LGBTI Data: developing an evidence-informed environment for LGBTI health policy

A discussion paper outlining why diverse sex, sexual orientation and gender indicators should be included in:

- national, publicly-funded health and other research;
- monitoring mechanisms including minimum data-sets (including mental health and suicide prevention); and
- the Australian Census.
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The National LGBTI Health Alliance is the national peak health organisation for a range of organisations and individuals from across Australia that work in a range of ways to improve the health and well-being of lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex and gender diverse (LGBTI) people and communities.

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Recommendations

1) That the Australian Government fund a national project led by AIHW in partnership with ABS, ARC, NHMRC, DOHA and other relevant bodies to explore and discuss the various issues involved in obtaining LGBTI data.

2) That the project publish standardised questions and response values for all LGBTI indicators (Sexual Attraction, Sexual Behaviour, Sexual Identity, Sex at Birth, Current Sex, Gender Identity); a guide for researchers including lessons learnt from the AIHW-led study; and an annual report of LGBTI Australian data.

3) That Australian Government agencies include LGBTI people within research funding grant guidelines, to promote an increase in LGBTI-related data.

4) That the Australian Bureau of Statistics consider proposed amendments to the 2016 Census that would enable the identification of LGBTI people, following development of questions, field testing of questions, and discussion about results.

5) That the Australian Government seek to explore ways to increase LGBTI content in National Minimum Data Sets, including in the areas of Mental Health and Suicide.
Introduction

1. Lesbian, Gay, Bisexual, Trans/transgender and Intersex (LGBTI\textsuperscript{1}) Australians are a population which is often neglected in Australian research and monitoring mechanisms. The Census does not allow Australians to record their diverse sex, sexual orientation or gender identity. Most national population research in Australia does not collect LGBTI demographic information. Monitoring mechanisms, such as National Minimum Data Sets (NDMS), also fail to capture the necessary information to determine if existing policy initiatives are achieving their desired outcome of improving the health and wellbeing of LGBTI Australians.

2. In recent years, following decades of social and legislative reforms, LGBTI Australians have begun to be included in various health and other public policies, strategies, action plans, programs and initiatives. However, due to the lack of comprehensive data about LGBTI people within most mainstream research, policy decision-makers have been forced to turn to smaller scale LGBTI-targeted studies for evidence to inform their policies. While uniquely valuable, these LGBTI-targeted studies often sample participants from within, and connected to, LGBTI communities. Accordingly, such statistics may only be seen as representative of respondents, rather than presenting a holistic picture of LGBTI Australians, many of whom may not be connected to LGBTI communities.

3. This paper will discuss different types of indicators that could be used to capture LGBTI-related data. We will briefly discuss barriers to the inclusion of LGBTI-related data and argue why action is necessary to provide the best possible evidence for public policy making.

4. The paper lists known examples of Australian LGBTI data and proposes new areas where LGBTI data could be incorporated. The paper also notes activities of comparable countries where a better knowledge base about LGBTI people is available. The paper presents recommendations for Australian Government departments, agencies and authorities.
Legislative and Social Reforms

5. Australia is a socially progressive country that largely acknowledges the diversity of its citizens, including people of diverse sex, gender and sexual orientation. Over the past decade there have been significant advances in the inclusion of lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) issues within public policy.

6. While it could be said that much of the focus of reforms over the past decades has been on same-sex attracted people (lesbian, gay and by association bisexual), there has also been some progress for people of diverse sex and/or gender (transgender and intersex).

7. As at April 2012, legislative reforms include:
   - decriminalisation of homosexuality\(^2\) in (1972-1997);
   - equalisation of age of consent laws\(^3\) (1975 – 2003);
   - introduction of equal opportunity and anti-discrimination laws at state\(^4\) (and soon federal\(^5\) levels of government;
   - recognition of same-sex couples\(^6\):
     - as domestic/defacto partners (all states and Commonwealth), or;
     - as a civil partnership/registered relationship (QLD, NSW, ACT, VIC, TAS)
     - within Family Law (Commonwealth)
   - same sex parenting reforms\(^7\) including:
     - recognition of lesbian mothers on birth certificates (all states);
     - access to artificial reproductive treatments (all states except SA);
     - recognition as parents in family law (Commonwealth);
     - access to altruistic surrogacy, including recognition of male couples on birth certificates (QLD, NSW, ACT, VIC & WA);
     - access to adoption for individual LGBTI people (QLD, NSW, ACT, VIC, TAS & WA);
     - access to step-parent adoption for same-sex partners (NSW, ACT, VIC, TAS, WA);
     - access to same-sex couple adoption (NSW, ACT, WA).
- access to updated birth certificates following gender affirmation surgery in limited circumstances\(^8\) (all states) and wider access to Australian Passports\(^9\) in a person’s affirmed sex or gender, without the requirement of sex reassignment surgery, and with a new ‘X’ category for people’s whose sex is indeterminate, unspecified or intersex.

8. Social reform achievements affecting LGBTI people include:
- Less Australians believe homosexuality is immoral (36% in 2001 to 29% in 2008\(^10\))
- Broader awareness and acceptance of LGBTI people in Australia.

9. As Australia’s legislative reforms for its LGBTI citizens progress, mechanisms to monitor the social inclusion, health and wellbeing and level of human rights enjoyed by LGBTI people become necessary.

**LGBTI data needed to inform decision making**

**Public Policy, particularly health**

10. LGBTI Australians have begun to be included within government and non-government public policy frameworks. This includes broad health strategies and plans\(^11\ 12\ 13\ 14\ 15\), as well as specific LGBTI policies, initiatives or programs\(^16\ 17\ 18\).

11. The decision to include (or not include) LGBTI Australians in particular policies is often made on the basis of the available data. In areas such as mental health\(^19\), sexual health\(^20\), and drug and alcohol usage\(^21\), there is significant national evidence of health disparities faced by same-sex attracted people. However in areas such as general health research\(^22\), socio-economic data\(^23\), mortality data-sets\(^24\), morbidity data-sets\(^25\), same-sex attracted people continue to be excluded from national statistics. For people of diverse sex and/or gender identity, there is no mention in nationally significant health data.

**Planning for LGBTI services**
12. The need for geography-based demographic information about LGBTI people has greatly increased in the past 5 years following the removal of same-sex discrimination in over 85 Commonwealth laws. Since this legislative reform there has been a select number of targeted services by the Federal Government in areas such as mental health capacity building\(^{26}\) and aged care community packages.\(^{27}\) To better target future initiatives, enhanced data is required.

