general health

Additional Findings Report
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Count Me In Too

LGBT Lives in Brighton & Hove

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Synopsis of key findings

This report addresses the general health of LGBT people. It includes in depth analysis of a questionnaire that was completed by 819 people and focus groups with 69 people. Although sex and sexual health are addressed in this report, it is contended that LGBT health cannot be reductively addressed through a sole focus on sexual health.

When examining general health the report found that LGBT people were more likely to say their health was poor and to smoke when compared with measures that address the general local population. The majority of the sample would like to be more physically active with women and trans people in particular seeking space that is friendly to them.

Sex and sexual health has been a key focus for LGBT people and particularly gay and bisexual men, and men who have sex with men. Yet there is little support for others in the LGBT population, with few information sources and a lack of knowledge regarding sexual health, despite the fact that almost the entire sample- 94%, had sex in the past three years. Most LGBT people in this research have had sexual health check ups but 30% of those who have had sex in the past 3 years said that they have never had a sexual health check up/do not need one. Women, trans people, those who are disabled/long term health impaired, those who have not tested positive for HIV, older LGBT people are less likely to have sexual health check ups than other LGBT people. The qualitative data indicated factors that contribute to this situation include a lack of information relevant to these groups, and the absence of friendly points of contact to address sexual health for those who are not men. Therefore, although sexual health literature is believed to be readily available, easy to read an understandable, it is not seen as catering for the diversity of the LGBT communities. Most young LGBT people report that they at times have anxieties about sex and this can be compounded by a lack of information during their formal education.

Those who are living with HIV have particular areas of need and experiences of vulnerability that are more acute than other LGBT people. They include experiences of homelessness, discrimination on the basis of their gender/sexual identities and feeling unsafe. They are also more likely than other LGBT people to say that they do not enjoy the LGBT scene.

79 people in this research said that they had taken payment for sex, most of these had male clients. Sex workers (those who regularly exchange sex or do so when they have to) are more likely to experience mental health difficulties, sexual assault and homelessness. Housing can be procured through having sex and 8% of LGBT people in this research having had sex or made themselves available to have sex in order to have somewhere to stay. Some young LGBT people are prone to using sex in order to have somewhere to stay, particularly where families of origin do not approve of their sexual/gender identities.

The final part of the report addresses particular areas of marginalisation and need, contesting the medical models of trans health; Deaf identities; and physical disabilities and long term health impairments. These groups shared experiences of multiple marginalisation and exclusions, from both mainstream services and LGBT communities.

Trans people in this research had particular issues with GP provision and the gender identity clinics that they used (particularly Charing Cross Hospital Gender Identity Clinic). Trans people found that these often act as barriers to their health and wellbeing. The majority of trans people sought safe GPs sought and requested a specialist local service. Information and ongoing care packages were also desperately needed.

The Deaf focus group and those who identified as deaf, hard of hearing, deafened or deaf-blind indicated some of the difficulties that Deaf people face in trying to access health services, highlighting communication with health professionals, and access to health services more generally. Deaf people indicated that they felt marginalised because they are Deaf and LGBT, and just over a fifth said that they found it difficult being Deaf and LGBT in Brighton & Hove. A contributory factor may be the lack of Deaf friendly LGBT pubs in Brighton & Hove. In addition to the exclusion and marginalisation Deaf LGBT people experience from mainstream and LGBT spaces, Deaf people are more likely to say that they have experienced domestic violence and abuse compared to other LGBT people. This indicates that key support networks (such as the family and partners) may be unavailable to Deaf LGBT people.

Similar to Deaf respondents, a quarter of respondents who identify as physically disabled or long term health impaired say they find it difficult or very difficult to be an LGBT disabled person in Brighton and Hove. There were venues and areas of Brighton & Hove praised as places that disabled LGBT people valued, however, they also pointed to isolation, exclusion and access issues as key concerns. Disabled people reported that they had experienced discrimination and abuse from other LGBT people and in LGBT venues, and they are more likely to participate in national LGBT groups than local groups. They indicated that they do not feel that they fit well into disabled and/or LGBT activities. LGBT people who identify as physically disabled or long term health impaired are more likely to be vulnerable to suicide; to have experienced hate crime; to have housing needs; and to feel uncomfortable in mainstream services. In addition, 'home' may not be a safe place as those who identified as disabled or having a long term impairment were more likely to have experienced abuse, violence or harassment from a family member or someone close to them than other respondents. The data suggested that LGBT people who are disabled wanted to be treated 'normally', with many asking for increased access, acceptance, understanding and information.

The final aspect of this report addresses GP services and future needs and priorities.

The research found that a slim majority of LGBT people have disclosed their sexual/gender identity to their GP. It was clear that GP's were not considered 'safe' and that for some the necessity of disclosing sexual/gender identities to GPs was like playing 'Russian Roulette'. Gay men are less likely than other groups to disclose their identity, and this may be because of the provision of specific services related to sexual

health and a desire to keep particular aspects of their lives 'off the record'. This was not a privilege afforded to all and trans people, lesbians and bi women, with mental health difficulties and those who are living with HIV are more likely to be 'out' to their GP's. This was often because sexual/gender identities had to be revealed in the course of treatment and no other options were presented. The focus groups indicated that signage could help with perceptions of LGBT friendliness and a willingness to address LGBT issues with GPs.

91% of people wanted a healthy living centre that offered a variety of services and catered for a range of activities and needs. 45% of LGBT people (n. 363) would like a GP / clinic specifically for LGBT people. Those who are disabled, isolated or have mental health difficulties are more likely to want a specialist GP service. However respondents were clear that a health living centre should be used to promote LGBT friendliness with other services rather than ghettoising LGBT people. There was also a desire to build community networks to support LGBT people.

The majority of LGBT people are happy to give information about their LGBT identities if the information is confidential and anonymous, and the service is considered LGBT friendly. However, trans monitoring needs to be carefully addressed.

Executive Summary

Physical health

- Although the majority of the sample described their health as good/very good in the past 12 months, this proportion was less than the general lifestyle survey 2003 undertaken with a random sample of the local population.
- Those who are trans, Deaf, disabled, are older, have lower incomes, have mental health difficulties, are living with HIV and council/temporary accommodation are more likely to report poor physical health in the past 12 months.
- LGBT people who are disabled and long term health impaired, and those who are older, were more likely to rate their health as poor than people in these groups in the 2003 survey of the local population.

Smoking

- 33% of LGBT people in this sample smoke cigarettes.
- Men, those aged between 26-35, those who are living with HIV, those who consider their physical health in the past 12 months to be poor, those who have used 'illegal drugs' are more likely to smoke.
- The majority (61%) of LGBT smokers say that they keep smoking because they are addicted to it. Over half (53%) of smokers also indicate that enjoyment is a reason for continuing to smoke.
- 90% of LGBT smokers are concerned about the effects that smoking has on their health. Women, lesbians and those who have not tested positive for HIV are more concerned than other LGBT people about the effects of smoking on their health.
- 71% of LGBT smokers would like help to stop smoking. Only 52% of LGBT smokers are aware of the free Stop Smoking Service in Brighton
- Over a quarter of those who smoked said that a LGBT stop smoking service would motivate them to give up smoking. A fifth of smokers said that nothing would motivate them to give up smoking.

Physical activity

- 79% of LGBT people in this sample would like to be more physically active.
- 44% of those who say that they would like to be more physically active indicate that a major reason stopping them from achieving this goal is lack of time. Almost a third (30%) say that cost is a factor stopping them from being more active.
- 43% of trans respondents to the question indicate that a lack of trans friendly spaces stops them being more physically active.
- Compared to 8% of men who wanted male only space, 22% (n. 58) of women say that a lack of women only spaces stops them achieving this goal.

Sex

- 94% of the sample said that they had had sex with someone in the last three years
- 91% of those who have had sex in the past 3 years have had sex with people of the same sex
- Of those who have had sex in the past three years, almost half (45%) have had sex with only one person in the last twelve months. 24% have had sex with between 2 and 5 people over the last twelve months, while 10% have had sex with between 6 and 10 people.
- Lesbian respondents are much more likely (72%, n. 186) than gay men (28%, n. 112) or those otherwise coded (including bisexual, queer and those of an 'other' sexuality) (44%, n. 40) to have had sex with only one person in the past twelve months.
- 27% of those who have not had sex in the past 3 years say that being LGBT and not having sex has not been easy.
- 66% of those who have not had sex in the past three years say they feel that not having sex is not respected in LGBT culture.
- Most young people (66%) at times have anxieties around sex

Sexual health and knowledge

- Just under a quarter of all respondents (25%, n. 202) have never had a sexual health check up, with 7% (n. 54) of respondents saying that they do not need one.
- Female respondents, lesbians, trans respondents, those who are deaf, deafened, hard of hearing and deaf blind, those who are disabled/long

term health impaired, those who have not tested positive for HIV are less likely to have sexual health check ups than other LGBT people. Older LGBT people are more likely to say that they do not need sexual health check ups and younger people are more likely never to have had a sexual health check up.

- 25% of those who have had sex in the past three years say they have never had a sexual health check up.
- 5% of those who have had sex in the last three years say they do not need a sexual health check up.
- Of those who have had 26 or more partners in the past 12 months, 83% have had sexual health check ups in the past 12 months. Those who have not had sex in the last twelve months are most likely to never have had a sexual health check up or to say that they do not need one (63%, n. 15).
- Those who are not out to their GP are less likely to have had sexual health check ups in the past 12 months and more likely to say that they have never had a sexual health check up.
- Monogamous and/or committed sexual relationships (61 responses) were the most common reason given for not needing a sexual health check up. 38 respondents said that they did not think they needed a sexual health check up or that they were not worried about the risks associated with their sexual practices or relationships. 29 people said that they do not need sexual health check ups because of who their partners are. Further analysis of this group revealed a large lesbian category and those who don't have sex with men. 14 people said that they hadn't had any symptoms and/or problems associated with their sexual practices and therefore did not need a sexual health check up.
- The unavailability of lesbian sexual health check ups, and the absence of information and clinics that cater for women who have sex with women, was noted in the qualitative data.
- Almost a third (30%, n. 211) have had their most recent sexual health check up at the Claude Nicol clinic. 18% (n. 125) have had their most recent sexual health check up at their GP surgery, 11% (n. 75) at a sexual health clinic outside Brighton and Hove, and 10% (n, 72) at a GU clinic.
- 39% (n. 307) said that they did not know where to find help around sex and relationships
- Those who are queer, lesbian or 'other' in terms of sexuality, those who are trans, who are on a low income, who feel isolated, who have not tested positive for HIV and have experienced sexual assault are more likely to say that they would not know where to find help around sex and relationships.
- The majority (71%) of respondents thought that information on sexual health is readily available in Brighton and Hove (although female respondents were less likely to think this was the case), and that information on sexual health available in Brighton and Hove is easy to read and understand. Slightly less (65%) agreed that the quality of the

information on sexual health available in Brighton and Hove is very good.

- Respondents are less likely to agree that the information available in Brighton and Hove on sexual health is appropriate to their sexual practices (55%), that information on sexual health available in Brighton and Hove is appropriate to their sexual and gender identity (59%) and that information on sexual health available in Brighton and Hove is diverse and caters for all groups (44%).
- Women, those of another/no gender, lesbians, bisexuals and those of another sexual identity and trans people are less likely to agree that the information on sexual health is appropriate to them.
- Those who are female, BME or of an ethnicity other than white/BME and bisexual are less likely to say that information on sexual health is diverse and caters for all groups.
- The qualitative data in part reflected the quantitative data regarding gender and sexuality and the absence of information for women/lesbians/bi people.

Living with HIV

- 55% (n. 443) of respondents have had an HIV test result. Of those who have had an HIV test result, 13% (n. 56) have tested positive and 87% (n. 386) have tested negative.
- All of those who are living with HIV are either gay, bisexual or queer, white; they are not trans and not Deaf.
- Out of the 56 respondents that tested positive, 26 people do not identify as disabled/long term health impaired.
- Those who are living with HIV are more likely to be over 36, be male (no women tested positive in this survey and women were the group most likely to have never received a HIV test result), not be employed, to live in Brighton & Hove and more likely to live in Kemptown and St. James Street (although the majority still lived elsewhere in the city).
- Those who are living with HIV are more likely to have taken 'illegal drugs' in the past five years, less likely to have experienced good emotional health in the past year and more likely to have disclosed their sexual or gender identity to their GP.
- 29% of those living with HIV have experienced homelessness. 18% have specialist housing needs and 30% of those who are living with HIV live in social housing.
- 37% of those who are living with HIV experienced discrimination on the basis of their gender and/or sexual identities in the areas where they lived.
- Those who are living with HIV are more likely to say that there are places, services or facilities in Brighton and Hove where they do not feel safe, compared to those who have either tested negative or have

not had a test result. Those who have tested positive are more likely not to feel safe inside LGBT venues, in the 'gay village' and in cruising grounds, than those who have tested negative or have not been tested.

- Those who have tested positive for HIV are more likely (14%) to disagree with the statement 'I enjoy going to/using LGBT commercial venues and events in Brighton and Hove' than those who last tested HIV negative (6%) and those who have never received an HIV test result (6%).
- Respondents who have tested HIV positive are more likely (15%) than those who last tested HIV negative (4%) or those who have not received an HIV test result (4%) to say that they rely upon voluntary services at a time of personal crisis.
- Those living with HIV are just as likely as other LGBT people to prefer to get their information from the LGBT switchboard, an LGBT community centre, local LGBT media (radio, magazines), local LGBT websites, national LGBT websites, web message boards, and flyers and posters. However, they are less likely to want to get their information from national LGBT media (excluding websites), listings, and email updates, and more likely to want to get information from email.

Sex work

- Just under 10% (n.79) people in this sample have taken payment for sexual acts in their life times
- Those who identified as disabled or long term health impaired, those who have mental health difficulties and who are HIV positive were more likely to have exchanged sex for payment.
- 95% (75) of those who said that they have taken payment for sexual acts, have exchanged sex for money, with 18% (14) saying that they exchanged sex for somewhere to stay
- The majority of those who sold or exchanged sex had male clients (92%), with 14% reporting that they sold or exchanged sex with women. Women sold/exchanged sex to men and women, men sold/exchanged sex almost exclusively to/with other men.
- 60% (n. 47) report that they no longer sell or exchange sex at the time of the research, and 25% (n. 20) report that doing so was 'just a one off'
- 15% said that selling or exchanging sex is a regular source of income or something that they do when they have to- these are defined as sex workers. 23% (n. 3) of those defined here as sex workers say that selling or exchanging sex is a regular source of income for them, while 77% (n. 10) say that it is something they do occasionally when they have to.
- Sex workers and those who are not sex workers but have sold or exchanged sex in the past are more likely to be male than those who

have never sold or exchanged sex. The majority of sex workers and those who have exchanged sex for payment are gay men.

- 46% of sex workers last had a sexual health check up within the past six months, compared to 39% of those who are not sex workers but have sold or exchanged sex and 18% of those who have never sold or exchanged sex.
- Sex workers are more likely to experience mental health difficulties, sexual assault and homelessness. They are more likely to drink alcohol, take 'illegal drugs' than are those who are not sex workers but who have in the past sold or exchanged sex (80%) or those who have never sold or exchanged sex (67%).
- 18% (n. 2) of sex workers have tested HIV positive, 25% (n. 17) of those who are not sex workers but who have sold or exchanged sex in the past have tested HIV positive, while 5% (n. 37) of respondents who have never sold or exchanged sex have tested HIV positive.
- 4% of LGBT people (n. 31) have had sex or made themselves available to have sex in order to have somewhere to stay in the past 5 years. A further 4% (n. 28) have done so outside the last five years.
- 10% of young people (n.12) have had sex or made themselves available to have sex for somewhere to stay.
- Those who have exchanged sex for payment, regularly or occasionally (46%, n. 6) when they need to, are more likely ($p < .0001$) to have had sex or made themselves available to have sex in order to have somewhere to stay.
- 40% (n. 16) of those who answered the question said that they worked independently as an escort with 28% giving another answer to how they worked. 20% work for an escort agency, massage parlour, flat or sauna (8 people), and 10% say that they work from streets/car parks.

Trans Health

- The majority of trans people think that their current GP is good or very good 68%, with 16% saying that their GP is poor or very poor. 7% said that the question was 'not applicable' indicating a disengagement from these services.
- Qualitative data pointed to the need to locate 'safe' GPs and using networks to find trans friendly GPs. The element of chance and luck was clear and referral systems were often problematic.
- Experiences of transphobic and ill-informed GPs can influence the engagement with future services, as well as affecting mental and physical health for trans people.
- 48% of trans people said that a question regarding the quality of care delivered by NHS gender identity clinic was 'not applicable', indicating a use of private services and/or a disengagement from health services by trans people. Of those who used NHS gender identity clinics, 45%

said that the quality of care was very poor with a further 23% saying that it was poor.

- Qualitative data indicated that Charing Cross was viewed in a negative light by many trans people, who saw it as unable to address their needs or to appropriately support them through their transition
- 65% of trans respondents indicated that a specialist local service was needed, with 51% asking for a specialist GP to improve the experiences of transitioning.
- 47% of trans people in this research said that their transition would have been improved by better information.
- Qualitative data indicated a need to provide ongoing and in some cases lifetime care for trans people.

Deaf, hard of hearing, deafened or deaf-blind people

- Twenty eight people (4%) in the sample identified themselves as deaf, hard of hearing, deafened or deaf-blind.
- The Deaf focus group indicated some of the difficulties deaf people face in trying to access health services, in particular communication with health professionals and access to health services more generally.
- Almost a third of LGBT Deaf people feel marginalised because of their LGBT Deaf identity. 18% (n. 5) of deaf respondents report experiencing bullying, abuse, discrimination, exclusion or not being able to access mainstream venues and events. 11% (n. 3) reported experiencing bullying, abuse, discrimination, exclusion or not being able to access health services, LGBT venues and events, housing, and LGBT services and groups.
- 30% (n. 7) of those who answered the question said that as a deaf person, they feared abuse and physical attack.
- 22% (n. 6) of deaf respondents find it difficult or very difficult being an LGBT deaf person in Brighton and Hove.
- 36% (n. 10) of deaf respondents find it difficult or very difficult to find information about what help or assistance is available to them.
- 47% (n. 13) of deaf respondents find it easy or very easy to access services specifically for LGBT deaf people.
- 46% (n. 13) find it difficult or very difficult to find deaf friendly LGBT pubs, clubs or organisations.
- Of those who have experienced domestic violence, Deaf and hard of hearing people are more likely to have been abused by people other than partners or family members. (54%, n. 7) than non-deaf people (35%, n. 56).

Physical Disability/Long Term Health Impairment

- 15% of the sample identified as having a long term health impairment or physical disability.
- A quarter of respondents who identify as disabled say they find it difficult or very difficult to be an LGBT disabled person in Brighton and Hove.
- The qualitative data indicated that LGBT disabled people had positive experiences in Brighton and Hove. They mentioned LGBT specific services, venues and spaces that they valued and enjoyed.
- The qualitative data pointed to isolation, exclusion and access issues as key areas where LGBT people who identified as disabled or long term health impaired had significant difficulties.
- 24% of those who identify as disabled report having experienced bullying, abuse, discrimination or exclusion from other LGBT people. 21% report having experienced bullying, abuse, discrimination or exclusion in employment or not being able to access employment because of their disabled LGBT identity. Health services and housing were also key areas. 19% (n. 16) report such experiences with respect to health services, while 17% (n. 14) report such experiences with respect to housing.
- Almost half of LGBT disabled people in this research regularly participate in national LGBT groups, compared to 21% for local disabled groups, 14% in local LGBT groups and 4% in national disability groups.
- Over half of respondents who identify as disabled say that they do not feel they fit well or at all into disabled activities, events and groups in Brighton and Hove.
- 38% of respondents who identify as disabled say they do not fit that well or do not fit at all into LGBT activities, events and groups in Brighton and Hove.
- LGBT people who identify as disabled are more likely to have serious thoughts of suicide, to have exchanged sex for payment and to feel uncomfortable using services because of their gender/sexual identity.
- LGBT people who identify as disabled or long term health impaired can have specific housing needs and experiences that differ from the rest of the LGBT population, but that are still related to their LGBT identities.
- Those who identified as disabled or having a long term impairment were more likely to have experienced abuse, violence or harassment from a family member or someone close to them than other respondents.

- Those who identified as physically disabled or long term health impaired are more likely to have experienced hate crime, to have safety fears and to think the police service had not improved in the past five years.
- Qualitative data suggested that LGBT people wanted to be treated 'normally' with many asking for increased access, acceptance, understanding and information.

GPs and healthy living centre for LGBT people

- 60% of LGBT people in this research have disclosed their sexual / gender identities to their GPs
- Those who are trans, lesbian, older people, those with mental health difficulties and those who are living with HIV are more likely to be out to their GPs.
- The qualitative data noted how LGBT people can experience difficulties with their GPs and source LGBT friendly GPs, as well as the imperative for some groups to tell their GPs about their sexual/gender identities.
- 45% of LGBT people (n. 363) would like a GP / clinic that is specifically for LGBT people. Those who are disabled, isolated or have mental health difficulties are more likely to want a specialist GP service.
- 91% would like to see a healthy living centre, with those who have a low income, who are isolated and who have mental health difficulties more likely to want such a centre.
- The qualitative data indicated a desire to have a range of services within the healthy living centre providing for the wellbeing of LGBT people. There was also a cautionary note that with the advent of a health living centre other services should also strive to be LGBT friendly.

Monitoring and future priorities and services

- The majority (85%) of LGBT people are happy to give information about their gender/sexual identities if they believe the service is LGBT friendly and the data is confidential and anonymous
- For some the small networks of LGBT Brighton & Hove are problematic when attempting to ensure anonymity.
- Monitoring gender variance and trans should be undertaken in line with policies that support trans people

- 61% of respondents would like to see consultations undertaken by questionnaire, 47% in open public meetings, 38% LGBT community forums, 38%community events and 36% LGBT focus groups. The citizen's panel was the least popular option (24%).
- Mental health (45%), sexual health (39%), drug use (37%), alcohol use (34%) and LGBT friendliness of the health service (24%) were the top five priorities identified to improve the health and wellbeing of LGBT people in the next five years.
- The focus groups indicated that signage could help with perceptions of LGBT friendliness and a willingness to address LGBT issues with GPs. There was also a desire to build community networks to support LGBT people.

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1. Introduction

1.1. Introduction

Brighton & Hove has a reputation of being a 'gay city' that is perceived to offer particular services for LGBT people. However, the benefits of this affect LGBT people unevenly, highlighting key areas for LGBT people in the city as well as LGBT people more broadly. Health issues and concerns pertaining to quality of life and the use of services in the city are important factors when considering LGBT lives. Therefore, this report will outline the health findings from the Count Me In Too study which focused on LGBT people who live, work and socialise in the city. It then offers recommendations to address the concerns in the report.

The report explores 'health' with a broad remit to include sex (beyond sexual health) and those who have been medicalised (that is, considered within the context of a medical model, are deemed to present with deviations from a notional 'norm' and these differences are viewed as pathologies) and disabled because of their physical embodiment and/or gender identities. Although this report refutes this medicalisation, it includes these issues due to their histories and contemporary place within health services. In taking account of disability, deafness and trans issues, the report seeks to advance social change for LGBT people, in part by contesting the medical model for the understanding of these areas. This chapter will firstly look at the Count Me In Too research, then explore key terms used in this report. It will then outline the structure of the remainder of the report.

