiatives and their evaluation
28. The GBQ+ Community Periodic Surveys (GCPS) be extended to rural areas
29. Involvement of LGBTIQA+ not-for-profit groups in research data collection.

Barriers to LGBTIQA+ inclusion in regional and rural healthcare planning

The health status and healthcare needs of lesbian, gay, bisexual, trans, intersex and gender diverse, queer and asexual (LGBTIQA+) people in rural[08] Australia are not well understood by their local healthcare services (i.e. hospitals, community health centres, primary healthcare providers and Shire Council health and aged care services).

LGBTIQA+[09] people are often challenged by significant levels of minority stress, structural stigma and discrimination, impacting their health and wellbeing. However, data most-used by regional and rural health services in Australia and their advising consultants do not include readily available data describing the health and wellbeing of LGBTIQA+ people living in their regional and rural catchments. Consequently, in the strategic, budgetary, and operational planning by rural health care providers, LGBTIQA+ people are invisible. Their health needs are not understood and are unintentionally neglected, resulting in further compounding of their health inequalities.

In Victoria the data sets used by healthcare services and their consultants in evidence-based priority setting are often drawn from 'Victoria-in-the-Future' (VITF) data sets[10] for population wide data, but these do not include data that can provide comparative anaysis of health conditions between the general population and sexuality or gender diverse sub populations. Data is also drawn from the Commonwealth Australian Institute of Health and Welfare's (AIHW) 'Australian Burden of Disease Database'[11]. AIHW generally presents data based on a subject's reported sex or gender, but not both[12]. AIHW draws data from more than 150 data sets[13] of which few, if any, report sexuality or gender identity or intersex variation.

The readily available Victorian and National evidence-based studies of LGBTIQA+ health and wellbeing that are reviewed in this report are rarely, if ever, used in regional and rural settings. Rural health services and their consultants appear unaware of these reports, and of the diversity of sexuality and gender identity and intersex variations within their communities. A reason given for the data not being used is that existing LGBTIQA+ health data allows only generalised or Statewide conclusions and is not specific condition-based data at the Local Government Authority (LGA) or SA3 levels (SA3 represent the area serviced by regional cities that have a population over 20,000 people). This limits healthcare service providers ability to understand, compare and plan for the LGBTIQA+ minority groups in their population catchment. A conclusion this paper makes is that the granularity of LGBTIQA+ health data is not needed at the LGA or SA3 level, given the well documented, consistent and significant LGBTIQA+ health disparities found in this review.

Therefore, there is a significant and urgent need to bring together what is currently known about the health and wellbeing of LGBTIQA+ people living in rural Australia.

[08] In this report regional, rural and remote areas are abbreviated as 'rural'.

[09] For definitions of each element LGBTIQA+ acronym and inclusive language see https://www.vic.gov.au/inclusive-language-guide . Key word definitions are included in Appendix 1.

[10] https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future

[11] https://www.aihw.gov.au/about-our-data/our-data-collections/australian-burden-of-disease

[12] https://www.aihw.gov.au/about-our-data/aihw-data-by-sex-and-gender

[13] https://www.aihw.gov.au/about-our-data/our-data-collections

This paper is the first to bring together Australian data on the health and wellbeing experiences of LGBTIQA+ people living in rural Australia (inclusive of regional, rural and remote areas). Sadly, it shows significantly greater health disadvantage is experienced by LGBTIQA+ people living in rural areas compared to (i) their non LGBTIQA+ peers living in rural areas, and (ii) greater disadvantage than their urban-living LGBTIQA+ peers.

Intersex variations – the 'I' in LGBTIQA+

The 'I' in LGBTIQA+ refers to those people born with innate variations of sex characteristics (IVSCs), also known as intersex variations. Intersex Human Rights Australia (IHRA)[14] notes people with innate variations of sex characteristics are a diverse and heterogeneous population, with a range of individual diagnoses and other characteristics, including observed/assigned sex classifications, gender identities, and sexual orientations. Some people born with innate variations of sex characteristics identify as LGBTQA+[15], but many do not. Identity frameworks used by LGBTQA+ individuals often do not apply to people with intersex variations however they can still share common issues with LGBTQA+ people including experiences of sex, gender and sexuality-based discrimination. There is little doubt that many people with intersex variations share the same minority stress, structural stigma and discrimination affecting their health and wellbeing as LGBT people.

IHRA encourages respect for intersex diversity as a population, including respect for sex assignments, sexual orientations and gender identities. LGBT and LGBTI are not synonyms, and the deliberate use of specific terms appropriate to each situation is encouraged. It recommends citing a range from 0.3% up to 1.7% of the population may be born with intersex variation[16], acknowledging the difficulties of finding a more exact figure due to past legacies of clinical secrecy, non-disclosure, stigma and misconceptions. The Australian Bureau of Statistics[17] estimates 0.3% of Australians were born with intersex characteristics but notes that small sampling sizes limit the reliability of this figure.

The research methods of some LGBTIQA+ health and wellbeing studies included in this review gave the choice for respondents to identify as a person with an intersex variation, and the acronym LGBTIQA+ is used in their publications. Other studies collected more limited data and typically used the acronym LGBT. No studies were found that reported separately on the experiences of rural living people born with intersex variation.

This report applies the acronym as it is used in the papers that are reviewed.

In the introduction, discussion and recommendations it uses the LGBTIQA+ acronym when it is intended to be inclusive of people with intersex variation and LGBTQA+ when the findings are more limited.

[14] https://interaction.org.au/16601/population-figures/

[15] https://interaction.org.au/allies/

[16] https://interaction.org.au/16601/population-figures/

[17] https://www.abs.gov.au/statistics/people/people-and-communities/estimates-and-characteristics-lgbti-populations-australia/2022#how-does-australia-compare-internationally-

LGBTIQA+ representation in Australian rural areas

In Australia significant populations live outside the State capital cities. The 2024 population of Australia was 27.12 million[18], with about 73% (19.79 million people) living in major cities, 26% (7.05 million people) or around 1 in 4, living in regional and rural areas, and 2% (542,000 people) living in remote areas[19]. In 2024 the Victorian population was 6.96 million, with about 23%[20] or 1.6m people living in regional, rural or remote areas.

A December 2024 'first-time' sexuality and gender identity report was released by the Australian Bureau of Statistics[21] which estimates that about 4.5% (or 1 in 22) Australians aged 16 or over identify as LGBTIQA+. The Victorian Population Health Survey 2017 reports a higher figure of 5.7% (1 in 17.5) of Victorian adults identify as LGBTIQA+[22]. The differences are likely due to data collection procedures, and the confidence individuals have in self-identifying when data is collected.

With about one person in 20 likely to identify as LGBTIQA+, about 80,000 LGBTIQA+ people can be expected to be living in Victoria's rural areas, and 352,000 nationally. Over the last decade the number of 'Pride' festivals and celebrations across regional towns nationally shows that small and previously closeted LGBTIQA+ communities are becoming visible and vibrant across rural Australia.

Some rural areas have attracted a higher proportion of LGBTIQA+ people to their communities; the Mount Alexander Shire is one such Local Government Area (LGA). The Loddon Campaspe Healthy Heart of Victoria Active Living Census noted that 7.9% (1 in 12) of participating Mount Alexander Shire residents identified as LGBTIQA+, compared to 3.4% across the whole Loddon – Campaspe region[23]. This report also shows their LGBTiQA+ cohort reported higher health risk factors when compared to the general population with 21.6% of LGBTIQA+ respondents rating health as "fair or poor" compared with 16.8% of the non-LGBTIQA+ respondents, and LGBTIQA+ respondents reporting greater levels of obesity and smoking.

Therefore, significant numbers of LGBTIQA+ people do live in regional, rural and remote Australia, and local health services should be inclusive of their healthcare needs.

[18] https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release

[19] https://www.aihw.gov.au/reports/australias-health/profile-of-australias-population#:~:text=Australia's%20population%20is%20concentrated%20in,remote%20areas%20(Figure%201).

[20] https://www.health.vic.gov.au/your-health-report-of-the-chief-health-officer-victoria-2018/who-we-are/demographic-data-2018

[21] https://www.abs.gov.au/statistics/people/people-and-communities/estimates-and-characteristics-lgbti-populations-australia/2022#how-does-australia-compare-internationally-

[22] https://vahi.vic.gov.au/sites/default/files/2021-12/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria.pdf Victorian Agency for Health Information 2020, The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017, State of Victoria, Melbourne

[23] https://www.rdv.vic.gov.au/__data/assets/pdf_file/0007/1884859/Active-Living-Census-Prelim-Selected-Findings_Loddon-Campaspe.pdf

NATIONAL STUDIES OF LGBTIQA+ HEALTH AND WELLBEING

There have been several national LGBTIQA+ health and wellbeing surveys. Some of these include findings of the health of LGBTIQA+ / LGBT people living in rural areas and provide statistical analysis comparing their health and wellbeing to LGBTIQA+ people living in metropolitan areas. These are summarised below.

Private Lives 3 (2020) the largest Australian survey

Private Lives 3[24] (PL3) is the third iteration of the Private Lives surveys, with the first conducted in 2005 and the second in 2011. The Private Lives 3 survey was conducted from July to October 2019. The survey is Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people to date. It was conducted by the Australian Research Centre in Sex Health and Society (ARCSHS) at La Trobe University.

The report provides a comprehensive snapshot of LGBTIQ Australians' everyday lives, based on data covering a wide range of topics such as households, mental health, use of health services, intimate partner and family violence, experiences of stigma and discrimination, and more. It is intended to provide a broad picture. While the authors note that it is beyond the scope to report on all possible intersections or LGBTIQ sub-populations some data are provided on: LGBTIQ people living with disability or long-term health condition; those from different cultural backgrounds; and those living in different locations (e.g. living in urban, regional or rural areas).

The findings summarised here only relate to health differences found between LGBTIQ people living in urban or rural areas. It is recommended readers view the full report and its recommendations to understand the broader findings.

As an overview, the findings distinguish better health and wellbeing outcomes for inner urban participants, and worse outcomes for outer urban and rural participants. On some measures, the outer urban participants were worse than both inner urban and rural participants.[25]

In the following section 'participants' all identify as LGBTIQ, and data cited refers to those in Private Lives 3 (2020) report.

- Overall, the proportions of participants living in outer suburban areas, regional cities or towns or rural/remote areas who felt accepted a lot or always were lower than those living in inner urban areas.
- When accessing a health or support service a lower proportion of participants in outer suburban areas (38.5%; n = 648) reported feeling accepted a lot or always when accessing a health or support service compared to those in regional cities or towns (40.9%; n = 549) or rural/remote areas (43.1%; n = 162).
- Just over a third (36.7%; n = 158) of participants residing in a rural/remote location rated their health as poor or fair, followed by 34.6% (n = 516) in a regional city or town, 34.9% (n = 649) in outer suburban areas and 25.7% (n = 758) in inner suburban areas.
- That 36.7% of LGBTIQ participants in rural/

[24] https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

[25] Grant, R., Amos, N., Lyons, A., McNair, R., Power, J., Carman, M., … Bourne, A. (2023). Out in Suburbia: Associations between residential location, mental health, and community connectedness among LGBTQ Australians. Social & Cultural Geography, 25(8), 1272–1290. https://doi.org/10.1080/14649365.2023.2296472

remote locations rated their heath as poor or fair is in stark contrast to the 14.7% of the general population aged over 15 years who reported their health as poor or fair (Australian Bureau of Statistics, 2018)[26].

- Outer suburban areas had the largest proportion of participants who reported high or very high levels of psychological distress (64.3%; n = 1,176). This was followed by those in regional cities or towns (61.9%; n = 910) and those in rural/remote areas (55.7%; n = 233), while inner suburban areas had the lowest proportion (50.7%; n = 1,466).

  In stark contrast, only 15.0% of the general Australian population report high or very high levels of psychological distress (Australian Bureau of Statistics, 2021)[27]

- Overall, outer suburban areas had the largest proportion (55.4%; n = 1,002) of LGBTIQ participants who reported being diagnosed or treated for a mental health condition in the past 12 months, followed by 53.5% (n = 779) in regional cities or towns, 50.5% (n = 213) in rural/remote areas and 49.4% (n = 1,384) in inner suburban areas.
- Of participants who reported high or very high levels of psychological distress, a higher proportion of those living in an inner suburban area reported accessing a mental health service that is LGBTIQ inclusive (27.3%; n = 399) than those living in outer suburban areas (19.0%; n = 223), regional towns or cities (18.4%; n = 167) or rural/remote areas (17.6%; n = 41).
- Furthermore, a higher proportion of those in an inner suburban area reported accessing any mental health service (63.2%; n = 923) than those living in outer suburban areas (57.8%; n = 678), regional towns or cities (54.5%; n = 494) or rural/remote areas (56.3%; n = 130).
- Overall, 46.3% (n = 862) of participants in outer suburban areas, 45.8% (n = 198) in rural/remote areas and 44.0% (n = 659) in regional towns or cities reported having experienced suicidal ideation in the past 12 months. This compared to 37.7% (n = 1,108) of participants in an inner suburban area.

  A stark comparison with 13.3% among the general Australian population who had experienced suicide ideation (Johnston et al., 2009)[28].

- Rural and remote areas had the largest proportion (8.4%; n = 27) of participants who reported having attempted suicide in the past 12 months, followed by 6.2% (n = 73) in regional towns or cities, 5.9% (n = 87) in outer suburban areas and 3.8% (n = 86) in inner suburban areas.

  This is a further stark comparison, as they compare with 3.2% attempted suicides among the general Australian population (Johnston et al., 2009)

[26] Australian Bureau of Statistics 2017-18, Self-assessed health status, ABS, viewed 3 January 2025, https://www.abs.gov.au/statistics/health/health-conditions-and-risks/self-assessed-health-status/latest-release

[27] Australian Bureau of Statistics 2021, First insights from the National Study of Mental Health and Wellbeing, 2020-21, ABS, viewed 3 January 2025, https://www.abs.gov.au/articles/first-insights-national-study-mental-health-and-wellbeing-2020-21.

[28] Johnston AK, Pirkis JE, Burgess PM. Suicidal thoughts and behaviours among Australian adults: findings from the 2007 National Survey of Mental Health and Wellbeing. Aust N Z J Psychiatry. 2009 Jul;43(7):635-43. doi: 10.1080/00048670902970874. PMID: 19530020.

In summary, PL3 reports that when compared to the general population. LGBTIQA+ people in rural locations experience:

- **lesser acceptance, including at health or support services**
- **more likely to experience poor or fair health**
- **higher levels of psychological distress**
- **higher diagnoses of a mental health condition**
- **greater difficulty in accessing a mental health service that is inclusive of LGBTIQ+ people**
- **substantially higher levels of suicide ideation and substantially higher levels of attempted suicide**

Writing Themselves In 4 (2021) – The Health and Wellbeing of LGBTQA+ Young People in Australia

Writing Themselves In 4[29] (WTI4) is the fourth national Australian survey of health and wellbeing among self-identifying LGBTQA+ young people (ages 14 to 21 years), conducted by the Australian Research Centre for Sex, Health and Society, at La Trobe University. The survey was open between September and October 2019, and the data analysed from several intersectional lens, including ethnicity, disability, religion/ spirituality, Aboriginal or Torres Strait Islander, and area of residence. Only findings relating to area of residence in regional, rural or remote Australia are summarised here. It is recommended readers view the full report and its recommendations to understand the broader findings.