**LGBTI Consumers – business needs to know**

13. LGBTI consumers are a niche market for many businesses.\(^{28}\)\(^{29}\)\(^{30}\) Access to data on geographical locations, income, household, family and other general data from the census would be of enormous benefit to companies seeking to pitch their advertising spend towards this niche market.

**Human Rights Monitoring**

14. The draft exposure of the National Human Rights Action Plan\(^{31}\) identifies the need to better collect data for the monitoring of human rights. Specifically under the target of “freedom from discrimination” the Action Plan notes that “The Australian Government will amend data collection to allow for or encourage disclosure of sexual orientation and gender identity to establish a better evidence base for service provision and policy development”.\(^{32}\) It remains unclear if this action item will include consideration of inclusion within the Australian Census and if the action item will extend to include people of diverse sex.

15. Given the increasing demand by governments and other organisations for data on LGBTI health, the National LGBTI Health Alliance believes it is necessary for Australia’s research and statistics agencies to review the current lack of data and determine strategies for full inclusion.

16. The National LGBTI Health Alliance acknowledges the small but significant increase in national data available regarding sexual orientation over the past decade (Mental Health, Drug and Alcohol, Sexual Health and same-sex couples in the Census). While this data may be improved upon through the diversification of LGBTI identifiers, we more urgently draw attention to the lack of data available on trans/transgender or intersex people.
LGBTI / Sex, Gender and Sexual Orientation

17. Lesbian, Gay, Bisexual, Trans/transgender and Intersex Australians are not a single group of people in the way that ‘Aboriginal and Torres Strait Islanders’ may be viewed as a single category. There are three distinct categories of demographics that may identify LGBTI Australians – sexual orientation, sex, and gender identity.

18. There are a multitude of combinations across the concepts relating to sex, gender and sexual orientation. A Trans-man may have a sexual orientation of gay, bisexual, or straight or be same-sex attracted and yet identify as heterosexual. A self-identifying lesbian may have been born with male anatomy but identifies their sex as intersex or female.

19. An approach to these complex issues may be for researchers to critically assess what concepts associated with sex, gender and sexual orientation are most applicable to their particular area of research:

- Is the reason for asking purely for demographics where perhaps ‘sexual identity’ (gay, bi, lesbian) along with options for diverse responses for ‘gender identity’ (trans/transgender) and ‘sex identity’ (intersex) may be appropriate?
- Is knowledge of ‘sexual attraction’ instead of ‘sexual identity’ labels (gay, bi, lesbian etc) more appropriate when discussing young people, still forming their identity, that sometimes can be fluid?33.
- When looking at biological health of Australians, consider the benefits of knowing someone’s biological history by asking their ‘sex at birth’ and their ‘sex today’ or ‘current gender identity’?
- In areas where health may be impacted by “minority stress”34, such as mental health or AOD, are questions relating to levels of ‘attraction’ more beneficial than questions related to ‘identity’?
- When looking at sexual health, are questions relating to ‘behaviour’ more appropriate than ‘identity’ or ‘attraction’?

20. There are multi-faceted issues to consider when collecting LGBTI data. This does not mean, however that researchers should abstain from collecting LGBTI data, or limiting data to the simplest categories of “identity”.

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33. The fluidity of sexual attraction is often discussed in the context of adolescence and is subject to change over time.
34. Minority stress refers to the stress experienced by members of minority groups due to societal discrimination and prejudice.
Sex and Gender

21. Gender is a social construct of “masculine” and “feminine”. Sex is the biological distinction of being “male” or “female”. Sex indicators are one of the most common demographic items contained in research, though it is unclear if all respondents conceptualise the distinction between sex and gender when completing research surveys. It is necessary for this distinction to be clearly understood by researchers before looking at the issues surrounding sex and/or gender.

22. There is no known guideline on categories of gender in research, by any leading research authority. Sex according to the Australian Health Data Dictionary is defined as “The biological distinction between male and female, as represented by a code.” Contained within the Dictionary are permissible values of “male”, “female” and “intersex or indeterminate”.

What is Intersex?

23. Intersex is defined by the Dictionary as “Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason”. Intersex people may have chromosomal, hormonal or anatomical differences that are nonetheless traditionally seen as male or female, both or neither.

24. Some intersex people view intersex within a medical construct and identify their sex as “female” or “male”. There are a number of different medical diagnoses of intersex. For many intersex people however, they may identify their sex as “intersex” or “indeterminate” and reject the notion of intersex within a medical construct. There is limited research on the number of intersex births, but widely quoted is the figure of a minimum of 1.7% of live births.

25. While the data dictionary may permit the recording of intersex, it discourages coding intersex for people over 90 days old. In most situations, sex markers are then overwritten with values of “male” or “female”, with no historical reference to the original determination of intersex. In addition, one major source of information about
the sex of Australian births is the Births Deaths and Marriages Register in each state. These registers do not allow birth certificates of babies to be issued with sex markers other than male or female.

26. For some intersex people, they may “discover” their intersex differences at later points in their lives, where others may be aware of their intersex difference throughout their life. Accordingly, there is no known source of health-related information about intersex people in Australia. There may also be unique challenges with obtaining accurate information about intersex people at all life stages.

**What is trans/transgender** and gender identity?

27. Trans/transgender as an umbrella term refers to someone whose gender identity is not consistent with the sex assigned to them at birth (male or female). Trans/transgender individuals, are born with sex anatomy that is not consistent with their self-identified gender; that is, they may be born with male or female sex anatomy but believe their gender is different to that anatomy. Over the course of their life this cohort of individuals may embark upon a journey of ‘transition’ from male to female, female to male, some other gender, or no gender at all.

28. Trans/transgender is currently classified as “Gender Identity Disorder” in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). Many trans/transgender individuals and advocates object to trans/transgender being framed within a medical construct and call for Gender Identity Disorder to be removed from the DSM.

29. **At birth,** Bob is issued a birth certificate identifying them as male. **When filling in a research form at age 15,** Bob marks sex = male and gender = male.

30. **At age 18,** Bob commences the process of transitioning and begins using the preferred name of Mary. **Over the next five years Mary identifies as sex = male but gender = “Gender Queer”**.

31. **At age 23, after years of hormone therapy,** Mary has surgical breast enhancement. **Mary may now choose to identify on research forms as sex= female and gender = trans/transgender.**
32. At age 30 Mary has surgery to construct female genitalia from male genitalia and legally changes their birth certificate to show their sex as female. Mary may now identify her research responses as sex = female and gender = female.