1.2. Count Me In Too: Background, Research Methods & Analysis notes

In 2000, the award winning Count Me In survey was developed from the grassroots of the then predominantly lesbian and gay communities, with backing from the East Sussex Brighton and Hove Health Authority. This research was used to form the LGBT community strategy for Brighton & Hove 2000-2006. Count Me In Too was initiated in 2005 as a joint venture between Spectrum[1] and the University of Brighton. It is a community led

1 Spectrum is Brighton & Hove's Lesbian, Gay, Bisexual & Transgender Community Forum established in 2002 to provide infrastructure and community development support to LGBT communities and promote partnership work and community engagement in the planning of services and policy. www.spectrum-lgbt.org

action research project that seeks to advance progressive social change in the city. The research phase ran from January 2006 to October 2006. The research consisted of a large scale questionnaire with 819 respondents and 20 focus groups that had 69 participants. The questionnaire offers both qualitative and quantitative data. The questionnaire was routed, such that not all respondents answered every question. This is particularly important for this report as respondents who indicated that they had experienced specific health issues were routed to the more detailed questions about their experiences. The quantitative data is analysed in SPSS software and we are operating at a significance level of $p<.05$.

This data was analysed in depth focusing on health issues, with the help of an analysis group that consisted of representatives from a broad range of statutory services and voluntary groups. During the analysis, the group advised on the information that would be most relevant to the analysis and that would progress positive social change for LGBT people. The report was then co-authored by Dr. Kath Browne and Dr. Jason Lim who sent draft reports to the analysis group and received comments back from this group.

Count Me In Too allows us to understand the diversity and complexity of the LGBT communities in greater depth and detail than ever before. Further details regarding the Count Me In Too research can be found in the initial findings reports located at www.countmeintoo.co.uk. In this report, the focus on health and wellbeing is augmented with insights into particular groups, namely disabled groups and trans people.

1.3. Key terms

There are other terms that are used in this analysis that are unique to the questionnaire or require some understanding at the outset. Table 1.3a outlines these terms.

Table 1.3a: Categories and definitions

Category	Definition
Sexual identity	The question used as the basis of this category asked for the sexual identity with which the respondent most closely identified. Those who defined as gay and female were recoded into the lesbian / gay woman category.
LGBT- Lesbian, Gay, Bisexual and Trans	The term LGBT is used for ease of understanding and to ensure that the diversity within these communities are partially acknowledged. The authors recognise the difficulties of categorising sexual and gender identities in this way. The term includes those who are questioning, unsure or do not identify with particular sexual or gender identities.

Trans	These were respondents who identified as being trans. Two of those who answered yes to the question 'Do you identify yourself as being trans or have you ever questioned your gender identity?' were removed from this category as they argued in comments sections that they were not trans but had questioned their gender identity.
Ethnicity	The question used for this category asked for ethnicities with which respondents most closely identified. Respondents were given four choices: White, BME (Black and Minority Ethnic), gypsy traveller and other
Deaf, hard of hearing, deafened or deaf-blind	The question used as the basis of this category was 'Are you or do you identify yourself as being deaf, hard of hearing, deafened or deaf-blind?
Disability	This category includes those who answered yes to the question: 'are you or do you identify as having a long term health impairment or a physical disability?' This category is not limited to physical disability and cannot be disaggregated by physical, sensory or mental disabilities or long term health impairments
Age	This was done in numerically with the following categories used: young people were defined as those under 26 and older people defined as those over 55.
Income	Income levels were measured in categories that asked for income before deductions.
Mental Health	The 'mental health' category in this report refers only to those who ticked that they had difficulties with any of the following: depression, anxiety, significant emotional distress, suicidal thoughts, panic attacks, problem eating / distress, fears / phobias, addictions / dependencies, anger management and self harm. The question also asked about stress, insomnia, confidence / self esteem and isolation but these categories were excluded because they included large proportions of the sample. Moreover, comments were written in the questionnaires such as - "sometimes not being able to sleep or getting stressed does not mean one has mental health difficulties" (questionnaire 74). These suggested that this question was read as 'have you ever experienced', rather than 'have you ever experienced difficulties'. These issues caused the action group to rethink the category of 'mental health difficulties' for the purposes of the initial findings report, and particularly in the cross tabulating with other identity categories. This category may be reconsidered in further analyses but a robust category was thought to be most appropriate for this report.

Isolation	Isolation was measured by those who answered 'yes' or 'sometimes' to the question 'Do you feel isolated in Brighton & Hove?' The figure was broken down into Yes / sometimes and no (the small category unsure (1.9%) was removed to ensure statistical significance). This captured current perception and therefore was chosen over the question that asked about 'isolation' under mental health difficulties experienced in the past 5 years.
HIV positive	This category was comprised of those who answered that their most recent HIV test result had been positive.
Domestic violence and abuse	This is defined as those who have experienced harassment, violence and/or abuse from a family member or someone close to the person (see Browne, 2007a)
Neighbourhood area	17% of our sample lived in St. James Street and Kemptown. 26% lived in 'areas of potential deprivation'; these are: North Portslade, Hangleton & Knoll, Brunswick (East), Hollingbury, Hollingdean, Saunders Park, St Peters, Tarner (South Hanover), Bristol Estate, Bevendean, Moulsecoomb, Whitehawk & Manor Farm, Queens Park & Craven Vale. 57% do not live in any of these areas and are categorised as living in 'none of the areas listed'.
Tenure	The majority of the sample lived in privately owned accommodation (47%). Just under a third (30%) lived in rented accommodation, and 7% lived in Council housing. A small number (5 people) lived in sheltered and supported accommodation. In order to describe the sample and undertake statistical tests, the tenure categories have been grouped into those that are meaningful for the data and housing services. Throughout this report social housing (9% of the sample) will be used to describe everyone who lives in rented Council housing, rented association, sheltered and supported housing, temporary accommodation or who is homeless. This will be compared to those who privately rent, those who own their own homes and those who exist in another of these categories.
'Illegal drugs'	This is used to describe the use of illegal drugs and/or using drugs without a prescription in the past 5 years

Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid. Parent carers look after a child who has a disability or a long-term illness. Young carers look after a parent or sibling with a disability or a long-term illness.

According to the 2001 Census there are approximately 23,000 carers living in Brighton & Hove, this equates to 8.4 people out of every 100 though some parts of the city, such as East Brighton and Hangleton & Knoll, contain higher numbers of carers than this. Research has shown that caring often has adverse effects on physical and emotional health, finance, work, education and social life. Women have particularly been found to suffer from emotional stress as a result of caring and more men are struggling to juggle paid work with the demands of caring. The Carers Centre for Brighton & Hove provides a wide range of services which are available to any carer in Brighton & Hove.

The questionnaire asked 'who relies on you for support (practically an emotionally) in a caring role on a regular basis' and the analysis group discussed whether this identified carers. We believe that this was understood by respondents to be much broader that those who are understood as carers in the definition above. Consequently the routed section that asked about LGBT carers was not seen as relevant to them. The number and experiences of LGBT carers is therefore not addressed in this report, but it is an important consideration for future investigations.

1.4. Outline of the report

The next chapter will address variations in physical health amongst LGBT communities in Brighton and Hove. Physical health is considered using respondents' own reported assessments of their own overall physical health, rather than through the collection of medical or physiological indicators of physical health.

Chapter 2 will address a range of smoking-related issues as they affect the LGBT people sampled in the survey. The chapter discusses how smoking varies by gender, age, HIV status, physical health, and the use of use of 'illegal drugs'. It addresses the reasons given by respondents for why they smoke and variations between LGBT respondents. The chapter then turns to health concerns and LGBT people who smoke, before finally addressing motivations and actions to give up smoking.

Chapter 3 outlines the number of people who want to be more physically active and address the reasons given by respondents for not being more physically active.

Chapter 4 begins a series of chapters that discuss sex, sexual health, sex work and HIV. It addresses both sexual activity, and not engaging with sexual activity, in order to explore the range of experiences of LGBT people, and amount of sexual activity they engage in.

Chapter 5 addresses sexual health check ups, knowledge of support for sex and relationships and information regarding sexual health. These sections will address diversity amongst LGBT people highlighting areas of need.

Chapter 6 looks at those who are living with HIV – that is, those who have tested positive for HIV. This chapter compares their experiences and needs to those who have tested negative or who have not had an HIV test. The chapter firstly outlines the prevalence of HIV in the research, and the variations within the sample of those living with HIV. It then looks at those who are living with HIV and compares them to LGBT people who have not tested positive for HIV in relation to support needs, social networks and support and information.

Chapter 7 begins by outlining the numbers of those who have taken payment for sexual acts, and breaks this down by particular identity groupings. The chapter examines what was exchanged for sex, and who sex was sold to. The chapter uses the frequency of engagement with sex work to define sex workers and explore specific needs associated with sex work. Finally the chapter examines exchanging sex for housing and the areas of need that can be established from the data.

Chapter 8 addresses both qualitative and quantitative data from the Count Me In Too research in relation to trans health. The chapter firstly examines trans people's experiences with GPs. It then moves on to explore Gender Identity Clinics (GIC), including Charing Cross and how experiences of transition can be improved. Finally the chapter addresses the absence of information and the need for ongoing care.

Chapter 9 firstly looks at Deaf identities and experiences, addressing issues of multiple marginalisation for Deaf LGBT people. It will then examine specific aspects of health that were identified in the research, before moving on to changes that LGBT people who identified as deaf, deafened, hard of hearing and deaf-blind would like to see. The aim of this chapter is to: highlight issues that need further attention; to offer the findings of Count Me In Too for services to use; and to initiate the research that is needed in this area.

Chapter 10 outlines the sample of those who identified as a physically disabled and long term health impaired in this research. It then explores measures of marginalisation and exclusion experienced by LGBT people who are disabled. It examines socialising and key areas of risk and need for LGBT people who are physically disabled and/or long term health impaired. Finally the chapter addresses ways in which respondents identified that they could feel more included.

Chapter 11 examines the complexities of coming out to GPs relating to gender and sexual identities as well as differences between LGBT people. The chapter then discusses the desirability of an LGBT specific service, before addressing the question of an LGBT healthy living centre.

Chapter 12 addresses whether LGBT people are happy to be asked about their gender/sexual identities and the geographical variations in this data collection. The local government duties to consult with the diverse populations of cities are then addressed examining participants responses to questions about how they feel consultations should occur. This chapter finally outlines the areas identified by those in the research as key priority areas in the next five years

The conclusion offers an overview of all the chapters.

2. Physical Health

2.1. Introduction

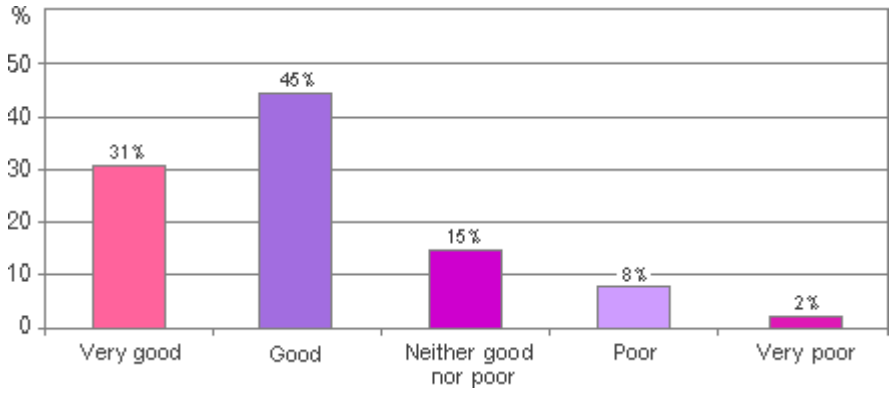
Physical health is a key measure of health and wellbeing. This chapter will address variations in physical health amongst LGBT communities in Brighton and Hove as sampled in the Count Me In Too survey. Here, physical health is considered using respondents' own reported assessments of their own overall physical health, rather than through the collection of medical or physiological indicators of physical health. Physical health varies amongst the LGBT community by trans identity, deaf identity, disability, age, income, isolation, mental health, HIV status, and housing tenure.

2.2. Physical health in the past twelve months

Figure 2.2a shows that the majority of the sample (76%) described their health as good/very good in the past 12 months. This is higher than the Count Me In measure of 'general health in the past 12 months', which found that 68.6% had good/very good general health (Webb and Wright, 2001). It is slightly lower than the data from the Brighton & Hove 2003 lifestyle survey[1], where 78% of people described their 'general health' as excellent, very good or good (the question posed asked 'in general how would you say your health is?). However, in this research 10% defined their physical health as poor/very poor, compared to 5% of those who defined their health as poor in the 2003 lifestyle survey. The average measure ('neither good nor poor', 15% in this research and 'fair' 16% in the 2003 lifestyle survey), was similar.

[1] Data provided by Brighton and Hove Primary Care Trust

Figure 2.2a: How would you describe your physical health over the last twelve months?



In this research results varied by trans identity, deaf identity, disability, age, income, isolation, mental health, HIV status, and housing tenure. Those who are trans, Deaf, disabled, are older, have lower incomes, have mental health difficulties, those who are living with HIV, and those who are living in council/temporary accommodation are more likely to report poor physical health in the past 12 months. However it does not vary by sexual identity or ethnicity.

2.2.1. Disability/long term health impairment

Table 2.2a: Physical health by disability

		Yes	No	Total
Good/Very good	No.	32	567	599
	%	**27.4**	**83.6**	**75.3**
Neither good nor poor	No.	38	81	119
	%	**32.5**	**11.9**	**15.0**
Poor/Very poor	No.	47	30	77
	%	**40.2**	**4.4**	**9.7**
Total	No.	117	678	795
	%	100	100	100

Just over a quarter (27%, n. 32) of respondents with a disability report having good or very good physical health; two fifths (40%, n. 47) report having poor or very poor physical health. This compares to only 4% (n. 30) of those without a disability who say they have poor or very poor physical health ($p < .0005$). It also compares to only 14% of those who said in the 2003 lifestyle survey who said that they had a long term illness/disability/health problem which limits their daily activities/work defined their health as poor. This indicates that LGBT people who are disabled/long term health impaired may have worse physical health than measures of the general population.

2.2.2. Age

Table 2.2b: Physical health by age

		>26	26-35	36-45	46-55	55+	Total
Good/Very good	No.	99	203	180	86	45	613
	%	**81.8**	**84.6**	**72.3**	**68.3**	**58.4**	**75.4**
Neither good nor poor	No.	17	24	40	28	14	123
	%	**14.0**	**10.0**	**16.1**	**22.2**	**18.2**	**15.1**
Poor/Very poor	No.	5	13	29	12	18	77
	%	**4.1**	**5.4**	**11.6**	**9.5**	**23.4**	**9.5**
Total	No.	121	240	249	126	77	813
	%	100	100	100	100	100	100

Over 80% of those under 35 years of age consider their physical health to be good or very good. As age increases, so the percentage drops, with only 58% of those aged over 55 reporting their physical health to be good or very good. Nearly a quarter (23%, n. 18) of this oldest group consider their physical health to be poor or very poor, compared to less than ten per cent of the entire sample ($p < .0005$). Although not directly comparable (as there was only one category 'poor'), only 7% (n.55) of those over 55 in the 2003 lifestyle survey said that their general health was poor.

2.2.3. Trans identity

Table 2.2c: Physical health by trans identity

		Trans identity	Not trans	Total
Good/Very good	No.	19	581	600
	%	**44.2**	**76.8**	**75.0**
Neither good nor poor	No.	11	112	123
	%	**25.6**	**14.8**	**15.4**
Poor/Very poor	No.	13	64	77
	%	**30.2**	**8.4**	**9.6**
Total	No.	43	757	800
	%	100	100	100

Those respondents who identify themselves as trans are significantly more likely to consider themselves as having poor or very poor physical health than those who are not trans. 77% (n. 581) of non-trans respondents say they have either good or very good physical health, compared to less than half (44%, n. 19) of those who identify as trans ($p < .0005$).

2.2.4. Deaf identity

Respondents who identify themselves as deaf have significantly poorer physical health than those who do not so identify themselves ($p < .007$). Just over half of deaf respondents (54%, n. 15) have good or very good physical health, compared to 76% (n. 590) of those who do not identify themselves as deaf.

Table 2.2d: Physical health by deaf identity

		Deaf identity	Not deaf	Total
Good/Very good	No.	15	590	605
	%	53.6	76.2	75.4
Neither good nor poor	No.	5	117	122
	%	17.9	15.1	15.2
Poor/Very poor	No.	8	67	75
	%	28.6	8.7	9.4
Total	No.	28	774	802
	%	100	100	100

2.2.5. Income

Table 2.2e: Physical health by income

		>10k	10-20k	20-40k	40k+	Total
Good/Very good	No.	91	181	257	76	605
	%	58.0	73.3	83.4	81.7	75.2
Neither good nor poor	No.	34	41	33	15	123
	%	21.7	16.6	10.7	16.1	15.3
Poor/Very poor	No.	32	25	18	2	77
	%	20.4	10.1	5.8	2.2	9.6
Total	No.	157	247	308	93	805
	%	100	100	100	100	100

Those with an income of over £20,000 a year have a higher than average likelihood of reporting good or very good physical health ($p < .0005$). While 83% (n. 333) of those earning more than £20,000 a year consider their physical health to be good or very good, only 58% (n. 91) of those earning less than £10,000 a year felt they had good or very good physical health. In that income bracket over a fifth (20%, n. 32) say they have poor or very poor physical health, compared to two per cent of those earning more than £40,000 a year.

2.2.6. Isolation

Table 2.2f: Physical health by feeling isolated

		Yes	No	Total
Good/Very good	No.	159	436	595
	%	60.0	83.2	75.4
Neither good nor poor	No.	67	52	119
	%	25.3	9.9	15.1
Poor/Very poor	No.	39	36	75
	%	14.7	6.9	9.5
Total	No.	265	524	789
	%	100	100	100

Those who feel isolated are less likely (60%, n. 159) to say that they have good or very good physical health than those who do not feel isolated (83%, n. 436) ($p < .0005$). Twice as many of those who feel isolated report having poor or very poor physical health (15%, n. 39) as those who do not feel isolated (7%, n. 36).

2.2.7. Mental health

In this analysis, we have recoded experience of the following as constituting the category 'mental health difficulties':

- **Significant emotional distress**
- **Depression**
- **Anxiety**
- **Anger management**
- **Fears/phobias**
- **Problem eating/eating distress**
- **Panic attacks**
- **Self harm**
- **Addictions/dependencies**
- **Suicidal thoughts**

Although the experience of difficulties with isolation, confidence/self esteem, stress and insomnia might also be considered mental health difficulties, they have been excluded from the analytical category 'mental health difficulties' that we are using here for statistical purposes (see chapter 1).

Table 2.2g: Physical health by experience of mental health difficulties

		Mental health difficulties	No mental health difficulties	Total
Good/Very good	No.	367	222	589
	%	**68.6**	**89.2**	**75.1**
Neither good nor poor	No.	101	20	121
	%	**18.9**	**8.0**	**15.4**
Poor/Very poor	No.	67	7	74
	%	**12.5**	**2.8**	**9.4**
Total	No.	535	249	784
	%	100	100	100

Table 2.2g shows that significantly fewer of those who experience mental health difficulties (69%, n. 367) report good or very good physical health compared to those who do not suffer from mental health difficulties (89%, n. 222) ($p < .0005$). 13% (n. 67) of those with mental health difficulties consider their physical health to be poor or very poor, a much higher proportion than the 3% (n. 7) of those who do not suffer from mental health difficulties.

2.2.8. HIV status

Only 40% (n. 27) of respondents who are HIV positive report good or very good physical health, compared to over three quarters (77%, n. 587) of those who are HIV negative or who have had no HIV test result.

Conversely, nearly a quarter (23%, n. 13) of the HIV positive group state their health to be poor or very poor, compared with 8% (n. 64) of those who are HIV negative or who have had no HIV test result (p = .0005).

Table 2.2h: Physical health by HIV status

		Positive	Negative / not tested	Total
Good/Very good	No.	27	587	614
	%	40.2	77.4	75.4
Neither good nor poor	No.	16	107	123
	%	28.6	14.1	15.1
Poor/Very poor	No.	13	64	77
	%	23.2	8.4	9.5
Total	No.	56	758	814
	%	100	100	100

2.2.9. Housing tenure

Table 2.2i: Physical health by housing tenure

		Privately rented	Council rented	Privately owned	Temporary/ homeless	Other	Total
Good/Very good	No.	196	12	311	3	92	614
	%	80.7	32.4	80.2	33.3	67.2	75.4
Neither good nor poor	No.	31	12	50	4	26	123
	%	12.8	32.4	12.9	44.4	19	15.1
Poor/Very poor	No.	16	13	27	2	19	77
	%	6.6	35.1	7	22.2	13.9	9.5
Total	No.	243	37	388	9	137	814
	%	100	100	100	100	100	100

Table 2.2i shows that there is a significant relationship between type of accommodation and physical health (p = .0005). While over 80% of those in privately owned and privately rented accommodation say that they have good or very good physical health, only 32% (n. 12) of those in rented council accommodation and 33% (n. 3) of those in temporary accommodation or who are homeless say they have good or very good physical health. 35% (n. 13) of those in rented council accommodation and 22% (n. 2) of those in temporary accommodation or who are homeless report their physical health to be poor or very poor. These are much higher rates than those for respondents who live in privately rented (7%, n. 16) or privately owned (7%, n. 27) accommodation.

2.3. Conclusion

This chapter has shown that compared to the 2003 lifestyle survey measure of general health, LGBT people rate their physical health over the past 12 months poorer than the general population. Those who are disabled and

long term health impaired and older in the 2003 survey were more likely to rate their health as poor than the rest of the population, LGBT people in these categories had higher proportions in the poor/very poor categories in relation to physical health. Moreover, within the LGBT sample, feeling physically healthy varied by trans identity, deaf identity, disability, age, income, isolation, mental health, HIV status, and housing tenure. Less than half of trans respondents rated their physical health as good/very good (compared to 78% of the general population). Similarly, those living with HIV, respondents living in rented council accommodation, and respondents living in temporary accommodation or who are homeless report having good or very good physical health were less likely than other LGBT people to say that they had good physical health in the previous year.

3. Smoking

3.1. Introduction

Smoking is a key issue for the National Health Service and has important implications for the provision of services. This chapter will address a range of smoking-related issues as they affect the LGBT people sampled in the survey. The chapter will discuss how smoking varies by gender, age, HIV status, physical health, and the use of use of 'illegal drugs'. It will also address the reasons given by respondents for why they smoke and variations within the sample. The chapter will then turn to health concerns and LGBT people who smoke, before finally addressing motivations and actions to give up smoking.

3.2. Prevalence of smoking

Table 3.2a shows that 33% of LGBT people in this sample smoke cigarettes. This is higher than the population figures released by General household survey in 2005, which showed that just under a quarter (24%) of the UK population smoke, (this is slightly less for women in the South East, where 24% of men and 21% of women smoke in this region). This is slightly less than the Count Me In survey found in 2000, where 38% of the sample were smokers. However, contrary to the Count Me In research, this research did find a difference by gender, as well as age. The prevalence of smoking cigarettes varies by gender, age, HIV status, physical health, and whether

respondents taken 'illegal drugs', or used drugs without a prescription in the past 5 years (herein used 'illegal drugs'). Men, those aged between 26-35, those who are living with HIV, those who consider their physical health in the past 12 months to be poor, and those who have used 'illegal drugs' are more likely to smoke.

Table 3.2a: Do you smoke cigarettes?

	Frequency	Percent	Valid %
Yes	270	33.0	**33.2**
No	543	66.3	**66.8**
Total	813	99.3	100.0
missing	6	0.7	
total	819	100.0	

3.2.1. Gender

As with general UK data, women in this research were less likely to smoke than men. Female respondents are significantly less likely (28%, n. 92) to smoke than male respondents (37%, n. 167) or those who identify as of no gender or an 'other' gender (39%, n. 10) (p = .014).