Most participants (57.8%) lived in the suburbs of state or territory capital cities, while 24.9% lived in regional towns or cities, 10.5% in rural or remote locations and 6.8% in the centre of capital cities. This is the first major study in Australia to include an examination of area of residence in a sample of young LGBTQA+ people (referred to below as 'participants') and thus provides useful information to assist rural organisations better understand and address the challenges faced by young LGBTQA+ living outside metropolitan areas.

This study of young LGBTQA+ people's experiences found:

- Almost three-fifths (57.0%) of participants in rural/remote areas reported they had felt unsafe or uncomfortable in the past 12 months at their educational setting due to their sexuality or gender identity, followed by 52.7% in regional cities or towns, 50.0% in outer suburban areas, and 40.1% in inner suburban areas.
- A greater proportion of participants in inner suburban areas reported feeling supported by classmates about their sexual identity, gender identity and/or gender expression (52.9%) than was the case for those in outer suburban areas (45.3%), regional cities or towns (36.1%), or rural/remote areas (29.6%).
- More participants in rural/remote areas reported experiencing high/very high psychological distress (87.5%) than those in regional cities or towns (83.3%), outer suburban

[29] https://www.latrobe.edu.au/arcshs/work/writing-themselves-in-4 Hill AO, Lyons A, Jones J, McGowan I, Carman M, Parsons M, Power J, Bourne A (2021) Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia. National report, monograph series number 124. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne. ARCSHS.

areas (79.8%), or inner suburban areas (73.2%).

- More participants in rural/remote areas reported in the past 12 months experiencing verbal harassment based on their sexuality or gender identity (45.4%) than those in regional cities or towns (41.0%), outer suburban areas (40.4%), or inner suburban areas (37.0%).
- Almost two-thirds (65.1%) of participants in rural/remote areas reported experiencing suicidal ideation in the past 12 months, followed by three-fifths (60.5%) in regional cities or towns, 57.1% in outer suburban areas, and 49.2% in inner suburban areas.
- Participants in rural/remote areas reported the highest levels of suicide attempts in the past 12 months (14.0%), almost twice that of those in inner suburban areas (7.1%).

The authors of WTI4 summarised the findings by stating that LGBTQA+ young people in rural and regional areas face:

- **lower levels of support in educational institutions**
- **more frequent verbal and physical harassment or assault based on their sexuality or gender identity**
- **higher levels of psychological distress**
- **higher levels of suicidality**

than those in larger metropolitan areas.

Alcohol and Other Drug Use (AOD) by LGBTQA+ communities in Australia:

A 2023 national consultation on alcohol and other drug (AOD) use in LGBTQA+ communities, funded by Pride Foundation Australia,[30] has found:

- LGBTQ+ communities are more likely to smoke, use illicit substances / drugs and drink at higher levels than non-LGBTQ+ people.
- There has been some decline in smoking and alcohol use among LGBTQ+ communities, but recent use of illicit drug use has not declined.
- There are differences in the frequency of the types of drug use, when analysed by sexual and gender identity.
- LBQ+ (lesbian, bisexual and queer) women drink alcohol at higher levels when compared to other women.
- GBMSM (gay, bisexual and men-who-have-sex-with-men) use crystal meth at a higher proportion than the general population. Recently use has declined among these men in Sydney and Melbourne, though this may be due to the impact of the COVID-19 pandemic.
- Importantly, higher alcohol and illicit drug use do not mean respondents report struggling to manage their use.
- Data on AOD use among people with an intersex variations was noted by the authors as a gap in the research.

The report noted the lack of LGBTQ+ specific AOD programs in rural Australia, and recommended future investment in AOD harm minimisation needs to be inclusive of rural and regional areas. Pride Foundation Australia[31] has developed AOD health interventions as a new Focus Area and has launched a philanthropic funding program.

[30] Findings from Alcohol and Other Drugs Consultation, Aldo Spina, Evaluation Consultant. Prepared for LGBTIQ+ Health Australia, Suite 2101, Level 21, 233 Castlereagh Street, Sydney NSW 2000, March 2023.

[31] https://pridefoundation.org.au

In summary LGBTQ+ communities are more likely to smoke, use illicit substances / drugs and drink at higher levels than non-LGBTQ+ people.

Specific AOD programs in rural Australia are needed, as is future investment in AOD harm minimisation needs to be inclusive of rural and regional areas.

Rainbow Realities

Introduction to study

The Rainbow Realities report[32] was completed in 2023 for the Commonwealth Department of Health and Aged Care to inform development of the Australian government's 10-year LGBTIQA+ Health and Wellbeing Action Plan 2025 - 2035.

Rainbow Realities provides a synthesis of pre-existing research plus more than 50 new analyses derived from the data of six surveys of LGBTQA+ populations in Australia: Private Lives 3 (National data set); Writing Themselves In 4 (National data set); SWASH (Sydney women's health report 2020); Trans Pathways (2017); Walkern Katatdjin (Reports 1 & 2; Rainbow Knowledge) and Pride and Pandemic (2022). The report presents its findings in 10 themes relating to either a key determinant or contributing factor to LGBTQA+ health outcomes, or a topic of particular concern.
These themes are:

- Mental Health and Suicidality
- Relationships, parenting and Sexual and Reproductive health
- Income Inequality Housing and Experiences of Homelessness
- Gender Affirmation and Trans-Affirming Practices
- Discrimination and Abuse
- General Healthcare
- Family Violence and Sexual Assault
- Aboriginal and Torres Strait Islander People
- Alcohol and Other Drugs
- Intersectional Identities

The Rainbow Realities "Intersectional Identities Theme" includes limited sub-theme data and analysis of the experiences of LGBTIQA+ people living in rural ('Residential location') Australia.

Within the other nine theme analyses there are new data comparing health and wellbeing outcomes of LGBTQA+ people living in Australian inner capital city, outer capital city, and rural areas. The statistical analysis in Rainbow Realities mostly uses 'adjusted odds ratios' (AOD) with 95% Confidence Intervals (CI)[33].

Unfortunately, these AOD/CI analyses are not brought together in the Rainbow Realities report to provide visibility of the health and wellbeing of LGBTIQA+ people living in rural Australia.

The following two sections brings together the much needed, but only limited visibility of LGBTQA+ health in rural Australia reported in the Rainbow Realities ~250-page report.

[32] Amos, N., Lim, G., Buckingham, P., Lin, A., Liddelow-Hunt, S., Mooney-Somers, J., Bourne, A., on behalf of the Private Lives 3, Writing Themselves In 4, SWASH, Trans Pathways, Walkern Katatdjin, and Pride and Pandemic teams (2023). Rainbow Realities: In-depth analyses of large-scale LGBTQA+ health and wellbeing data in Australia. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. ISBN: 978-0-6458786-0-8 https://www.latrobe.edu.au/arcshs/work/rainbow-realities

[33] For an easy to understand description of AOD and CI analyses in public health settings -Jan 11 2023: https://kids.frontiersin.org/articles/10.3389/frym.2022.926624#:~:text=Interpreting%20Odds%20Ratios,odds%20of%20disease%20%5B4%5D.

Poorer health and wellbeing for LGBTQA+ people living in rural Australia

Greater suicidality + poorer access to mental health professionals:

- Among the 83.7% of Australian LGBTQA+ young people reported having ever experienced suicidal ideation, suicide attempt or self-harm (and therefore having a mental health need), only 72.6% had ever accessed professional support. For LGBTIQA+ people living in rural Australia the probability of these young people seeing a mental health professional is about half (0.56 regional city / town; 0.54 rural / remote) of those living in inner suburban areas.

Greater psychological stress during pandemic:

- Psychological distress scores during the pandemic differed across the population. LGBTQA+ adults who lived in outer suburban or in regional areas more often reported their mental health worsened.

Greater experience of homelessness:

- Recent or any experience of homelessness were about 1.25 times more likely for LGBTQA+ people living in either a regional city or town, or in a rural or remote location compared to participants living within the inner suburbs of capital cities. LGBTQA+ people in rural areas were up to 1.5 times more likely to experience ongoing homelessness.

Lower income levels:

- LGBTQA+ adults living in a regional city or town were 1.6 times more likely to report receiving an average weekly income of $0-$799 per week (i.e. low weekly earnings), while those living in rural or remote areas were 2.2 times more likely to be living on low weekly incomes, compared to those LGBTQA+ people living in inner-suburban areas.

Higher levels of intimate partner or family violence:

- Reports of new or more frequently occurring violence from an LGBTQA+ intimate partner during the pandemic were highest, and 1.4 times more likely in regional city/town and 1.6 times more likely in rural or remote areas compared to inner urban areas.
- Experiences of violence from a family member during the pandemic also varied across different sociodemographic traits. Specifically, violence from a family member was found to be about 1.7 times more likely for those living outside of inner-suburban areas (in outer suburban, regional and rural or remote areas) than inner urban areas.
- Reports of new or more frequently occurring violence from a family member during the pandemic were highest and 1.9 times that of inner urban areas for those living in outer suburban areas and 1.5 times for regional cities or towns.

Lesser access to sexual & reproductive health

- Compared to inner urban areas, participants were about 30% less likely to access cervical screening if they were residing in regional city or town, rural or remote area, but were most likely to access screening if they attended a regular GP, reported that their GP or healthcare practice were aware of their sexuality and/or gender

Poorer Adult Mental Health and Community Connections

- Cisgender participants living in regional cities or towns were 25% more likely than those living in inner suburban areas to report high or very high psychological distress, lifetime suicidal ideation, and lifetime suicide attempts.
- However, among trans and gender diverse participants, residential location was not associated with a change psychological distress, lifetime suicidal ideation, or lifetime suicide attempt. (The Rainbow Realities report (Ch 3) notes trans and gender diverse people experience very high rates of psychological distress, suicidal ideation or lifetime suicide attempt, that these are the greatest for young

people. As noted above these do not change with residential location.)

- Cisgender participants were about 30% less likely to feel connected to the LGBTQA+ community, and less likely to have a positive feeling of participation in the LGBTQA+ community if they lived in regional, rural or remote area.
- However, no significant differences of LGBTQA+ community connection were found between trans and gender diverse adults living in inner and outer suburban areas, those living in regional, rural, and remote areas reported low levels of LGBTQA+ community connection.
- Trans and gender diverse people who lived in outer suburban areas, or rural or remote areas were considerably, about 50%, less likely than those living in inner suburban areas to report that their local community was affirming of their gender identity.

Poorer Youth Mental Health, Community Connections and Greater Homelessness

- Both cisgender sexual minority and trans and gender diverse youth living in rural and remote areas were significantly (~30%+) more likely than those in outer suburban areas to report high or very high levels of psychological distress.
- Cisgender LGBTQA+ young people living in rural or remote areas were ~ 30% more likely than those living in outer suburban areas to have experienced recent (<12 months) verbal harassment and ~60% more likely to receive physical harassment.
- Cisgender LGBTQA+ young people living in rural or remote areas were about 30% more likely than those living in outer suburban areas to have experienced suicidal ideation and 47% more likely to have attempted suicide in the last 12 months.
- Cisgender LGBTQA+ young people were 22% more likely to have experienced homelessness if they were living in a regional city or town or 32% if living in a rural or remote area compared to inner urban areas..
- Trans and gender diverse young people in a regional city or town were 33% more likely than those in an outer suburb to have experienced homelessness.
- Residential location was not associated with cisgender LGBTQA+ participants' participation in LGBTQA+ youth events. In contrast, trans and gender diverse young people living in an inner-suburban area had the highest odds of taking part in LGBTQA+ youth events.
- Young trans and gender diverse people living in rural or remote areas reported the lowest levels of happiness, 26% less, while cisgender young people living in inner-suburban areas reported greater happiness than all other areas.

Better health and wellbeing for LGBTIQA+ people living in rural Australia

For LGBTIQA+ people there are some health and wellbeing benefits from living in rural Australia.

Lower struggles with alcohol consumption

- Compared to inner-city LGBTQA+ people LGBTQA people living in rural or remote areas were about 50% less likely to report struggles with alcohol consumption while those living in regional cities or towns were about 30% less likely.

Alcohol support service preferences

- LGBTQA+ adults were about 30% less likely to hold a preference for LGBTQA+-specific services if they lived regional cities or towns and rural or remote areas.

Lower Alcohol and Other Drugs Risk

- Four distinct latent classes ('typologies') of AOD risk emerged within the data. These risk profiles were characterised as: No AOD risk (13.3% of the sample); Low AOD risk (15.1% of the sample); Moderate AOD risk (30.1% of the sample) and Moderate alcohol only risk (41.5% of the sample).
- Participants classed as 'no AOD risk' were 70% more likely to be living in a regional city or town or 60% more likely to be living in a rural or remote area.
- Those classed as 'moderate AOD risk' (the highest risk class) were more likely to be living in an inner-suburban area and were markedly more likely to report being the victim of sexual assault in the previous 12 months, and the least likely to report past-year verbal abuse or harassment (e.g. being spat at or receiving offending gestures, and physical threats).
- Heterosexism and family cost less likely as a barrier to parenting among LGBTIQA+ people in rural areas.
- Those living in a regional city or town or in a rural or remote area were up to half as likely to feel that societal heterosexism was a barrier to parenting.
- Those living in a regional city or town, or a rural or remote area were about 30% less likely to feel that heterosexism within a fertility service was a barrier.
- Those living in regional cities and towns and rural or remote areas were 30-60% less likely to report the cost of raising a child is a barrier to parenting.

In summary Rainbow Realities reports the health and wellbeing for LGBTIQA+ people living in rural areas is characterised by:

- **Poorer health and wellbeing for LGBTQA+ people living in rural Australia**
- **Greater suicidality + poorer access to mental health professionals**
- **Greater psychological stress during pandemic:**
- **Greater experience of homelessness:**
- **Lower income levels:**
- **Higher levels of intimate partner or family violence:**
- **Lesser access to sexual & reproductive health**
- **Poorer Adult Mental Health and Community Connections**
- **Poorer Youth Mental Health, Community Connections and Greater Homelessness**

Better health and wellbeing for LGBTIQA+ people living in rural Australia is characterised by:

- **Lower struggles with alcohol consumption**
- **Lower Alcohol and Other Drugs Risk**
- **Heterosexism and family cost less likely as a barrier to parenting among LGBTIQA+ people in rural areas.**

Overview – Victoria-wide comparisons between LGBTIQ+ and non-LGBTIQ+

Health outcomes of LGBTIQ+ people across Victoria (aggregated metropolitan, regional and rural) are generally poorer then their non-LGBTIQ+ peers. The Australian Research Centre in Sex, Health and Society (ARCSHS) at Latrobe University, and other University-based studies are summarised in the Victorian Government discussion paper informing 'Pride In Our Future: Victoria's LGBTIQ+ strategy 2022-32' [34].