33. The above scenario is not necessarily representative of trans/transgender people, but is an illustration of how the journey undertaken by a gender diverse person may elicit different responses at different times of their journey. They may have completed or be in the process of transitioning (moving from one sex to the other) or may choose not to transition. During or at the conclusion of the individual’s unique transition process, a trans/transgender person may see their gender identity as strictly “male” or “female” or continue to identify as “transgender”.

34. At points along their journey their gender identity may not match their biological sex, and may also be inconsistent with the legal sex on documents such as birth certificates, passports or drivers licenses. This self-perception as a “man” or a “woman” regardless of their biological history can cause significant challenges when trying to identify trans/transgender people within research.

What is possible to capture in research?

35. It may be necessary therefore to identify an individual’s “Sex at Birth”, “Current Sex” and “Gender Identity” to capture a holistic view of sex and gender diverse people. If such an approach is adopted, each question should be accompanied by explanatory text to ensure broad understanding of the question’s meaning. Where this three-question approach is not possible, and a single question is required, an approach of asking a question around a person’s Sex/Gender, and providing options of “male” “female” and “other” with freeform text may provide a suitable compromise.

36. Alternatively, framing the question in terms of an individual’s lifetime, (e.g. during your lifetime, have any of the following broad terms described you? “Male”, “Female”, “Trans/transgender/transsexual” “intersex”) with the ability for multiple responses, may provide insight into the existence of diverse sex and/or genders.

37. As part of the paper’s recommendations, it is proposed that further investigation, testing and recommendations of standardised research questions be developed.
We therefore do not propose specific examples, but can happily provide suggestions about question approaches upon request.

**Sexual Orientation**

38. Sexual Orientation is made up of at least three aspects of a person’s sexuality: identity, behaviour and attraction. It is not simply categories of heterosexual, homosexual (gay or lesbian) and bisexual. Nor is sexual orientation merely variants of a scale from “exclusively” gay through to “somewhat” gay to “exclusively straight”. Sexual Orientation has three core components, each different to the other, which collectively make up a person’s sexual orientation:

39. **Sexual Identity** – refers to the self-identified label that a person may choose to describe themselves. Common identities include heterosexual/straight, homosexual/gay/lesbian and bisexual. Note: these may change over time.

40. **Sexual Behaviour** – refers to the types of sexual experiences/encounters a person may have. This may be consistent or inconsistent with their sexual identity, that is to say a man having sex with a man may identify as heterosexual and may or may not feel attracted to people of both sexes.

41. **Sexual Attraction** – refers to attraction a person may feel regardless of their sexual identity or the behaviour/sexual experiences they may have had. “Same-sex attracted” is an important term, particularly in relation to younger people and others who may feel sexually attracted to people of the same sex but have not yet formed a self-identified sexual identity.\(^{42}\)

42. A national survey of 10,173 men and 9,134 women, the *Australian Study of Health and Relationships*\(^ {43} \), found that “relatively few Australians reported a sexual identity other than heterosexual. However, both same-sex attraction and homosexual experience are more common than homosexual or bisexual identity would suggest”\(^ {44} \).

43. While only 1.6% of male respondents identified as gay/homosexual and 0.9% identified as bisexual, 8.6% of respondents reported some level of same-sex
attraction or homosexual experience. For women, 0.8% identified as lesbian and 1.4% identified as bisexual; yet 15.1% of women recorded some same-sex attraction or homosexual experience.

44. This study shows that asking questions on sexual attraction or sexual behavior reveals an additional 6.1% of men and 12.9% of women who may share similar experiences as those who identify as lesbian, gay or bisexual. This principle of disparate figures between attraction, experience and identity are comparable in other countries.45

45. Due to perceived lack of benefit of asking multiple questions on a single ‘demographic’ factor like sexual orientation, researchers may limit the number of questions to a single question. It is necessary however to assess which of the three indicators (identity, behaviour or attraction) is the most appropriate to include and not simply include sexual identity.

46. Individuals at the time of participating in research or data collection may acknowledge their same-sex attraction, but may not self-identify as lesbian, gay or bisexual for a range of reasons. These include not yet assigning themselves a sexual identity"46, using other identity labels47, or self-identifying as heterosexual, but having levels of same-sex attraction and/or behaviour.

47. In the field of HIV research, there is a wide body of knowledge about “men who have sex with men” that may have similar sexual health challenges to those who identify as gay or bisexual. The principles of “identity vs behaviour” learnt through years of research within the HIV/STI field, as well as lessons learnt about “attraction vs identity” within the field of same-sex attracted and gender-questioning young people48, are applicable and informative to a wide range of research incorporating LGBTI people.
Capturing LGBTI – discussion of challenges

From the Health Care professional’s perspective

48. The Alliance’s MindOUT! Project, Phase 1 research\(^4^9\) of mainstream mental health services found that only 60% of respondents believed their staff members would “feel confident and be competent in sensitively and appropriately asking questions to identify a LGBTI person’s sexual orientation and gender identity.” In the same survey, 79% felt staff would treat LGBTI clients with sensitivity but only 31% of organisations would consider LGB/TI as a specific group for the purposes of organisational planning.

From the researcher’s perspective

49. While the proposition to include sexual orientation, gender identity and diverse responses for sex is a simple one, the National LGBTI Health Alliance recognises that it presents a range of challenges in practice.

50. Perhaps the most critical of these is research funding. Each and every question/response add additional costs and time to research projects - from the cost involved in collecting, through to the costs involved in analysing the data. Accordingly, the inclusion of any question is subject to a rigorous evaluation by research teams of the value of including the data.

51. While a researcher may desire to know the full suite of indicators for sexual orientation (attraction, behaviour and identity), sex and gender (sex at birth, current sex, gender identity), the costs of six question may be prohibitive. It may also be somewhat confusing to respondents in population size surveys, if not appropriately worded and tested, leading to another cost and time barrier to including LGBTI indicators.
52. **National Sex, Gender and Sexual Orientation Research Methods Project**

The National LGBTI Health Alliance recommends Australia’s research agencies support researchers through this process by undertaking a project to:

- Explore updates of key research architecture to ensure they are LGBTI inclusive (data dictionaries, minimum data sets, funding policies etc);
- Outline the government and community need for LGBTI data to deliver upon policy and service demands;
- Develop standardised questions and responses for LGBTI indicators in research (including focus testing of question suite in a variety of settings);
- Recommending where particular question sets should be considered for research inclusion (including updates to succeeding iterations of established research);
- Discuss technical aspects of how and why LGBTI indicators should be included in different types of studies (population health, targeted studies, longitudinal studies) and within particular fields of research;
- Discuss how collection methods may impact information provided (privacy, anonymity and confidentiality);
- Methodological challenges in the inclusion of such data, particularly where comparability to previous studies is a factor.