3.2.2. Age

As can be seen from table 3.2b, those aged between 26 and 35 years of age are the most likely age group to smoke (41%, n. 99). 35% (n. 42) of those aged under 26 and 36% (n. 88) of those aged between 36 and 45 smoke. By comparison, only 22% (n. 28) of those aged between 46 and 55, and only 17% (n. 13) of those over 55 smoke (p = .0005).

Table 3.2b: Rates of smoking by age

		>26	26-35	36-45	46-55	55+	Total
Smoker	No.	42	99	88	28	13	270
	%	**34.7**	**41.1**	**35.5**	**22.4**	**16.9**	**33.3**
Non-smoker	No.	79	142	160	97	64	542
	%	**65.3**	**58.9**	**64.5**	**77.6**	**83.1**	**66.7**
Total	No.	121	241	248	125	77	812
	%	100	100	100	100	100	100

3.2.3. Gender and age

While 40% (n. 25) of men aged under 26 smoke, only 28% (n. 15) of women in this age group smoke. And while 32% (n. 23) of men aged 46 to 55 smoke, only 8% (n. 4) of women in this age group smoke. Table 3.2c also shows that for men, the most likely age group to smoke is those aged between 26 and 35 (47%, n. 57). For women, the most likely age group to smoke is those aged between 36 and (34%, n. 33).

Table 3.2c: Do you smoke by age and gender

			>26	26-35	36-45	46-55	55+	Total
male	Smoker	No.	25	57	54	23	8	167
		%	**40.3**	**47.1**	**37.5**	**31.9**	**16.3**	**37.3**
	Non-smoker	No.	37	64	90	49	41	281
		%	**59.7**	**52.9**	**62.5**	**68.1**	**83.7**	**62.7**
	Total	No.	62	121	144	72	49	448
		%	100	100	100	100	100	100
female	Smoker	No.	15	36	33	4	4	92
		%	**28.3**	**32.1**	**33.7**	**8.3**	**17.4**	**27.5**
	Non-smoker	No.	38	76	65	44	19	242
		%	**71.7**	**67.9**	**66.3**	**91.7**	**82.6**	**72.5**
	Total	No.	53	112	98	48	23	334
		%	100	100	100	100	100	100

For male smokers p=.004, hence there is a significant relationship between age and smoking cigarettes.
For female smokers p=.011, hence there is a significant relationship between age and smoking cigarettes.
For no gender or 'other' counts are too small in some cells for the significance test to be valid.

3.2.4. HIV status

Those who are living with HIV are more likely to smoke than other LGBT people. 48% (n. 27) of those living with HIV smoke, compared to 33% (n. 127) of those who last tested HIV negative or who have not had an HIV test result (p = .036).

3.2.5. Physical health

Table 3.2d shows that only 30% (n. 185) of those who consider their physical health good or very good are smokers, compared to 43% (n. 52) of those who consider their physical health to be neither good nor poor, and 41% (n. 31) of those who consider their physical health to be poor or very poor.

Table 3.2d: Rates of smoking by physical health

		Very good or good	Neither good nor poor	Poor or very poor	Total
Smoker	No.	185	52	31	268
	%	**30.2**	**43.0**	**40.8**	**33.1**
Non-smoker	No.	427	69	45	541
	%	**69.8**	**57.0**	**59.2**	**66.9**
Total	No.	612	121	76	809
	%	100	100	100	100

Table 3.2e shows that smokers are less likely to consider their physical health as very good or good (p = .008). While 69% (n. 185) of smokers feel their physical health to be very good or good, this figure rises to 79% (n. 427) for non-smokers.

Table 3.2e: Physical health by smoking

		Smoker	Non-smoker	Total
Good/Very good	No.	185	427	612
	%	69	78.9	75.6
Neither good nor poor	No.	52	69	121
	%	19.4	12.8	15
Poor/Very poor	No.	31	45	76
	%	11.6	8.3	9.4
Total	No.	268	541	809
	%	100	100	100

3.2.6. Use of 'illegal drugs'

Using 'illegal drugs' in the past 5 years increases the likelihood of smoking ($p < .0005$). 44% (n. 178) of those who have used 'illegal drugs' are smokers, while only 22% (n. 89) of those who have not used 'illegal drugs' are smokers (table 3.2f).

Table 3.2f: Smoking by use of 'illegal drugs'

		Used drugs	Not used drugs	Total
Smoker	No.	178	89	267
	%	44.0	22.3	33.2
Non-smoker	No.	227	310	537
	%	56.0	77.7	66.8
Total	No.	405	399	804
	%	100	100	100

Conversely, smoking increases the likelihood of using 'illegal drugs'. 67% (n. 178) of smokers have used 'illegal drugs', compared to 42% (n. 227) of those who do not smoke ($p = .0005$).

Table 3.2g: Use of 'illegal drugs' by smoking

		Smoker	Non-smoker	Total
Used drugs	No.	178	227	405
	%	66.7	42.3	50.4
Not used drugs	No.	89	310	399
	%	33.3	57.7	49.6
Total	No.	267	537	804
	%	100	100	100

3.3. Reasons for smoking

Those who said that they smoked were asked a series of questions relating to their motivations, behaviours and needs. Table 3.3a below shows that a majority (61%) of smokers say that they keep smoking because they are addicted to it. Over half (53%) of smokers also indicate that enjoyment is a reason for continuing to smoke.

The data presented below shows that the reasons given vary by identity: the reason 'it helps me think' varies by sexual identity, gender and age. The reason 'pressures of life' varies by gender, while the likelihood of citing the reasons 'I like the smoking culture' and 'it helps me feel in control' vary by age.

Table 3.3a: What keeps you smoking?

	Frequency	Per cent
I am addicted	165	61.1
I enjoy it	143	53.0
It's one of my vices	88	32.6
Pressures of life	87	32.2
I like the smoking culture	78	28.9
I can't give up	62	23.0
It helps me think	36	13.3
It helps me feel in control	17	6.3
Why do I need to quit?	10	3.7
It keeps me young	1	.4

3.3.1. Sexual identity

Gay male smokers are less likely (9%, n. 14) than gay women/lesbian smokers (18%, n. 13) or smokers identifying as an other sexuality (23%, n. 9) to say that 'it helps me think' is an important reason for why they continue to smoke ($p = .034$).

Table 3.3b: Smoking because 'it helps me think' by sexual identity

		Lesbian	Gay	Otherwise coded	Total
Not 'it helps me think'	No.	60	140	30	230
	%	82.2	90.9	76.9	86.5
'It helps me think'	No.	13	14	9	36
	%	17.8	9.1	23.1	13.5
Total	No.	73	154	39	266
	%	100	100	100	100

3.3.2. Gender

Table 3.3c shows that female smokers are more likely (39%, n 35) than male smokers (27%, n. 45) to cite 'pressures of life' as an important reason for why they continue to smoke. However, the most likely group to cite this reason is that comprising those identifying as of no gender or of an 'other' gender (70%, n. 7) (p = .006).

Table 3.3c; Smoking because of 'pressures of life' by gender

		Male	Female	No gender or 'other'	Total
Not 'pressures of life'	No.	120	55	3	178
	%	72.7	61.1	30	67.2
'Pressures of life'	No.	45	35	7	87
	%	27.3	38.9	70	32.8
Total	No.	165	90	10	265
	%	100	100	100	100

Table 3.3d shows that smokers who identify as an 'other' gender or of no gender are more likely (40%, n. 4) than male or female smokers to say that they continue smoking because 'it helps me think'. Female smokers, in turn, are more likely (19%, n. 17) to offer this reason than male smokers (9%, n. 15) (p = .004).

Table 3.3d: Smoking because 'it helps me think' by gender

		Male	Female	No gender or 'other'	Total
Not 'it helps me think'	No.	150	73	6	229
	%	90.9	81.1	60	86.4
'It helps me think'	No.	15	17	4	36
	%	9.1	18.9	40	13.6
Total	No.	165	90	10	265
	%	100	100	100	100

3.3.3. Age

Table 3.3e: Smoking because 'it helps me think' by age

		>26	26-35	36-45	46-55	55+	Total
Not 'it helps me think'	No.	30	87	78	25	10	230
	%	71.4	90.6	89.7	89.3	76.9	86.5
'It helps me think'	No.	12	9	9	3	3	36
	%	28.6	9.4	10.3	10.7	23.1	13.5
Total	No.	42	96	87	28	13	266
	%	100	100	100	100	100	100

Those aged under 26 (29%, n. 12) and those aged over 55 (23%, n. 3) are more likely than other age groups to say that they continue to smoke because 'it helps me think' (p = .022). 9% (n. 9) of those aged 26 to 35, 10% (n. 9) of those aged 36 to 45, and 11% (n. 3) of those aged 46 to 55 gave this reason.

Table 3.3f: Smoking because 'I like the smoking culture' by age

		>26	26-35	36-45	46-55	55+	Total
Not 'I like the smoking culture'	No.	20	72	63	23	10	188
	%	47.6	75	72.4	82.1	76.9	70.7
'I like the smoking culture'	No.	22	24	24	5	3	78
	%	52.4	25	27.6	17.9	23.1	29.3
Total	No.	42	96	87	28	13	266
	%	100	100	100	100	100	100

Table 3.3f shows that over half (52%, n. 22) of smokers aged under 26 say that a like of 'the smoking culture' is an important reason why they continue to smoke. This is significantly higher proportion than for any other age group ($p = .008$).

Table 3.3g: Smoking because 'it helps me feel in control' by age

		>26	26-35	36-45	46-55	55+	Total
Not 'It helps me feel in control'	No.	37	86	86	27	13	249
	%	88.1	89.6	98.9	96.4	100	93.6
'It helps me feel in control'	No.	5	10	1	1	0	17
	%	11.9	10.4	1.1	3.6	0	6.4
Total	No.	42	96	87	28	13	266
	%	100	100	100	100	100	100

Table 3.3g shows that those aged under 35 are more likely than other age groups to say they continue smoking because 'it helps me feel in control' ($p < .05$). 12% (n. 5) of those under 26 and 10% (n. 10) of those aged 26 to 35 offered this reason, compared to 1% (n. 1) of those aged 26 to 45, 4% (n. 1) of those aged 46 to 55, and none of those aged over 55.

3.4. Health concerns and smoking

Table 3.4a shows that the majority (90%) of LGBT smokers in this sample were concerned about the effects of smoking on their health. Women, lesbians and those who have not tested positive for HIV are more concerned than other LGBT people about the effects of smoking on their health.

Table 3.4a: Are you concerned about the effects of smoking on your health?

	Frequency	Percent	Valid %
Yes	241	89.3	89.9
No	27	10.0	10.1
Total	268	99.3	100.0
missing	2	.7	
total	270	100.0	

There was a difference in the levels of this concern by identity categories. It varied by gender, sexuality and HIV status.

3.4.1. Gender

Male respondents (86%, n. 143) are significantly less likely than female respondents (96%, n. 87) or respondents who identify as of no gender or of an 'other' gender (100%, n. 11) to say that they are concerned about the effects of smoking on their health (p = .02).

3.4.2. Sexuality

85% (n. 133) of gay male smokers are concerned about the effects of smoking on their health, a significantly lower proportion than the 96% (n. 71) of lesbian smokers and the 95% (n. 38) of smokers who identify in an other sexuality category who are concerned about the health effects of smoking (p = .022; counts for bisexual respondents too small for statistical significance).

3.4.3. HIV status

Smokers who have tested HIV positive are less likely (74%, n. 20) to be concerned with the health effects of smoking than those who have tested HIV negative (92%, n. 117) or who have not had an HIV test result (90%, n. 102) (p = .02).

3.5. Support in giving up smoking

Although the majority (71%) of LGBT smokers would like help to stop smoking, this is less than those who are concerned about the health implications of smoking. This desire for help with stopping smoking varies by gender, with women less likely to want help than other LGBT people.

Table 3.5a: Would you like help to stop?

	Frequency	Percent	Valid %
Yes	188	69.6	**70.9**
No	77	28.5	**29.1**
Total	265	98.1	100.0
missing	5	1.9	
total	270	100.0	

3.5.1. Gender

Female smokers are less likely (64%, n. 57) than male smokers (73%, n. 120) or smokers who identify as of no gender or an 'other' gender (100%, n. 10) to want help to stop smoking (p = .041).

3.6. Awareness of the free 'Stop Smoking Service' in Brighton

Table 3.6a shows only 52% of LGBT smokers are aware of the free Stop Smoking Service in Brighton. Awareness of this service varies by HIV status and age. Those living with HIV and those who are over 26 are more likely to know about this service.

Table 3.6a: Are you aware of the free Stop Smoking Service in Brighton?

	Frequency	Percent	Valid %
Yes	136	50.4	**51.7**
No	127	47.0	**48.3**
Total	263	97.4	100.0
missing	7	2.6	
total	270	100.0	

3.6.1. HIV status

Smokers who have tested HIV positive are much more likely (78%, n. 21) than smokers who have tested HIV negative (52%, n. 65) or smokers who have not had an HIV test result (43%, n. 47) to be aware of the Stop Smoking Service ($p = .005$).

3.6.2. Age

Table 3.6b: Awareness of Stop Smoking Service by age

		>26	26-35	36-45	46-55	55+	Total
Yes	No.	13	51	48	16	8	136
	%	**31**	**52.6**	**56.5**	**59.3**	**66.7**	**51.7**
No	No.	29	46	37	11	4	127
	%	**69**	**47.4**	**43.5**	**40.7**	**33.3**	**48.3**
Total	No.	42	97	85	27	12	263
	%	100	100	100	100	100	100

Awareness of the Stop Smoking Service increases with age ($p = .045$). While only 31% (n. 13) of smokers aged under 26 are aware of the Stop Smoking Service, this proportion rises to 53% (n. 51) of those aged 26 to 35 and increases for each age group. 67% (n. 8) of smokers aged over 55 know of the Stop Smoking Service.

3.7. Potential motivators to give up smoking

Table 3.7a shows the proportion of LGBT smokers who indicated that each of a range of potential motivations for giving up smoking would be effective for them.

Table 3.7a: What would motivate you to give up smoking?

	Frequency	Per cent
Smoking ban	130	48.1
LGBT stop smoking service	71	26.3
Nothing	52	19.3
Other	44	16.3
LGBT counsellor	33	12.2
More information available	20	7.4
More LGBT friendly information	16	5.9

This research was undertaken prior to the smoking ban (government ban on smoking in public buildings and workplaces was introduced in England on 1st Jul 2007), which was clearly seen as a prime motivator for giving up smoking. Further research needs to be carried out to assess the impact that the smoking ban has had on levels of smoking. However second to this was an LGBT stop smoking service, over a quarter of those who smoked said that this would motivate them to give up smoking. A fifth of smokers said that nothing would motivate them to give up smoking.

3.7.1. Nothing

Table 3.7b shows that saying that nothing would provide a motivation for giving up smoking varies by age ($p = .016$). The least likely age group to say that nothing would motivate them to give up smoking are those aged 26 to 35 (13%, n. 12). 22% (n. 9) of smokers aged under 26 and 21% (n. 17) of smokers aged 36 to 45 said that nothing would motivate them to give up smoking. The figure rises to 32% (n. 9) for those aged 46 to 55 and to 56% (n. 5) for those aged over 55.

Table 3.7b: Responding that nothing would provide a motivation to give up smoking by age

		>26	26-35	36-45	46-55	55+	Total
No	No.	32	80	63	19	4	198
	%	78	87	78.8	67.9	44.4	79.2
Yes	No.	9	12	17	9	5	52
	%	22	13	21.3	32.1	55.6	20.8
Total	No.	41	92	80	28	9	250
	%	100	100	100	100	100	100

3.7.2. Motivations for giving up smoking: Qualitative data

The questionnaire also offered respondents the opportunity to provide other answers than the ones suggested by the tick boxes on the questionnaire. Table 3.7c below shows the frequency by which respondents indicated other potential motivators for them to give up smoking. 8 respondents said that self motivation was key, with health again coming up in this data. Support or a partner stopping was seen as important by 5 people and this may offer some insights into how targeting groups/couples rather than individuals may be effective.

Table 3.7c: Major categories from qualitative data: 'What would motivate you to give up smoking?'

Categories	No. of responses
Self motivation/making the decision	8
Health reasons/illness	7
Partner stopping/partner not liking smoking	5
Pregnancy/children	4
Finance/cost	3
I am a social smoker/only smoke when drinking	3
Friends stopping/less friends who smoke	2

Note: Where responses fall into more than one category they are counted in each category that they fall into.

Table 3.7d shows responses that could not be grouped into categories of responses in table 3.7c and illustrate the variations in experiences and desires. Included in these are life stresses and clinics that operate outside of working hours.

Table 3.7d: Other responses from qualitative data: 'What would motivate you to give up smoking?'

I shall give up this year
I have almost stopped!
More nicotine
I only smoke 2/3 a day
if all cigarettes tasted like arse
Legalising weed so I can afford IT and not have to mix with shitty tobacco
LGBT Non smoking Group
I'll get round to it!
if I knew that, I wouldn't still smoke
Being ready
Getting older
Less health fascism (i.e. the more pressure to quit I am subjected to, the more determined I become to resist
hypnosis
I AM a trained counsellor - and I SMOKE
not sure

Less Stress in life and more support. I only smoke because it takes the edge off the stress of life
free detox services - nicotine is highly addictive, an injection to rid body of nicotine & place to recover
Less 9-5 focussed clinics I can't take time off work to attend

3.8. Conclusions

This chapter has examined the prevalence of smoking among LGBT people in Brighton and Hove, the reasons they offer for smoking and their concerns relating to the health effects of smoking and how to stop smoking. 33% of LGBT people in the sample smoke. Male respondents and those identifying as an 'other' gender are more likely to smoke than women. Younger people are also more likely to smoke, although this varies with gender: women aged between 36 and 45 are more likely to smoke than other women. Those living with HIV, those who use 'illegal drugs', and those who consider their physical health to be neither good nor poor, poor or very poor are more likely to smoke than the rest of the sample. The majority (61%) of smokers say that they keep smoking because they are addicted to it. Over half (53%) of smokers also indicate that enjoyment is a reason for continuing to smoke. Amongst those who smoke, men, gay men, and those who have tested positive for HIV are less likely than other groups (by gender, sexuality or HIV status, respectively) to say they are concerned about the effects of smoking upon their health. In terms of help to stop smoking, female smokers are less likely to want help to stop smoking than male smokers or those of no gender or an 'other' gender, while awareness of the free Stop Smoking Service increases with age, and is also more prevalent among those who have tested positive for HIV than those who have not. The questionnaire was carried out shortly before the smoking ban in public buildings and workplaces came into effect. The prospect of a smoking ban was the most popular response when people were asked what would motivate them to give up smoking (48% of LGBT smokers). Further research needs to be carried out to assess the impact that the smoking ban has had on levels of smoking. 26% of LGBT smokers said that an LGBT stop smoking service would motivate them to give up smoking, but 19% said that nothing would motivate them to give up smoking. Those over 55 are the most likely age group to say that nothing would motivate them to give up smoking.

4. Physical activity

4.1. Introduction

Physical activity is seen as a key area of health and wellbeing in the 21st century. This chapter will outline the amount of people who want to be more physically active and address the reasons respondents give for not being able to be more physically active.

4.2. Physical Activity

Table 4.2a shows that the majority of LGBT people in this sample would like to be more physically active (79%). There are no differences in wanting to be more physically active by smoking behaviour, age or gender.

Table 4.2a: Would you like to be more physically active?

	Frequency	Percent	Valid %
Yes	631	77.0	**78.9**
No	138	16.8	**17.3**
Unsure	31	3.8	**3.9**
Total	800	97.7	100.0
missing	19	2.3	
total	819	100.0	

4.3. Reasons for not being more physically active

Table 4.3a shows that 44% (n. 362) of those who say that they would like to be more physically active indicate that a lack of time is major reason stopping them from achieving this goal. Almost a third (30%, n. 247) say that cost is a factor stopping them from being more active.

While some of these reasons for not being more physically active have received a low frequency of response from the overall sample of those who would like to be more physically active, the proportion of certain identity groups giving these responses is sometimes higher than for the overall sample.

Table 4.3a: If you would like to be more physically active than you are at the moment, please select the three main reasons that stop you.

Categories	Frequency	Percent
Lack of time	362	44.2
Cost	247	30.2
No-one to do it with	175	21.4
Body image	172	21.0
Dislike of exercise	152	18.6
Don't feel comfortable	123	15.0
No LGBT specific facilities	88	10.7
Lack of facilities	64	7.8
Disabilities	64	7.8
Other	63	7.7
Need women only space	60	7.3
Injury	51	6.2
Transport	44	5.4
homophobia / transphobia	30	3.7
Need men only space	29	3.5
Need trans friendly space	18	2.2

4.3.1. Trans friendly spaces

43% (n. 15) of trans respondents to the question indicate that a lack of trans friendly spaces stops them being more physically active.

4.3.2. Men only spaces

8% (n. 27) of male respondents to the question indicate that a need for men only spaces stops them being more physically active. Taking just these 27 men who indicate that there is a need for men only spaces, 41% of them (n. 11) are aged between 36 and 45. Table 4.3b shows that the other age groups compose smaller proportions of this group.

Table 4.3b: What is stopping you being more physically active? – need men only space

Men		>26	26-35	36-45	46-55	55+	Total
need men only space	No.	5	4	11	4	3	27
	%	18.5	14.8	40.7	14.8	11.1	100

4.3.3. Women only spaces

Compared to less than 10% of men who wanted male only space, 22% (n. 58) of women, who would like to be more physically active, say that a lack of women only spaces stops them achieving this goal. Taking just these 58 women who indicate that there is a need for women only spaces, 38% of them (n. 22) are aged between 36 and 45. Table 4.3c shows that the other age groups compose smaller proportions of this group, with only 9% (n. 5) of these respondents aged over 55 and only 3% (n. 2) of them aged under 26.

Table 4.3c: What is stopping you being more physically active? – need women only space

Women		>26	26-35	36-45	46-55	55+	Total
need women only space	No.	2	15	22	14	5	58
	%	3.4	25.9	37.9	24.1	8.6	100

4.3.4. Disabilities

Table 4.3d shows that the likelihood of disability stopping respondents being more physically active increases with age ($p = .0005$), so that while only 1% (n. 1) of those under 26 say that disabilities stop them being more physically active, this figure rises to 15% (n. 15) for those aged between 46 and 55, and to 22% (n. 11) for those aged over 55.

Table 4.3d: What is stopping you being more physically active? – disabilities

		>26	26-35	36-45	46-55	55+	Total
Without disabilities	No.	101	183	175	84	40	583
	%	99	95.3	86.2	84.8	78.4	90.1
With disabilities	No.	1	9	28	15	11	64
	%	1	4.7	13.8	15.2	21.6	9.9
Total	No.	102	192	203	99	51	647
	%	100	100	100	100	100	100

4.3.5. No one to do it with

Those who feel isolated are significantly more likely (33%, n. 76) than those who are not isolated (23%, n. 92) to say that having no one to be physically active with stops them being physically active ($p = .008$).

4.3.6. Homophobia and trans-phobia

Table 4.3e can only be taken as indicative as the counts are too small to offer a valid test result, however the table indicates that trans people (21%) are more likely to not partake in physical activity due to homophobia/transphobia when compared to other LGBT people (4%).