It shows LGBTIQ+ people have significantly poorer physical and mental health compared to national averages, including significantly:

- higher rates of drug use, alcohol, smoking, chronic disease, homelessness, and disability
- higher rates of anxiety and depression, psychological stress, lower life satisfaction
- Recent Victorian studies provide a more detailed and nuanced picture of the health and wellbeing of LGBTIQA+ people, reported below in Fig 1 [35] [36]:

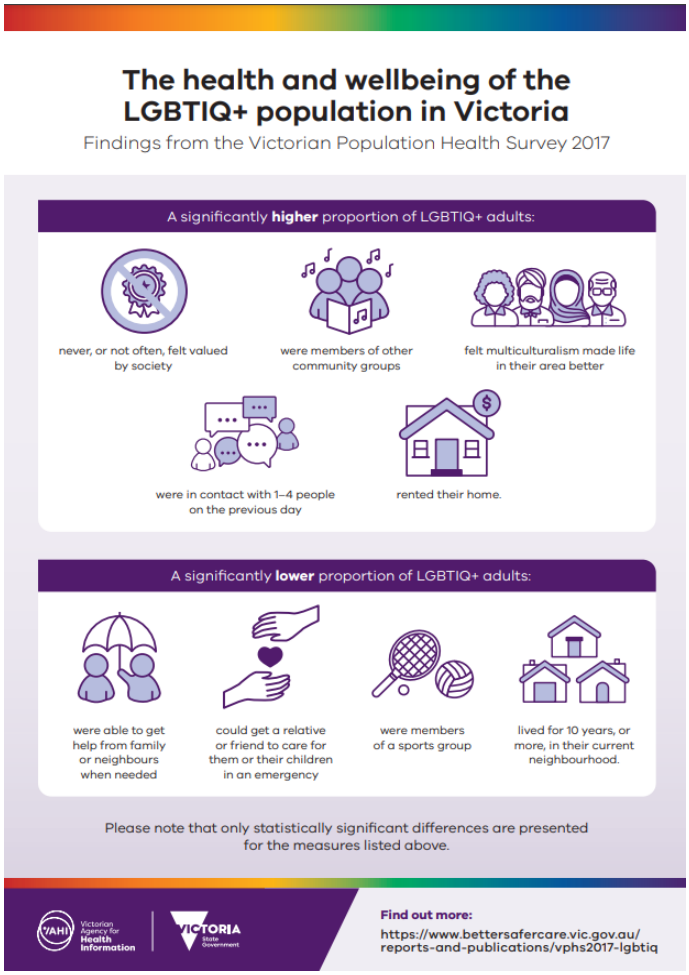

Fig 1: The Health and Wellbeing of the LGBTIQ+ population in Victoria

[34] Discussion Paper for the Victorian LGBTIQ+ Strategy Govt of Vic, June 2020 https://engage.vic.gov.au/lgbtiqstrategy

[35] https://vahi.vic.gov.au/sites/default/files/2021-12/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria-facthseet1.pdf

[36] https://vahi.vic.gov.au/sites/default/files/2021-12/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria-facthseet2.pdf

Key outcomes statistics

Across a range of measures, LGBTQ+ Victorians experience poorer outcomes:

38.1 per cent report having a disability or long-term health condition, including mental health, compared with 17.7 per cent of the general Australian population

More LGBTIQA+ people in rural and regional areas rate their health as 'poor' or 'fair' compared with outer and inner suburban communities

21.3 per cent have been homeless

24 per cent of young LGBTQ+ people have been homeless

54.3 per cent report high or very high levels of psychological distress in the past four weeks compared with 13 per cent of the general Australian population

Victorians in outer suburban, regional and rural areas report higher rates of psychological distress compared to those living in inner city areas

73.2 per cent have considered suicide compared with 13.2 per cent of the general Australian population

9.4 per cent of young LGBTQ+ Victorians have attempted suicide in the past 12 months

Victorians in outer suburban, regional and rural areas are more likely to have recently attempted suicide compared to those living in inner city areas

17.9 per cent have struggled to manage their alcohol use in the past 12 months

Compared with the general population, significantly more LGBTQ+ adult Victorians:

could not raise $2,000 within two days in an emergency

experienced food insecurity in the previous year

Compared with the general population, significantly fewer LGBTIQA+ adult Victorians:

could get help from family or neighbours when needed

could get a relative or friend to care for them or their children in an emergency

Sources: Australian Bureau of Statistics 2019; Department of Health and Human Services 2018; Hill et al. 2020, 2021a, 2021b, 2021c; VAHI 2020

Fig 2: Victoria's LGBTIA+ strategy, 'Pride in Our Future 2022-2032', quantified the poorer health outcomes in the Key Outcome Statistics below [37].

[37] https://www.vic.gov.au/pride-our-future-victorias-lgbtiq-strategy-2022-32 page 16.

These key Statewide health outcomes provide an important guide for regional and rural health care service providers to better understand the health care needs of their LGBTIQ+ populations.

Comparing LGBTIQ+ with non-LGBTIQ+ health and wellbeing in Rural Victoria

Background

The health and wellbeing of the LGBTIQ+ populations in Victoria was analysed and reported by the Victorian Agency for Health Information (VAHI) [38] with data extracted from the 2017 Victorian Population Health Survey (VPHS) and published in 2020 to support the Victorian Governments preparation of its 2022 LGBTIQ+ Strategy.

The 2017 VPHS involved approximately 426 interviews in each of the 79 Victorian LGAs (local government areas), totalling 33,654 interviews. All survey respondents were asked questions on their sexual orientation, gender identity and intersex status. Respondents were given the option to answer, or not answer, any of the questions or skip the entire section of the survey.

In the Victorian Population Health Survey 2017, 5.7% of the adult population identified as LGBTIQA+. Of these, 1.8% of adults identified as 'gay or lesbian' and 2.8% identified as 'bisexual', 0.3% as queer, pansexual or asexual, 0.3% as transgender/gender diverse, 0.3% as 'other', and 0.2% with intersex variations. A further 2.8% did not know if they were non-LGBTIQA+ and 3.4% refused to answer the question or skipped the entire section. The remaining adults identified as being non-LGBTIQA+ (88.1%).

These figures were aggregated across all Local Government Areas (LGA's). As noted previously, the proportion of LGBTIQA+ people can vary across regional and rural LGA's, with evidence that LGBTIQA+ people may make up 7.9% of the population in Mount Alexander Shire of Victoria, about 50% greater than the Victorian Statewide average of 5.7%.

The VHIA report provided significant new detail on the socio-economic characteristics and health status of Victoria's LGBTIQ+ adult populations compared with non-LGBTIQA+ people on a state-wide basis, through 36 tables and detailed conclusions. In addition to this, the VHAI report also published a further 87 tables in its appendices, for which no interpretation, discussion or conclusions were presented.

Twenty-nine (29) of these appendix tables included statistical analysis (at 95% confidence intervals) comparing the socio-economic and health status of LGBTIQ+ adults and non-LGBTIQ+ adults living in rural Victoria. 'Rural' (i.e. regional, rural and remote) is defined as any areas not in Metropolitan Melbourne ('Metro'). 'Metro' is defined by local government areas (LGA's) that extend from city of Wyndham in the west to Yarra Ranges in the east, and Whittlesea in the north to Mornington Peninsula in the south [39].

We have conducted a secondary analysis of data in the twenty-nine rural versus metro tables in Appendix 1 of the VHAI paper and report where differences between LGBTIQ+ and no-LGBTIQ+ people were statistically significant. Statistical significance tests were not included in the appendices that enable comparisons between Rural and Metro LGBTIQA+ and non-LGBTIQ+ populations. Data from the VHAI paper discussed below are

[38] https://vahi.vic.gov.au/reports/population-health/health-and-wellbeing-lgbtiq-population-victoria . Citation: Victorian Agency for Health Information 2020, The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017, State of Victoria, Melbourne.

[39] https://www.viccouncils.asn.au/find-your-council/council-map and https://www.viccouncils.asn.au/__data/assets/pdf_file/0009/32859/metropolitan-municipalities-map.pdf

reproduced in Appendix 3 of this report.

This previously uninterpreted or discussed data provides an important more detailed and nuanced 'piece in the jig-saw puzzle' to guide evidence-based health service priority setting for LGBTIQ+ populations in rural areas. They provide the most comprehensive data yet in showing the differences in health and wellbeing of LGBTIQ+ adults with non-LGBTIQ+ adults living in rural Victoria and therefore should guide targeted healthcare interventions. It is likely these findings will be mirrored in other States and Territories.

Physical and mental health differences

Physical health

- A significantly greater proportion of LGBTIQ+ adults (29.3%) reported their health as Fair or Poor compared to non-LGBTIQ+ adults (19.0%) in 'Rural' Victoria.
- LGBTIQ+ adults in 'Rural' Victoria are more likely to have two or more chronic diseases (36.6%), a significantly greater likelihood than non-LGBTIQA+ adults (23.7%).
- Smoking cigarettes daily was significantly greater amongst of LGBTIQ+ adults (21.4%) compared to non-LGBTIQ+ adults (14.1%) in 'Rural', with about 1 in 5 LGBTIQ+ adults smoking daily in 'Rural' Victoria
- Family violence was experienced by a significantly greater proportion of LGBTIQ+ adults in 'Rural' Victoria (11.8%). This is twice the proportion that non-LGBTIQ+ adults (5.6%) living in 'Rural' Victoria experience.
- Poorer dental health was reported by a significantly greater proportion of LGBTIQ+ 'Rural' adults (32.9%) about 50% more than non-LGBTIQA+ 'Rural' adults (23.7%) who self-report 'Fair or Poor' dental health.

There was no significant difference in diagnosis of asthma between LGBTIQ+ and non-LGBTIQ+ people living in 'Rural' Victoria; but in 'Metro' areas a significantly greater proportion of LGBTIQ+ (29.4%) compared to non-LGBTIQ+ people (19.2%) have an asthma diagnosis.

Mental health

- Diagnoses of anxiety or depression were experienced by a significantly greater proportion of LGBTIQ+ people (49.4%) living in 'Rural' Victoria compared to non-LGBTIQ+ adults (31.7%) living in 'Rural' Victoria.
- Significantly greater proportion of LGBTIQ+ adults (26.3%) living in 'Rural' Victoria were experiencing levels of 'High or very High' psychological stress compared to non-LGBTIQ+ adults (15.5%) living in 'Rural' Victoria.

In Summary, when comparing LGBTIQ+ adults living in rural Victoria with non-LGBTIQ+ adults living in rural Victoria, significant health differences were found. LGBTIQ+ people are more likely to have:

- Lower health status.
- Be 50% more likely to suffer from two or more chronic health diseases.
- More likely to smoke daily.
- More likely to have poorer dental health.
- Greater diagnoses of anxiety or depression.
- More likely to experience higher psychological stress.
- Experience twice the level of family violence.

Socioeconomic differences

Economic

- A significantly greater proportion of LGBTIQ+ people (36.1%) living in 'Rural' Victoria were in the low-income group, (earning up to $40k) compared to non-LGBTIQ+ 'Rural' living adults (22.6%). A significantly smaller proportion of rural living LGBTIQ+ people (13.8%) earned a high household income of over $100k compared to non-LGBTIQ+ adults (26.7%) living in 'Rural' Victoria. There was no significant difference between the two groups in the middle-income range ($40k-$100k).
- Employment rate was significantly lower amongst 'Rural' living LGBTIQ+ adults (54.8%) when compared to non-LGBTIQ+ adults (63.9%) living in 'Rural' Victoria.
- 'Rural' living LGBTIQ+ adults were (23.5%) less able to raise $2k quickly in event of an emergency, compared to non-LGBTIQ+ adults (14.2%) in 'Rural' Victoria.
- Food insecurity was experienced by a significantly greater proportion of 'Rural' living LGBTIQ+ adults (14.5%), about double the proportion of non-LGBTIQ+ (7.5%) adults who had experienced food insecurity in 'Rural' Victoria.

Similar differences were seen in Metro comparisons of LGBTIQ+ and non-LGBTIQ+, apart from the employment status, which showed no significant difference between LGBTIQ+ and non-LGBTIQ+ people living in Metro Melbourne.

Personal and Community Connectedness

- Being married or living with a partner in 'Rural' Victoria was significantly lower for LGBTIQ+ adults (46.0%) than non-LGBTIQ+ adults (64.8%), and a significantly greater proportion of LGBTIQ+ adults had never married. The latter an unsurprising finding, given how recently marriage equality has been achieved.
- Social isolation is greater for 'Rural' living LGBTIQ+ people, as shown by a significantly greater proportion of LGBTIQ+ people (29.0%) who had spoken to only between 1-4 adults in the last day compared to non-LGBTIQ+ adults (19.8%) living in 'Rural' Victoria. In 'Metro' areas no significant differences were found between LGBTIQ+ and non-LGBTIQ+ adults in the number of people they had spoken to in the last 24 hrs.
- The feeling of not being valued by society was experienced by a significantly greater proportion of 'Rural' living LGBTIQ+ adults (20.6%) who felt 'never or not often' valued by society compared to non-LGBTIQ+ adults (12.6%) in 'Rural' Victoria. A lower proportion of 'Rural' living LGBTIQ+ adults (37.1%) felt 'Yes, definitely' valued by society compared to non-LGBTIQ+ (48.8%) in 'Rural' Victoria.
- The period of living in the same neighbourhood was found to be significantly lower proportion of 'Rural' living LGBTIQ+ adults (39.6%) compared to non-LGBTIQ+ adults (47.5%) who lived in the same 'Rural' neighbourhood for greater than ten years.

Discrimination, Safety and Trust

- Discrimination had been experienced by a significantly greater proportion of rural living LGBTIQ+ adults (25.2%) than non-LGBTIQ+ adults (13.9%) in 'Rural' Victoria.
- The feeling of a lack of personal safety was experienced by a significantly greater proportion of 'Rural' living LGBTIQ+ adults (22.0%) who 'never' or 'not often' felt safe walking down a street at night, compared to non-LGBTIQ+ adults (15.3%) in 'Rural' Victoria. Also, significantly fewer rural living LGBTIQ+ (56.2%) felt 'definitely' felt safe walking down a street at night compared to non-LGBTIQ+ adults (64.5%) in 'Rural' Victoria.
- The feelings of a lack of trust were experienced by a significantly greater proportion of 'Rural' living LGBTIQ+ adults (23.1%) who "never or not often'' had feelings of trust, compared to non-LGBTIQ+ adults (15.1%) in 'Rural' Victoria.

In Metro areas, there was significant difference in discrimination levels, but no differences for LGBTIQA+ compared to non-LGBTIQA+ people in personal safety or feelings of trust.

In summary, when comparing LGBTIQ+ adults living in 'Rural' Victoria with non-LGBTIQ+ adults living in 'Rural' Victoria, significant socio-economic differences were found. LGBTIQ+ people are more likely to:

- Live in households with lower income.
- Be unemployed.
- Being unable to raise $2k in case of an emergency.
- Experience less trust.
- Have experienced twice the likelihood of food insecurity.
- Not be married or living with a partner.
- Be more isolated from friends and neighbours.
- Feel less valued.
- Stay in the same neighbourhood for less than ten years.
- Experience more discrimination.
- Feel less safe.
- Feel a lack of trust.

Socio-economic similarities

When comparing LGBTIQ+ people living in 'Rural' Victoria with non-LGBTIQ+ adults, some socio-economic indicators showed there were no statistical differences in the following areas:

Economic:

No differences between LGBTIQ+ and non-LGBTIQ+ in 'Rural' were found for:

- Educational attainment (i.e. High school; TAFE or Trade; or University): A similar result to that found in 'Metro'.
- Likelihood of having private health insurance: A similar result to that found in 'Metro'.
- Home ownership: A similar result to that found in 'Metro'; however, at a State-wide level a significantly greater proportion of LGBTIQ+ people's homes were mortgaged or rented.

Personal and Community Connectedness

No differences between LGBTIQ+ and non-LGBTIQ+ in 'Rural 'were found for:

- Country of birth: In 'Metro' a significantly greater proportion of LGBTIQA+ adults were born in Australia than overseas.
- Language spoken at home: In 'Metro' a significantly greater proportion of LGBTIQ+ homes spoke English compared to non-LGBTIQ+ people's homes.
- Aboriginal or Torres Strait Islander status: A similar result to that found in 'Metro'.