**From the respondent’s perspective**

53. The Alliance recognises that disclosure of a person’s sex, gender identity or sexual orientation is a very personal decision. It will be impacted by a range of factors including the known context of the data collection; the level of privacy, anonymity and confidentiality perceived; and the knowledge of how and why the information will be used, along with other socio-cultural factors.

54. Additionally, the mode of collecting responses may impact upon levels of sexual orientation disclosure. In situations where research is collected by a researcher or questioner, there may be lower levels of disclosure for fear of discrimination or generally not wishing to “reveal” one’s identity to another person.
55. It is also possible that questions and response options are misunderstood by respondents, such as not declaring a same-sex partner due to the question label of “marital status” where the answer of “married” is interpreted by the respondent as not being applicable to same-sex partners.

56. Analysis of research data in the United States notes that self-identification of a person’s sexual orientation and a willingness to disclose a person’s sexual orientation, as lesbian, gay or bisexual, can be impacted by race, ethnicity, culture, age and geographical location.50 51

57. People of diverse sex and/or gender may also not disclose their sex/gender histories and identities for a wide range of reasons. A person’s self-identification of their gender may also be impacted by the point of their transition at the time of the data collection.52

58. LGBTI people may be hesitant in disclosing their status, their gender/sex history or levels of same-sex attraction/behaviour for a wide range of reasons. However, careful design and testing of surveys, and ensuring adequate training of staff collecting, coding and analysing the data, should help to lower the non-response rate.
Census

59. The Australian Census\(^53\) is collected every five years by the Australian Bureau of Statistics (ABS). The ABS’s mission is to “assist and encourage informed decision making, research and discussion within governments and the community, by leading a high quality, objective and responsive national statistical service.”\(^54\)

60. Australia lacks the authoritative data on the number of LGBTI people that the Census, over time, would provide. For example, the Census would enable modelling of the number of LGBTI people in Australia to occur.

61. As the major source of socio-economic information on the Australian population, the Census provides crucial data on a range of individual characteristics (age, ancestry, family relationships, indigenous status, relationship status, education, employment, housing, languages spoken, income, voluntary hours, etc.) and collective information about education and qualifications, employment, income and unpaid work, cultural and language diversity, Indigenous people, disability and the need for carers, childcare, migration trends, and household and family characteristics.

62. The issue of including sexual orientation within the Census has been discussed for a number of years but with little actual investigation by the ABS of the issue\(^55\) \(^56\). Lack of data about LGBTI people puts this cohort of Australians at a significant disadvantage in terms of enabling policy makers and service delivery agencies to accurately predict where resources including healthcare and education targeting the LGBTI population may be required. Further, businesses and other parties seeking to promote their products and services to LGBTI people are unable to utilise the Census data that would be commonly available for almost any other market segment of customers and clients.

63. In addition, various research undertaken across Australia may link data to the Census to model their results on the Australian population. The lack of Census data about same-sex attracted people and people of diverse sex and/or gender prevents this taking place.
Finally, as Australia’s national statistics agency, ABS policies and approaches to the Census set a benchmark for other research. This is an important factor when seeking to compare the results of multiple sources of related data. Accordingly, the leadership that could be shown by the ABS through the Australian Census and ABS publications, in the area of sex, gender and sexual orientation identifiers is influential when seeking the broad inclusion of LGBTI indicators in research.

The Australian Bureau of Statistics has commenced seeking informal thoughts on the 2016 Census, and has confirmed a call for public submissions, accompanied by an information paper which will be available in late 2012.

As discussed later in the paper, national statistic bodies in comparable countries have investigated aspects of our recommendations. We believe that the findings from these investigations should inform the ABS in their investigations and field testing and not be used as a rationale for no investigation by Australia. We note that acceptability and understanding of terms and language may be specific to Australia and that Australian results may not be totally consistent with international experiences. Further, we note the additional descriptive text we proposed was not included in international field tests and that this may have had an impact on results. We also note the ABS’s ability to include messages about questions in its media strategy, as was seen in various Census collections regarding Jedi as a religion.

Existing LGBTI Data in Census

Since the 1996 Census, ABS data has allowed for same-sex couples to be identified as part of the Australian Census. Officially included in the 2011 Census Dictionary, the data is created using a combination of the respondent’s sex and their declared “relationship in the household” between Person 1 and Person 2 etc.

There are many challenges with this current approach:
• Term “marital status” does not include opportunity for same-sex couples married overseas to be recognized as married. Rather they are coded as “de facto” and from the 2011 Census onwards will be published as “relationship as reported”.

• Responses under “relationship in household” frame their responses within the words “de facto partner of person 1”, which is not necessarily a term which is well understood.

• It only captures same-sex couples who are under the same roof on Census night. That is to say, it doesn’t capture relationships across two homes or single same-sex attracted people.

• It only captures relationships between “Person 1” and their partner, thus in shared accommodation arrangements where Person 1 is not in the same-sex relationship, no indication is provided.

69. The ABS has previously indicated that collecting data on same-sex couples “may have some limitations, including reluctance to identify as being in a same-sex de facto marriage and lack of knowledge that same-sex relationships would be counted as such in the Census”.

Sex / Gender

70. There is no opportunity for people of diverse sex and/or gender identity to be recorded. Currently, Question 3 asks, “Is the person male or female?” and instructs participants to record one or the other option.

Sexual Orientation

71. Beyond the indicative same-sex couple data, there is no record of an individual’s sexual orientation.

Proposed amendments to Census

72. Update Question 5: Remove reference to the term “de facto” and include descriptive text “(including same-sex couples)”. De facto is a word not widely understood, thus introducing a barrier to accurate recording. For those who do understand the term, confusion over the legal requirements of the term may ensue. De facto people are required to live together for various lengths of time depending on the relevant piece of legislation.
73. A better approach would be through the simple phrase, “Partner of Person 1”, rather than the current term “de facto partner of person 1” that appears in Question 5.

74. For decades now, same-sex partners have not legally been recognised as a in a same-sex relationship. Accordingly, they have become accustomed to not recording their relationship on official documents.

75. Question 5 “What is the person’s relationship to Person1/Person2?” currently includes descriptive information underneath it. A descriptive dot point such as “(de facto) partner of Person 1, includes same-sex couples” is likely to lead to a higher reporting rate of same-sex couples and ensure couples are aware their relationship may be declared.

76. **Update Question 3: Provide an option of “other” under “Sex/Gender” category with descriptive text**
   Use of “other” boxes is currently permissible in a range of Census questions. Most contain explanatory answers indicating what other options may include.