Table 4.3e: What is stopping you being more physically active? – homophobia / transphobia by trans

		Trans	Not trans	Total
Not 'homophobia / transphobia'	No.	27	577	604
	%	79.4	96.3	95.4
'Homophobia / transphobia'	No.	7	22	29
	%	20.6	3.7	4.6
Total	No.	34	599	633
	%	100	100	100

4.3.7. Other reasons for not being more physically active

Table 4.3f below shows the frequency by which respondents indicated other reasons that stopped them being more physically active. 21 people said that 'laziness' prevented them being more physically active with 14 people saying that a lack of motivation/will was the cause.

Table 4.3f: Major categories from qualitative data: 'What is stopping you being more physically active?'

Categories	No. of responses
Laziness	21
Lack of motivation/will	14
Various health problems	8
Cost	6
Lack of energy	5
Age	4
Childcare (lack of)	4
Work/other commitments	4
Partner not as active/interested as me	3
Poor quality facilities	3
Already do enough/happy with current regime	3

Table 4.3g shows responses that could not be grouped into these categories of responses.

Table 4.3g: Other responses: 'What is stopping you being more physically active?'

Would like cheap access to a warm swimming pool, close to home
Lack of knowledge and energy
Boring.
I certainly do a lot of walking but would like to do more. I'm not inactive!
joints are not a good as they were and I get little help from the NHS
Happy & Immune now
Accessible with parking
Lazy, sometimes don't put my needs first, poor organisation
lack of decent sports clubs for my age in Brighton
GE
they're all full of muscled gay guys! gyms that is
haven't prioritised it
showers
Smoking prevents exercise to an extent
Large classes for alternative exercise eg Pilates, yoga are off-putting. Smaller classes are expensive
Mood

Note: Where responses fall into more than one category they are counted as many times as categories they fall into.

4.4. Conclusions

Almost 4 out of 5 respondents (79%) indicated that they would like to be more physically active. Amongst those who would like to be more physically active, 44% indicated that a lack of time and 30% indicated that cost stopped them from being more physically active. 43% of the trans respondents who would like to be more physically active cite a lack of trans spaces as something that stops them from achieving this desire. 8% of men indicated that a lack of male-only spaces stops them from being more physically active, while 22% of women indicated a need for women-only spaces. Those who feel isolated are more likely (33%) than those who do not feel isolated (23%) to say that having no one to be physically active with stops them being more physically active. Stating that homophobia or trans-phobia stops them being more physically active varies by gender and age. Those aged 36 to 45 are more likely to give this as a reason than other age groups for both male and female respondents. The other most frequently cited reasons for not being able to be more physically active are laziness, and lack of motivation or willpower.

5. Sex

5.1. Introduction

This chapter begins a series of chapters that discuss sex, sexual health, sex work and HIV. Sex is an important consideration for those working with LGBT people regarding their health and wellbeing as well as broader social, identity and other issues. Although there has been an extensive engagement with sexual behaviours and activities relating to HIV and gay and bisexual men, other forms of sexual activities and engagements are often ignored.

Defining 'sex' or 'having sex' can present difficulties. The questionnaire did not set out a standard definition for respondents to frame their answers within. Instead, it allowed participants to offer their own understandings of sex. It is difficult to delimit which sexual practices or acts might be included in such a definition; however, as LGBT practices may not sit easily within heteronormative understandings of sex, the absence of a strict definition was important. Respondents may have different understandings of what constitutes 'sex' or 'having sex'. Questionnaire 1 illustrates how definitions of 'sex' can be difficult to pin down.

> **"sleep" is a very difficult term to define. A person may have numerous sexual experiences without sleeping with someone**
>
> *Questionnaire 1*

Since Count Me In Too did not ask respondents to specify the precise nature of their sexual practices or whether or not they were practicing safer sex, care should be taken before drawing any conclusions about sexual health and/or the risks of the transmission of STIs from the data in this

chapter. This chapter will address both sexual activity and not engaging with sexual activity in order to explore the range of experiences LGBT people have and the amount of sexual activity they engage in.

5.2. Sex in the past three years

Table 5.2a shows that 94% (n. 759) of those who answered the question (and 93% of the entire sample) said that they had had sex with someone in the last three years.

Table 5.2a: Have you had sex with someone in the last 3 years?

	Frequency	Percent	Valid %
Yes	759	92.7	**93.7**
No	51	6.2	**6.3**
Total	810	98.9	100.0
Missing	9	1.1	
Total	819	100.0	

There are some variations in the likelihood of having had sex in the last three years – by sexual identity and by HIV status. Gay men and lesbians, those who have not tested positive for HIV are more likely to say they have had sex in the past 3 years.

While similar proportions of lesbians (94%, n. 260) and gay men (95%, n. 407) have had sex with someone in the last three years, a significantly smaller proportion (87%, n. 92) of those who identify their sexuality as bisexual, queer or 'other' say that they have had sex with somebody in the past three years ($p = .006$).

Those who have tested HIV negative are more likely (97%, n. 375) than those who have tested HIV positive (93%, n. 52) to have had sex in the past three years. Those who have not had an HIV test result are least likely to have had sex in the last three years (90%, n. 322) ($p = .0005$).

Those who are aged between 26-35 are the most likely to have had sex in the past 3 years (99%). This is followed by those aged 36-45 (96%) and those under 26 (94%). Those aged between 46-55 (87%) and over 55 (79%) are the least likely to have had sex in the past three years ($p<.0001$).

Table 5.2b: Have you had sex with someone in the last 3 years? - By age

		>26	26-35	36-45	46-55	55+	Total
Yes	No.	113	238	240	108	60	759
	%	**94.2**	**98.8**	**96.4**	**87.1**	**78.9**	**93.7**
No	No.	3	9	16	16	51	3
	%	**1.2**	**3.6**	**12.9**	**21.1**	**6.3**	**1.2**
Total	No.	120	241	249	124	76	810
	%	100	100	100	100	100	100

5.3. Sexual partners and relationships

Amongst those who have had sex with someone in the last three years, the majority (91%, n. 694) have sex with members of the same sex (see table 5.3a). 6% (n. 47) of respondents said that they have sex with members of the opposite sex.

Table 5.3a: I have sex with…

	Frequency	Per cent
Members of the same sex	694	91.4
Members of the opposite sex	47	6.2
Members of a different sex	13	1.7
Members of both male/female sexes	31	4.1
Members of all sexes	13	1.7

Almost half (45%, n. 338) of those who have had sex in the past three years say that they have had sex with only one person in the last twelve months. 24% (n. 184) say they have had sex with between 2 and 5 people over the last twelve months, while 10% (n. 73) say they have had sex with between 6 and 10 people. 8% (n. 60) say they have had sex with more than 26 people in the last 12 months. Table 5.3b shows how many people respondents had had sex with in the last twelve months (this only included those who had said they had had sex with somebody in the last three years).

Table 5.3b: How many people have you had sex with in the last 12 months?

in the last 12 months	Frequency	Percent	Valid %
None	23	3.0	3.0
1	338	44.5	44.7
2 - 5	184	24.2	24.3
6 - 10	73	9.6	9.7
11 - 15	34	4.5	4.5
16 - 20	28	3.7	3.7
21 - 25	16	2.1	2.1
26 or more	60	7.9	7.9
Total	756	99.6	100.0
Missing	3	.4	
Total	759	100.0	

5.4. Relationship forms

Most respondents who answered the questions (81%, n. 520) say that they usually have monogamous relationships with one person. 52%, (n. 305) of those who have monogamous relationships with one person say that they have had sex with one person in the past twelve months, and a further 25% (n. 146) of people who characterised their sexual relationships in this way

say that they have had sex with between 2 and 5 people in the past twelve months. By contrast, smaller proportions of people who characterise their sexual relationships in different ways say they have had sex with fewer than 6 people in the past twelve months. 28% (n. 8) of those who say 'I don't usually have committed relationships' say they have had sex with more than 26 people over the past twelve months, compared to 4% (n. 25) of those who say they usually have a monogamous relationship with one person. Of those who say that they are polyamorous, 35% (n. 6) say they have had between 6 and 10 sexual partners in the past twelve months, and 24% (n. 4) say they have had sex with more than 26 people in the last twelve months. Finally, of those who usually have open relationships, almost a third (31%, n. 21) say they have had sex with more than 26 people over the past twelve months. Table 5.4a compares the number of sexual partners with the type of relationships respondents said that they have. It shows the number of people respondents have had sex with in the last twelve months by the different ways the respondents characterise their sexual relationships.

Table 5.4a: I usually have relationships with ...

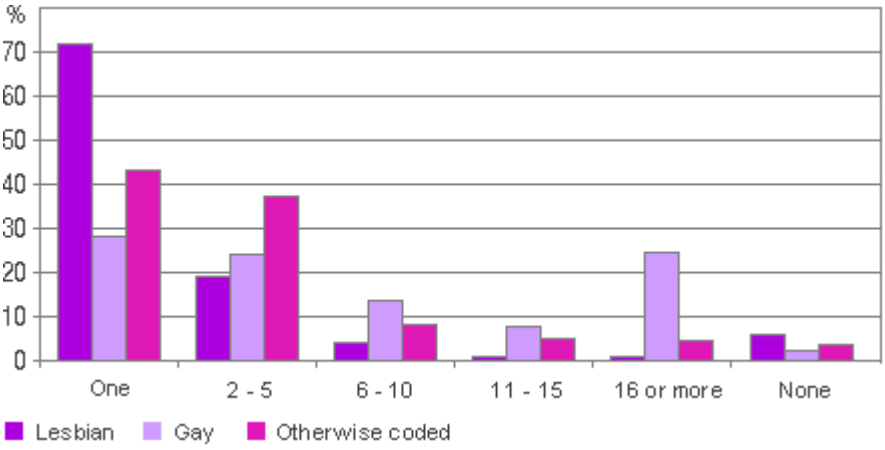
in the last 12 months		One person in monogamous relationship	I don't usually have committed relationships	I am poly-amorous	I usually have open relationships	Other	Total
None	No.	17	1	0	0	1	19
	%	2.9	3.4	0	0	4.2	2.6
1	No.	305	5	0	8	7	325
	%	52.4	17.2	0	11.8	29.2	45.1
2 - 5	No.	146	8	4	10	8	176
	%	25.1	27.6	23.5	14.7	33.3	24.4
6 - 10	No.	49	2	6	11	2	70
	%	8.4	6.9	35.3	16.2	8.3	9.7
11 - 15	No.	23	3	1	1	3	31
	%	4	10.3	5.9	1.5	12.5	4.3
16 - 20	No.	10	1	1	12	1	25
	%	1.7	3.4	5.9	17.6	4.2	3.5
21 - 25	No.	7	1	1	5	2	16
	%	1.2	3.4	5.9	7.4	8.3	2.2
26+	No.	25	8	4	21	0	58
	%	4.3	27.6	23.5	30.9	0	8.1
Total	No.	582	29	17	68	24	720
	%	100	100	100	100	100	100

5.5. Sexual identity

Figure 5.5a shows that there is a significant relationship between sexual identity and the number of people respondents report having had sex with in the last twelve months ($p = .0005$). Lesbian respondents are much more likely (72%, n. 186) than gay men (28%, n. 112) or those otherwise coded (including bisexual, queer and those of an 'other' sexuality) (44%, n. 40) to

have had sex with only one person in the past twelve months. Conversely, gay men are much more likely (25%, n. 99) to have had sex with more than 16 people over the past twelve months than are lesbians (<1%, n. 1) or those otherwise coded (4%, n. 4).

Figure 5.5a: Number of people you have had sex with… by sexual identity



5.6. Not having sex

The 51 people (6% of the sample) who have not had sex in the past three years were posed a series of questions relating to their experiences. This enables an insight into some aspects of the lives and experiences of those who identify as LGBT but who are not currently sexually active. As LGBT identities can often be sexualised and sexuality is often associated with sex, this is a clear area that is worthy of investigation.

Table 5.6a: Have you found it easy to not have sex and be LGBT?

	Frequency	Percent	Valid %
Yes	36	70.6	**73.5**
No	13	25.5	**26.5**
Total	49	96.1	100.0
Missing	2	3.9	
Total	51	100.0	

While the majority of those who have not had sex in the past three years (74%, n. 36) have found it easy to be LGBT, over a quarter (27%, n. 13) say that being LGBT and not having sex has not been easy.

Table 5.6b: Has not having sex been a conscious choice?

	Frequency	Percent	Valid %
Yes	27	52.9	**55.1**
No	22	43.1	**44.9**
Total	49	96.1	100.0
Missing	2	3.9	
Total	51	100.0	

Over half (55%, n. 27) of those who have not had sex for the past three years say that this has been a conscious choice (table 5.6b).

When this data is combined with that regarding whether respondents enjoy using the LGBT scene, 20 people who have chosen to not have sex in the past 3 years enjoy using the scene, but 14 do not use the scene. 8 out of the 12 people who said that it was not a conscious choice not to have sex in the past 3 years do not use the scene. These figures are small however, they point to the need to further investigate the scene's diverse role in creating sexual opportunities. Although it cannot be said that all of those who have chosen not to have sex avoid the scene, this group has a higher proportion of people who say that they do not use the scene compared to other LGBT people.

Table 5.6c: Do you feel that not having sex is respected in LGBT culture

	Frequency	Percent	Valid %
Yes	13	25.5	**34.2**
No	25	49.0	**65.8**
Total	38	74.5	100.0
Missing	13	25.5	
Total	51	100.0	

Table 5.6c shows that almost two-thirds (66%, n. 25) of those who have not had sex in the past three years say they feel that not having sex is not respected in LGBT culture. The qualitative response below illustrates how frequently having sex is valued in LGBT culture and how those who do not have sex expect admissions of this fact to invite stigmatisation.

> **I do not tell people that I have not had sex for such a long time because I know that their reaction would not be pleasant and I will probably be branded as a "freak".**
>
> *(Questionnaire 259)*

Being branded as a 'freak' due to not having sex can have implications for support networks and finding help. Although this research is indicative, the perception of the likelihood of an 'unpleasant reaction', coupled with the lack of respect for LGBT people who have not had sex, could lead to isolation.

5.7. Sex and young people

Most young people (66%) have anxieties around sex at least some of the time (see table 5.7a). After the age questions, young people were routed through to specific questions for them. Those aged under 26 were posed questions that were designed by Allsorts, the LGBT youth project in Brighton &Hove including the question 'as a young person, have you ever had anxieties about sex?'.

Table 5.7a: As a young person, have you ever had anxieties about sex?

	Frequency	Percent	Valid %	Cumulative %
All of the time	5	4.1	4.1	4.1
Most of the time	21	17.2	17.2	21.3
Some of the time	54	44.3	44.3	65.6
Hardly ever	35	28.7	28.7	94.3
Never	7	5.7	5.7	100.0
Total	122	100.0	100.0	

66% of young people have had anxieties about sex at least some of the time. This could have multiple causes and implications and can also be considered in the context of access to sexual health information, a subject that will be discussed in the next chapter. As questionnaire 422 indicates, ease of access to sexual health information can be difficult for LGBT young people, particularly since there is little LGBT specific sex education in schools.

Ease of access depends on age. I don't think most schools are very good regarding LGBT sex education

(Questionnaire 422)

Sex education can focus on particular forms of heterosexual sex, which can mean that LGBT young people are disadvantaged in terms of the available information. LGBT young people may have different experiences of anxieties with little support or information avenues to pursue.

5.8. Conclusions

This chapter has explored sex in terms of sexual activity and partners, including those who do not have sex. The majority of LGBT people in this sample have had sex in the past 3 years, most have had sex with under 5 partners in the past 12 months. Numbers of sexual partners varies by sexual identity, with gay men having more sexual partners in the past twelve months than other grouping. The majority of those who have not have sex in the past 3 years believe that not having sex is not respected in LGBT culture. The majority of young people in this research have anxieties around sex at least some of the time. This indicates a key area of support for LGBT young people who may not receive LGBT specific advice and guidance in schools.

6. Sexual health and knowledge

6.1. Introduction

Sexual health is a key LGBT issue. Due to the risks of HIV, attention on sexual health as it pertains to LGBT people is often focused on gay and bisexual men. In this chapter, however, the focus is broadened to consider sexual health as it relates to a wider range of people within the LGBT grouping in Brighton and Hove. This will include the diverse sexual and gender identities that form part of this research and a variety of sexual practices and lifestyles. The chapter will address sexual health check ups, knowledge of support for sex and relationships, and information regarding sexual health. These sections will address diversity amongst LGBT people highlighting particular areas of need.

6.2. Sexual health check ups

This section will first address the entire sample and only look at those who have had sex in the past three years, in order to offer insights into recent sexual activity. It will break down these categories by particular identities and areas of need and sexual practices. The section will finish by looking at the reasons given for not having sexual health check ups and the location of sexual health check ups.

6.2.1. Sexual health check ups

Just under a quarter of respondents (25%, n. 202) have never had a sexual health check up, with 7% (n. 54) of respondents saying that they do not need one. A third (33%, n. 268) of respondents have last had a sexual health check up within the last year (see table 6.2a). These patterns varied by gender identity, sexual identity, trans identity, deafness, disability, age, and HIV status. Female respondents, lesbians, trans respondents, those who identify as deaf/deafened or hard of hearing, those who are disabled/long term health impaired, those who have not tested positive for HIV are less likely to have sexual health check ups than other LGBT people. Older LGBT people are more likely to say that they do not need sexual health check ups and younger people are more likely never to have had a sexual health check up. This has clear implications when examining the

data received from sexual health check ups and when considering who is not included in this data. It can also have relevance when considering public health campaigns regarding sexual health.

Table 6.2a: When did you last have a sexual health check up?

	Frequency	Percent	Valid %
Within the last 6 months	162	19.8	20.0
Within the last 7 to 12 months	106	12.9	13.1
Between 1 and 5 years ago	192	23.4	23.7
More than 5 years ago	94	11.5	11.6
I don't need a sexual health check up	54	6.6	6.7
Never	202	24.7	24.9
Total	810	98.9	100.0
Missing	9	1.1	
Total	819	100.0	

6.2.1.1. Gender

Female respondents and those who identify with no gender or an 'other' gender are significantly more likely (38%, n. 127 and 35%, n. 9, respectively) to have never had sexual health check up than male respondents (15%, n. 65) ($p = .0005$). 11% (n. 36) of female respondents, 8% (n. 2) of those of no gender or of an 'other' gender, and 4%, (n. 16) of male respondents say they do not need a sexual health check up. Male respondents are more likely to have last had a sexual health check up within the last six months (28%, n. 127) than women (9%, n. 29) or those of no gender or an 'other' gender (15%, n. 4). Male respondents are also more likely to have last had a sexual health check within the last 7-12 months (17%, n. 75), compared to women (9%, n. 29) and those of no gender or an 'other' gender (8%, n. 2) (see table 6.2b).

Table 6.2b: When did you last have a sexual health check up? – by gender

		Male	Female	No gender or 'other'	Total
Within the last 6 months	No.	127	29	4	160
	%	28.3	8.7	15.4	19.9
Within the last 7 to 12 months	No.	75	29	2	106
	%	16.7	8.7	7.7	13.2
Between 1 and 5 years ago	No.	116	70	5	191
	%	25.9	21.1	19.2	23.7
More than 5 years ago	No.	49	41	4	94
	%	10.9	12.3	15.4	11.7
I don't need a sexual health check up	No.	16	36	2	54
	%	3.6	10.8	7.7	6.7
Never	No.	65	127	9	201
	%	14.5	38.3	34.6	24.9
Total	No.	448	332	26	806
	%	100.0	100.0	100.0	100.0

6.2.1.2. Sexuality

Gay men are more likely (29%, n. 122) to have had a sexual health check up within the last six months than lesbians (8%, n. 23). 17% (n. 8) of bisexual respondents and 15% (n. 9) of those who identify as queer or an 'other' sexual identity have had a sexual health check in the past six months. Bisexual respondents are more likely (21%, n. 10) to have last had a sexual health check within the last 7-12 months than other respondents. 16% (n. 70) of gay men, 12% (n. 7) of those identifying as queer or of an 'other' sexual identity, and 7% (n. 19) of lesbians have last had a sexual health check within the past 7-12 months. Gay men (4%, n. 16) and bisexual respondents (4%, n. 2) are less likely than lesbians (10%, n. 28) or those identifying as queer or an 'other' sexual identity (13%, n. 8) to say that they do not need a sexual health check up. Lesbians (40%, n. 110) are the most likely group to say that they have never had a sexual health check up. This compares to 34% (n. 16) of bisexual respondents, 25% (n. 15) of those identifying as queer or an 'other' sexuality, and 14% (n. 61) of gay men. See table 6.2c ($p = .0005$).

Table 6.2c: When did you last have a sexual health check up? – by sexual identity

		Lesbian	Gay	Bisexual	Otherwise coded	Total
Within the last 6 months	No.	23	122	8	9	162
	%	**8.4**	**28.6**	**17**	**14.8**	**20**
Within the last 7 to 12 months	No.	19	70	10	7	106
	%	**6.9**	**16.4**	**21.3**	**11.5**	**13.1**
Between 1 and 5 years ago	No.	59	114	7	12	192
	%	**21.5**	**26.7**	**14.9**	**19.7**	**23.7**
More than 5 years ago	No.	36	44	4	10	94
	%	**13.1**	**10.3**	**8.5**	**16.4**	**11.6**
I don't need a sexual health check up	No.	28	16	2	8	54
	%	**10.2**	**3.7**	**4.3**	**13.1**	**6.7**
Never	No.	110	61	16	15	202
	%	**40**	**14.3**	**34**	**24.6**	**24.9**
Total	No.	275	427	47	61	810
	%	100.0	100.0	100.0	100.0	100.0

6.2.1.3. Trans

Trans respondents are more likely (24%, n. 10) than non trans respondents (6%, n. 42) to say that they do not need a sexual health check up ($p = .0005$) (see table 6.2d). They are also more likely (38%, n. 16) than non trans respondents (24%, n. 184) to say that they have never had a sexual health check up. 5% (n. 2) of trans respondents have had a sexual health check up within the last 6 months, compared to 21% (n. 158) of non trans respondents.

Table 6.2d: When did you last have a sexual health check up? – by trans identity

		Trans	Not Trans	Total
Within the last 6 months	No.	2	158	160
	%	4.8	20.9	20.1
Within the last 7 to 12 months	No.	2	102	104
	%	4.8	13.5	13
Between 1 and 5 years ago	No.	6	184	190
	%	14.3	24.3	23.8
More than 5 years ago	No.	6	86	92
	%	14.3	11.4	11.5
I don't need a sexual health check up	No.	10	42	52
	%	23.8	5.6	6.5
Never	No.	16	184	200
	%	38.1	24.3	25.1
Total	No.	42	756	798
	%	100.0	100.0	100.0

6.2.1.4. Deaf, hard of hearing, deafened, deaf-blind.

Table 6.2e (below) shows that those who are deaf are less likely to have a sexual health check up than other LGBT people. 18% (n. 5) of deaf respondents say they don't need a sexual health check up, compared to 6% (n. 47) of respondents who do not identify as deaf. However, there are mixed patterns pertaining to when sexual health check ups were undertaken.. 25% (n. 7) of those who identify as deaf say they have had a sexual health check up in the last six months. This compares with 20% (n. 152) of those who do not identify as deaf. 29% (n. 8) of deaf respondents have had a sexual health check up more than a year ago but within the last five years, compared to 24% (n. 182) of those who do not identify as deaf. 4% (n. 1) of deaf respondents have had a sexual health check up within the last 7 to 12 months, compared to 14% (n. 104) of non-deaf respondents

Table 6.2e: 'When did you last have a sexual health check up?' by deaf identity

		Deaf	Not deaf	Total
Within the last 6 months	No.	7	152	159
	%	25	19.7	19.9
Within the last 7 to 12 months	No.	1	104	105
	%	3.6	13.5	13.2
Between 1 and 5 years ago	No.	8	182	190
	%	28.6	23.6	23.8
More than 5 years ago	No.	2	90	92
	%	7.1	11.7	11.5
I don't need a sexual health check up	No.	5	47	52
	%	17.9	6.1	6.5
Never	No.	5	195	200
	%	17.9	25.3	25.1
Total	No.	28	770	798
	%	100.0	100.0	100.0

6.2.1.5. Disability/Long term health impaired

Respondents who identified as disabled are less likely (15%, n. 18) to never have had a sexual health check up than respondents who do not identify as disabled (27%, n. 181) (p = .001) (table 6.2f). They are also more likely (34%, n. 40) than respondents who do not identify as disabled (18%, n. 121) to have last had a sexual health check up within the past six months.