Discrimination, Safety and Trust

No difference between LGBTIQ+ and non-LGBTIQ+ in 'Rural' were found for:

- Feelings about 'opportunities to have a say' in society, a similar result to 'Metro'.
- Tolerance in feeling multiculturalism has made life better. However, in 'Metro' areas a significantly greater proportion of LGBTIQ+ people (66.5%) felt multiculturalism made life better than did non-LGBTIQ+ people (55.8%).
- Life satisfaction. In 'Metro' areas a significantly greater proportion of LGBTIQ+ people report Low or Medium life satisfaction than non-LGBTIQ+ people
- Feeling of being worthwhile in society. In 'Metro' areas a significantly greater proportion of LGBTIQ+ people (22.7%) report Low or Medium feeling that life is worthwhile than non-LGBTIQ+ people (16.6%).

In summary, when comparing LGBTIQ+ adults living in rural Victoria with non-LGBTIQ+ adults living in Rural Victoria, there are no significant differences in:

- Country of birth.
- Language spoken at home.
- Aboriginal or Torres Strait Islander status.
- Educational attainment.
- Likelihood of private health insurance.
- Feelings about 'opportunities to have say' in society.
- Diagnosed with asthma.
- Home ownership.
- Life satisfaction.
- Feeling of being worthwhile in society.
- Tolerance in feeling multiculturalism has made life better.

RURAL HEALTH SERVICE ACCESS

The data outlined above indicate clear health inequalities for LGBTIQA+ people in rural areas. These are both when compared to their urban counterparts, and to their rural non-LGTBQA+ peers. Some of these data highlight difficulties accessing LGBTIQA+ inclusive healthcare services in rural areas, however there are few studies exploring rural services in detail.

The Reality of Rural Health Services

Healthcare service provision for all people in rural Australia, regardless of their sexuality or gender identity, differs significantly from that in capital cities. The Australian Institute of Health and Welfare review Australia's rural and remote health services [40] and Australia's National Strategic Framework for Rural and Remote Health [41], developed in 2011 through collaboration between the Commonwealth, State and the Northern Territory governments and by the Commonwealth parliaments the Rural Health Standing Committee, identify key differences:

- Limited access to services: People in regional and rural areas often have limited access to healthcare services compared to those in capital cities. This includes fewer hospitals, clinics, and specialist services.
- Workforce shortages: There is a significant shortage of healthcare professionals in rural and regional areas. This includes doctors, nurses, and allied health professionals, which can lead to longer wait times and reduced access to care. Limited and shared resources between towns mean that not all medical services are available all the time. In a rural area, one may often have to wait until a specialist is in the area or travel to a regional or metropolitan clinic or hospital for more support, diagnosis and treatment.
- Poorer infrastructure: Healthcare infrastructure in rural and regional areas is often less developed. This can include outdated facilities, limited medical equipment, and fewer technological advancements.
- Long travel distances: People in rural and regional areas often need to travel long distances and may need for overnight accommodation to access healthcare services. This can be a significant barrier, especially for those with limited mobility or financial resources.
- Limitations to telehealth: While telehealth has been expanding, its implementation in rural and regional areas can be hampered by issues such as internet connectivity and digital literacy, and it is not suited to all types of consultations.
- Limited funding and resources: There is often less funding and resources allocated to healthcare in regional and rural areas compared to capital cities, which can affect the quality and availability of services.

The 2011 National Strategic Framework for Rural and Remote Health aims to address these disparities by promoting collaborative partnerships, sustainable workforce development, and appropriate models of care.

It is unfortunate that no LGBTIQA+ health organisations, at State or national level, were consulted nor did any provide a written submission to the Framework development. The Framework is silent on the poor health of the approximately 350,000 LGBTIQA+ people in rural Australia.

In addition to these structural differences, social differences exist between capital cities and

[40] Australian Institute of Health and Welfare (AIHW) 2024, Rural and remote health, viewed 19 January 2025, https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[41] National Strategic Framework for Rural and Remote Health, 2011 https://www.health.gov.au/sites/default/files/documents/2020/10/national-strategic-framework-for-rural-and-remote-health.pdf?form=MG0AV3

regional, rural and remote areas that can negatively impact on healthcare access by LGBTIQA+ people.

Primary care consultation with a local doctor (when available) may be problematic due their lack of training in LGBTIQA+ health issues. Further, there are more overseas-trained doctors working in regional and rural areas, who may bring more conservative attitudes than Australian trained doctors.

Long travel distances and possible need for overnight accommodation when a return trip cannot be made in a day makes it difficult to avoid disclosing the reason for medical travel to family, friendship and workplace networks. While telehealth may be available, it is not always suitable for talking about deeply personal healthcare matters for LGBTIQA+ people.

Being anonymous in regional and rural areas is not the possibility it is in urban areas. Smaller population size and greater social and employment connectedness can make an anonymous visit to a doctor difficult or impossible. In medical clinics it is more likely to see family, friends or colleagues in waiting rooms, who may be staff in medical clinics or passing by in the street.

Several universities now offer GP, nursing and allied health training with emphasis on rural medicine. Ensuring adequate inclusion of LGBTIQA+ health care within specialist regional and rural GP health care training should be a priority.

Loddon Mallee, Victoria healthcare services access for LGBTIQA+ people

The Loddon Mallee area of north-western Victoria is unusual in that three studies of LGBTIQA+ healthcare have been reported in recent years. The Loddon Mallee covers an area of 59,000 square kilometres with a population of about 314,000 [42], from Macedon in the south to Swan Hill and Mildura in the northwest, and includes major regional centres of Kyneton, Castlemaine, Bendigo, Mildura and Swan Hill.

LGBTIQA+ healthcare in GP clinics

A study by Thorne Harbour Health and Cobaw Community Health [43] (now Sunbury Cobaw Community Health) in ~2019 explored what impeded better physical and mental health for the lesbian, gay, bisexual, transgender, intersex, queer, asexual, and people with other gender and sexuality identities (LGBTIQA+) across the Loddon Mallee region. The aim of the study was to identify what can be done systemically to strengthen the delivery of health services (particularly GP services) to LGBTIQA+ people in the region.

A limited survey was conducted and the project team then met with patients, GP clinicians and clinic practice managers to understand their experiences in provision of medical services to LGBTIQA+ people. The aim was to advise on strengthening the delivery of GP services in the Loddon Mallee.

Findings included the need to:

- Work actively with clinics (GP's, Nurses, Practice Managers, Administrators and Reception

[42] Loddon Mallee regional plan https://www.rdv.vic.gov.au/__data/assets/pdf_file/0004/1663618/Loddon_Mallee_RSP-1-Web.pdf

[43] GP Medical Clinics and the provision of equitable LGBTIQA+ healthcare across the Loddon Mallee Region, Claudia Validum, Program Coordinator, Thorne Harbour Country and Belinda Brain Country LGBTIQA+ Inclusion Program Cobaw Community Health. Occasional publication, Sunbury Cobaw Community Health, 12-28 Macedon Street, Kyneton, Vic, 3444, Australia.

staff) to emphasise the value of and support participation in LGBTIQA+ Inclusive Practice training and share these learnings with other clinics.

- Build and share a regional LGBTIQA+ referral guide for medical practitioners.
- Promote the first point of contact in a GP clinic to be welcoming to LGBTIQA+ people. For example, clearly displaying LGBTIQ+ related posters, brochures and information, up-to-date and replenished in waiting room (also recommended removal of heterosexist language and images) and details of regional and Melbourne LGBTIQA+ specific services, program and events.

Pathways to Pride

The Pathways to Pride report [44] conducted during 2019-20 found systemic barriers LGBTI+ young people face in accessing appropriate, safe, and current evidence-based health and wellbeing services through General Practitioners (GPs) across the Loddon sub-region, the southern half of the Loddon Malle Region of northwest Victoria. It also found gaps in existing and emerging resources and training, and opportunities for change to reduce those systemic barriers and thereby increase LGBTI+ young people's access to care. It is likely that these findings are applicable across regional and rural Victoria, and regional and rural areas nationally.

This summary is limited to those findings about the experiences of young people accessing medical services. The most common concerns LGBTI+ young people have when searching for a healthcare provider generally, and in the Loddon Area, include:

- Confidentiality
- Will this doctor be competent in LGBTI+ matters and know the answers to my questions?
- Will they understand my unique health needs?
- Is this doctor LGBTI+ friendly, and will their clinic be a safe space for me?
- That young people will be taken seriously (because of their age) and not be told it's "Just a phase".

Research cited supports concerns about being identified and treated respectfully are one of the key barriers to young people accessing health services. LGBTI+ young people who have questions related to their sexual orientation and/or gender identity can be fearful about disclosing same sex attraction, sex and gender diversity to their GP due to stigma, discrimination and perceived assumptions about:

- Their gender or sexual identity.
- The gender of their romantic and/or sexual partner/s.
- Relationship characteristics (monogamous, single, partner, polyamorous).
- Sexual practices (e.g. assuming all gay-identified young men engage in anal sex).
- Sexual desire (including not acknowledging asexuality).

This study finds that LGBTI+ young people's experience with GPs is not only informed by whether they encounter outright queer or trans phobia, but also heterosexist attitudes and language, and any assumption of heterosexuality, conscious or otherwise. These experiences are reported to commonly result in 'closed' communication with patients.

LGBTI+ young people in the Loddon sub-region had mixed and inconsistent experiences when visiting a GP, ranging from ignorant to harmful interactions. It finds this is, in part, due to a lack of consistency in GP training in provision of safe, appropriate, and contemporary evidence based LGBTI+ inclusive health and wellbeing care. As a result, LGBTI+ young

[44] 'Pathways to Pride' Author: Kate Phillips, Project Lead, Thorne Harbour Country, Published: May 2022. Available from Thorne Harbour Country, 58 Mundy St, Bendigo VIC 3550; E: thcountry@thorneharbour.org. NB: The participants involved in this report gave permission to include their views or opinions for the purpose of system improvement. This report is to be used for this purpose and this purpose ONLY.

people are finding their own ways to get healthcare. They are asking peers and LGBTI+ community members for recommendations, utilising online resources and services, and increasingly relying on informal health promotion such as TikTok videos.

The report notes LGBTI+ young people need to be protected from the dangers of accessing misinformation, and of not accessing professional healthcare when needed, and, that LGBTI+ young people need to be able to access affirming healthcare, which in turn would have a positive impact on their mental health and wellbeing, contributing to longer term health benefits and outcomes.

The systemic barriers identified included location-specific barriers, such as: the concentration of services in regional cities and particularly in Melbourne; the lack of GPs in rural and regional Victoria generally; the lack of GP's in rural and regional Victoria trained and knowledgeable in LGBTI+ issues and able to provide informed, individualised care; and negative experiences with rural and regional clinics. These barriers are seen alongside broader systemic barriers such as a lack of safety, autonomy and privacy; lack of inclusive support; and lack of connection into the LGBTI+ community for peer support.

Supporting LGBTIQA+ communities in small rural settings

A targeted LGBTIQA+ health promotion intervention in 2020-22 in the regional town of Castlemaine[45], in Central Victoria outlined an initial needs assessment to inform the intervention, the role and activities of the new LGBTIQA+ health promotion officer (HPO) role and presented evaluation data on the program outcomes.

It noted historical attempts to set up a voluntary committee to support the local LGBTIQA+ community were unsuccessful.

Previous attempts placed too much responsibility on volunteers and were symptomatic of fragmented health interventions.

It concluded that modest ongoing funding of a LGBTIQA+ HPO role, in combination with existing support of partner organisations, resulted in volunteers being more willing to lead community activities and take part in creating a wider network of social and health supportive activities. This connection and support of individuals in a small regional community lead to better health and wellbeing outcomes.

The implementation of this role was a critical place-based intervention in a local rural setting to supplement specialist LGBTIQA+ services offered by statewide agencies. It concluded that local roles, such as the HPO, should be more readily available in all regional community health settings to support LGBTIQA+ communities address ongoing discrimination and stigma, and develop a network of pride and support. It was noted this is a small resource in health funding terms, however if focused on enhancing social and other activity-based connectedness, it can have a positive impact on the health and wellbeing of LGBTIQA+ people in their local communities.

[45] 'Supporting LGBTIQA+ communities in small rural settings: a case study of health promotion in a community health service.' Couch D and Clow S (2023) Australian Journal of Primary Health, 29(4), 306–311. https://pubmed.ncbi.nlm.nih.gov/36617533/

LGBTIQA+ Primary Health Care Priorities in Western Australia – Insights for Advocacy and Action

The report 'LGBTIQA+ Primary Health Care Priorities in Western Australia – Insights for Advocacy and Action study'[46], completed in 2024 sought to better understand the existing health services available for LGBTIQ+ people in Western Australia (WA) and to provide recommendations for addressing gaps and improving services and policy. The project facilitated a primary health care needs assessment and consultation process to support priority setting for LGBTIQ+ health in WA.

Living Proud is one of the main community-controlled organisations for LGBTIQ+ people living in WA, and the project aimed to assist Living Proud in understanding how future programs and resources are constructed to better address the specific health needs of WA's LGBTIQ+ communities.

This study reviewed Australian and international literature and found similar, over-representation by LGBTIQA+ people in a range of ill-health and poor wellbeing measures. About 20% of WA's 2.7m population lives outside the greater Perth area[47], however the report did not review differences in health outcomes of LGBTIQA+ people living in Perth suburban areas compared to those living in regional, rural or remote areas.

This body of work led to insights, developed in the WA context, which are likely to have applicability across Australia. Insights particularly relevant to rural areas include:

- Community inclusion forms a consistent thread throughout the research on improving LGBTIQA+ health, as it enables local communities to shape health services according to their needs and ensures that health care providers remain attuned to the needs of their LGBTIQA+ clients and broader community.
- The WA LGBTIQA+ community-controlled sector is primarily volunteer-driven, with scarce infrastructure to support operations, however the services form a crucial and unique part of LGBTIQA+ health care.
- An underfunded community-controlled sector relies on partnership and collaborative approaches with mainstream Government and Community Health Services.
- While there are significant gaps in providing LGBTIQA+ inclusive health care, rural and remote LGBTIQA+ communities experience greater inequity and barriers to accessing appropriate and safe health care.
- Both global and Australia-specific research shows a need for significant improvements in training amongst health care professionals and medical training institutes (particularly mainstream organisations) to provide quality care to LGBTIQA+ people.
- The operations and physical spaces of clinics and other medical environments where health care is delivered offer a significant opportunity to improve LGBTIQA+ inclusion.
- Health promotion action can contribute to population level benefits in health and quality of life outcomes. However current programs and strategies are limited that specifically address the health needs of LGBTIQA+ people.
- Government and policy changes can significantly

[46] Hallett, J., Rosenberg, S., Crawford, G., Atkinson, M., Gray, C. & Thomas, T. (2024) LGBTIQA+ Primary Health Care Priorities in Western Australia: Insights for Advocacy and Action. Collaboration for Evidence, Research and Impact in Public Health (CERIPH), Curtin University: Perth, Western Australia. https://www.livingproud.org.au/wp-content/uploads/2024/05/CERIPH-Living-Proud-LGBTIQA-Primary-Health-Care-Priorities-Report.pdf

[47] Australian Bureau of Statistics 2022, Snapshot of Western Australia, ABS, viewed 8 January 2025, https://www.abs.gov.au/articles/snapshot-wa-2021 .

improve LGBTIQA+ health outcomes. Without government-level support and funding, adverse health outcomes experienced by many LGBTIQA+ Western Australians will remain.