77. To better understand the diversity of sex and gender, options other than “male” and “female” must be provided. We recognise that sex is not gender and gender is not sex, but argue that to the average Australian, these concepts are intrinsically linked. Accordingly, we believe it appropriate that the question expand to include gender and introduce an option of “Other”, with an accompanying free form text field and descriptive explanation. We also note the inclusion of sex and gender within the one question will prevent the necessity to include two questions on each topic, which could lead to deeper confusion by respondents.

78. **3 What is the persons sex/gender?**
   *Mark one box for each person like this –
   *Examples of other sex/genders may be: Trans/transgender; Transsexual; Intersex;*
   - Male
   - Female
   - Other
79. Providing an explanation of other as including trans/transgender and intersex will signpost the purpose of the other box. Indeed by including a non-binary option, the ABS may find a decrease in non-responsive answers currently experienced.

80. **Additional Question: Seek information on Sexual Orientation, with descriptive text**

   Providing a question on sexual orientation would allow for the recording of all LGB people. While a more interesting indicator might be one of “sexual attraction”, we recognise that this would be of little value to most ABS stakeholders.

81. The more likely information sought by the users of ABS data will be on the issue of “Sexual Identity”, and accordingly would propose that this be the focus of the sexual orientation question. A question could be:

82. **Which of the following best describes the way the person thinks of their sexual orientation?**

   - **Answering this question is OPTIONAL.**
   - Your information is protected with confidentiality under Australia’s Privacy laws.
   - If you do not wish to answer, please mark the “I would rather not say” box

   - [ ] Straight/Heterosexual (attracted to the opposite sex)
   - [ ] Gay/Lesbian/Homosexual (attracted to the same sex)
   - [ ] Bisexual (attracted to both sexes)
   - [ ] Undecided; not sure; questioning
   - [ ] I would rather not say

83. It may be necessary, due to layout of Census design to move the bracketed explanation from the response answer to part of the descriptive text under the question. However, without an explanation of the meaning, there may be different levels of understanding of the labels used.

84. It is also important to note that the term “best describes” and “thinks of their” have been deliberately used. It is important that the individual concerned has input into the answer
of the question and that the question recognises that while not all respondents will fit neatly into a specified category, a “best describes” answer is a suitable outcome.

**Consultation, testing, decisions: should be made involving dialogue with LGBTI community**

85. The National LGBTI Health Alliance recognises changes to Census questions should only occur following rigorous testing to ensure that the question is both understood and answered, and that data is as accurate as possible. We recommend the inclusion of explanatory descriptive text which will assist in maximising understanding.

86. We stand ready to work with the ABS on the design of any field questions and to link the ABS with leading LGBTI researchers both in Australia and internationally to discuss the findings of the ABS investigation.

**Monitoring – Research**

87. Australia has an increasing need to monitor various aspects of the lives of its LGBTI citizens. One form of data that could be used for monitoring outcomes is national population and longitudinal studies. This section will discuss the need for LGBTI indicators to be included within research and the options available for this inclusion.

**Where do we need to know about LGBTI people?**

88. Indicators of LGBTI outcomes are required in almost all areas of research to inform public policy. In the area of human rights, the introduction of federal anti-discrimination laws on the basis of sexual orientation and gender identity, along with the Government’s stated desire to monitor human rights outcomes will increase the demand for data to be available.

89. In areas such as health and wellbeing, the inclusion of LGBTI people within public policy documents such as the National Male Health and National Women’s Health policies will increasingly require quality data to inform the action plan stemming from these policies.
Where do we have existing data on LGBTI people?

90. There are questions on sexual identity contained in leading national research for mental health, alcohol and other drugs and sexual health. However, the former two surveys do not record indicators for sexual health for same-sex attracted individuals. For sex and gender diverse individuals, and within a broad range of other health fields, data for LGBTI people are limited to a few studies that have focused on LGBTI populations.

91. The sampling methods used in LGBTI-specific surveys are often through promotion of the survey through existing LGBTI networks (community press, websites, e-lists etc). As such, these surveys do not provide a truly representative sample of same-sex attracted and sex/gender diverse Australians. Inclusion within mainstream, national, population-size studies is therefore necessary.

92. McNair, Gleitzman and Hillier provide a wide discussion on why same-sex attracted women are not included in population-based health research. These principles apply equally to same-sex attracted men and are similar to the challenges faced by sex and gender diverse people.
### Known LGBTI Data sources

#### Mainstream Research

93.

<table>
<thead>
<tr>
<th>Contains</th>
<th>Research Title</th>
<th>Organisations</th>
<th>Year</th>
<th>LGBTI data published?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Identity</td>
<td><strong>National Drug Strategy Household Survey</strong></td>
<td>Australian Institute of Health and Welfare</td>
<td>2007</td>
<td>Not Published</td>
</tr>
<tr>
<td>Sexual Identity</td>
<td><strong>National Survey of Mental Health and Wellbeing</strong></td>
<td>Australian Bureau of Statistics</td>
<td>1997</td>
<td>Not included</td>
</tr>
<tr>
<td>Sexual Identity &amp; Gender</td>
<td><strong>Victorian Public Health Survey</strong></td>
<td>Public Health Unit, Department of Health,</td>
<td>2001</td>
<td>Unpublished, included since 2009</td>
</tr>
<tr>
<td>Sexual Identity</td>
<td><strong>The SEEF Project:</strong> Understanding the impact of social, economic and geographic disadvantage on the health of Australians in mid to later life: What are the opportunities for prevention? (Sub-study to NSW’s 45 and Up Longitudinal Study)</td>
<td>The Sax Institute</td>
<td>45UP</td>
<td>Not included</td>
</tr>
<tr>
<td></td>
<td><a href="http://goo.gl/AN9BA">http://goo.gl/AN9BA</a></td>
<td></td>
<td>SEEF</td>
<td>Currently unpublished</td>
</tr>
</tbody>
</table>
| Sexual Attraction Behaviour & Identity | **Australian Study of Health and Relationships**  
| --- | --- | --- | --- | --- |
| Same-sex Couples | **The Household, Income and Labor Dynamics in Australia**  
Unknown which year data was introduced | Melbourne Institute of Applied Economic and Social Research, Melbourne University | Since 2001 | Unknown |
| Sexual Identity | **The Australian Longitudinal Study of Women’s Health**  
Sexual Orientation only asked for:  
- Young Cohort, second wave (2000)  
- Med Age Cohort, third wave (2001)  
- Young Cohort, third wave (2003)  
[78](78)  
[79](79)  
[80](80) | University of Newcastle  
University of Queensland | YngW2 - 2000  
MedW3 - 2001  
YngW3 - 2003 | Y  
Y  
Y |
## Key LGBTI Specific Research