Table 6.2f: When did you last have a sexual health check up? – by disability

		Disabled	Not disabled	Total
Within the last 6 months	No.	40	121	161
	%	34.2	17.9	20.3
Within the last 7 to 12 months	No.	16	87	103
	%	13.7	12.9	13
Between 1 and 5 years ago	No.	21	167	188
	%	17.9	24.7	23.7
More than 5 years ago	No.	12	78	90
	%	10.3	11.6	11.4
I don't need a sexual health check up	No.	10	41	51
	%	8.5	6.1	6.4
Never	No.	18	181	199
	%	15.4	26.8	25.1
Total	No.	117	675	792
	%	100.0	100.0	100.0

6.2.1.6. Age

Table 6.2g: When did you last have a sexual health check up? – by age

		>26	26-35	36-45	46-55	55+	Total
Within the last 6 months	No.	18	48	55	24	17	162
	%	14.9	19.9	22.2	19.4	22.4	20
Within the last 7 to 12 months	No.	19	29	37	12	9	106
	%	15.7	12	14.9	9.7	11.8	13.1
Between 1 and 5 years ago	No.	25	66	59	27	15	192
	%	20.7	27.4	23.8	21.8	19.7	23.7
More than 5 years ago	No.	0	19	38	25	12	94
	%	0	7.9	15.3	20.2	15.8	11.6
I don't need a sexual health check up	No.	8	8	13	13	12	54
	%	6.6	3.3	5.2	10.5	15.8	6.7
Never	No.	51	71	46	23	11	202
	%	42.1	29.5	18.5	18.5	14.5	24.9
Total	No.	121	241	248	124	76	810
	%	100.0	100.0	100.0	100.0	100.0	100.0

Those aged over 55 are more likely than other age groups to say that they do not need a sexual health check up – 16% (n. 12), compared to 7% (n. 8) of those aged under 26, 3% (n. 8) of those aged 26 to 35, 5% (n. 13) of those aged 36 to 45, and 11% (n. 13) of those aged 46 to 55. Those aged under 26

are the most likely age group to never have had a sexual health check up: 42% (n. 51) of this group have never such a check up, compared to 30% (n. 71) of those aged 26 to 35, 19% (n. 46 and n. 23, respectively) of both the 36-45 and 46-55 age groups, and 15% (n. 11) of those aged over 55 (p = .0005). Those aged under 26 are the least likely (15%, n. 18) group by age to have last had a sexual health check up within the last six months (see table 6.2g). However, they are the most likely group by age (16%, n. 19) to have last had a sexual health check up within the last 7-12 months. Those aged between 46 and 55 are more likely than other age groups to have last had a sexual health check up more than five years ago – 20% (n. 25), compared to 16% (n. 12) of those over 55, 15% (n. 38) of those aged 36 to 45, 8% (n. 19) of those aged 26-35, and none of those aged under 26.

6.2.1.7. HIV status

Over three-quarters (76%, n. 42) of those who have tested positive for HIV have last had a sexual health check up within the last six months, compared to 27% (n. 103) of those who last tested HIV negative, and 5% (n. 16) of those who have not had an HIV test result. Over half (51%, n. 183) of those who have not had an HIV test result have never had a sexual health check, compared to 4% (n. 15) of those who have tested HIV negative. 35% (n. 134) of those who last tested HIV negative last had a sexual health check up more than a year ago but within the last five years. This compares to 15% (n. 54) of those who have not had an HIV test result and 6% (n. 3) of those who have tested HIV positive (p = .0005).

Table 6.2h: When did you last have a sexual health check up? – by HIV status

		HIV+	HIV-	No result	Total
Within the last 6 months	No.	42	103	16	161
	%	**76.4**	**26.7**	**4.5**	**20.2**
Within the last 7 to 12 months	No.	8	72	26	106
	%	**14.5**	**18.7**	**7.3**	**13.3**
Between 1 and 5 years ago	No.	3	134	54	191
	%	**5.5**	**34.7**	**15.1**	**23.9**
More than 5 years ago	No.	1	46	45	92
	%	**1.8**	**11.9**	**12.6**	**11.5**
I don't need a sexual health check up	No.	1	16	34	51
	%	**1.8**	**4.1**	**9.5**	**6.4**
Never	No.	0	15	183	198
	%	**0**	**3.9**	**51.1**	**24.8**
Total	No.	55	386	358	799
	%	100.0	100.0	100.0	100.0

6.3. Sex and sexual health check ups

This section will explore sexual health check ups in relation to those who have had sex in the past three years. Table 6.3a shows that when those who have not had sex within the past three years are taken out of the

analysis, still a quarter (25%, n. 189) of the remaining respondents say they have never had a sexual health check up. 5% (n 38) of those who have had sex in the last three years say they do not need a sexual health check up. 34% (n. 105) have had a sexual health check up within the last year, while 11% (n. 82) have not had a sexual health check up with the last five years. These patterns vary by gender, sexuality, age, the number of people respondents have had sex with in the last twelve months, and whether respondents have disclosed to their GP that they are lesbian, gay, bisexual and/or trans. Women, lesbians, those who have not had sex in the past 12 months, those who are not out to their GP are less likely to have had sexual health check ups recently or ever at all.

Table 6.3a: When did you last have a sexual health check up? - For those who have had sex in the last three years

	Frequency	Percent	Valid %	Cumulative %
Within the last 6 months	154	20.3	20.4	20.4
Within the last 7 to 12 months	105	13.8	13.9	34.4
Between 1 - 5 years ago	186	24.5	24.7	59.0
More than 5 years ago	82	10.8	10.9	69.9
I don't need a sexual health check up	38	5.0	5.0	74.9
Never	189	24.9	25.1	100.0
Total	754	99.3	100.0	
System missing	5	.7		
Total	759	100.0		

6.3.1.1. Gender

Table 6.3b: Sexual health check ups among those who have had sex in the last three years – by gender

		Male	Female	Total
Within the last 12 months	No.	196	55	251
	%	46.3	18	34.5
Between 1 - 5 years ago	No.	113	67	180
	%	26.7	22	24.7
More than 5 years ago	No.	44	36	80
	%	10.4	11.8	11
I don't need a sexual health check up or never	No.	70	147	217
	%	16.5	48.2	29.8
Total	No.	423	305	728
	%	100.0	100.0	100.0

Among those who have had sex within the past three years, male respondents are much more likely (46%, n. 196) than female respondents (18%, n. 55) to have last had a sexual health check up within the last twelve months ($p = .0005$) (table 6.3b). Women are more likely (48%, n. 147) than men (17%, n. 70) to say that they do not need a sexual health check up or to have never had one.

6.3.1.2. Sexuality

Among those who have had sex within the past three years, gay men (29%, n. 116) are more likely than other groups to have had a sexual health check up within the last six months (p = .0005) (see table 6.3c). 8% of lesbians (n. 21) have had a sexual health check up within the last six months, while the figures for bisexual respondents and those who identify as queer or of an 'other' sexual identity are 18% (n. 8) and 19% (n. 9), respectively. Bisexual respondents are less likely (5%, n. 2) than respondents of other sexual identities to have last had a sexual health check up more than five years ago. Lesbian respondents are more likely (42%, n. 107) than bisexual respondents (34%, n. 15), those identifying as queer or of an 'other' sexual identity (25%, n. 12), or gay respondents (14%, n. 55) to never have had a sexual health check up. They are also more likely (9%, n. 22) to say they do not need a sexual health check up, compared to bisexual respondents (5%, n. 2), those identifying as queer or of an 'other' sexual identity (6%, n. 3) and gay respondents (3%, n. 11).

Table 6.3c: Sexual health check ups among those who have had sex in the last three years – by sexual identity

		Lesbian	Gay	Bisexual	Otherwise coded	Total
Within the last 6 months	No.	21	116	8	9	154
	%	8.2	28.6	18.2	18.8	20.4
Within the last 7 to 12 months	No.	18	70	10	7	105
	%	7	17.3	22.7	14.6	13.9
Between 1 - 5 years ago	No.	56	112	7	11	186
	%	21.8	27.7	15.9	22.9	24.7
More than 5 years ago	No.	33	41	2	6	82
	%	12.8	10.1	4.5	12.5	10.9
I don't need a sexual health check up	No.	22	11	2	3	38
	%	8.6	2.7	4.5	6.3	5
Never	No.	107	55	15	12	189
	%	41.6	13.6	34.1	25	25.1
Total	No.	257	405	44	48	754
	%	100.0	100.0	100.0	100.0	100.0

6.3.1.3. Age

Among those who have had sex in the last three years, those aged 46 to 55 are more likely than other age groups to say that they do not need a sexual health check – 9% (n. 10), compared to 3% (n. 7) of those aged 26 to 35 and 5% of those aged under 26 (n. 6), those aged 36 to 45 (n. 12) and those aged over 55 (n. 3) (p = .0005). However, this 46 to 55 year old age group are among the two least likely age groups to never have had a sexual health check up. 17% of both those aged 46 to 55 (n. 18) and those aged over 55 (n. 10) have never had a sexual health check up, compared to 19% (n. 45) of those aged 36 to 45, 30% (n. 70) of those aged 26 to 35, and 41% (n. 46) of those aged under 26.

Those aged 46 to 55 are the most likely age group (20%, n. 21) to have last had a sexual health check more than five years ago. This compares to 15%

(n. 9) of those aged over 55, 14% (n. 34) of those aged 36 to 45, and 8% (n. 18) of those aged 26 to 35 (see table 6.3d). Those aged over 55 are the most likely age group (25%, n. 15) to have last had a sexual health check up within the last six months. Those aged under 26 are the least likely age group to have had a sexual health check up within the last six months (16%, n. 18).

Table 6.3d: Sexual health check ups among those who have had sex in the last three years – by age

		>26	26-35	36-45	46-55	55+	Total
Within the last 6 months	No.	18	47	53	21	15	154
	%	15.9	19.8	22.2	19.8	25.4	20.4
Within the last 7 to 12 months	No.	19	29	36	12	9	105
	%	16.8	12.2	15.1	11.3	15.3	13.9
Between 1 and 5 years ago	No.	24	66	59	24	13	186
	%	21.2	27.8	24.7	22.6	22	24.7
More than 5 years ago	No.	0	18	34	21	9	82
	%	0	7.6	14.2	19.8	15.3	10.9
I don't need a sexual health check up	No.	6	7	12	10	3	38
	%	5.3	3	5	9.4	5.1	5
Never	No.	46	70	45	18	10	189
	%	40.7	29.5	18.8	17	16.9	25.1
Total	No.	113	237	239	106	59	754
	%	100.0	100.0	100.0	100.0	100.0	100.0

6.3.2. Number of people respondents have had sex with in the last 12 months.

83% of those who have had 26 or more partners in the past 12 months have had sexual health check ups in the past 12 months. Those who have not had sex in the last twelve months are most likely to never have had a sexual health check up or to say that they do not need one (63%, n. 15). The proportion of respondents who have never had a sexual health check up or say that they do not need a sexual health check up declines in relation to the number of people respondents have had sex with in the last twelve months ($p = .0005$, see table 6.3e). This is also clear the other way around, such that the proportion of respondents who have last had a sexual health check up within the last twelve months increases with the number of people that respondents have had sex with in the last twelve months. In other words, the more partners a person had in the past 12 months the more likely they are to have a sexual health check up in the past 12 months. This indicates that sexual activity can be important in engaging in sexual health check ups and also points to a level of knowledge and responsibility amongst those who are sexually active.

36% (n. 121) of those who have had sex with one person in the last 12 months have never had a sexual health check up or say that they do not need one, and the figure declines to 3% (n. 2) of those who have had sex with 26 or more people in the last twelve months.

Those who have not had sex in the last 12 months are least likely to have had a sexual health check in this time period (8%, n. 2). 21% (n. 69) of those who have had sex with one person in the last twelve months have last had a sexual health check within this period. This figure rises with increasing numbers of sexual partners in the last twelve months through 53% (n. 18) of those who have had sex with between 11 and 15 people in the last year to 83% (n. 50) of those who have had sex with 26 or more people during the last year.

Table 6.3e: Sexual health check ups among those who have had sex in the last three years – by the number of people respondents have had sex with in the last 12 months

		0	1	2-5	6-10	11-15	16-20	21-25	26+	Total
Within the last 12 months	No.	2	69	61	33	18	16	11	50	260
	%	8.3	20.7	32.8	45.2	52.9	59.3	68.8	83.3	34.5
Between 1 and 5 years ago	No.	4	95	46	12	12	7	3	6	185
	%	16.7	28.4	24.7	16.4	35.3	25.9	18.8	10	24.5
More than 5 years ago	No.	3	49	19	6	1	1	1	2	82
	%	12.5	14.7	10.2	8.2	2.9	3.7	6.3	3.3	10.9
don't need a check up or never	No.	15	121	60	22	3	3	1	2	227
	%	62.5	36.2	32.3	30.1	8.8	11.1	6.3	3.3	30.1
Total	No.	24	334	186	73	34	27	16	60	754
	%	100	100	100	100	100	100	100	100	100

6.3.3. Disclosure of LGBT identity to GP

Table 6.3f: Sexual health check ups among those who have had sex in the last three years – by the whether respondents have disclosed to their GP that they are Lesbian, Gay, Bisexual and/or Trans

		Yes	No	Total
Within the last 6 months	No.	99	60	159
	%	20.4	18.8	19.8
Within the last 7 to 12 months	No.	76	30	106
	%	15.7	9.4	13.2
Between 1 and 5 years ago	No.	115	76	191
	%	23.7	23.8	23.8
More than 5 years ago	No.	56	37	93
	%	11.5	11.6	11.6
I don't need a sexual health check up	No.	37	17	54
	%	7.6	5.3	6.7
Never	No.	102	99	201
	%	21	31	25
Total	No.	485	319	804
	%	100.0	100.0	100.0

Among those who have had sex in the last three years, those who have not disclosed their lesbian, gay, bisexual and/or trans identity to their GP are more likely (31%, n. 99) than those who have disclosed this information to their GP (21%, n. 102) to never have had a sexual health check up ($p = .01$) (table 6.3f). This indicates a clear area of concern, those who are not out to

their GP are less likely to have had sexual health check ups in the past 12 months and more likely to say that they have never had a sexual health check up.

Those who have not disclosed their lesbian, gay, bisexual and/or trans identity to their GP are slightly less likely to have last had a sexual health check up within the last six months (19%, n. 60, compared to 20%, n. 99) and less likely to have last had a sexual health check up within the last 7 to 12 months (9%, n. 30), compared to those who have disclosed their sexual and/or gender identities (16%, n. 76).

6.3.4. Reasons for not having a sexual health check up

The qualitative data offers some important insights into why LGBT people do not think they need a sexual health check up- table 6.3g outlines the key categories in this data. The most frequent response offered was that respondents were in 'monogamous' and/or 'committed' sexual relationships (61 responses).

38 respondents answered that they did not think they needed a sexual health check up or that they were not worried about the risks associated with their sexual practices or relationships. Associated with this, identities of partners can influence understandings of sexual health needs. 29 people said that because of who their partners are they do not need sexual health check ups. This included a large lesbian category and those who don't have sex with men. This points to the lack of knowledge available regarding lesbian sexual health and women who have sex with women. A further 22 respondents said that they felt they always had safe sex and therefore did not feel they needed a sexual health check up.

14 people said that they hadn't had any symptoms and/or problems associated with their sexual practices and therefore did not need a sexual health check up.

3 people have not been offered a sexual health check up with 7 people saying they don't know what a sexual health check up is. For 4 people fear of discrimination is an issue and 16 people were embarrassed by the procedure.

Table 6.3g: Major categories from qualitative data: If you feel you do not need/never had a sexual health check up, please tell us why

Categories	No. of responses
Monogamous/committed relationship	61
For up to 2 years	4
For between 2 and 5 years	4
For between 5 and 10 years	7
For between 10 and 15 years	7
For more than 15 years	3
For an unspecified time	22
I am not worried (incl. re: risks/behaviour)/I don't think I need one	38
Identity of partners:	29
I only have sex with someone/people I trust/are faithful	13
I only have sex with other lesbians	11
Of Which: Lesbian sex means I don't need one	5
I don't have sex with men	3
I don't have sex with person of same-sex	1
Straight women	1
I always have safe sex/protected sex	22
Haven't had sex	20
For up to 2 years	2
For between 2 and 5 years	1
For between 5 and 10 years	2
For more than 10 years	1
Embarrassment/fear of procedure	16
I haven't had any symptoms or problems	14
I don't know what a sexual health check up is	7
Fear of discrimination/prejudice/insensitivity to identity/having to come out to doctor	4
I have had tests for other reasons – the tests included sexual health	4
I haven't been offered a sexual health check up	3
I have discussed sexual health with my GP	1

Notes:
1. Where responses fall into more than one category they are counted as many times as categories they fall into.
2. Where a response falls into one or more category and contains a comment that does not fall into one of the major categories, the response is counted within the major categories it falls into and is listed in table 6.3h 'Other responses: If you feel you do not need/never had a sexual health check up, please tell us why'.
3. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.
4. The subsets listed under the headings 'Monogamous/committed relationship' and 'Haven't had sex' are mutually exclusive. This is not the case for major categories listed under 'Identity of partners'.
5. The subset 'Lesbian sex means I don't need one' is mutually exclusive of the major category 'I am not worried (incl. re: risks/behaviour)/I don't think I need one'. The total for these two categories may be combined to come up with a new total (43).

6.3.4.1. Monogamous relationships

In common with many other respondents who identified as another sexual identity (gay men, bisexual people, queer respondents etc), many lesbians said that they did not feel the need for a sexual health check up because they were in a 'monogamous' and/or 'committed' relationship. Often, this reason was coupled with others to do with the identity of sexual partners – lesbian relationships were especially given as a reason for not needing a sexual health check (11 responses explicitly stated this) – and to do with trusting in sexual partners to be 'faithful'. The two following responses show examples of such reasoned explanations for why these respondents did not feel they needed to have a sexual health check up.

> **I am in a stable relationship. I have had regular smears but not necessarily sexual health check ups. I have been tested for Hep B and C for work and do not feel I am at risk of other STDs**
>
> *(Questionnaire 157)*

> **I am in a long-term lesbian relationship (24 years) & neither of us has sex outside of our relationship also this was my first full sexual relationship**
>
> *(Questionnaire 11)*

6.3.4.2. Fear and lack of knowledge/information

In addition to the 16 people who cited fear or embarrassment as a reason for not having a sexual health check up and the four people who cited fear of 'discrimination, insensitivity etc.', 19 respondents said that they had not had a sexual health check up because of one of the following reasons: 'I would like more information/a consultation/don't know where to get one'; 'I don't know what a sexual health check up is'; and 'I haven't been offered a sexual health check up'. The following response indicates how both fear and a lack of knowledge can impede the take up of sexual health check ups.

> **unsure of where to go... unsure of procedures... unsure of confidentiality... scared... do i need to go on!**
>
> *(Questionnaire 131)*

These very real fears can be added to by uncertainty regarding how LGBT identities and bodies will be treated and reacted to. Some respondents pointed to the need for health service providers to find ways of assuring LGBT patients that their specific identities, bodies and needs will be dealt with sensitively (see chapters 12 and 13). Providers of sexual health services need to be aware of the complexity of LGBT people and this challenges some of the current premises of sexual health.

I have a long term partner and we are monogamous, so I've never felt the need to have one. Also because I identify as male, it would be a very intrusive thing for me to experience being in a female body. So I would only do it if I felt I had to.

(Questionnaire 284)

In this questionnaire, the respondent's male identity and life could be challenged if he were to be treated as a woman during a sexual health check.

14 respondents said that they did not think they needed a sexual health check up because they had not, at least recently, had any symptoms or problems. While, an assessment of the risks of contracted an STI (sexually transmitted infection) can be made on a relatively informed basis, uneven knowledge of sexual health can lead some respondents to make such assessments on the basis of false understandings and generalisations regarding the symptoms of STIs.

I have not had cause to attend a clinic but would so if I detected suspect symptoms.

(Questionnaire 252)

38 respondents indicated that they had not had a sexual health check up because they did not feel they needed one. Most of these respondents asserted or implied that they were not concerned with what they had assessed as the sexual health risks their sexual practices and relationships presented them with.

never felt i have taken risks that qualify me, or concern me to the level i would need a check up.

(Questionnaire 45)

This may be an informed decision regarding sexual practices from the available information. It indicates that sexual health information can be key in decision-making regarding sexual health check ups, as well as the sexual practices that an individual engages in.

Furthermore, it should not be assumed that individuals who do not seek sexual health check ups fail to do so because of ignorance or because they do not have any understanding of the risks of being infected with an STI:

This question implies that you need a reason NOT to have a check up. I think you need to have a reason to have a check up. How many people would have a check up if they are in a long term relationship (gay or straight), for example? I doubt many would, and why should they?

(Questionnaire 442)

Needing a reason *to* have a check up and the assertions of monogamous and committed relationships challenge assertions that LGBT people are more at risk than 'straight people' in similar relationship forms. This needs

further exploration, as sexual health cannot be presumed on the basis of sexual identities, be they LGB or 'straight'.

6.3.4.3. Lesbian sexual health

Several lesbian respondents said that they did not think they needed a sexual health check up because they thought that only having sex with other lesbians meant they did not need a one and/or meant that they were at very low risk of contracting an STI.

> **Lesbian sex implies I don't need it- do I???**
>
> *(Questionnaire 70)*

> **I was advised by the community nurse that lesbians do not need sexual check ups.**
>
> *(Questionnaire 95)*

These responses indicate a lack of information amongst lesbian respondents and also among health professionals regarding the risks of lesbian sex. Where individuals presume that 'lesbian sex' has particular risks associated with it, such assumptions can overlook aspects of sexual health other than STIs that are dealt with during sexual health check ups (e.g. thrush; bacterial vaginosis). It also overlooks the range different of sexual practices among lesbians, each of which may have different implications for sexual health. As questionnaire 196 suggests, health service providers should not assume "that all lesbians do is kiss and cuddle."

> **should be more on lesbian sexual practices (particularly s/m and anal sex for women by women...in other words services seem to assume that all lesbians do is kiss and cuddle!)**
>
> *(Questionnaire 196)*

Many lesbian and other female respondents either stated that they did not know what a sexual health check was or conflated them with smear tests.

> **I don't know what this means and where I would go. I have had a smear test.**
>
> *(Questionnaire 055a)*

> **I didn't have a sexual health check up- I don't know that these are available for women/lesbians- but I did have a smear test. Is this what you mean?**
>
> *(Questionnaire 610)*

However, a lack of knowledge of sexual health check ups and a feeling among many lesbians that they do not need sexual health check ups should not automatically be taken to mean that all such respondents are making 'poor' decisions regarding their sexual health. As the following quote demonstrates, many respondents make reasoned judgements

regarding the risks surrounding their sexual health (such as the risks of being infected by an STI), often without full access to information regarding sexual health check ups.