LGBTIQA+ health and rural Primary Health Networks (PHN's)

Australia's thirty Primary Health Networks (PHN's) support primary health care in their local area by working directly with GPs, allied health professionals, hospitals and community health services to provide better access to frontline health services.

PHN Core functions are[48]: (i) Coordinate and integrate local health care services in collaboration with Local Hospital Networks (LHN) to improve quality of care, people's experience and efficient use of resources. (ii) Commission primary care and mental health services to address population health needs and gaps in service delivery and to improve access and equity, and (iii) Capacity-build and provide practice support to primary care and mental health providers to support quality care delivery.

Only three of the fifteen of rural PHN's[49] have published material to support primary health care providers unsderstand, plan or improve services to rural LGBTIQA+people.

- Murrumbidgee PHN in July 2023 published a LGBTIQA+ health needs assessment[50].
- Gippsland PHN in March 2023 issued a LGBTIQA+ health and wellbeing issues paper[51].
- The Western Australia Health Alliance, on behalf of Perth North PHN, Perth South PHN and Country WA PHN have published a LGBTIQA equity and inclusion framework[52].

Without any resulting studies, strategy evaluation or other follow-up publications available, it is unclear whether these publications have resulted in changes at local health care services or capacity building to support LGBTIQA+ health care in their PHN catchments.

LGBTI health impacts during natural disaster response and recovery

Whatever their cause, disasters devastate individuals, families and communities, and cause short and long term physical and mental ill-health to many, if not all, in the affected communities. Natural disasters of flood and fire are expected to become more frequent in rural Australia because of a changing climate, so it is important to understand how these disasters may impact LGBTI people differently so that healthcare services can be prepared.

Taking a social geographers' viewpoint the University of Western Sydney (School of Social Sciences) and University of Sydney (School of Geosciences, Asia – Pacific Natural Hazards and Disaster Risk Research Group) have studied the

[48] https://www.health.gov.au/our-work/phn/what-PHNs-do

[49] https://www.health.gov.au/sites/default/files/documents/2022/09/primary-health-networks-phns-national-map-of-phn-boundaries_0.png

[50] https://static1.squarespace.com/static/5b04e035f93fd49e35a6ba32/t/656024e1bcd188506e2c348a/1700799722044/MPHN+-+HNA+-+Final+Report+-+Updated+recommendations.pdf

[51] https://gphn.org.au/wp-content/uploads/files/pdf/Gippsland-PHN-Priorities-Issues-Paper-LQBTIQ-Health-and-Wellbeing-V3.pdf

[52] https://www.wapha.org.au/wp-content/uploads/2023/02/WAPHA_LGBTIQA_Equity-Inclusion-Framework.pdf

experiences on LGBTI people living through natural disaster and recovery. These studies and reviews include Australian experience (Queensland floods, NSW Blue Mountains fires and Victoria's Rochester floods) and overseas disasters.[53] [54] [55] [56] [57]. Their aim is to improve understanding of the specific experiences of LGBTI populations in disasters and to explore how vulnerability and resilience are manifest in disasters, and to achieve effective disaster risk reduction (DRR) that incorporates these groups. One study has reported on the specific experiences and needs of Victorian LGBTI+ communities in emergencies[58].

Key findings of these studies summarised below provide guidance to rural health care and disaster management agencies in their planning and response to natural disasters.

Heteronormative policy settings further marginalise and exclude LGBTI people from disaster response and recovery services:
The unique vulnerabilities LGBTI people face is underpinned by heteronormative assumptions of individual sexualities and gender identities. Studies in Australia and overseas confirm and highlight LGBTI people's reluctance to access emergency services because of historic or anticipated bias and discrimination from service providers.

When a 'couple' is defined by government or non-governmental agencies as an opposite-sex partners, and 'families' defined an opposite-sex couple and their biological children, those in same-sex relationships and their children are not recognised and sometimes excluded from the usual support provided to heterosexual residents. Overcoming exclusion requires, at the least, providing an invasive explanation of personal lives – a stressful experience. Further vulnerabilities arise for LGBTI people from loss of safe personal and queer communal spaces, at times exposing LGBTI people to harassment. Evidence is provided of verbal and physical abuse in the close quarters of emergency shelters.

A key finding is consideration of sexuality and gender must not be just treated as 'inconsequential' to disaster planning as a transgression that needs 'to be controlled and contained', rather it should be 'acknowledged as central to the human experience'.

Involvement of faith-based groups
Involvement of faith-based groups in disaster response and recovery creates fear and increased

[53] Dale Dominey-Howes, Andrew Gorman-Murray & Scott McKinnon (2014) Queering disasters: on the need to account for LGBTI experiences in natural disaster contexts, Gender, Place & Culture: A Journal of Feminist Geography, 21:7, 905-918, DOI: 10.1080/0966369X.2013.802673.

[54] D. Dominey-Howes, A. Gorman-Murray & S. McKinnon, 'On the disaster experiences of sexual and gender (LGBTI) minorities: insights to support inclusive disaster risk reduction policy and practice', Australian Journal of Emergency Management, Monograph No. 3, Diversity in Disaster, pp. 60-68.

[55] Andrew Gorman-Murray, Scott McKinnon, Dale Dominey-Howes, Catherine J.Nash & Rillark Bolton (2018) Listening and learning: giving voice to trans experiences of disasters, Gender, Place & Culture, 25:2, 166-187, DOI: 10.1080/0966369X.2017.1334632

[56] D. Dominey-Howes, A. Gorman-Murray & S. McKinnon, 'Emergency management response and recovery plans in relation to sexual and gender minorities in New South Wales, Australia', International Journal of Disaster Risk Reduction 16: 1-11.

[57] D. Dominey-Howes, A. Gorman-Murray & S. McKinnon, 'On the disaster experiences of sexual and gender (LGBTI) minorities: insights to support inclusive disaster risk reduction policy and practice', Australian Journal of Emergency Management, Monograph No. 3, Diversity in Disaster, pp. 60-68.

[58] W. Leonard, A Duncan & D Parkinson 'Findings from the first Victorian study of the experiences and needs of LGBTI communities in emergencies', Australian Journal of Emergency Management, Monograph No. 3, Diversity in Disaster, pp. 31-33.

vulnerability to some, due to perceived or actual stigmatisation, unequal treatment or anti-LGBTI discrimination, or, due to triggering of past traumatic experiences with faith-based groups. While faith-based groups may be involved in providing voluntary services, it becomes particularly problematic when contracted to provide services on behalf of government, especially when in a jurisdiction that exempts faith-based groups from anti-discrimination legislation. This reluctance and fear intensify during a time of crisis when people may feel more vulnerable and exposed. It is reported that for some LGBTI people, a fear of the consequences of disclosing their sexual orientation or gender identity leads some to going without the emergency services they need. It is also reported that, at an extreme, religious stigmatisation and abuse can descend to perceptions or accusations that the disaster is a 'divine retribution' against LGBTI people.

LGBTI people show a range of complex vulnerabilities.

LGBTI people should not be considered as a singular group – they are diverse and have any different challenges and needs wrought by intersections of socio-economic resources, gender, race/ethnicity, age and regional or national location.

Overall, LGBTI people, their families of choice and communities are more vulnerable than the wider population due to a range of contextual reasons. For example, the mental and emotional wellbeing of LGBTI people may be more at risk as their otherwise private lives are made bare, in ways outside of their control and visible, in crowded spaces such as evacuation shelters. This increases their perceived and actual stress due to 'inappropriate stares, verbal comments and insults or even threats to their wellbeing'.

Trans and intersex people face the risk of added censure, control, containment and exclusion in disaster situations, where only 'female' and 'male' toilets and washrooms may be provided. Emergency shelters and relief services are reported to be particularly problematic. Instances of trans women being abused or accused, or even worse arrested, for using the 'wrong' bathroom by fellow displaced people, volunteers or government workers have been reported. Further, securing and administering at times complex hormone replacement therapies, or managing on-going gender affirmation processes, including surgical recovery, is a further cause for anxiety and stress for some trans people.

The media failure to include the impacts of disaster on LGBTI people

The media broadly reports disasters as heterosexual events affecting 'heterosexual couples and their families'. The wider media is generally silent on LGBTI experiences and certainly non-inclusionary of trans and intersex experiences. Even the LGBTI media tends to give preference to the experiences of (white) gay men over others and, again, is quieter on the experiences and needs of lesbians, bisexuals, trans and intersex people.

LGBTI people, their families and communities demonstrate a wide range of resilient capacities and adaptive strategies

There is remarkable resilience, social capital and adaptive ability within LGBTI communities and networks, and these might act as 'models' that can be employed by other groups in society. Some LGBTI individuals, couples and families build and then rely upon 'families of choice' and networks (thus, their social capital) to provide practical, material (from LGBTI organisations and businesses, financial relief, and referral services) and emotional support in times of disaster – rather than relying on governmental and community support specifically. Moreover, LGBTI people have and do find ways of navigating an either hostile environment or one perceived to be less supportive of their lives. Building these resources and ensuring they are widely communicated can help to speed up recovery processes for LGBTI people.

Emergency service organisations and individuals overwhelmed in showing sensitive and inclusive behaviour.

At a broad level, organisations, agencies and others providing emergency management planning, response and recovery services are not overtly

discriminatory in their approaches. In fact, they look to 'treat everyone equally', but often indicate they feel overwhelmed by the expectation to 'provide special services' to an ever-increasing number of minority groups (e.g., LGBTI people) and lack specialised training on the needs of such minorities.

Proposals to improve emergency service response and recovery for LGBTI people include:

- Training of emergency service personnel in sensitivity, needs and experiences of LGBTI people (especially to trans issues and transphobia)
- Consideration of how to include non-family and non-traditional households in disaster response and recovery
- Sensitivity to the health and medical needs of trans people, and others requiring ongoing health and medical attention, such as older people and people with disabilities.
- Strengthen LGBTI inclusion and participation in disaster management systems, staff and volunteers
- Demonstrate organisational commitment to working with and meeting the needs of the LGBTI community in service delivery
- Reflection on how disaster planning and funding might be used to enhance endogenous abilities within and across diverse social groups and solidarities
- Continue to build an evidence base to improve natural disaster response and recovery.

DISCUSSION

What we know

While there have been improvements in rights and protections for LGBTIQA+ people in all Australian States and Territories in recent years, many of Australia's LGBTIQA+ people have past experiences or still experience, discrimination, stigma and trauma. It is well-established that minority stress[59] and structural stigma[60] are the key drivers of LGBTIQ+ health disparities. Stigma, prejudice, and discrimination, including the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes create a hostile and stressful social environment that causes mental health problems[61]. Being a lesbian, gay, bisexual, intersex, queer, asexual, transgender or gender diverse person is not a cause of ill-health.

This research review shows remarkably consistent findings across four major surveys: 'Private Lives 3', 'Writing Themselves in 4' and the 'Rainbow Realities 2023' report, the secondary analysis of the 'Victorian 2017 Population Health Survey', plus, the other research papers cited. They show unambiguously there is a significant health inequality for the about 1 in 20 or ~ 352,000 LGBTIQA+ people living in rural Australia when compared to

(i) their LGBTIQA+ peers living in Australian inner metropolitan areas, and

(ii) their equivalent non-LGBTIQA+ people living in rural areas.

In summary, LGBTIQA+ people living in rural Australia are more likely to experience:

- **Lower physical health status**, including:
  - more likely to experience two or more chronic illnesses.
  - Poorer health and life satisfaction.
  - Lesser acceptance, including at health care services.
- **Higher diagnoses of mental health conditions,** including:
  - Greater diagnoses of anxiety or depression.
  - Experience higher psychological stress (including young people and during the COVID pandemic).
  - Greater difficulty in accessing inclusive mental health services.
- **Higher suicide risk** (both LGBTIQA+ adult and youth), including significantly,
  - Higher suicide ideation
  - Higher suicide attempts
- **Greater daily tobacco smoking and greater likelihood of illicit substance use**
- **Less likely to have AOD harm reduction campaigns** inclusive of LGBTI+ people and issues they face.
- **Poorer dental health**.
- **Mixed and inconsistent experiences in healthcare services, ranging from feeling unaccepted to ignorant to harmful interactions,** especially LGBTI+ young people.
- **Lesser access to sexual and reproductive health**

[59] Minority stress refers to the chronic stress faced by individuals belonging to stigmatized minority groups. For LGBTIQ+ individuals, this includes experiences of discrimination, victimization, anticipation of discrimination, concealment of their identity, and internalization of stigma.

[60] Structural stigma involves societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized group. This can include laws and policies that discriminate against LGBTIQ+ individuals, lack of legal protections, and societal attitudes that perpetuate discrimination and exclusion.

[61] |Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003 Sep;129(5):674-697. doi: 10.1037/0033-2909.129.5.674. PMID: 12956539; PMCID: PMC2072932.

This review also shows socio-economic life of LGBTIQA+ people in rural Australia is likely to be poorer than non-LGBTIQA+ people.

LGBTIQA+ people are more likely to experience:

- **Greater social isolation,**
  - Life as a single person (not being married or living with a partner)
  - Lack of mainstream community connectedness
  - Lack of LGBTIQA+ community connectedness (especially for cisgendered)
  - Greater isolation from friends and neighbours
- **Greater Discrimination** and verbal harassment (especially youth)
- **Lower personal safety** for youth, especially in educational settings
- **Less valued, less accepted and have less trust**
- **Poorer life satisfaction**
  - Especially trans and gender diverse people who report the lowest levels of happiness.
- **Verbal or physical harassment or assault** (including based on sexuality of gender identity)
  - Especially youth (14-21 yrs.)
- **Twice the level of family / partner domestic violence.**
- **Lower levels of support in educational institutions for young people**.
- **Greater financial hardship, living in lower economic households**
  - Lower household incomes
  - Lower likelihood of employment
  - Higher inability to raise $2k in event of emergency
- **Greater homelessness**
  - More likely to experience ongoing homelessness
- **Twice the likelihood of food insecurity**
- **Disadvantage during natural disasters and disaster recovery, including**
  - Marginalisation and exclusion due to heteronormative assumptions / policy
  - Involvement of faith-based may trigger past traumatic experiences, fear of discrimination, actual discrimination and / or reluctance to seek services.
  - LGBT people showing a range of vulnerabilities.
  - Invisibility due to a lack of media inclusion of non-heteronormative social networks.
- **Poorer access to health services knowledgeable about LGBTIQA+ health**

The evidence is sufficient for rural healthcare services (including Shire Councils) to use in strategic, budgetary and operational planning., and data at the local health service catchment area or local government authority is not needed.

What don't we know

What are the effective health promotion interventions?

This paper does not review the effectiveness of health promotion interventions in LGBTIQA+ rural communities however we did report one recent intervention in the Mount Alexander Shire in central Victoria[62]. It was successful in increasing the social connectedness of LGBTIQA+ individuals, improving social cohesion and increased likelihood of individuals engaging with the local health services, all positive indicators in overcoming physical and mental health disadvantage. This finding is consistent with the Western Australian insights of the importance of community inclusion in lifting the health of communities.

Understanding which targeted LGBTIQA+ health

[62] Couch D and Clow S (2023) 'Supporting LGBTIQA+ communities in small rural settings: a case study of health promotion in a community health service'. Aust Journal of Primary Health 29(4) 306-311.

interventions work in regional, rural and remote communities of Australia, and how to effectively evaluate them, is an essential next step in overcoming the health disadvantage identified in this report. A review of local and international literature in these areas is a high priority, to guide future health promoting interventions. The review should be presented as a national resource for rural health services to use in developing, implementing, evaluating and improving their LGBTIQA+ health services.