<table>
<thead>
<tr>
<th>Data Contained</th>
<th>Research Title</th>
<th>Conducted by</th>
<th>Year</th>
<th>LGBTI data published?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex at Birth</td>
<td>TranZnation: A report on the health and wellbeing of transgendered people in Australia and New Zealand</td>
<td>ARCSHS</td>
<td>2006</td>
<td>Y</td>
</tr>
<tr>
<td>Sexual Identity</td>
<td>Sydney Women and Sexual Health Survey</td>
<td>ACON In partnership with UNSW and USYD</td>
<td>2006 2008</td>
<td>Limited information</td>
</tr>
<tr>
<td>Sexual Identity (women only)</td>
<td>Gay Community Periodic Survey (Adelaide, Canberra, Melbourne, Perth, Queensland, Sydney)</td>
<td>National Centre in HIV Social Research with the Kirby Institute and state AIDS Council and state Health Department</td>
<td>1996 but varies by state 2011</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><a href="http://nchsr.arts.unsw.edu.au/publications/">http://nchsr.arts.unsw.edu.au/publications/</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour Identity</td>
<td>Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians</td>
<td>ARCSHS, GLHV, Beyond Blue, Movember Foundation</td>
<td>PL1 – 2006</td>
<td>Y</td>
</tr>
<tr>
<td>Gender Identity</td>
<td></td>
<td></td>
<td>PL2 - 2012</td>
<td></td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>WTi2 – 2004</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>WTi3 – 2010</td>
<td>Y</td>
</tr>
</tbody>
</table>
Identified research for inclusion

95. As a general principle, LGBTI indicators should be included in all research. It would be impossible to list all the specific areas in which LGBTI data is required.

96. The National LGBTI Health Alliance believes that through discussion, design, testing and funding all challenges surrounding the introduction of LGBTI indicators are able to be resolved. Further as discussed in this paper, the need for LGBTI data to better inform public policy and service allocation necessitates the inclusion of LGBTI data.

97. While respecting the individual choices of research teams about the data to be collected, the Alliance believes that more leadership from key government agencies on the issue of LGBTI data is necessary.

98. This leadership could be through a range of mechanisms including:

- **Development of an Australian guideline for LGBTI indicators.** Such a document may outline standardised questions, discussion of methodological challenges, sampling approaches, statistical validity and reporting guidelines.

- **Inclusion of LGBTI data within funding** priorities and guidelines to incentivise the collection of LGBTI data

- **Annual reporting of available LGBTI data** available as part of annual publication series, to note the available data across research fields and encourage discussion within research circles.

99. Key population health surveys that are sought for immediate consideration to include better LGBTI data are:

- Australian Health Survey (ABS)\(^81\)
- Australian Survey of Disability, Ageing and Carers (SDAC)\(^82\)
- Household Expenditure Survey\(^83\)
- Household Income and Labour Dynamics in Australia Survey (HILDA)\(^84\)
Monitoring - other data sets

100. Monitoring outcomes, particularly health outcomes, may also be possible by introducing LGBTI data in data sets that are nationally aggregated, from instances of police reports of violence relating to sexual orientation, sex and/or gender identity; recording sexual orientation in clinical settings; and through the introduction of government mandated requirements to collect in national minimum data sets.

101. The issues discussed regarding privacy, confidentiality and understanding the purpose/use of the data being collected are of particular relevance. Additionally however, as some data sets may be collected by a third party (Police, Doctor, Nurse, Allied Health Professional etc) training around asking questions in data sets is particularly important.

102. Australia’s health data collected is largely based on one of three data dictionaries, all of which should be updated to better reflect LGBTI demographics:

- **National Health Data Dictionary Version 15 (NHDD)**
- **National Community Services Data Dictionary Version 6 (NCSDD)**
- **National Housing Assistance Data Dictionary (NHADD)**

103. Requirements for Minimum Data Set reporting are various, but none contain the requirement for sexual orientation to be included. Surprisingly, not even the instances of sexually transmitted infections and blood borne viruses identifies sexual orientation.

104. The Australian Institute of Health and Welfare discusses the standardised terminologies used under the Australian Family of Health and Related Classifications and principles used for inclusion under these classifications.
Identified data sets for possible LGBTI inclusion

105. However, there are a number of potential sources where LGBTI identifiers could be either included or aggregated from existing sources.

General Practitioners – Clinical Management System

106. General Practitioners are the starting point of accessing health care for most LGBTI people. Most of Australia’s leading clinical management systems have fields for the collection of sexual orientation information\(^87\), but diverse sex and/or gender identity is not believed to be recorded. While the introduction of a “gender identity” field may be possible, the introduction of diverse “sex” categories are likely to present challenges due to the binary nature of minimum data sets and other data transmission information such as Medicare data. The starting point for practically acquiring information into minimum data sets will be reliant upon the ability of industry systems to cater for the information to be included.

107. McNair\(^88\), Bowers et al\(^89\), the Gay and Lesbian Medical Association (US)\(^90\), Well proud\(^91\) and the Fenway Institute\(^92\) discuss in detail how and why GPs should ask information on sexual orientation and gender identity.

108. Further training of GPs about sensitively broaching the topic of sexual orientation and diverse sex/gender would be required to ensure appropriate approaches were used to solicit open, honest answers.

E-Health

109. It may be possible, in the future, for an individual to elect to include their sexual orientation, diverse sex and/or gender identity within their personally controlled e-health record\(^84\). If included in future releases of E-Health information, patients will maintain control over which medical practitioners may access their information. Patients may also opt-in to their e-health record being included as part of research.

110. Through the future enhancement of e-health to include options for LGBTI identifiers that consumers can choose to include or not, a rich source of LGBTI information
may become available over time for future research. However, more importantly, the inclusion of LGBTI identifiers in a personal e-health record will allow a patient to easily share or not share this information with medical professionals, on a case-by-case basis.

Mortality Datasets

111. Statistics around deaths in Australia are collated by the ABS based on information from the Registrars of Deaths, Births and Marriages in each state. As part of this state based registration process, the cause of death information is provided either by a Medical Practitioner (Medical Certificate of Cause of Death) or as a result of a coronial inquest, based upon coroner report data. ABS also receives information from the National Coroners Information System. ABS then codes causes of death by health classification using International Classification of Diseases 10th revision (ICD-10).

112. Of particular interest to LGBTI mental health specialists is the data created identifying suicides in Australia. This data can be generated in a range of ways via the coroners system. One of the main sources of information around a suicide comes from the state police department.