> **I've had a smear test but haven't had any other specific sexual health check up - never been offered it and don't feel I've put myself in any risk. Although lesbians can be at risk of STIs, it is less so than other groups. You also hear less about sexual health checks for lesbians so you are less aware of it.**
>
> *(Questionnaire 667)*

This response suggests a certain level of knowledge regarding the risks for lesbians of contracting STIs. Thus, it cannot be assumed that lesbians *in general* are more likely not to seek sexual health check ups because of a lack of knowledge regarding the risks of infection or sexual health check up services. Rather, there may be a need for more and better communicated information targeted at specific groups of lesbians regarding why and when they might need sexual health check ups, what they would involve and how to access them (see also section 6.6). Health professional and other health service providers can play a part in informing lesbians and offer them appropriate services. This point is important in the context of responses indicating that, for some lesbians, smear tests may be all that they are offered:

> **apart from smear tests, nothing is specifically targeted for lesbians.**
>
> *(Questionnaire 570)*

The absence of specific services for lesbians may mean that women do not have anywhere to go:

> **there is nowhere to go for gay women other than GP. i dont like explaining to GP every time i go and see a different doctor that i am a lesbian**
>
> *(Questionnaire 724)*

Questionnaire 724 indicates that having to continually come out to GP's can mean that services are not used. Coming out to GP's will be address in chapter 11.

6.3.4.4. Other responses

Table 6.3h shows other responses regarding why respondents felt they did not need to have a sexual health check up. These did not fit any of the categories in table 6.3g above.

Table 6.3h: Other responses: If you feel you do not need/never had a sexual health check up, please tell us why

I was refused a smear test at 65 because of my age despite 2 previous colposcopys (ies?)
Thinking about getting a health check up as i recently split up with my only sexual partner and plan to sleep with more people
I would like to have a sexual health check.
Never gotten round to it but know that I should.
stigma attached to it
cannot use this service because of mental health problems
Nothing has come up when checked and nothing new is going on.
i have one every month
Never got round to it- have not been sexually active for very long
lack of discretion to access
Fear of what if

6.3.5. Location of most recent sexual health check up

Almost one third (30%, n. 211) of respondents have had their most recent sexual health check up at the Claude Nicol clinic. 18% (n. 125) have had their most recent sexual health check up at their GP, 11% (n. 75) at a sexual health clinic outside Brighton and Hove, and 10% (n, 72) at a GU clinic other than the Claude Nicol and the Warren Browne clinics. 20% said that they have never had a sexual heath check up. Table 6.3i shows the location where respondents have had their most recent sexual health check up.

Table 6.3i: Where did you have your most recent sexual health check-up?

	Frequency	Percent	Valid %
Claude Nicol	211	25.8	30.1
I haven't had a sexual health check up	143	17.5	20.4
GP	125	15.3	17.8
Another sexual health clinic outside Brighton & Hove	75	9.2	10.7
GU clinic (other than Claude Nicol or Warren Browne)	72	8.8	10.3
Other	24	2.9	3.4
Another sexual health clinic in Brighton & Hove	21	2.6	3.0
Warren Browne	18	2.2	2.6
THT	8	1.0	1.1
LGBT social venue	4	.5	.6
Total	701	85.6	100.0
Missing	118	14.4	
Total	819	100.0	

By grouping some of these categories of responses, it can be seen that these patterns vary by HIV status, sexual identity, and gender identity. Those who are living with HIV are more likely to use the Claude Nicol compared to other groups, and less likely to go to their GP for a sexual health check up. In contrast lesbians and LGBT women generally are more likely to use their GP with LGBT men more likely to use Claude Nicol. This clearly has implications in terms of targeting sexual health information and the use of particular centres by different groups within the LGBT collective. It also has implications for the use of GPs by gay men. As will be discussed later (see chapter 11), gay men are less likely to be out to their GPs than other groups and perhaps this can in part be accounted for by the provision of other services targeted at gay men, which means that disclosure of their sexual identity to their GP is not essential. This is in contrast to other groups who rely more on this service and may have to negotiate difficult GPs as well as locate friendly GP services. As the qualitative data noted above this can mean that sexual health is not discussed and sexual health check ups are not undertaken.

It should be noted that the Terrence Higgins Trust (THT) do not offer sexual health check ups, only HIV testing, so the fact that a number of respondents indicated that they last had a sexual health check up with THT suggests that (similar to women equating these to smear tests) they might not fully understand what a full sexual health check up is.

6.3.5.1. HIV status

Only 2% (n. 1) of those who tested HIV positive last had a sexual health check up at their GP, compared to 12% (n. 42) of those who last tested HIV negative and 56% (n. 74) of those who have not had an HIV test result ($p = .0005$). By contrast, over half of those who have tested HIV positive (56%, n. 30) last had a sexual health check up at the Claude Nicol clinic; this compares with 46% (n. 162) of those who last tested HIV negative and 11% (n. 15) of those who have not had an HIV test result. Table 6.3j also shows that those who have tested HIV positive are more likely (30%, n. 16) to have last had a sexual health check up at a GU clinic, the Warren Browne or another sexual health clinic in Brighton and Hove than those who last tested HIV negative (22%, n. 78) and those who have had no HIV test result (11%, n. 14).

Table 6.3j: Where did you have your most recent sexual health check-up? – by HIV status

		HIV+	HIV-	No result	Total
GP	No.	1	42	74	117
	%	1.9	12	55.6	21.7
GU clinic, Warren Browne or other sexual health clinic in B&H	No.	16	78	14	108
	%	29.6	22.2	10.5	20.1
Claude Nicol	No.	30	162	15	207
	%	55.6	46.2	11.3	38.5
Another sexual health clinic outside Brighton & Hove	No.	4	49	18	71
	%	7.4	14	13.5	13.2
THT, LGBT social venue or other	No.	3	20	12	35
	%	5.6	5.7	9	6.5
Total	No.	54	351	133	538
	%	100.0	100.0	100.0	100.0

6.3.5.2. Sexual identity

Lesbian respondents are much more likely (57%, n. 73) than gay men (9%, n. 31), bisexual respondents (21%, n. 6) and those who identify as queer or as an 'other' sexual identity (22%, n. 8) to have last had a sexual health check up at their GP (p = .0005). Table 6.3k shows that lesbians are less likely than other groups to have last had a sexual health check up at a GU clinic, Warren Browne or other sexual health clinic in Brighton and Hove (9%, n. 11) or at the Claude Nicol clinic (19%, n. 25). Gay men are the most likely group to have last had a sexual health check up at either of these categories of clinic (25%, n. 85 and 46%, n. 160, respectively). Bisexual respondents are more likely than other sexual identity groups to have last had a sexual health check up at a sexual health clinic outside Brighton and Hove (21%, n. 6) or with the Terrence Higgins Trust (THT), at an LGBT venue or elsewhere (10%, n. 3).

Table 6.3k: Where did you have your most recent sexual health check-up? – by sexual identity

		Lesbian	Gay	Bisexual	Other	Total
GP	No.	73	31	6	8	118
	%	56.6	8.9	20.7	22.2	21.8
GU clinic, Warren Browne or other sexual health clinic in B&H	No.	11	85	4	9	109
	%	8.5	24.5	13.8	25	20.1
Claude Nicol	No.	25	160	10	12	207
	%	19.4	46.1	34.5	33.3	38.3
Another sexual health clinic outside Brighton & Hove	No.	15	47	6	4	72
	%	11.6	13.5	20.7	11.1	13.3
THT, LGBT social venue or other	No.	5	24	3	3	35
	%	3.9	6.9	10.3	8.3	6.5
Total	No.	129	347	29	36	541
	%	100.0	100.0	100.0	100.0	100.0

6.3.5.3. Gender

Table 6.3l: Where did you have your most recent sexual health check-up? – by gender identity

		Male	Female	Total
GP	No.	32	82	114
	%	8.8	51.3	21.8
GU clinic, Warren Browne or other sexual health clinic in B&H	No.	91	15	106
	%	25.1	9.4	20.3
Claude Nicol	No.	166	36	202
	%	45.7	22.5	38.6
Another sexual health clinic outside Brighton & Hove	No.	49	19	68
	%	13.5	11.9	13
THT, LGBT social venue or other	No.	25	8	33
	%	6.9	5	6.3
Total	No.	363	160	523
	%	100.0	100.0	100.0

Female respondents are much more likely (51%, n. 82) than male respondents (9%, n. 32) to have last had a sexual health check up at their GP (p = .0005). Male respondents are much more likely than female respondents to have last had a sexual health check up at a GU clinic, Warren Browne or another sexual health clinic in Brighton and Hove (25%, n. 91, compared to 9%, n. 15), or at the Claude Nicol clinic (46%, n. 166, compared to 23%, n. 36) (see table 6.3l above).

As indicated above, understandings of lesbian sexual health and the absence of information and services can mean that women feel that there is nowhere to go to have a sexual health check up. In the qualitative data 7 comments called for a specialist sexual health clinic for lesbians.

> **there is none for lesbians and there should be - i don't want to talk to my GP - I want a lesbian health clinic like gay guys do**
>
> *(Questionnaire 192)*

Such responses are an indication of how many respondents access information about sexual health primarily when in consultation with medical professionals for treatment or screening. This has implications for primary points of contact and the use of GPs, as well as a desire to see specialist provision for particular groups.

6.3.5.4. Deaf identity

61% (n. 11) of respondents who identify as deaf last had a sexual health check up at the Claude Nicol clinic. 11% (n. 2) of deaf respondents last had a sexual health check up at a GU clinic, the Warren Browne or another sexual health clinic in Brighton and Hove, another 11% at another sexual health clinic outside Brighton and Hove, and another 11% with THT, at an LGBT social venue or elsewhere. 6% (n. 1) of deaf respondents last had a sexual health check at their GP.

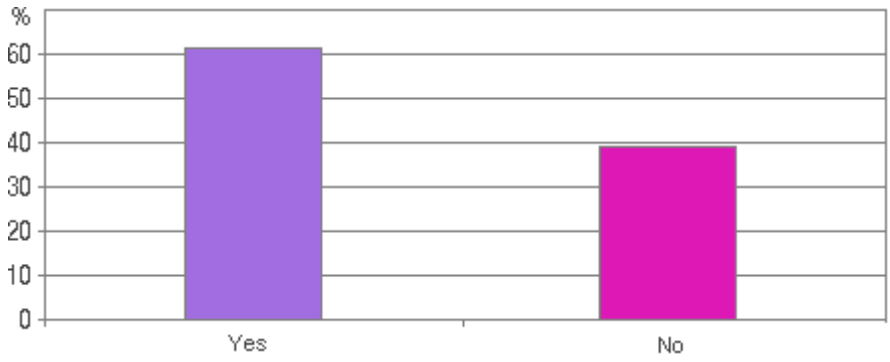
6.3.5.5. Sex working

Sex working is defined here as taking payment for sex or exchanging it for goods such as drugs, alcohol or somewhere to stay. Among those who are or who have been sex workers, 55% (n. 6) last had a sexual health check up at the Claude Nicol clinic. 18% (n. 2) had their last sexual health check up at a GU clinic, the Warren Browne or another sexual health clinic in Brighton and Hove, 18% (n. 2) at a sexual health clinic outside Brighton and Hove, and 9% (n. 1) at their GP.

6.4. Knowledge of where to find help pertaining to sex/relationships

Figure 6.7a shows that while 61% (n. 489) of those who answered the question said that they did know where to find help around sex and/or relationships, 39% (n. 307) said that they did not. Knowledge regarding sex and relationships varies by sexual identity, trans identity, income, feeling isolated, HIV status and whether respondents has suffered sexual assault. Those who are queer, lesbian or 'other' in terms of sexuality, those who are trans, who are on a low income, who feel isolated, who have not tested positive for HIV and have experienced sexual assault are more likely to say that they would not know where to find help around sex and relationships. This indicates that there is a need to educate particular groups regarding sex and relationships, or perhaps provide information relevant to them.

Figure 6.7a: If you needed help around sex/relationships would you know where to find it?



6.4.1. Sexual identity

Table 6.4a shows that those who identify as queer are more likely (54%, n. 15) to not know where to find help pertaining to sex and/or relationships than other groups by sexual identity. Those who identify as an 'other' sexual identity (47%, n. 14) and lesbians (44%, n. 120) are more likely than bisexual respondents (36%, n. 17) and gay men (34%, n. 141) to not know where to find help about sex and/or relationships (p = .01).

Table 6.4a: If you needed help around sex/relationships would you know where to find it? – by sexual identity

		Lesbian	Gay	Bisexual	Queer	Otherwise coded	Total
Yes	No.	151	279	30	13	16	489
	%	**55.7**	**66.4**	**63.8**	**46.4**	**53.3**	**61.4**
No	No.	120	141	17	15	14	307
	%	**44.3**	**33.6**	**36.2**	**53.6**	**46.7**	**38.6**
Total	No.	271	420	47	28	30	796
	%	100.0	100.0	100.0	100.0	100.0	100.0

6.4.2. Trans identity

Table 6.4b illustrates that those who are trans are less likely to know where to find help around sex/relationships. 56% of those who are trans do not know where to find help around sex/relationships compared to 37% of those who are not trans (p.=0.019)

Table 6.4b: If you needed help around sex/relationships would you know where to find it? – by gender identity

		Trans	Not Trans	Total
Yes	No.	17	464	481
	%	**43.6**	**62.3**	**61.4**
No	No.	22	281	303
	%	**56.4**	**37.7**	**38.6**
Total	No.	39	745	784
	%	100.0	100.0	100.0

6.4.3. Income

Those earning incomes above £20,001 a year are more likely to know where to find help around sex and/or relationships (p = .011). Table 6.4c shows that 43% (n. 65) of those earning less than £10,000 a year and 45% (n. 108) of those earning between £10,001 and £20,000 a year did not know where to find help about sex and/or relationships. By contrast, 33% (n. 102) of those earning between £20,001 and £40,000 a year and 31% (n. 28) of those earning more than £40,001 a year did not know where to find such help.

Table 6.4c: If you needed help around sex/relationships would you know where to find it? – by income

		>10k	10-20k	20-40k	40k+	Total
Yes	No.	87	132	203	63	485
	%	**57.2**	**55**	**66.6**	**69.2**	**61.5**
No	No.	65	108	102	28	303
	%	**42.8**	**45**	**33.4**	**30.8**	**38.5**
Total	No.	152	240	305	91	788
	%	100.0	100.0	100.0	100.0	100.0

6.4.4. Isolation

Those who feel isolated in Brighton & Hove are more likely (47%, n. 120) than those who do not feel isolated (34%, n. 175) to not know where to find help around sex and/or relationships (p = .0005).

6.4.5. HIV status

Those who have not had an HIV test result are more likely (44%, n. 156) to not know where to find help around sex and/or relationships than those who have tested positive for HIV (38%, n. 21) and those who last tested negative for HIV (34%, n. 129) (p = .018).

6.4.6. Sexual assault

Table 6.4d shows that who have experienced sexual assault (39%) are less likely to know where to find help around sex/relationships if they needed it than those who have not experienced sexual assault (62%). This may be because they have exhausted avenues that are presumed to be open for this purpose or may be because they have less knowledge or access to support systems and networks. Although these reasons should be investigated, there is a clear need to address this with survivors of sexual assault.

Table 6.4d: If you needed help around sex/relationships would you know where to find it? By experiences of sexual assault

		No sexual assault	Sexual assault	Total
Yes	No.	473	11	484
	%	**62.1**	**39.3**	**61.3**
No	No.	289	17	306
	%	**37.9**	**60.7**	**38.7**
Total	No.	762	28	790
	%	100.0	100.0	100.0

6.5. Information on sexual health available in Brighton & Hove

This section discusses respondents' views on the information on sexual health that is available in Brighton and Hove. The questionnaire did not specify particular sources of information regarding sexual health instead it asked respondents comment on the information available on sexual health generally.

6.5.1. Availability of information

Table 6.5a: Responses regarding whether information on sexual health is readily available in Brighton and Hove

	Frequency	Percent	Valid %
Strongly agree	202	26.6	**28.0**
Agree	313	41.2	**43.4**
Neither agree nor disagree	145	19.1	**20.1**
Disagree	53	7.0	**7.4**
Strongly disagree	8	1.1	**1.1**
Total	721	95.0	100.0
Missing	38	5.0	
Total	759	100.0	

71% of respondents who answered the question agree or strongly agree that information on sexual health is readily available in Brighton and Hove

(table 6.5a above). While only 9% of respondents disagree or strongly disagree that such information is readily available, 20% of respondents neither agree or disagree that information on sexual health is readily available in Brighton and Hove. However, female respondents were less likely to think this was the case.

While the vast majority of male respondents (80%, n. 332) strongly agree or agree that information on sexual health is readily available in Brighton and Hove, only 57% (n. 161) of female respondents strongly agree or agree that this is the case. 13% (n. 36) of female respondents disagree or strongly disagree that information on sexual health is readily available, compared to 6% (n. 24) of male respondents. 30% (n. 86) of female respondents neither agree nor disagree that information on sexual health is readily available.

6.5.2. Ease of reading and understanding

Table 6.5b shows that, of those who answered the question, 71% (n. 507) agree or strongly agree that information on sexual health available in Brighton and Hove is easy to read and understand. Only 4% (n. 31) disagree or strongly disagree that it is easy to read and understand, but almost a quarter (24%, n. 172) neither agree nor disagree that it is easy to read and understand.

Table 6.5b: Responses regarding whether information on sexual health available in Brighton and Hove is easy to read and understand

	Frequency	Percent	Valid %
Strongly agree	186	24.5	**26.2**
Agree	321	42.3	**45.2**
Neither agree nor disagree	172	22.7	**24.2**
Disagree	26	3.4	**3.7**
Strongly disagree	5	.7	**0.7**
Total	710	93.5	100.0
Missing	49	6.5	
Total	759	100.0	

6.5.3. Quality of information on sexual health

65% (n. 457) of those who answered the question agree or strongly agree that the quality of the information on sexual health available in Brighton and Hove is very good. 29% (n. 204) neither agree nor disagree, and 6% (n. 42) disagree or strongly disagree that the quality of such information is very good.

6.5.4. Appropriateness of information on sexual health to respondents' sexual practices

55% (n. 386) of respondents who gave an answer to the question agree or strongly agree that the information available in Brighton and Hove on sexual health is appropriate to their sexual practices. However, almost a

third (31%, n. 215) neither agree nor disagree, and 15% (n. 105) disagree or strongly disagree that sexual health information available in Brighton and Hove is appropriate to their sexual practices (table 6.5c above).

Table 6.5c: Responses regarding how appropriate information on sexual health available in Brighton and Hove is to respondents' sexual practices

	Frequency	Percent	Valid %
Strongly agree	142	18.7	**20.1**
Agree	244	32.1	**34.6**
Neither agree nor disagree	215	28.3	**30.5**
Disagree	78	10.3	**11.0**
Strongly disagree	27	3.6	**3.8**
Total	706	93.0	100.0
Missing	53	7.0	
Total	759	100.0	

Amongst those who answered this question, responses varied by sexual identity, trans identity and gender. Lesbians, bisexual people, those who identify as queer or 'other', trans people, female respondents are less likely to think that the information is appropriate to them compared to other LGBT people.

6.5.4.1. Sexual identity

Figure 6.5a: 'Information on sexual health available in Brighton & Hove is appropriate to my sexual practices' - By sexual identity

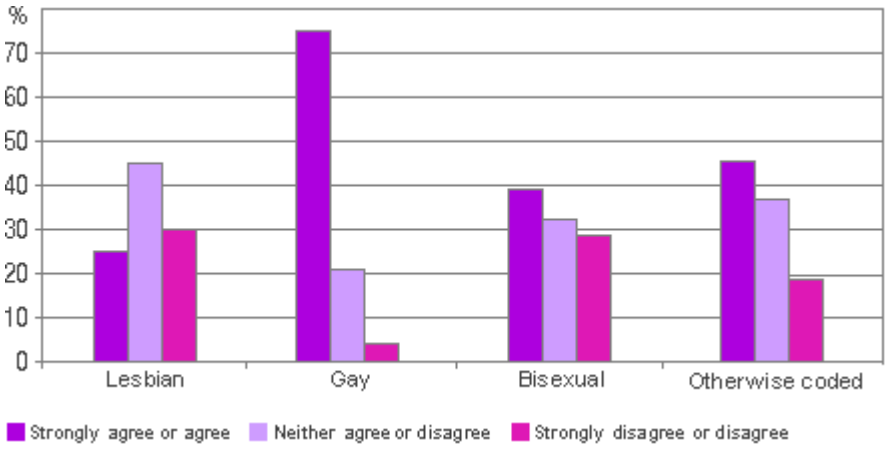


Figure 6.5a shows that gay men are much more likely (75%, n. 293) than lesbians (25%, n. 59), bisexual respondents (39%, n. 15) or those who identify as queer or of an 'other' sexual identity (45%, n. 19) to agree or strongly agree that information on sexual health available in Brighton and Hove is appropriate to their sexual practices ($p = .0005$). Lesbians (30%, n. 70) and bisexual respondents (28%, n. 11) are the most likely to disagree or strongly disagree that sexual health information available in Brighton and Hove is appropriate to their sexual practices. 19% (n. 8) of those identifying as queer or of an 'other' sexual identity, and only 4% (n. 16) of gay men disagree or strongly disagree that information on sexual health is appropriate to their sexual practices.

The focus groups offered some insights into how lesbian's and bisexual female respondents find the available information on sexual health. Frustration was a key emotion as the information does not address their sexual health needs.

Naomi: **Well, the only… I absolutely do not and never have thought that AIDS was a lesbian issue and there was an attempt for lesbians to get on… and why on earth anybody would want to get on that particular bandwagon I've no idea, but…**

Susan: **They did, yes, they did.**

Naomi: **… there was, and I thought… always thought it was completely foolish and a waste of time and there must be many unused dental dams around. [LAUGHTER] But, I mean the only health issues that I really know about for lesbians are like breast cancer… so I know precious little about that, but I do know that it's an issue for women who don't have children, I believe it is. I've really got very little to say, I'm very ignorant, woefully ignorant, maybe that's an issue…**

Susan: **This is a women's thing isn't it … but…**

Naomi: **I am woefully ignorant. No, it is a lesbian thing as well.**

(Women's focus group)

Naomi prompts concern about the effects that a lack of appropriate sexual health information can have for lesbians who have a lack of access to appropriate sexual health information. She also suggests that the content of such sexual health information has, in the past at least, been dominated by issues arising from the sexual health concerns of gay men. Similarly bisexual respondents felt that there is little information on sexual health that is appropriate for them as bisexual people. In this case, a bisexual woman suggests how the information on sexual health that she needs is specific to her being *both* a woman and bisexual. Her needs, in this sense, are different from those of both straight women and lesbians, and it would be insufficient and inappropriate for her to be given sexual health information that pertained to either of these groups.