What about health and wellbeing of LGBTIQA+ Minorities & Intersections?

Information is missing from this review. The sample sizes of the research reviewed do not allow an understanding of specific experiences of rural living of trans, bi, asexual and people with intersex variations. Such information is essential to guide their healthcare needs and should be researched and reported. Similarly, the intersections of sexuality and gender diversity with those living with Aboriginal and Torres Strait Islander heritage, disability, and from diverse cultural/religious backgrounds living in rural areas is missing and needs to be researched and reported in ways useful to regional and rural healthcare services.

Are further analyses of existing databases needed?

Further analysis of the Private Lives 3 database, and other data sets La Trobe University or other research centres hold should be considered, but only if it has prospect for providing new evidence to aid shaping of rural LGTIQA+ primary health and health service planning.

Can added information be gained from Pride festivals and celebrations?

In recent years, many regional and rural areas hold 'Pride' festivals and celebrations, some supported by not-for-profit groups such as Rural Pride Australia (RPA) [63] or Q+ [64]. When these organisations attend regional and rural pride events, they contact many LGBTIQA+ groups and people. RPA and Q+ have expressed great interest in working with LGBTIQA+ health researchers to collecting survey data from the regional and rural communities they visit.

GBQ + Community Periodic Survey – an example

The GBQ+ Community Periodic Surveys (GCPS) [65] are repeated, cross-sectional surveys of gay, bisexual and queer men, and non-binary people who have sex with gay, bisexual and queer men, conducted in the metropolitan areas of seven Australian states and territories. The surveys are a key part of Australia's behavioural surveillance system for HIV, monitoring sexual practices, drug use and patterns of testing for HIV and other STIs. The surveys were formerly known as the Gay Community Periodic Surveys (from 1996 to 2023), but the name was updated in 2024 to reflect the gender and sexuality diversity. The work is led by the Centre for Social Research in Health, at the University of New South Wales.

Initiated in 1996, the GCPS are conducted in capital cities and other densely populated areas of Australia where gay men congregate: Adelaide, Canberra, Melbourne, Perth, Queensland (Brisbane, Cairns and the Gold Coast) and Sydney. In 2014, Tasmania was added to the network of GCPS locations. The GCPS deliberately target men and non-binary people who are socially and sexually involved with gay, bi, and queer men, and recruit participants at LGBTQ community venues and events, sexual health services, and online.

Data have been analysed and reports written on each of the capital cities Adelaide, Canberra, Melbourne, Perth and Sydney, and States Queensland (Brisbane, Cairns and the Gold Coast) and Tasmania and for some specialised cohorts (e.g. recent migrants). However, data collection is

[63] http://www.niche.org.au/ & https://ruralpride.au/

[64] https://quplus.com.au/

[65] https://www.unsw.edu.au/research/csrh/our-projects/gbq-community-periodic-surveys

not targeted from rural populations, so no reports have been published on the sexual health of GBO, or sexual practices, drug use and patterns of testing for HIV and other STI's in rural Australia.

It is recommended that the GBO+ Community Periodic Survey be expanded to both be collected during regional queer festivals and report on rural Australia.

What does success look like?

A vision of 'success' is useful when proposing change, so it is reasonable to ask what does 'success' look like for a LGBTIQA+ person living in regional, rural and remote Australia?

Healthcare service providers

Success is for staff at healthcare organisation (including heath and aged care services by Shire Councils) to have some understanding the world experienced by LGBTIQA+ people. This means training that explains minority stress often felt by LGBTIQA+ people - the chronic stress faced by individuals belonging to stigmatized minority groups, including experiences of discrimination, victimization, anticipation of discrimination, concealment of their identity, and internalization of stigma. Understanding of the structural stigma experienced too, the societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized group. This can include current and past laws and policies that discriminate against LGBTIQ+ individuals, lack of legal protections, and societal attitudes that perpetuate discrimination and exclusion. For older LGBTIQA+ people especially, how past experiences of structural stigma and experiences of grief and trauma from the HIV epidemic, childhood abuse and triggers of significant fear and stress.

Success in a tangible way means public signage that LGBTIQA+ people can expect and do experience:

- A welcoming, safe, included and respected experience
- Staff who will not make heteronormative assumptions, or mis-gender clients.
- A comprehensive model of health, including sexuality, gender identity and intersex variation, and including consideration of physical, cultural, emotional, economic and social aspects of an individual's life.
- GPs are knowledgeable of LGBTIQA+ health matters and are willing to refer to, and familiar with, specialist physicians that may be needed.
- Health promotion and early intervention services are specifically tailored targeting identified LGBTIQA+ needs (e.g. mental health, suicide prevention, AOD, sexual health), while others that are mainstream are inclusive of LGBTIQA+ people.
- LGBTIQA+ people are consulted through advisory / consultative committees encouraging LGBTIQA+ participation and/or the formation of specialist LGBTIQA+ advisory committee.
- When healthcare organisations are present at public events (e.g. Agricultural Shows, Machinery Field-days, horse races, sporting events and Pride events) with signage and content making their inclusion of LGBTIQA+ people visible to all.

Success is also achieving fair, rationale, evidence-based decisions in rural health care planning and delivery, including:

- Evidence informed, use of data, such as those cited in the paper.
- Ensuring sufficient targeted funding for health services and staff training in LGBTIQA+ health, and,
- Funded health interventions / health promotion / social inclusion campaigns to overcome the inequality 'gap' in health and wellbeing status for LGBTIQA+ people and the general community.

Research and Rural Medical Training
Success is seeing universities and research organisations undertaking LGBTIQA+ health research having active programs outside capital cities in rural areas, with solid linkages to universities specialising in rural medical training, to transfer this knowledge to current and next-generation health care professionals.

Peer led advocacy
Success is State based and national LGBTIQA+ peer led advocacy groups having a sharp focus on their LGBTIQA+ constituency living in rural Australia – the 28% of Australians living outside capital cities. They will:

- Understand the needs of their regional rural and remote constituency.
- Each have a regional, rural and remote health strategy in place.
- Be active in advocacy, collaboration and representation on regional, rural and remote health forums, with a visible voice.
- Have fit-for-purpose networks of regional offices and outreach, and
- Actively share information with universities training rural healthcare workers.

Philanthropy
Philanthropy is often at the forefront of funding new innovative health promotion and care. Australia's small and emerging LGBTIQA+ philanthropic organisations have and continue to fund important and innovative projects in rural Australia, however their capacity is limited. Success will see mainstream philanthropy also fund LGBTIQA+ projects that intersect with their regional, rural and remote priority area.

The Changing Rural Rainbow Landscape
In recent years important legislative advances have been made in areas of anti-discrimination law, banning of 'gay conversion' therapy, legalisation of marriage equality and the ability for birth certificates to reflect gender identity (in some states and territories). These have all led to greater social change, understanding and knowledge of LGBTIQA+ lives, including in rural Australia. LGBTIQA+ people are now more likely to stay in regional and rural areas, stopping the 'brain drain' and less likely to move to capital cities. LGBTIQA+ 'tree-changers' are moving in from metropolitan to regional and rural areas.

As this is happening, each year new generations of younger people in rural Australia realise they are sexually or gender diverse, and do not fit the heteronormative model around them. While for some young people, and their families (parents, siblings, grandparents) coming to terms with their sexuality, gender identity or intersex variation may be easier than the past, for others it is just as difficult or more difficult as it was for past generations. The advent of the social media provides many young rural LGBTIQA+ people with an affirming connection to information, support services and peer social networks. Unfortunately, social media can also expose youmg LGBTIQA+ people to homophobic and transphobic abuse.

Success will see rural young people and their families supported, able to see successful LGBTIQA+ people as leaders and positive role models in their communities, live in a society where discrimination is something of the past and health outcomes are no different than their heteronormative brothers and sisters.

'Success' is multifaceted and needs to be seen through the various eyes of the diverse LGBTIQA+ people and communities of rural Australians.

RECOMMENDATIONS

Rural Health Service Providers

There is much that regional health services (including Shire Council health and aged care services) can do today, and it is pleasing that some are making noteworthy progress in addressing LGBTIQA+ health inequality. Recommendations are:

1. **Acknowledge the problem is real, and in your catchment.** LGBTIQA+ health data at the LGA or SA3 is not needed for local health care planning, given the well documented, consistent and significant LGBTIQA+ health disparities found in this review The health inequality of the approximately 5-6% of LGBTIQA+ people in rural areas is real, as demonstrated in this review. These are the 'hidden people', those now older, brought up in a lifetime of exclusion and hiding their identity, those younger coming to understand their non-heteronormative sexuality, gender identity or intersex variation and those in middle life. The compounding relationships between socio-economic disadvantage and poor health outcomes are well established [66]. Those at the intersections of low socio-economic status and disability, CALD, Indigenous or Torres Strait Islander heritage and being LGBTIQA+ can experience the greatest health disadvantage.
2. **LGBTIQA+ inclusion in strategic and operational/project planning**. Health services and their consultants should draw on this evidence-based information as well as any local knowledge of the health needs of LGBTIQA+ people in their catchment, when updating strategic and operational / project planning. Data presented here adequately describes the problem. When Australian Census 2026 data become available that includes LGBTQ identifiers for all people 16 years and over, it will provide a useful addition to the findings of this review [67].
3. **Create an LGBTIQA+ welcoming environment.** Any person using a health service may be LGBTIQA+ - but only a few will present making their identity immediately known, most will wait until they see if it is safe to do so. Therefore, a visibly LGBTIQA+ welcoming and safe environment is essential, with signage and reception, nursing, medical and allied staff training needed to support this. Clients need to feel reassured it is safe to disclose their sexuality, gender or intersex identity, something often essential to enable the most suitable healthcare service. The Victorian Government has an inclusive service planning and practices for LGBTIQA+ communities guide [68]. Rainbow Health Australia's 'Rainbow Tick' [69] is recommended, a world first quality accreditation framework to help health and human services organisations become safe and inclusive for the LGBTIQ community.
4. **Act on the priority health issues shown for LGBTIQA+ people: mental health; self-harm / suicide; AOD (alcohol, cigarette, vaping and other drug use); needle exchange; family violence; housing; and social connection**. Existing service provision in these areas can be reviewed and adapted to run specialist LGTBTIQA+ streams or existing programs

[66] Se for example https://www.aihw.gov.au/getmedia/11ada76c-0572-4d01-93f4-d96ac6008a95/ah16-4-1-social-determinants-health.pdf.aspx and https://www.health.vic.gov.au/your-health-report-of-the-chief-health-officer-victoria-2018/health-inequalities/social .

[67] https://ministers.treasury.gov.au/ministers/andrew-leigh-2022/media-releases/new-topic-2026-census

[68] https://www.health.vic.gov.au/community-health/community-health-pride-lgbtiq-inclusive-practice-resources

[69] https://rainbowhealthaustralia.org.au/rainbow-tick

reviewed to ensure they are inclusive of LGBTIQA+ people. Added new services can be created within current funding, from philanthropic sources, bidding for new government initiatives, and cost savings.

5. **Initiate novel ways to provide specialist LGBTIQA+ services** These may include HIV medicine, trans medical and surgical affirmation care, surgeries and counselling for people with intersex variations, fertility services particularly surrogacy for LGBTIQA+ people. These services are generally provided in urban centres as they often require high patient numbers to be sustainable. Novel ways to provide these services are possible.

   In NSW some regional sexual health services have taken responsibility for providing many of these services. In Victoria trans affirming hormone therapy being provided using a shared care model in regional community health services such as the Gateway gender service in Wodonga. Seeking the provision of satellite visiting services from urban specialist centres is another way to fill the gap. Added or new novel services could be created within the current funding cycle from philanthropic or other external funding sources.

6. **Ensure data collection is inclusive of LGBTIQA+ people.** Health services should collect health data, under appropriate confidentiality arrangements, which includes sexuality, gender identity and intersex variation status, and that this data should be analysed regularly and used to continuously improve the scope and service delivery of health services.

7. **Adopt LGBTIQA+ inclusive governance.** Hospital and community health service governance boards and advisory committees should publicly look for and appoint suitably qualified LGBTIQA+ people, preferably with lived experience in their regional /rural settings. This helps health service providers in gaining important insights into local LGBTIQA+ health concerns, shows good-will, supports community engagement and improves priority setting.

8. **Convene a specialist LGBTIQA+ advisory committee / reference group** of local people with lived experience to guide local LGBTIQA health and wellbeing activities as a way of identifying finer details of local needs, drawing on existing networks for effective delivery strategies, and building peer led activities and reach 'hard to reach' groups and individuals.

9. **Share experiences amongst other regional, rural and remote healthcare providers** Rural health care service providers should share their experiences and evaluation of successful LGBTIQA+ health promotion programs with other regional and rural services, possibly through an annual rural LGBTIQA health forum.

10. **Participate in Regional Pride activities** is another way to show support and be visible e.g. a stall at the annual picnics, staff participation in Pride Marches, sponsoring health related events etc.

LGBTIQA+ Community led health & wellbeing organisations

This applies to the LGBTIQA+ community led health organisations of Thorne Harbour Health in Victoria; ACON in NSW, QC in Queensland, Samesh in SA, Working It Out in Tasmania, Living Proud in WA, NTAHC in NT, Meridian in ACT and LGBTIQA+ Health Australia nationally. The LGBTIQA+ community led health organisations had their origins in community led AIDS Councils of the 1980's, who adopted a service design and delivery based on community health principles of the 1970's and 80's[70]. These have proven remarkedly effective and should be the basis of regional and rural programs.

[70] https://www.adelaide.edu.au/stretton/ua/media/741/policy-brief-lessons-from-history-of-services.pdf

LGBTIQA+ community led health organisations have not yet had a sharp strategic focus on LGBTIQA+ rural health and applying resources commensurate with the populations living outside capital city urban areas. Operationally Thorne Harbour Health has one regional office, in Bendigo (Thorne Harbour Country) with resourcing disproportionate to the population or vast area it seeks to serve. ACON in NSW has offices and programs in the northern rivers (Lismore), Hunter Valley (Islington) and a regional outreach program for other areas[71]. Queensland (LGBTIQ) Council has regional offices in Cairns, Toowoomba, Townsville and Sunshine Coast[72]. Despite this, there was no input into development of the 2011 National Framework for Rural and Remote Health or membership of rural health organisations e.g. National Rural Health Alliance[73].

11. **Be visible leaders of LGBTIQA+ health and wellbeing in regional, rural and remote areas.** The poorer health outcomes of regional and rural LGBTIQA+ people should be acknowledged through each organisation having its regional, rural and remote LGBTIQA health and wellbeing strategy and action plan. The plans should seek collaborations with rural health service providers to support information exchange on effective working with LGBTIQA+ communities and people, and actively seek Commonwealth, State and/or philanthropic funding to deliver the plans.

12. **Include rural LGBTIQA+ people in governance and senior management.** Each organisation should adopt a 'nothing for us without us' approach, by:

    - Including a rural nominated position, or person with proper knowledge and lived experience of rural areas on their governing board, and their senior management team.
    - Annually hold one or more Board meetings in rural locations to hear directly about rural issues, and,
    - Maintaining a rural advisory group of LGBTIQA+ people with lived experience in their local area.

13. **LGBTIQA+ Health Australia providing a voice for LGBTIQA+ regional rural and remote people** by joining the National Rural Health Alliance[74], (comprising 53 national organisations committed to improving the health and wellbeing of the over 7 million people in rural Australia) and being proactive in making submissions to rural health enquiries and be included in LGBTIQA+ and mainstream rural health forums.