113. Obtaining information from a source other than the victim present ethical questions around the victim’s right to privacy. It is crucial therefore that any questions continue to be framed around identified “associated issues” with sexuality, not focused on “sexual identity”. These issues could include questioning sexual attraction, same-sex experience/behaviour or bullying and other issues with being perceived to be LGBTI (eg not masculine/feminine enough). It is also important to note that while maintaining the victim’s right to privacy, there is a strong public policy benefit of learning more about causes (and thus hopefully prevention) of suicides in Australia. As further research into the mental health of diverse sex and/or gender identity emerges, consideration may also need to be given towards inclusion of these identifiers in a similar “associated issues” approach.

Police Databases

114. Criminal reports captured within the various state police reporting systems require a “finger search” within the body of the report for key words such as “same-sex” or
“LGBTI” to identify any statistics relating to the LGBTI community. Police are not trained on collecting consistent data and this leads to a significant under-reporting of LGBTI related crime.

**Mental Health Data Sets**

115. The Bettering the Evaluation and Care of Health (BEACH) database use classifications from the *International Classification of Primary Care, 2nd edition* (ICPC-2), along with the psychological chapter of ICPC-2 for treatment and referrals (ICPC-2 PLUS)\(^98\).

116. BEACH contain the following relevant LGBTI diagnostic codes:

- P09 - Concern about sexual preference
- P45009 - Advice/education; sexuality
- P58005 - Counselling; sexual; psychological

117. The National Hospital Morbidity Database 'mental health related hospital' data contains both patient admissions and ambulatory-equivalent information. It uses codes based on ICD-10-AM

118. National Hospital Morbidity Database\(^99\) uses codes:

- F52 - Sexual dysfunction, not caused by organic disorder or disease
- F64 - Gender identity disorders
- F65 - Disorders of sexual preference
- F66 - Psychological and behavioural disorders associated with sexual development and orientation

119. The NHMD does not contain demographic information around sexual orientation, diverse sex and/or gender identity\(^100\). Accordingly, information currently within the database could only inform instances of case presentations relating to the above codes.

120. As is discussed through the Alliance’s MindOUT! Project\(^101\), there is a greater need for research and data in terms of LGBTI mental health outcomes. Enhancing the above data sources to identify demographic information will enhance the mental health outcomes of LGBTI people.
Minimum Data Sets

121. National Minimum Data Sets are created by agreement between the state and Commonwealth governments. As such, the Alliance recognises the challenges and length of time it may take to secure national agreement for the inclusion of LGBTI people within minimum data sets. However, the Alliance also believes that this process of scoping, discussion and engagement should commence sooner, rather than later. To assist in facilitating focused discussions, some key data sets are listed below for consideration to include LGBTI people:

- Home and Community Care MDS
- Aged Care Assessment Program MDS
- Alcohol and other Drug Treatment Services NDMS
- Admitted patient mental health care NMDS
- Community mental health care NMDS
- Residential mental health care NMDS
- Supported Accommodation Assistance Program (SAAP) Client data collection MDS (homelessness)
The international LGBTI experience

122. There is significant progress internationally of including LGBTI people within national surveys across a wide range of topics. Most comparable countries to Australia recognise same-sex couples in their national Census, but recognise the inherent challenges in receiving accurate data given both the structure of Census relationship questions (only referring to the relationship of the first respondent and requiring couples to live together) in addition to sensitivities around disclosure of sexual identity.

123. The 2008 Statistics New Zealand discussion paper\textsuperscript{110} on Sexual Orientation, discusses many international examples. The paper acknowledges the emerging importance of collecting sexual orientation data along with the difficulties of respondents answering questions where concepts have been poorly defined or understood.

124. Aside from Nepal’s recent inclusion of a “third gender” in part of their national Census, there has been no international discussion identified about the inclusion of trans/transgender or intersex people within Census. The US Department of Minority Health has committed to the inclusion of gender identity within population health studies and is currently consulting and testing on question designs. A considerable number of state health and population surveys include sexual orientation and gender identity indicators within them.

Nepal

125. In 2011 the Nepal Census recognised an additional category of “third gender” as part of its Census collection of Household Listings\textsuperscript{111}. Sadly, the more comprehensive Schedule\textsuperscript{112} to the Census, which is a sample survey of every 8\textsuperscript{th} residence, continues to identify citizens as male or female.\textsuperscript{113}

India

126. The Census of India 2011 Household Schedule\textsuperscript{114} permits for individual respondents to elect a sex indicator other than male or female. Data from the responses have not yet been made available by the Census Commissioner.
United Kingdom

127. In 2006 the Office of National Statistics in the UK commenced investigation of including sexual orientation in the 2011 Census\textsuperscript{115,116}. Like Australia, the UK seeks to include sexual orientation in the Census to measure the impact of the suite of UK Equalities legislation. To date, the UK has not included sexual orientation within their Census, but following a “Sexual Identity” project, the UK has begun to include sexual orientation information in a range of national surveys. This work built on the two previous papers by the Scottish Government in 2003\textsuperscript{117,118}.

UK Office for National Statistics – Useful documents


129. Discussion of Census Assessment to User Feedback regarding proposal to include sexual orientation in 2011 Census. (March 2006)

130. Developing survey questions on sexual identity: Rationale and design of sexual identity questioning on the Integrated Household Survey (IHS) (December 2008)

131. Developing survey questions on sexual identity: Cognitive/in-depth interviews (July 2009)

132. Developing survey questions on sexual identity: Exploratory focus groups report (August 2008)
LGBTI Data: Developing an evidence-informed environment for LGBTI health policy


133. **Equality and Human Rights Commission**
http://www.equalityhumanrights.com/uploaded_files/research/beyond_tolerance.pdf

**New Zealand**

134. Despite commencing consultation on including Sexual Orientation as part of the 2011 New Zealand Census, a broad decision was taken in 2008, mid-way through the project, that no new information would be contained in the 2011 Census. It is anticipated that the issue will be reconsidered as part of planning for the 2016 Census.

Statistics NZ – useful documents

135. Sexual orientation data in probability surveys: Improving data quality and estimating core population measures from existing New Zealand survey data (February 2010)


**Canada**

137. Statistics Canada considered the issue of sexual orientation as part of the 2006 Census. It cited results of its testing:

The focus groups demonstrated that the survey context is important because it provided an explanation as to why the question was being asked and how the data could be used. For example, participants were most willing to answer questions within the context of a health survey or a discrimination and human rights survey. Most participants did not approve of including a sexual orientation question on the Census.  