Ruth: **Sexual health. I think there's… I know the Claude Nichol I've heard nothing but good about them and then there's… on top of that there's the Wilde Clinic for gay men and then there isn't so much here, but you know in London there was things specifically aimed at lesbians, but there's nothing aimed at bisexual people and that's a whole different thing on its own, because you've got… I mean I'm poly-amorous anyway, so I'm sleeping with people from both genders and so there isn't any information that's specifically aimed at bisexual people and about the issues around that and it's like, it's like if**

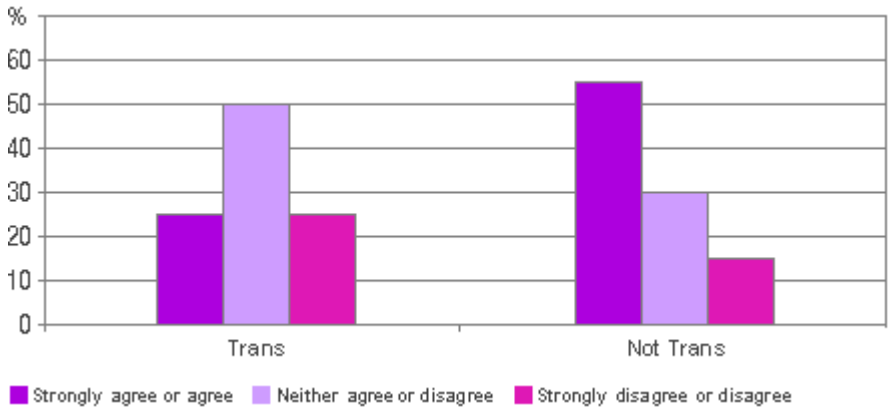
you look at the stuff that's aimed at straight women it doesn't really mention herpes that much about, you know, the chances of like contact between say women and oral sex with herpes and that sort of thing, so it's like it gets ignored, even though that from what I've heard, the actual health advisers up at the Claude Nichol seem to, you know, have a pretty good idea about it, but there doesn't seem to be, you know, you either go to a straight one or you go to gay one, there isn't anything in between.

(Bisexual focus group)

6.5.4.2. Trans

Trans respondents are less likely (25%, n. 6) than non-trans respondents (56%, n. 374) to agree or strongly agree that the information on sexual health available in Brighton and Hove is appropriate to their sexual practices ($p = .011$). They are also more likely to disagree or strongly disagree (25%, n. 6, compared to 15%, n. 97) that such information is appropriate to their sexual practices. 50% (n. 12) of trans respondents, however, neither agree nor disagree that sexual health information in Brighton and Hove is appropriate to their sexual practices, compared to 30% (n. 198) of non-trans respondents (see figure 6.5b).

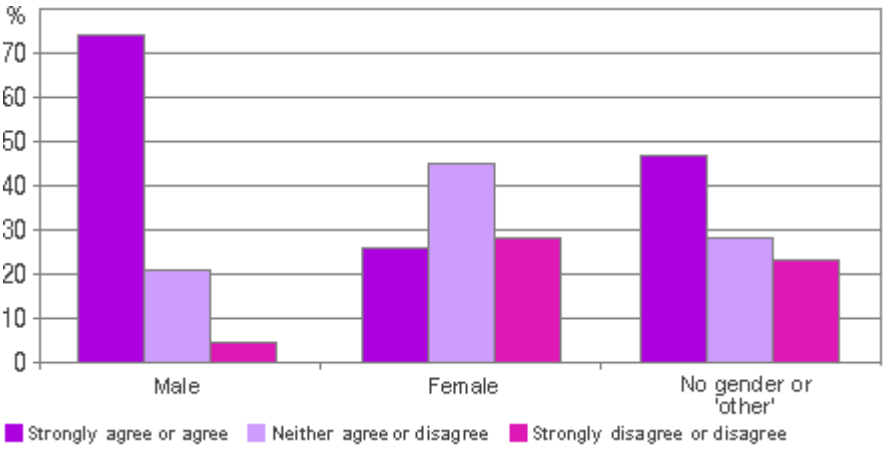
Figure 6.5b: 'Information on sexual health available in Brighton & Hove is appropriate to my sexual practices' - By trans identity



6.5.4.3. Gender

In terms of gender, male respondents are much more likely (74%, n. 302) than female respondents (26%, n. 71), but also more likely than those of no gender or an 'other' gender (48%, n. 10) to agree or strongly agree that information available in Brighton and Hove on sexual health is appropriate to their sexual practices ($p = .0005$) (figure 6.5c). Women (29%, n. 78) and those of no gender or an 'other' gender (24%, n. 5) are much more likely than men (5%, n. 21) to disagree or strongly disagree that sexual health information in Brighton and Hove is appropriate to their sexual practices.

Figure 6.5c: 'Information on sexual health available in Brighton & Hove is appropriate to my sexual practices' - By gender



6.5.5. Appropriateness of information on sexual health to sexual or gender identities

Table 6.5d: The information on sexual health available in Brighton and Hove is appropriate to respondents' gender identity or sexuality

	Frequency	Percent	Valid %
Strongly agree	152	20.0	**21.5**
Agree	263	34.7	**37.1**
Neither agree nor disagree	183	24.1	**25.8**
Disagree	79	10.4	**11.2**
Strongly disagree	31	4.1	**4.4**
Total	708	93.3	100.0
Missing	51	6.7	
Total	759	100.0	

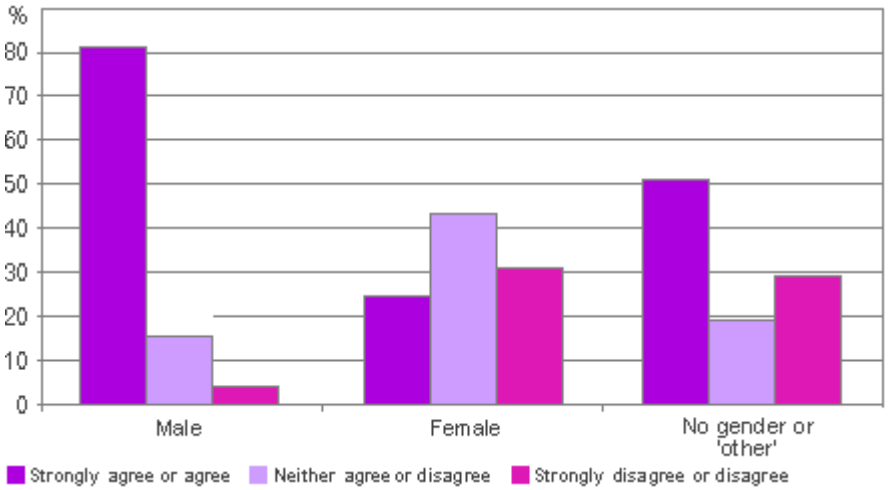
59% (n. 415) of respondents who answered the question strongly agree or agree that information on sexual health available in Brighton and Hove is appropriate to their sexual and gender identity. 16% (n. 110) of respondents disagree or strongly disagree that information on sexual health available in Brighton and Hove is appropriate to their sexual and gender identity, with just over a quarter of respondents (26%, n. 183) neither agreeing nor disagreeing. This indicates that the majority of people believe that the information is appropriate; however, there are some variations by identity groupings. Women, those of another/no gender, lesbians, bisexuals and those of another sexual identity and trans people are less likely to agree that the information on sexual health is appropriate to them.

6.5.5.1. Gender

Figure 6.5d (below) shows that male respondents are more likely (81%, n. 332) than those identifying as of no gender or an 'other' gender (52%, n. 11) and much more likely than women (25%, n. 69) to strongly agree or agree with the proposition 'information on sexual health available in Brighton

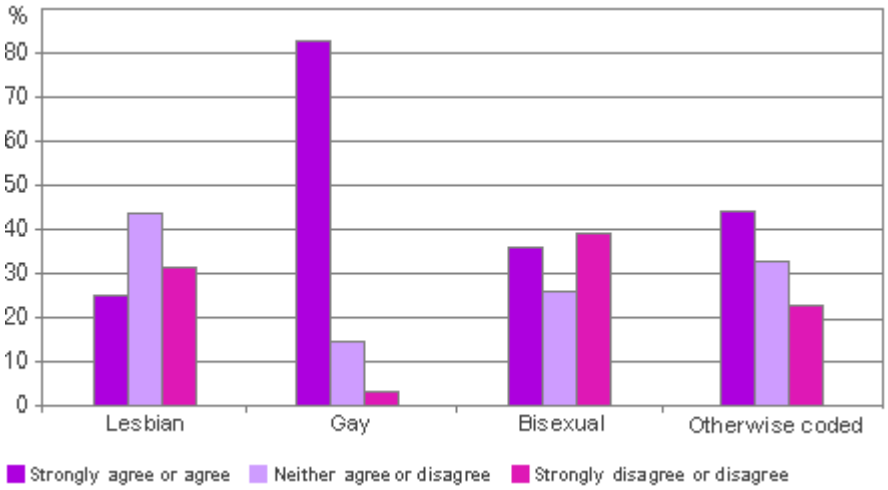
and Hove is appropriate to my gender identity or sexuality' (p = .0005). Female respondents are much more likely (43%, n. 118) than either those of no gender or an 'other' gender (19%, n. 4) or men (15%, n. 61) to neither agree nor disagree with the proposition. Men are much less likely (4%, n. 16) to disagree or strongly disagree with the proposition than female respondents (32%, n. 87) or those of no gender or an 'other' gender (29%, n. 6).

Figure 6.5d: 'Information on sexual health available in Brighton & Hove is appropriate to my gender identity or sexuality' - By gender



6.5.5.2. Sexuality

Figure 6.5e: 'Information on sexual health available in Brighton & Hove is appropriate to my gender identity or sexuality' - By sexuality



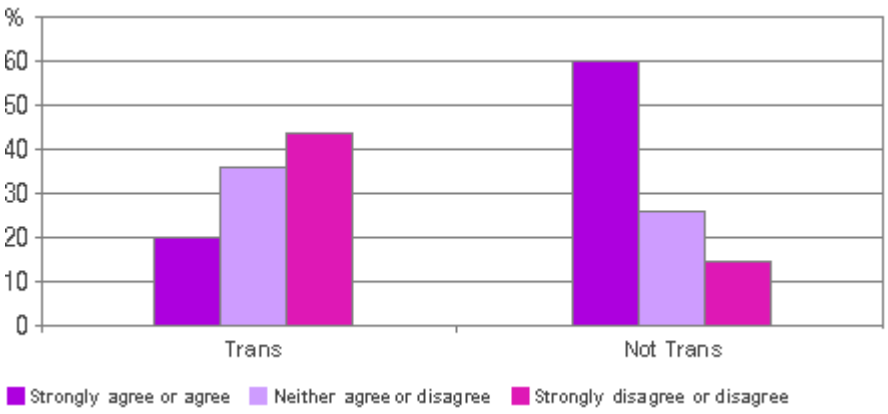
Gay men are more likely (83%, n. 324) to strongly agree or agree with the proposition that 'information on sexual health available in Brighton and Hove is appropriate to my gender identity or sexuality' than those who are identity as bisexual (36%, n. 14) or identify as queer or in an 'other' sexuality (44%, n. 19) (p = .0005) (see figure 6.5e above). Lesbians are less

likely than all of these groups to strongly agree or agree with the proposition (25%, n. 58). Gay men are also the least likely group by sexuality to disagree or strongly disagree with the proposition (3%, n. 11). 23% (n. 10) of those identifying as queer or of an 'other' sexuality disagree or strongly disagree with the proposition as do almost a third (32%, n. 74) of lesbians. 39% (n. 15) of bisexuals disagree or strongly disagree that sexual health information is appropriate to their gender identity or sexuality.

6.5.5.3. Trans

Trans respondents are also much more likely (44%, n. 11) than all other respondents (15%, n. 97) to disagree or strongly disagree with the proposition that 'information on sexual health available in Brighton and Hove is appropriate to my gender identity or sexuality' ($p = .0005$) (see figure 6.5f). They are much less likely (20%, n. 5, compared to 60%, n. 403 for non-trans respondents) to strongly agree or agree with the proposition.

Figure 6.5f: 'Information on sexual health available in Brighton & Hove is appropriate to my gender identity or sexuality' - By trans identity



6.5.6. Diversity of information on sexual health

Table 6.5e: Information on sexual health available in Brighton and Hove is diverse, catering for all groups

	Frequency	Percent	Valid %
Strongly agree	121	15.9	17.2
Agree	191	25.2	27.1
Neither agree nor disagree	262	34.5	37.2
Disagree	100	13.2	14.2
Strongly disagree	31	4.1	4.4
Total	705	92.9	100.0
Missing	54	7.1	
Total	759	100.0	

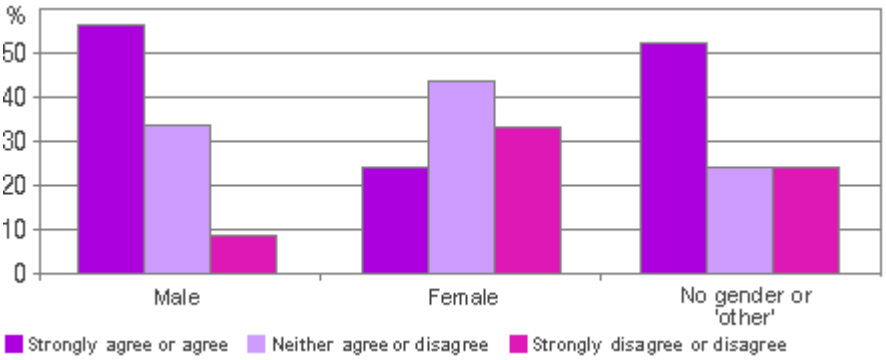
Less than half (44%, n. 312) of respondents who offered an answer to this question agree or strongly agree that information on sexual health

available in Brighton and Hove is diverse and caters for all groups. 19% (n. 131) disagree or strongly disagree, and 37% (n. 262) neither agree nor disagree that such information is diverse, catering for all groups (see table 6.6a). Responses to this question vary by gender, ethnicity and sexual identity. Those who are female, BME or of an ethnicity other than white/BME and bisexual are less likely to say that information on sexual health is diverse and caters for all groups.

6.5.6.1. Gender

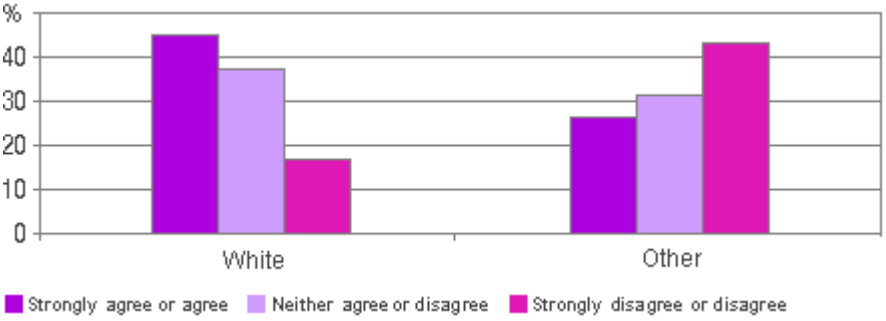
Figure 6.5g (below) shows that female respondents are far less likely (25%, n. 68) to strongly agree or agree that sexual health information is diverse and caters for all groups, compared to male respondents (57%, n. 231) and those identifying as of no gender or an 'other' gender (52%, n. 11). Women are more likely to disagree or strongly disagree that sexual health information is diverse and caters for all groups (32%, n. 89) than those of no gender or an 'other' gender (24%, n. 5), and especially compared to men (9%, n. 35) ($p = .0005$).

Figure 6.5g: 'Information on sexual health available in Brighton & Hove is diverse, catering for all groups' - By gender



6.5.6.2. Ethnicity

Figure 6.5h: 'Information on sexual health available in Brighton & Hove is diverse, catering for all groups' - By ethnicity



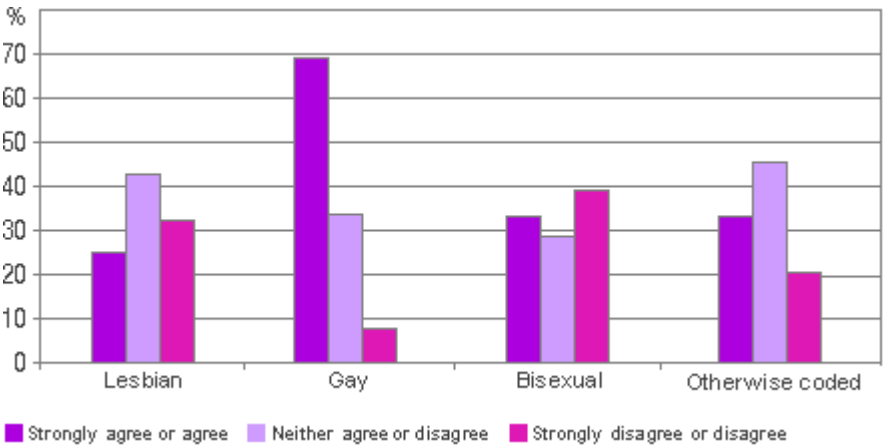
In terms of ethnicity, white respondents are more likely (46%, n. 300) than those in other ethnicity groups (BME, Gypsy traveller or 'other') (26%, n. 11)

to strongly agree or agree that sexual health information is diverse and caters for all groups (p = .0005). Those in other ethnicity groups than white are much more likely (42%, n. 18) to disagree or strongly disagree that sexual health information is diverse and caters for all groups than white respondents (17%, n. 111) (see figure 6.5h above).

6.5.6.3. Bisexual

Bisexual respondents are more likely (39%, n. 15) than other sexuality groups to disagree or strongly disagree that information on sexual health available in Brighton and Hove is diverse and caters for all groups (p = .0005) (see figure 6.5i below). This compares to 33% (n. 77) of lesbians, 21% (n. 9) of those identifying as queer or of an 'other' sexuality, and only 8% (n. 30) of gay men. Lesbians are the least likely sexuality group to strongly agree or agree that sexual health information is diverse and caters for all groups (25%, n. 58). This compares to a third (33%, n. 13) of bisexual respondents and of those of identifying as queer or an 'other' sexuality (33%, n. 14), and to 58% (n. 227) of gay men.

Figure 6.5i: 'Information on sexual health available in Brighton & Hove is diverse, catering for all groups' - By sexuality



6.5.6.4. Other responses regarding information on sexual health

Table 6.5f: Major categories from qualitative data: 'Is there anything else you want to tell use about sexual health information in Brighton and Hove?'

Categories	No. of responses
No information/not enough information for:	
Lesbians/Women	35
Bisexual	10
Of Which: Bisexual women	4
Trans	7
LGBT people generally	1

Polyamorous/people who have sex with multiple partners	1
People living with HIV	1
People with BDSM/fetish lifestyle	1
Those who have experienced rape and/or sexual abuse	1
Elderly	1
Non-scene users	1
No information/not enough information at all	3
It caters mainly/too much for:	
Men/Gay men	21
Stopping spread of HIV	6
Straight people	5
Young people	2
No information/not enough information regarding:	
Safe sex for women who have sex with women	11
Specific STIs	3
Safe sex for people who have sex with people who collectively have various gender and sexual identities	2
Avoiding transmission of HIV	2
Safe sex for married men who have sex with men	1
Sexual health in broader sense than stopping STIs	1
Information is difficult to access/not very 'visible'	8
I have never/not recently looked for sexual health information	8
People ignore sexual health information/are unaware of sexual health issues	8
Of Which: Gay men	2
Young people	3
Better distribution/dissemination of information needed	6
Of WhichIn bars/venues	3
By Terrence Higgins Trust	2
About lesbian sexual health	1
Problematic/inappropriate language or content of sexual health information	5
I don't think I need sexual health information	3
Information is readily available	3
Information is available if you know where to look	2
Information is available at:	
Cafes	2
Bars	1
Saunas	1
More information regarding clinics needed	2
Specialist sexual health clinics needed for lesbians	7
Clinic waiting times too long/more appointments needed	7
Of Which: Claude Nicol	3
Do not feel comfortable/safe using existing clinic services	2
Praise for sexual health services/information providers:	
NHS/Miscellaneous clinics	4
Claude Nicol	3
VCS	4
Of Which: Terrence Higgins Trust	2

LGBT Switchboard	1
General	3
Need better distribution/availability of:	
Condoms	3
Dental dams	2

Notes:
1. Where responses fall into more than one category they are counted in each category that they fall into.
2. Where a response falls into one or more category and contains a comment that does not fall into one of the major categories, the response is counted within the major categories it falls into and is listed under 'Other responses' in Table 6.8a below.
3. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.
4. Subsets of a major category (marked by 'Of Which') are not mutually exclusive with respect to other subsets of the same major category: a single response (counted only once under the major category) may fall into more than one subset of the major category.
5. The total of the subsets (marked by 'Of Which') for any major category do not necessarily enumerate the total number of responses for that major category.
6. The category 'Specialist sexual health clinics needed for lesbians' and the categories listed below this are separated from the rest of the table to indicate that they do not pertain to sexual health information per se.

The questionnaire also offered respondents the opportunity to provide any other comments regarding sexual health information in Brighton and Hove. Table 6.5f below shows the frequency by which respondents indicated other kinds of comments regarding sexual health information.

6.6. Women's Sexual health information

The qualitative questionnaire data in part reflected the quantitative data regarding gender and sexuality and the absence of information for women/lesbians/bi people (45 answers in total). Many of the 35 responses that discussed women and lesbians contrasted the lack of sexual health information available for women and especially lesbians with the perceived abundance of sexual health information available for men, especially gay men. The majority of the 21 responses that suggested that sexual health information focuses on the needs of men:

> **There is lots of good info for gay men, though always room for improvement. Very little for lesbians, bisexuals or trans people. As sexual health info is largely provided by organisations primarily concerned by HIV prevention this isn't surprising but disappointing considering the findings of the last count me in survey.**
>
> *(Questionnaire 304)*

Questionnaire 304 suggests that the prevalence of sexual health information for men might be a consequence of the fact that much of the responsibility for the provision of sexual health information lies with organisations concerned with preventing transmission of HIV. Questionnaire 67 (below) also makes the comparison between the amount of sexual health information available for gay men and that available for lesbians and also makes the link to how sexual health information aimed

primarily at men is concerned with stopping the transmission of HIV and other STIs:

> **there's a lot of information on HIV and Aids and STDs relating to being 2 gay men but it doesn't make you aware that 2 women can also pass STDs to each other, I told a female friend of mine this and she was shocked 2 women can pass STDs to each other she thought it was penetration that passed them!!!**
>
> (Questionnaire 67)

> **I think there is a lack of relevant, well researched sexual health information for lesbians (and perhaps celibate women) everywhere. Info on women's sexual health always seems to be for sexually active straight women. You just don't see articles on whether celibate women need smear tests etc.**
>
> (Questionnaire 610)

> **Not enough information on lesbian sexual health and some specific practices. No one to ask. Would never ask my doctor or any straight person.**
>
> *(Questionnaire 241)*

Respondent 67 recognises the consequences of a lack of sexual health information specific to lesbians and the lack of awareness amongst many lesbians regarding the risks of transmitting STIs through lesbian sexual practices. The absence of information on lesbian sexual health links to the responses regarding the perception that sexual health check ups are not needed for lesbians/women who have sex with women (see section 6.3.4.3 above).

HIV transmission may also be the reason that there is a focus on heterosexual women and why there is dubious knowledge and understanding of STI's. The absence of information centres for lesbians/bi women means that 'straight' doctors are not seen as approachable or able to be consulted with on these issues. A number of other comments also picked up on the need for information to be relevant to lesbian sexual practices, and not make assumptions regarding what these practices are.

As questionnaire 304 (above) suggests when remarking upon the lack of information for bisexual and trans people, it is not only lesbians for whom there is a dearth of sexual health information. There is a need for more information for bisexual people, and the provision of sexual health information for bisexual people needs to account for gender differences as well as differences of sexuality.

> **I haven't found enough sexual health info specific to bi women, that cover -safer sex with women - things to be aware of when you may be having sex with men/women of varying sexualities – e.g. I have sex with bi women, bi men, lesbian women, straight men. I would like safer**

sex info appropriate to all these groups, in one place so I don't have to hunt it all down in different places! I also think it would be of use in the LGBT community, as unsafe sex can happen when a person has sex with someone they wouldn't include in their primary identity (e.g. a lesbian having sex with a man).