State Governments

14. **Include people with regional, rural and remote lived experience / expertise on State government LGBTIQA+ advisory committees.** Membership of LGBTIQA+ advisory bodies to State governments should include at least one LGBTIQA+ person with lived experience from rural areas.

    Some State governments have LGBTIQA+ health advisory committees, and Victoria has extended this by appointing a 'whole of government' Taskforce plus Working Groups in key areas, including health & wellbeing. These important advisory committees rarely have members with a responsibility for giving voice to the needs of rural communities. To extend advice available to governments, these committees should

[71] https://www.acon.org.au/who-we-are-here-for/regional-nsw/#regional-outreach

[72] https://www.qc.org.au/where-we-are

[73] https://www.ruralhealth.org.au/about/memberbodies

[74] https://www.ruralhealth.org.au/

include a LGBTIQA+ person with expertise / lived experience in rural areas.

15. **Health datasets be 'fit-for-purpose' by including LGBTIQA+ Regional, rural and remote health and wellbeing data.** State governments should ensure that data collection by state-funded health services and data sets used for State government strategic and operational planning are 'Fit for purpose' by being inclusive of LGBTIQA+ health care planning data.

    For example, the Victorian Department of Health should commission the Victorian Population Health Survey (VPHS) / Victorian Agency for Health Information (VAHI) to report regularly on the health and wellbeing of LGBTIQA+ Victorians in metropolitan and rural Victoria.

    Data provided to State government by public hospitals, community health centres, sexual health and homelessness services should also be LGBTIQA+ inclusive.

16. **Improve LGBTIQA+ health practitioner training for rural practitioners** by funding linkages between rural health training, LGBTIQA+ health research, and community led LGBTIQA+ health and wellbeing organisations.

    For example, in Victoria facilitating collaborative linkages between Monash Rural Health (Bendigo or their other regional locations), La Trobe University Australian Research Centre for Sex Health and Society / Rainbow Health and Thorne Harbour Health should be considered to improve health practitioner training in LGBTIQA health for rural practitioners.

17. **Establish State based LGBTIQA+ rural Communities of Practice** of health professional practitioners for information sharing and professional network development.

18. **Fund State based natural disaster support and recovery organisations to become LGBTIQA+ inclusive,** by undertaking LGBTIQA+ training, reviewing procedures and recruiting LGBTIQA+ staff and volunteers.

Commonwealth Government

19. **Ensure the voice of rural LGBTIQA Australians is heard in the implementation of the 'National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025-35'** [75] and its funded programs [76].

    The 'Rainbow Realities' report that informed the 'National Action Plan' as included in this review, did not bring together in a readily visible form or discuss the poorer health outcomes of LGBTIQA+ in rural Australia. The data was disbursed through the report and not interpretated. There is a need to bring this information to the fore.

    As already noted, Australian data on LGBTIQA+ health in rural Australia has not been brought together previously, and the development of the National Framework for Rural and Remote health did not receive representation for LGBTIQA+ health organisations. Therefore, with no community or health organisation championing this principal issue, there is a real risk that rural LGBTIQA+ health issues

[75] National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025-35 https://www.health.gov.au/sites/default/files/2024-12/national-action-plan-for-the-health-and-wellbeing-of-lgbtiqa-people-2025-2035.pdf

[76] 'System-Wide' Change: 10-Year Action Plan for better LGBTIQA+ health https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/system-wide-change-10-year-action-plan-for-better-lgbtiqa-health

will not get adequate consideration in the implementation of the National Action Plan.

Therefore, a deliberate decision to vary the largely city-centric status quo on LGBTIQA+ health is needed and specifically include a rural voice of LGBTIQA+ people to the Commonwealth Department of Health & Aged Care and government.

20. **Establish and fund a National Rural LGBTIQA+ Health Advisory Council.** It could be established by LGBTIQA+ Health Australia, Commonwealth Department of Health & Aged Care, or University with expertise in rural health training, with representation from:
    - State and national peak LGBTIQA+ led community health organisations.
    - LGBTIQA+ health researchers
    - Rural health training specialists
    - State and Commonwealth Departments of Health
    - Representatives of regional Primary Health Networks (PHN's)
    - Representatives of regional health service providers; and
    - LGBTIQA+ people with lived experience of rural living.

The purpose of the working group should include:

- Advising government on the implementation of the National Action Plan for the Health and Wellbeing of LGBTIQA+ people 2025-35' with respect to rural living LGBTIQA+ people
- Advocacy for the health needs of rural LGBTIQA+ people to Commonwealth and State governments, health service providers and philanthropy
- Advocacy and oversight of national data collection, interpretation and sharing of LGBTIQA+ rural health data and research.
- Sharing information on successful health promotion interventions and research findings
- Building LGBTIQA+ capacity in rural health services
- Provide guidance to LGBTIQA+ rural health research
- Hold a national 'communities of practice' conference on LGBTIQA+ regional health on a regular basis for information and ideas sharing and capacity building
- Facilitate collaborations between Commonwealth, State and health service providers and rural health educators.

21. **Direct the Australian Institute of Health and Welfare (AIHW) to include rural LGBTIQA+ health and wellbeing indicators in their 'Australian Burden of Disease' reports.** Similarly, Commonwealth-funded health services including aged care services should be encouraged to collect patient demographics including diverse sexuality, gender and sex characteristics, and the database be analysed and reported on a periodic basis.

22. **Initiate and fund development and delivery of rural LGBTIQA+ health assessment, regional LGBTIQA+ referral guides and training package for use by rural PHN's** (Primary Health Networks). PHN's support primary health care in their local area by working directly with GPs, allied health professionals, hospitals, and community health services to provide better access to frontline health services. Rural PHN's should be supported to conduct LGBTIQA+ health needs assessment, regional specific LGBTIQA+ referral guides and provide rural health practitioner training in LGBTIQA+ health needs, monitor local LGBTIQA+ health status and share resources and experience.

Arts and Culture

23. **Recognize and fund the positive health benefits from mainstream cultural and specialist Pride events in regional, rural and remote communities**. Mainstream and LGBTIQA+ arts culture and Pride events have been shown[77] to contribute to identity construction and create opportunities for connection with other LGBTQI+ residents and the rural community more broadly. Such connection is known to improve mental health.

Philanthropy

24. **Continue and grow LGBTIQA+ led philanthropy granting to rural LGBTIQA+ health.** Philanthropy is often at the forefront of funding new innovative health promotion and care, and Australia's small and emerging LGBTIQA+ philanthropic organisations have funded important and innovative projects in rural Australia. Continuation of this is essential.

25. **Grow reach of mainstream philanthropy to be inclusive of LGBTIQA+ health and wellbeing in their rural granting programs.** LGBTQA+ led health and wellbeing organisations and LGBTIQA+ led philanthropy should collaborate to educate rural focussed mainstream philanthropy, so they learn how to include LGBTIQA+ projects within their health and wellbeing programs.

Further research

26. **Further research is needed to better understand the rural lived experiences and health needs of trans, bi, asexual and people with intersex variation, and LGBTIQA+ people of Aboriginal and Torres Strait Islander heritage, living with disability and cultural/religious diversity living in regional, rural and remote settings**. Current research does not adequately describe the experiences of these marginalised groups.

27. **A review is needed of Australian and international literature of effective LGBTIQA+ targeted health promotion initiatives and their evaluation** which suit Australian rural areas. Such a review could be conducted jointly by organisations with specialists in rural health and LGBTIQA+ health. Findings should be presented as a national resource for rural health service providers.

28. **The GBQ+ Community Periodic Surveys (GCPS) be extended to regional, rural and remote areas** on an appropriate cycle to provide information on HIV, monitoring sexual practices, drug use and patterns of testing for HIV and other STIs amongst gay, bisexual and queer men, and non-binary people who have sex with gay, bisexual and queer men in rural areas.

29. **Involvement of LGBTIQA+ not-for-profit groups in research data collection.** LGBTIQA+ not-for-profit groups (e.g. Rural Pride Australia - https://ruralpride.au/ and Q+ - https://www.qplusct.org/) can support research data collection and delivery of health promoting services. They have expressed interest in doing so when attending rural Pride events, as they make contact with many LGBTIQA+ 'difficult to reach' groups and people. Such opportunities of working with grass roots organisations should be explored further by both researchers and health care service providers.

[77] Lewis, C., & Markwell, K. (2020). Drawing a line in the sand: the social impacts of an LGBTQI+ event in an Australian rural community. Leisure Studies, 40(2), 261–275. https://doi.org/10.1080/02614367.2020.1831043

APPENDIX 1: DEFINITIONS & INCLUSIVE LANGUAGE GUIDE

Key definitions[78]

Gender: is part of a person's personal and social identity. It refers to a way a person feels and sees themselves. It can be about differences in identity, expression and experience as a woman, man or gender diverse person.

Gender diverse: Gender diverse is an umbrella term for a range of different genders. There are many terms gender diverse people may use to describe themselves. Language in this area is dynamic and always changing, particularly among young people. Some examples include genderfluid, genderqueer, gender non-conforming, agender, bi-gender and non-binary.

Non-binary: Non-binary is a term for people whose gender sits outside of the spectrum of man or woman or male and female. A person who is non-binary might feel like they have a mix of genders, or like they have no gender at all. A person might identify solely as non-binary or relate to non-binary as an umbrella term. They might consider themselves as genderfluid, genderqueer, trans masculine, trans feminine, agender or bigender.

Trans or transgender: Transgender refers to someone whose gender does not exclusively align with their sex recorded at birth. Not all trans people will use this term to describe themselves.

Cis or cisgender: (pronounced 'sis'): Cisgender refers to a person whose gender is the same as their sex recorded at birth. Not all cisgender people will be aware of this term or use it to describe themselves.

Sistergirl and brotherboy: Sistergirl and brotherboy are terms used in Aboriginal and Torres Strait Islander communities to describe transgender people. Using these terms can validate and strengthen their gender identities and relationships. Sistergirls and brotherboys might be non-binary, female or male.

Sistergirl describes gender diverse people that have a female spirit and take on female roles within the community, including looking after children and family. Brotherboy describes gender diverse people that have a male spirit and take on male roles within the community.

Other Aboriginal and Torres Strait Islander peoples may also use these words. For example, lesbian and heterosexual Aboriginal and Torres Strait Islander women may refer to themselves as 'sistagirls', 'sistas' or 'tiddas', which has the meaning of the word 'sisters'. Gay Aboriginal men may also refer to themselves as sistas.

In broader Aboriginal and Torres Strait Islander communities, the terms 'sistagirl' and 'brothaboy' are used as terms of endearment for women and men with no reference to gender diversity.

It is important to note that not all First Nations people who are transgender use these terms.

Sex: Sex refers to a person's biological sex characteristics. This includes their sex chromosomes, hormones and reproductive organs.

Sex recorded at birth: Data collection often refers to sex recorded at birth. This is based upon a person's sex characteristics and reproductive organs observed at, or soon after, birth.

Variations of sex characteristics: Some people are born with a variation to physical or biological sex characteristics including chromosomes, hormones or anatomy. These are often called intersex variations. There are many different intersex variations that can be identified prenatally, at birth, puberty or adulthood.

People with intersex variations use a range of different terminology to name their bodies and experiences. Some use the term 'intersex', which is signified by the 'I' in LGBTIQA+ communities. Others do not connect to the term 'intersex' or with the acronym LGBTIQA+.

[78] https://www.vic.gov.au/inclusive-language-guide/key-terms-used-in-lgbtiqa-inclusive-language-guide

People with variations of sex characteristics are usually assigned male or female at birth or infancy, just like everyone else. Intersex people can have any gender identity or sexuality.

You can read more about the diversity and health needs of the intersex population at (i) Am Equal. It outlines the future directions for Victoria's Intersex community. You can also learn more at the Intersex Human Rights Australia website.

Endosex: Endosex refers to people whose sex characteristics meet medical and social norms for typically 'male' or 'female' bodies. Not all endosex people will be aware of this term or use it to describe themselves.

Sexuality or sexual orientation: Sexuality or sexual orientation describe a person's intimate, romantic and/or sexual attractions to others. It can include sexual identity (how a person thinks of their sexuality and the terms they identify with).

It can also include attraction (romantic or sexual interest in another person) and behaviour or relationships.

These attractions may be towards someone of the same gender or sex, another gender, all genders, no gender or a combination.

There are many different terms used to sexuality. Some people may choose to describe their sexuality in terms of feelings, behaviours or experiences such as 'same sex' or 'gender attracted'. Others may choose to use no term at all. Sexuality may be fluid for some people and change over time. For others it can be the same throughout their life.

Asexual: Asexual refers to a person who does not experience sexual attraction but may or may not experience romantic attraction towards others. Asexual people can be any gender or sexual orientation.

Lesbian: Lesbian refers to a woman (cis or trans) or gender diverse person who is romantically and/or sexually attracted to women.

Gay: A gay person is romantically and/or sexually attracted to people of the same sex and/or gender as themselves. This term is often used to describe men who are attracted to other men, but some women and gender diverse people may describe themselves as gay.

Bisexual: A bisexual person is romantically and/or sexually attracted to people of their own gender and other genders. The term 'bi+' or multi-gender attracted (MGA) are sometimes used to describe communities of people who are attracted to multiple genders.

Pansexual: A pansexual person is romantically and/or sexually attracted to people of all genders and regardless of gender.

Queer: Queer is often used as an umbrella term for diverse genders or sexualities. Some people use queer to describe their own gender or sexuality, as an identity that does not correspond to heterosexual norms. For some people, especially older people, 'queer' has negative connotations, because in the past it was used as a discriminatory term.

Questioning: Questioning refers to people who are exploring or questioning their gender or sexual orientation. People may not wish to have one of the other labels applied to them yet, for a variety of reasons. It is important these people feel welcome and included in LGBTIQA+ communities.

Heterosexual: Heterosexual is another word for 'straight'. It generally refers to men who are attracted to women, or women who are attracted to men.

Rainbow families: Rainbow families are families where LGBTIQA+ people are parents, co-parents and carers. This includes soon-to-be parents, donors and surrogates.

Rainbow families come in all different shapes and sizes. They can be sole parents or carers and can live across one or many homes. They can also be of diverse sex, gender, ability, race, culture, and spirituality.

Intersectionality: Intersectionality describes how a person's attributes and circumstances combine to shape their life. This can include their privilege and experiences of discrimination or disadvantage. Intersectionality helps us to better understand inequality. It highlights how different forms of inequality can combine and compound each other. This can include inequality related to sexuality, gender, age, class, ability or race.

Taking an intersectional approach to policy analysis means that government services better account for the specific and varied needs of the community. It supports more effective services that respond to interconnected and overlapping forms of discrimination and inequality for the whole community.

Take the example of employment discrimination experienced in the trans community. Traditional policy approaches would tend to make generalised observations about trans people. These observations often fail to account for the significant diversity within the community. An intersectional approach would look at differences in employment discrimination that are experienced by different kinds of trans people – such as trans people of colour, trans people with a disability, and trans people of different genders.

Taking an intersectional approach in Australia requires a recognition of the ongoing impacts of colonisation. Non-Aboriginal people have benefitted from the colonisation and dispossession of Aboriginal and Torres Strait people, and Australia's laws, policies, systems and structures have and continue to omit Aboriginal people, resulting in and entrenching systemic racism. Despite this, Aboriginal and Torres Strait Islander people, families and communities remain strong and resilient.