Canada has included questions about sexual identity within its Canadian Community Health Survey since 2003 and its General Social Survey on
Victimisation since 2004\textsuperscript{122}. The British Columbia Adolescent Health Survey\textsuperscript{123} has collected sexual orientation data since 1992.

**United States**

138. The US Census Bureau did not collect Census information about LGBTI individuals in the 2010 Census. It has however recognised same-sex couples (both married spouse and unmarried partner)\textsuperscript{124125126} and has continued to enhance a wide range of national research data to include LGBTI indicators\textsuperscript{127128129}. A good website for current sources of same-sex attracted data in the US is [http://www.gaydata.org/ds001_INDEX.html](http://www.gaydata.org/ds001_INDEX.html).

139. In July 2011, the Office for Minority Health, US Department of Health and Human Services announced that it would begin to integrate sexual orientation and gender identity questions into population health surveys\textsuperscript{130}. As part of the plan to “Improve data collection for the LGBT Community” it has engaged in an 18-24 month project to develop and evaluate questions on sexual orientation and gender identity\textsuperscript{131}.

140. There are a two significant papers outlining inclusion of LGBTI indicators from the US:


- Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities (March 2011) *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, Institute of Medicine, National Academy of Sciences, Washington DC, USA ([www.iom.edu/lgbthealth](http://www.iom.edu/lgbthealth))
Endnotes

1 The National LGBTI Health Alliance uses “LGBTI” as a recognisable acronym to collectively refer to a group of identities that includes lesbian, gay, bisexual, trans/transgender and intersex people and other sexuality, sex and gender diverse people, regardless of their term of self-identification.

This paper may also refer to “same-sex attracted” people as a collective referral to lesbian, gay and bisexual people, in addition to “sex and/or gender diverse” people as a collective referral to trans/transgender and intersex people.


3 Ibid. Carbery G 2010


6 Various legislation, most comprehensive summary available at, including links to specific legislation http://en.wikipedia.org/wiki/Recognition_of_same-sex_unions_in_Australia#State_registries_in_Australia

7 Various legislation, most comprehensive summary available at, including links to specific legislation http://en.wikipedia.org/wiki/LGBT_adoption_and_parenting_in_Australia


20 Australian Research Centre in Sex, Health and Society, (2002) *Australian Sexual Health Survey*, La Trobe University, Melbourne Victoria


23 The Australian Census is the leading source of socio-economic data about Australians. Currently the only inclusion of LGBTI people is where two people in a same-sex relationship declare their relationship on the Census. The Australian Bureau of Statistics has acknowledged this to be a likely under-reporting of statistics for same-sex couples.


32 Ibid at p31 (Action item 147)

33 See further discussion by Hillier 2006, Hillier 2008.


36 The definition used in the Dictionary is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.


38 We note however that trans/transgender is not appropriate in research where a wide range of self-identification labels may occur. Such labels includes, but are not limited to trans man, trans woman, GenderQueer, transgender, trans* and any number of other culturally specific terms including eunuch (Indian), fa’afatines (Samoan), ladyboy (Thai). Where issues of non-conforming genders are a key outcome of the research, we would encourage more diverse language is used to be all encompassing. For example, it is highly likely that a eunuch from India, would not identify under a response category of “trans/transgender”
and thus be more likely to resort to the physical sex of “man” when looking to answer a question in relation to sex/gender.


41 Asscheman, H, Diamond, M, Di Ceglie, D, Kruijver, F, Martin, J, Playdon, Z, Reed, T, Reid, R (2002), Definition and Synopsis of the Aetiology of Adult Gender Identity Disorder and Transsexualism, Gender Identity Research and Education Society, London


50 Badgett, MVL 2009, Best Practices for Asking Questions about Sexual Orientation on Surveys, The Williams Institute, University of California, California, USA, p 3 (http://www.escholarship.org/uc/item/706057d5).

51 Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities (March 2011) The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding, Institute of Medicine, National Academy of Sciences, Washington DC, USA, p 74 (www.iom.edu/lgbthealth)


54 Census Service Charter, Australian Bureau of Statistics


LGBTI Data: Developing an evidence-informed environment for LGBTI health policy


59 Investigations into the inclusion of sexual orientation within the Census have occurred in Canada, Scotland, England/Wales and New Zealand. While not recommending for inclusion, sexual orientation was recognised as having much interest in the information. Alternative forms of “Relationship in Household” language are used internationally. India and Nepal have included a “third gender” option on their 2011 Census.


63 http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2901.0Chapter9102011

64 2011 Census Dictionary, Relationship in Household (Category 17 – In de facto marriage, male same-sex couple & Category 18 – In de facto marriage, female same-sex couple) http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2901.0Chapter8602011

65 Mr Paul Lowe, Australian Bureau of Statistics, Senate Economics Legislation Committee Estimates, Thursday 20 October 2011, pp145-147

66 http://www.abs.gov.au/ausstats/abs@.nsf/bb8db737e2af84b8ca2571780015701e/74f6507d8b687bf0ca25720a00797b0!OpenDocument

67 http://www.abs.gov.au/ausstats/abs@.nsf/bb8db737e2af84b8ca2571780015701e/de1f616d457bf36cca25720a007f4caff!OpenDocument


83 http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3302.0Explanatory%20Notes12010

84 http://melbourneinstitute.com/hilda/


88 Mc Nair, R., (2012) A guide to sensitive care for lesbian, gay and bisexual people attending general practice, General Practice and Primary Health Care Academic Centre, The University of Melbourne


97 See http://apps.who.int/classifications/icd10/browse/2010/en


101 See Phase 2 Project Plan, contained in final report of phase 1 www.lgbtih health.org.au/mindout


http://meteor.aihw.gov.au/content/index.phtml/itemid/471383

http://meteor.aihw.gov.au/content/index.phtml/itemid/339019


121 Statistics Canada Canadian Community Health Survey http://www.statcan.gc.ca/concepts/health-sante/cycle2_1/index-eng.htm


123 British Columbia’s Adolescent Health Survey, McCreary Centre Society (http://www.mcs.bc.ca/ahs)


129 Black, D., Gates, G., Sanders, S. and Taylor, L., (2000) Demographics of the gay and lesbian population in the US: Evidence from available systematic data sources. 37,139-154 identifies the following US surveys
as containing at least one form of sexual orientation question: General Social Survey; National Health and Social Life Survey; National Survey of Family Growth; National Longitudinal Survey of Adolescent Health; National Health and Nutrition Examination Survey; Womens Physicians Health Study; and Nurses Health Study II.


\(^{131}\) The project outline can be found at http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=209&id=9004