[79] https://www.vic.gov.au/inclusive-language-guide/top-five-principles

APPENDIX 2: TOP FIVE PRINCIPLES[79]

How others describe us has an enormous impact in our health and welbeing. A lack of inclusive communication contributes to discrimination that can prevent LGBTIQA+ people from accessing help. Using inclusive language can help build trust between health service providers abd LGBTIQA+ people and their communities.

The following five principles are a useful guide to health care service providers and the broader community in using language that is inclusive of LGBTIQA+ people.

1. Move beyond assumptions:

- Assuming that everyone is heterosexual, or cisgender can have negative impacts on the lives of LGBTIQA+ people. It is good practice to avoid making assumptions about people based on their appearance or stereotypes.
- Accept and respect how people define their gender and sexuality. Ask them how they wish to be addressed. If you are speaking on behalf of a group, consult widely to ensure language is reflective of the whole group.

2. Acknowledge diversity:

- LGBTIQA+ people are diverse. LGBTIQA+ communities are not homogenous.
- We should always use language with care and consideration and an awareness of the diversity within and between groups and people. For example, acknowledging diversity means referring to 'LGBTIQA+ communities' rather than just one community.
- When using inclusive language, it is important to consider the intersections of a person's identity. These are different aspects that make up someone's identity and experiences, such as race, religion, gender, sexual orientation, income or social status, age, parenting/caring roles, ability or migration status.

3. Respect privacy:

- We all have a right to privacy. Everyone has the right to choose what information they want to disclose. Someone may or may not want to inform others of personal information relating to their gender and/or sexuality. It may be illegal to force someone to share this information. You should not share or discuss anyone's personal information without their explicit consent.
- Allow yourself to be led by how someone talks about themselves, their family and their relationships. Ask or be guided by them about who to share this information with. For example, in an early year's centre or school you might ask 'Who is in your family?'

4. Share your pronouns:

- Pronouns are the words we use instead of someone's name when we talk about them, such as she/her, he/him, they/them. Some people use more than one pronoun, such as she/they or he/they. Using someone's correct pronouns is an essential part of showing respect and inclusion. Normalising the sharing of pronouns can make a big difference to the inclusion of trans and gender diverse people. Sharing your pronouns can signal to your colleagues and others that you are someone who understands and will also respect their pronouns. You can do this by wearing a pronoun badge, introducing yourself with your pronoun/s, or adding your pronoun/s to your email signature.

Like all words people use to describe their identity, pronouns can look different for everyone and can change over time. If you are unsure about someone's pronouns, use the gender-neutral terms 'they' and 'them' or the person's name until you have a chance to confirm with them privately. Some people do not use pronouns but prefer the use of their name instead.

- Sharing pronouns is optional. While some people are comfortable sharing theirs, others may not be, and it is important that no one feels pressured. Furthermore, some people's pronouns may be context specific. For example, someone might not use their pronouns in a particular environment or around particular people because they do not feel safe or comfortable to do so.

5. Learn from mistakes

- It's okay to make mistakes. People may worry that they will offend someone or be embarrassed if they use the wrong term, name or pronoun, particularly for trans and gender diverse people.

APPENDIX 3

– Original data and it's interpretation from 'The health and wellbeing of the LGBTIQ population in Victoria [80]

PARAMETER	RURAL NON-LGBIQA+	RURAL LGBIQA+	STATISTICAL SIGNIFICANCE	INTERPRETATION OF DATA, INCLUDING COMPARISON OF RURAL WITH METROPOLITAN
Table 3. Country of birth -Australia	86.6%	87.4%	No Sig difference	No significant difference in the proportion of LGBTIQA+ and non-LGBTIQA+ people born in Australia or Overseas in Rural Victoria. In Metro a significantly greater proportion of LGBTIQA+ were born in Australia than overseas.
Table 6. Language spoken at home English	93.0%	91.2%	No Sig difference	No significant difference in the proportion of LGBTIQA+ homes and non-LGBTIQA+ homes that spoke English or a language other than English at home in Rural Victoria. In Metro significantly a greater proportion of LGBTIQA+ homes spoke English compared to non-LGBTIQA+ people's homes.
Table 9: Aboriginal / Torres Strait Islander	1.5%	4.2%	No Sig difference (Caution)	No significant difference between the proportion of LGBTIQA+ and non-LGBTIQA+ people identifying as Aboriginal / Torres Strait Islander. At a State level (Rural & Metro combined), a significant 2.1% of Aboriginal and Torres Strait Islander people identified as LGBTIQA+, but it is noted this should be interpreted with caution.
Table 12: Marital Status [Married or living with partner / widowed divorced or separated / never married]	68.8%	46.0%	Married or living with partner Sig. diff 5%	A significantly lower proportion of LGBTIQA+ people (46.0%) than non-LGBTIQA+ people (64.8%) reported being married or living with a partner in Rural Victoria, and a significantly greater proportion of LGBTIQA+ people had never married. A similar finding to Metro, where 50.3% LGBTIQA+ were married or living with a partner, significantly less than 62.2% non-LGBTIQA+ people married or living with a partner.

[80] https://vahi.vic.gov.au/sites/default/files/2021-12/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria.pdf

PARAMETER	RURAL NON-LGBIQA+	RURAL LGBIQA+	STATISTICAL SIGNIFICANCE	INTERPRETATION OF DATA, INCLUDING COMPARISON OF RURAL WITH METROPOLITAN
Table 15: Household income -up to $40k	22.6%	36.1%	Sig. diff 5%	Less $40k: Significantly greater proportion of LGBTIQA+ people (36.1%) were in the low-income group, earning up to $40k in Rural Victoria compared to non-LGBTIQA+ people (22.6%). $40-$100k: No significant difference between LGBTI+ and non-LGBTIQA+ people in the middle-income range $40-100k in Rural Victoria. Greater $100k: Significantly smaller proportion of LGBTIQA+ people (13.8%) earned high household of over $100k compared to non-LGBTIQA+(26.7%) in Rural Victoria. In Metro similarly significant differences were found, except differences were less pronounced, with proportionally fewer LGBTIQA+ in the low-income group and proportionally greater in the high-income group.
Table 15: Household income -$40-$100k	35.4%	34.5%	No Sig difference	
Table 15: Household income - Over $100k	26.7%	13.8%	Sig diff 5%	
Table 18: Educational attainment: [Did not complete high school; TAFE or Trade; University].			No Sig difference	No significant difference in educational attainment (not complete high school; TAFE or Trade; or University) between LGBTIQA+ people and non-LGBTIQA+ people in Rural or Metro Victoria.
Table 21: Employment: [Employed, Not employed; Not in workforce]	63.9%	54.8%	Employed Sig diff 5%	A significantly lower proportion of LGBTIQA+ people (54.8%) were employed compared to non-LGBTIQA+(63.9%) in Rural Victoria. No significant difference in employment status between LGBTIQA+ and non-LGBTIQA+ people was found in Metro.
Table 24: Can raise $2k in event of an emergency.	83.7%	75.8%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (23.5%) could not raise $2k quickly in event of an emergency, compared to non-LGBTIQA+ people (14.2%), in Rural Victoria. A similar result was found in Metro, except only 18% of LGBTIQA+ people in Metro could not raise $2k in event of an emergency.
Table 27: Private health insurance – Yes	45.4%	36.8%	Sig diff 5%	No significant difference existed in the proportion of LGBTIQA+ people (36.8%) and non-LGBTIQA+ people (45.4%) who held private health insurance coverage in Rural Victoria. Metro data showed the same finding.

PARAMETER	RURAL NON-LGBIQA+	RURAL LGBIQA+	STATISTICAL SIGNIFICANCE	INTERPRETATION OF DATA, INCLUDING COMPARISON OF RURAL WITH METROPOLITAN
Table 30: Had Experienced Food Insecurity	7.5%	14.4%	Sig diff 5%	Significantly greater proportion of LGBTIQA+ (14.5%), about double the proportion of non-LGBTIQA+(7.5%) people experienced food insecurity in Rural Victoria. In Metro, significantly more LGBTIQA people also experienced food insecurity (11.6%) compared to non-LGBTIQA+ people (5.4%).
Table 33 Feelings of Trust: [Never or not often / Sometimes / Yes definitely]	15.1%	23.1%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (23.1%) never or not often had feeling of trust, compared to non-LGBTIQA+ people (15.1%) In Metro there were no significant differences between LGBTIQA+ and non-LGBTIQA+ people in feelings of trust.
Table 36: Feeling safe walking down a street at night: [Never or not often / Sometimes / Yes, definitely / NA]	14.2% 64.5%	22.0% 56.2%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (22.0%) 'never' or 'not often' felt safe walking down a street at night, compared to non-LGBTIQA+ people (15.3%) in Rural Victoria. Also, significantly fewer LGBTIQA+ (56.2%) felt 'definitely' felt safe walking down a street at night compared to non-LGBTIQA+ people (64.5%) in Rural Victoria. In Metro there were no significant differences in feeling of safety.
Table 39: Feeling valued by society: [Never not often / Sometimes / Yes definitely]	11.5% 48.8%	20.6% 37.1%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (20.6%) felt 'never or not often' valued by society compared to non-LGBTIQA+ people (12.6%) in Rural Victoria; also, a lower proportion of LGBTIQA+ people (37.1%) felt 'Yes, definitely' valued by society compared to non-LGBTIQA+(48.8%) in Rural Victoria. In Metro the only significant finding was that a lower proportion of LGBTIQA+ people (42.5) felt 'yes definitely' valued by society, compared to non-LGBTIQA+ people (49.1%)
Table 42: Opportunities to 'Have a say': [Never not often / Sometimes / Yes definitely]	-	-	No Sig difference	No significant differences were found between LGBTIQA+ and non-LGBTIQA+ people in their feelings about 'having a say' in Rural Victoria. The similar was found in Metro.
Table 45: Tolerance – Does multiculturalism make life in your area better? [Never not often / Sometimes / Yes definitely.]	-	-	No Sig difference	No Significant difference was found between LGBTIQA+ and non-LGBTIQA+ people in the extent to which they felt multiculturalism made life better in Rural Victoria. In Metro a significantly greater proportion of LGBTIQA+ people (66.5%) felt multiculturalism made life better than non-LGBTIQA+ people (55.8%).
Table 48: Spoken to someone in last day; [None; 1-4 people; 5-9 people; 10+ people	19.8%	29.0%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (29.0%) had spoken to only between 1-4 people in the last day compared to non-LGBTIQA+ people (19.8%). While not statistically significant there was a trend for Rural LGBTIQA+ to have spoken on fewer occasions to 5-9 or 10+ people in the 24hr period. In Metro no significant differences were found.

PARAMETER	RURAL NON-LGBIQA+	RURAL LGBIQA+	STATISTICAL SIGNIFICANCE	INTERPRETATION OF DATA, INCLUDING COMPARISON OF RURAL WITH METROPOLITAN
Table 51: Property ownership status [Owned / has mortgaged or renting / Other]	-	-	No Sig difference	No Significant difference was found between LGBTIQA+ and non-LGBTIQA+ people in the proportion owning or mortgaged/renting their home. The same was found in Metro; however, at a State-wide level a significantly greater proportion of LGBTIQA+ people's homes were mortgaged or rented.
Table: 54 Neighbourhood tenure (years) [less1 / 1-5 / 5-10; greater 10]	49.1%	39.6%	Sig diff 5%	Significantly lower proportion of LGBTIQA+ people (39.6%) compared to non-LGBTIQA+ people (47.5%) lived in the same neighbourhood for greater than ten years. The similar result was found in Metro.
Table 57: Experiences of discrimination [Yes /No]	13.9%	25.2%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (25.2%) had experienced discrimination than non-LGBTIQA+ people (13.9%) in Rural Victoria. Metro data indicated a similar significant difference, except a greater proportion of Metro LGBTIQA+ people (32.3%) experienced discrimination. The data does not support testing if this difference is statically significant but is does suggest discrimination against LGBTIQA+ in Rural Victoria may be less than Metro.
Table 60: Self-Rated Health Status [Excellent & Very Good / Good / Fair & Poor]	19.0%	29.3%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (29.3%) reported their health as Fair or Poor compared to non-LGBTIQA+ people (19.0%) in Rural Victoria. A similar result to Metro, except in Metro a significantly fewer LGBTIQA+ people reported Excellent & Good health compared to their non-LGBTIQA+ peers.
Table 63: Life satisfaction status [Low or medium / High / Very High]	-	-	No Sig difference	No Significant Difference in the proportion of LGBTIQA+ and non-LGBTIQA+ people experiencing Low, Medium, High or Very high life satisfaction in Rural Victoria. In Metro significantly greater proportion of LGBTIQA+ people report Low or Medium life satisfaction than non-non-LGBTIQA+ people.
Table 66: Feeling of life being worthwhile [Low or medium / High / Very High]	-	-	No Sig difference	No Significant difference between LGBTIQA+ and non-LGBTIQA+ people in the feeling of life being worthwhile in Rural Victoria. In Metro significantly greater proportion of LGBTIQA+ people (22.7%) report Low or Medium feeling that life is worthwhile than non-LGBTIQA+ people (16.6%).
Table 69: Psychological distress level [Mild / Moderate / High or Very High]	15.5%	26.3%	Sig diff 5%	Significantly greater proportion of LGBTIQA+ people (26.3%) experiencing levels of 'High or very High' psychological stress than non-LGBTIQA+ people (15.5%) in Rural Victoria. Similar statistically significant results were found in Metro populations.

PARAMETER	RURAL NON-LGBIQA+	RURAL LGBIQA+	STATISTICAL SIGNIFICANCE	INTERPRETATION OF DATA, INCLUDING COMPARISON OF RURAL WITH METROPOLITAN
Table 72: Diagnosis of anxiety or depression [Yes / No]	31.7%	49.4%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (49.4%) diagnosed with anxiety or depression compared to non-LGBTIQA+ people (31.7%) in Rural Victoria. Similar significant differences are found in Metro data; however, data shows there may be a greater proportion of LGBTIQA+ people diagnosed with anxiety or depression in Rural Victoria. The analysis does not allow us to determine if this is a significant difference.
Table 75: Experience of family violence [Yes / No]	5.6%	11.8%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (11.8%) have experienced family violence, this is twice the experience of non-LGBTIQA+ people (5.6%) living in Rural Victoria. In both Rural and Metro LGBTIQA+ people experience about twice the level of family violence than non-LGBTIQA+ people do.
Table 78: Smoking status [Daily / Occasional / Ex-smoker / non-smoker]	14.1%	21.4%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (21.4%) smoke daily compared to non-LGBTIQA+ people (14.1%) in Rural Victoria A similar significant result to Metro However, about 1 in 4.5 LGBTIQA+ people smoking daily in Rural Victoria compared to about 1 in 6 in Metro.
Table 81: Diagnosed with asthma. [Yes / No]	-	-	No Sig difference	No Significant difference in diagnosis of asthma between LGBTIQA+ and non-LGBTIQA+ people. In Metro a significantly greater proportion of LGBTIQA+ (29.4%) compared to non-LGBTIQA+ people (19.2%) have an asthma diagnosis.
Table 84: Morbidity status [No chronic disease / One chronic disease / two or more chronic diseases]	28.7%	36.6%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (36.6%) have two or more chronic diseases, about 50% more than non-LGBTIQA+ people (23.7%) living in Rural Victoria. A similar result to Metro.
Table 87; Self-reported dental health status [Excellent & very Good / Good / Fair & Poor]	23.7%	32.9%	Sig diff 5%	A significantly greater proportion of LGBTIQA+ people (32.9%) about 50% more experience than non-LGBTIQA+ people (23.7%) self-report 'Fair or Poor' dental health in Rural Victoria. In Metro no significant differences were evident.