(Questionnaire 38)

This respondent notes that it is not only lesbians who compose the population of women who have sex with women. Bisexual women can have sex with people who collectively have various gender and sexual identities. The implications of this is that bisexual women might engage in a wider variety of different kinds of sexual practices than often allowed for in sexual health literature targeted at either straight women or lesbians, and might therefore have different requirements for information regarding sexual health risks and precautions. Such an argument can be made for bisexual men, too. The bisexual focus group reiterated this point.

6.7. Gay men and sexual health

Despite the number of responses suggesting that sexual health information for gay men is widely available in Brighton and Hove, some respondents expressed concerns regarding rising levels of STIs among gay men in the city:

… Info available does not include enough on more recent problems such as Syph coming back, Chlamydia or Hep C

(Questionnaire 600)

Others linked the transmission of STIs to sexual practices among gay men and the prevalence of such sexual practices to problems with the effectiveness of sexual health information.

… Gay men in Brighton (those on the scene) tend to sleep around and the same std can be passed on and by the time you get cleared and sleep with another guy you catch it again.

(Questionnaire 572)

… I am very concerned with unsafe sex practices which are rife so I'm doubtful about current effectiveness of information and its distribution.

(Questionnaire 064)

There is a perceived gap between the available information on sexual health and the reality of sexual practice among some gay men. In

particular, respondents drew attention to how men who would ordinarily be receptive to messages regarding safe sex may, under certain circumstances such as depression or isolation, act differently. For individuals experiencing such mental health difficulties, the communication of sexual health information might need to be part of a broader strategy dealing with these individuals' broader health issues, indicating that multiple marginalisations cannot be addressed through a focus on one aspect of health.

> **yeah, it's all in the world of pamphlets left on the side of bars or cafes, what's out there in literature and what really occurs especially with gay men are poles apart - i've know guys who would never have unsafe sex become depressed and then have bouts of unsafe sex - because of that attitude of feeling so alone and unloved in the world - condoms hmmmm FUCK it**
>
> *(Questionnaire 690)*

Still other respondents made suggestions as to how perceived problems with the effectiveness of sexual health information could be addressed. Questionnaire 572 suggests that ways could be found for making screening and testing for STIs more acceptable and commonplace among gay men.

> **testing should be made more fashionable and less looked down upon. All gay men should view std screening as a must then we would all be safer…**
>
> *(Questionnaire 572)*

Several focused on the provision of information and free condoms at venues on the LGBT scene.

> **More active promotion in LGBT venues, such as major club nights (Revenge on a Saturday night, Wild Fruit). The provision of free condoms on the scene, and a rotation of service providers attending such venues to inform individuals of the services available in Brighton from all areas of sexual health, community projects, support and social groups, and any other interested parties.**
>
> *(Questionnaire 653)*

> **I think the provision of free condoms and lube for the men in gay venues is a good thing.**
>
> *(Questionnaire 299)*

These respondents argue that efforts to improve the provision and distribution of sexual health information should consider such contexts for communication and the spaces where LGBT people will access sexual health information. However, such efforts should also consider the importance of not overlooking those who do not socialise on the scene very

much; other modes of and contexts for communication need to be found for such individuals.

> **Not going out on the scene much I cannot comment on whether it provides adequate information on sexual health.**
>
> *(Questionnaire 283)*

Other responses indicated that people were too new to Brighton & Hove and that they haven't accessed the information for a number of years. The context as well as the relevance of the information are clearly factors in whether and how people access sexual health information.

Table 6.8a shows responses that could not be grouped into these categories of responses. These show individual responses that relate to particular life courses, circumstances and stories as well as some requests for funding and celebration of current success stories.

Table 6.8a: Other responses: 'Is there anything else you want to tell use about sexual health information in Brighton and Hove?'

The individual I had sex with was unaware of my gender identity and therefore my true sexuality also. I assume she thought I was a heterosexual male.
I had a catholic upbringing. 95% of my sexual health knowledge was learnt off the internet, friends or trial and error
information needed on clinics and opening times with easier accessibility
Does not match the availability of services
More government money to address huge rise in general rates of STD infection in B&H
Advice on sex within a relationship when one partner is not monogamous
You are doing a good job, but must learn to 'blow your own trumpet' about key successes more
Never used any facilities of this nature in Brighton
I have only ever had one physical experience with a woman and none with men I think this is something gay straight and bi would find hard to understand but before i moved to Brighton didn't want to commit to a boy friend when I knew I liked women as well and haven't met any people worth getting into a relationship with since but I'm looking

6.8. Conclusions

Just under a quarter of all respondents (25%, n. 202) have never had a sexual health check up, with 7% (n. 54) of respondents saying that they do not need one.

This chapter has shown that there are differences between LGBT people on the basis of having sexual health check ups, relevance of sexual health information and knowledge or availability of support around sex and relationships. These could be related to the emphasis on particular forms of sexually transmitted diseases and perceived risks amongst LGBT people.

Female respondents, lesbians, trans respondents, those who are disabled/long term health impaired, those who have not tested positive for HIV are less likely to have sexual health check ups than other LGBT people. Older LGBT people are more likely to say that they do not need sexual health check ups and younger people are more likely never to have had a sexual health check up. 25% of those who have had sex in the last three years say that they have never had, and 5% that they do not need, a sexual health check up.

Yet, those who are most sexually active are the most likely to get sexual health check ups 83% of those who have had 26 or more partners in the past 12 months have had sexual health check ups in the past 12 months. Conversely, those who have not had sex in the last twelve months are most likely to never have had a sexual health check up or to say that they do not need one (63%, n. 15).

In addition to what will be discussed in chapter 11, there is evidence to suggest that being out (perhaps finding a friendly GP) is linked to likelihood of having a sexual health check up, as those who are not out to their GP are less likely to have had sexual health check ups in the past 12 months and more likely to say that they have never had a sexual health check up.

39% (n. 307) said that they did not know where to find help around sex and relationships. This varies between LGBT people with queer, lesbian or 'other' in terms of sexuality, those who are trans, who are on a low income, who feel isolated, who have not tested positive for HIV and have experienced sexual assault being more likely to say that they would not know where to find help around sex and relationships. This indicates a particular area of support need and relevant information/signposting to appropriate services/support networks and groups. Although the majority (71%) of respondents thought that information on sexual health in Brighton & Hove is readily easy to read and understand and the quality is good, respondents are less likely to agree that the information available in Brighton and Hove on sexual health is appropriate to their sexual practices and/or their sexual and gender identity and is diverse and caters for all groups. This indicates areas of success for this information and also areas for development, particularly the diversification of the literature to cater more fully for the breadth of LGBT people, particularly, lesbians, bisexuals, trans people, female respondents and those who are BME.

7. Living with HIV

7.1. Introduction

This chapter explores those who are living with HIV – that is, those who have tested positive for HIV. As Count Me In Too included a broader range of LGBT people than just those living with HIV, it can offer some comparative insights into the experiences of LGBT people who are living with HIV in Brighton & Hove. This chapter compares their experiences and needs to those who have tested negative or who have not had an HIV test. However, these findings should be read alongside the existing body of literature that focuses specifically on this area. The chapter will firstly outline the prevalence of HIV in the research, and the variations between the sample of those living with HIV. It then looks at those who are living with HIV and compares them to LGBT people who have not tested positive for HIV in relation to support needs, social networks and support and information.

7.2. Prevalence

Table 7.2a shows that, of those who answered the question, 55% (n. 443) of respondents have had an HIV test result.

Table 7.2a: Have you ever received an HIV test result?

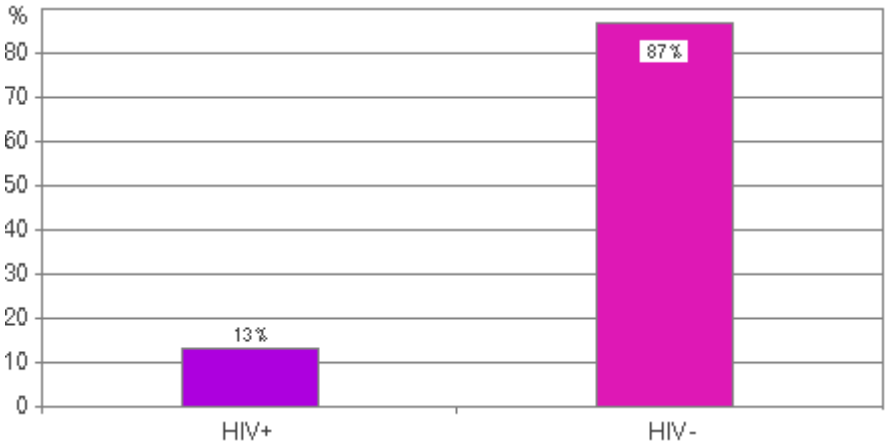
	Frequency	Percent	Valid %
Yes	443	54.1	**55.0**
No	362	44.2	**45.0**
Total	805	98.3	100.0
missing	14	1.7	
total	819	100.0	

Of those who have had an HIV test result, 13% (n. 56) have tested positive and 87% (n. 386) have tested negative (see table 7.2b and figure 7.2a).

Table 7.2b: What was your most recent result?

	Frequency	Percent	Valid %
HIV+	56	12.6	**12.7**
HIV-	386	87.1	**87.3**
Total	442	99.8	100.0
missing	1	.2	
total	443	100.0	

Figure 7.2a: What was your most recent result?



Among those who have tested HIV negative, only 45% (n. 168) of respondents have last had an HIV test result within the last twelve months (see table 7.2c).

Table 7.2c: If negative, were the results within the last 12 months?

	Frequency	Percent	Valid %
Yes	168	43.5	**44.9**
No	207	53.4	**55.1**
Total	374	96.9	100.0
missing	12	3.1	
total	387	100.0	

What is interesting to note here is that, among those who have had an HIV test, there are certain groups of people where very few if any members of the group have tested positive for HIV. This means that statistical analysis is not possible to show likelihood, however descriptive statistics indicate the groups under discussion in this chapter. All of those who are living with HIV are white, and identify as gay, bisexual or queer. None of those living with HIV are trans or Deaf. No women reported having tested positive for HIV.

7.2.1. Sexual identity

Among those who have been tested for HIV, no lesbians or those of an 'other' sexual identity have tested positive (the numbers of those who tested negative are 64 and 13 in these two groups, respectively). This compares to 4% (n. 1) of bisexual respondents, and, more notably, 15% (n. 3) of queer respondents and 16% (n. 52) of gay male respondents.

7.2.2. Trans identity

Although 18 people who identified as trans had been tested for HIV, none of them have tested positive. This compares to the 13% (n. 56) of non-trans people who have tested positive for HIV.

7.2.3. Ethnicity

Nobody who identified as BME or as a Traveller or Other ethnicity has tested positive for HIV, compared to the 14% (n. 56) of white respondents who have tested HIV positive. 12 respondents who identified as BME and 17 who identified as a traveller or of an other ethnicity say they have been tested for HIV.

7.2.4. Deaf identity

Although 17 deaf respondents have had an HIV test, all of these respondents have last tested negative.

7.2.5. Disability

Despite HIV being a recognised disability/long term health impairment, 7% (n. 26) of those who do not identify as disabled/long term health impaired have tested positive for HIV. 36% (n. 29) of those who identify as disabled and/or long term health impaired have tested positive for HIV (see chapter 11).

7.3. Categories of living with HIV

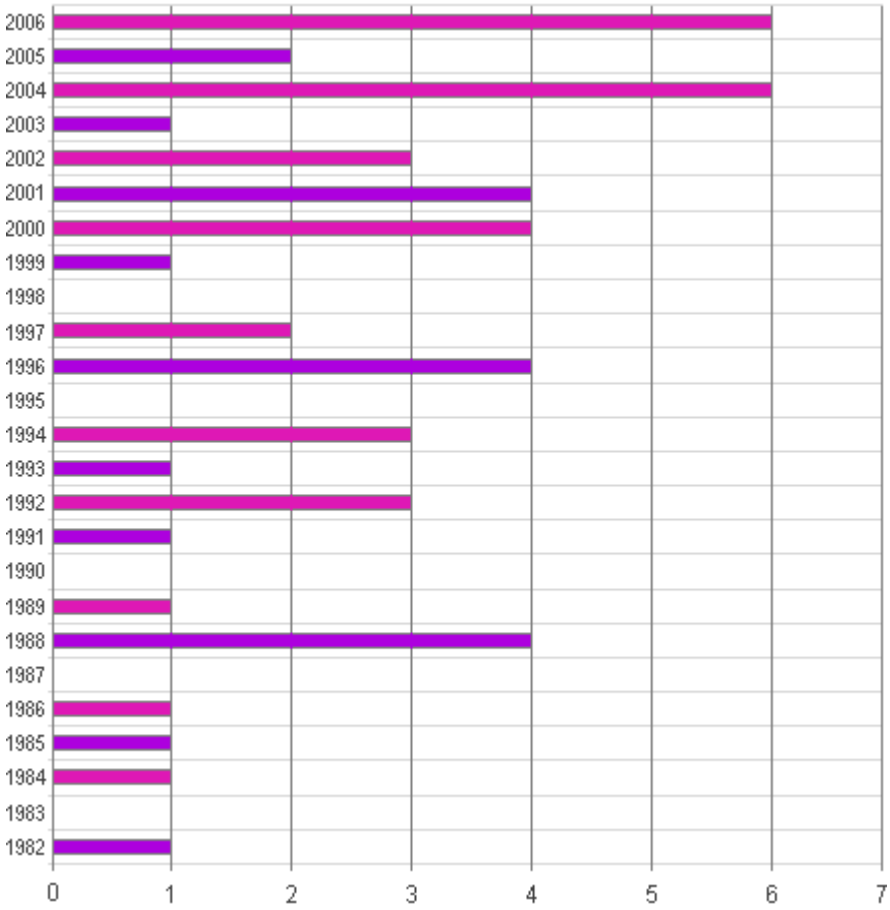
For the rest of this chapter, those who answered the question about HIV test results have been recoded into three categories as can be seen in table 7.3a below. While 48% (n. 386) of respondents have had an HIV test and tested negative, 7% (n. 56) have tested positive. 45% (n. 362) of respondents have not had an HIV test or have not yet received an HIV test result.

Table 7.3a: HIV test result recoded into three categories

	Frequency	Percent	Valid %
Taken test, result positive	56	6.8	**7.0**
Taken test, result negative	386	47.1	**48.0**
Not received a result	362	44.2	**45.0**
Total	804	98.2	100.0
missing	15	1.8	
total	819	100.0	

Figure 7.3a shows the frequency of the years in which respondents report they received their positive diagnosis for HIV. 50 respondents out of the 56 who say they have tested HIV positive offered a response. As can been seen, the two most frequent years for diagnosis (2004 and 2006 with 6 apiece) are within the two most recent years before the survey was conducted. Furthermore, over half of the respondents (n. 26) have received their HIV positive diagnosis since 2000. The earliest diagnosis reported is 1982.

Figure 7.3a: Year of first HIV diagnosis



The likelihood of having had an HIV test and of having tested positive both vary by: whether or not the respondents live in Brighton and Hove; age; gender; income; employment status; and area of residence. Those who are living with HIV are more likely to be over 36, be male (no women tested positive in this survey, women were the group most likely to have never received a HIV test result), not be employed, to live in Brighton & Hove and in Kemptown and St. James Street (although the majority still lived elsewhere in the city).

7.3.1. Age

Those who have tested positive for HIV are more likely (39%, n. 22) to be aged between 36 and 45 than those who have tested HIV negative (35%, n. 134) or those who have not had an HIV test result (26%, n. 93) ($p = .003$). They are also more likely to be aged 46 to 55 than those who have tested HIV negative (15%, n. 57) or those who have not received an HIV test result (14%, n. 52). Those who have tested HIV positive are less likely to be aged under 26 (4%, n. 2) or aged between 26 and 35 (23%, n. 13) than the other those who have tested HIV negative or those who have not had an HIV test result (see table 7.3b).

Table 7.3b: HIV test results by age

		Taken test, result positive	Taken test, result negative	Not received a result	Total
>26	No.	2	46	72	120
	%	3.6	11.9	19.9	14.9
26-35	No.	13	115	108	236
	%	23.2	29.8	29.8	29.4
36-45	No.	22	134	93	249
	%	39.3	34.7	25.7	31
46-55	No.	13	57	52	122
	%	23.2	14.8	14.4	15.2
55+	No.	6	34	37	77
	%	10.7	8.8	10.2	9.6
Total	No.	56	386	362	804
	%	100.0	100.0	100.0	100.0

7.3.2. Gender

98% (n. 54) of those who have had a positive HIV test result are male, making them much more likely to be male than those who have been tested for HIV but who last tested negative (73%, n. 279) and especially those who have not received an HIV test result (32%, n. 114) (p = .0005). 65% (n. 236) of those who have never received an HIV test result (including those who have never been tested) are women. No women in the survey reported having tested HIV positive. 2% (n. 1) of those who have tested HIV positive identify as of no gender or an 'other' gender, compared to 4% (n. 14) of those who last tested HIV negative, and 3% (n. 11) of those who have never received a result (see table 7.3c).

Table 7.3c: HIV test results by gender

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Male	No.	54	279	114	447
	%	98.2	72.7	31.6	55.9
Female	No.	0	91	236	327
	%	0	23.7	65.4	40.9
No gender or 'other'	No.	1	14	11	26
	%	1.8	3.6	3	3.3
Total	No.	55	384	361	800
	%	100.0	100.0	100.0	100.0

7.3.3. Income

Those who have not received an HIV test result are more likely (25%, n. 88) to earn less than £10,000 a year than those who last tested negative for HIV (15%, n. 59) and those who have tested HIV positive (16%, n. 9) (p = .0005). Those who have tested HIV positive are more likely (48%, n. 27) to earn between £10,001 and £20,000 a year than those who have last tested HIV negative (28%, n. 109) and those who have not received an HIV test result

(30%, n. 107). They are less likely, however, to earn between £20,001 and £40,000 a year – 18% (n. 10), compared to 43% (n. 166) of those who last tested HIV negative and 37% (n. 130) of those who have never received an HIV test result. 18% (n. 10) of those who have tested HIV positive earn more than £40,001 a year, a higher proportion than the 13% (n. 50) of those who last tested HIV negative and the 9% (n. 31) of those who have not received an HIV test result (see table 7.3d).

Table 7.3d: HIV test results by income

		Taken test, result positive	Taken test, result negative	Not received a result	Total
>10k	No.	9	59	88	156
	%	**16.1**	**15.4**	**24.7**	**19.6**
10-20k	No.	27	109	107	243
	%	**48.2**	**28.4**	**30.1**	**30.5**
20-40k	No.	10	166	130	306
	%	**17.9**	**43.2**	**36.5**	**38.4**
40k+	No.	10	50	31	91
	%	**17.9**	**13**	**8.7**	**11.4**
Total	No.	56	384	356	796
	%	100.0	100.0	100.0	100.0

7.3.4. Employment

Table 7.3e shows that those who have tested positive for HIV are more likely (36%, n. 20) not to be in employment than those who last tested HIV negative (16%, n. 63) or those who have not received an HIV test result (18%, n. 64) ($p = .001$). They are also less likely to be employed full time (47%, n. 26) than those who last tested HIV negative (60%, n. 231) or those who have not received an HIV test result (53%, n. 190).

Table 7.3e: HIV test results by employment

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Employed full-time	No.	26	231	190	447
	%	**47.3**	**60**	**52.5**	**55.7**
Other	No.	9	91	108	208
	%	**16.4**	**23.6**	**29.8**	**25.9**
Not employed (inc retired)	No.	20	63	64	147
	%	**36.4**	**16.4**	**17.7**	**18.3**
Total	No.	55	385	362	802
	%	100.0	100.0	100.0	100.0

Interestingly, despite the differences by income and employment, those who are living with HIV do not have significantly different educational qualifications when compared with the rest of the sample.

7.3.5. Residence in Brighton and Hove

96% (n. 54) of those who have had a positive HIV test result live in Brighton and Hove, making this group more likely to live in Brighton and Hove than those who last tested HIV negative (89%, n. 340) and those who have not received an HIV test result (84%, n. 303) (p = .017).

Table 7.3f: HIV test results by 'Do you currently live in Brighton and Hove?'

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Yes	No.	54	340	303	697
	%	**96.4**	**88.8**	**84.2**	**87.2**
No	No.	2	43	57	102
	%	**3.6**	**11.2**	**15.8**	**12.8**
Total	No.	56	383	360	799
	%	100.0	100.0	100.0	100.0

7.3.6. Area of residence

Those who have tested HIV positive are more likely (24%, n. 13) to live in Kemptown or the St James Street area than those who last tested HIV negative (19%, n. 70) or those who have not received an HIV test result (14%, n. 50). They are also much more likely to live in one of the other 'areas of potential deprivation' in Brighton and Hove (41%, n. 22) than those who have last tested HIV negative (25%, n. 91) and those who have not received an HIV test result (25%, n. 86) (p = .006) (see the list of Key Terms in the Introduction for a definition of 'areas of potential deprivation'). They are less likely (35%, n. 19) to live in other areas of Brighton and Hove or outside of Brighton and Hove than those who last tested HIV negative (56%, n. 207) and those who have not received an HIV test result (61%, n. 212).

Table 7.3g: HIV test results by area of residence

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Kemptown and St James Street	No.	13	70	50	133
	%	**24.1**	**19**	**14.4**	**17.3**
Other areas of potential deprivation	No.	22	91	86	199
	%	**40.7**	**24.7**	**24.7**	**25.8**
None of these areas	No.	19	207	212	438
	%	**35.2**	**56.3**	**60.9**	**56.9**
Total	No.	54	368	348	770
	%	100.0	100.0	100.0	100.0

7.4. Support needs

This section looks at the relationships among HIV status and potential support needs pertaining to taking 'illegal drugs' and/or alcohol, emotional and mental well being, sexual behaviour and disclosure of gender and/or sexual identity to GPs. Those who are living with HIV are more likely to have taken 'illegal drugs' in the past five years, less likely to have good emotional health in the past year and have disclosed their sexual or gender identity to their GP.

7.4.1. 'illegal drugs' and alcohol

Those who have tested HIV positive are more likely (69%, n. 38) to have taken 'illegal drugs' within the last five years than those who last tested HIV negative (55%, n. 208) and those who have not received an HIV test result (44%, n. 158) ($p = .0005$). However, there is no significant relationship between drinking alcohol and HIV status.

7.4.2. Emotional and mental well being

Table 7.4a: HIV test results by emotional and mental well being over the last twelve months

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Very good	No.	9	94	85	188
	%	**16.1**	**24.5**	**23.5**	**23.4**
Good	No.	15	156	137	308
	%	**26.8**	**40.6**	**37.8**	**38.4**
Neither good nor poor	No.	17	59	75	151
	%	**30.4**	**15.4**	**20.7**	**18.8**
Poor	No.	11	57	58	126
	%	**19.6**	**14.8**	**16**	**15.7**
Very poor	No.	4	18	7	29
	%	**7.1**	**4.7**	**1.9**	**3.6**
Total	No.	56	384	362	802
	%	100.0	100.0	100.0	100.0

Table 7.4a shows that only 16% (n. 9) of those who have tested positive for HIV describe their emotional and mental well being over the last twelve months as 'very good' and only 27% (n. 15) describe it as 'good'. This makes them less likely to do so than either those who have last had a negative HIV test result (25%, n 94 described their emotional and mental well being as 'very good' and 41%, n. 156 as 'good') or those who have not received an HIV test result (24%, n. 85 described their emotional and mental well being as 'very good' and 38%, n. 137 as 'good') ($p = .023$). Respondents living with HIV are also more likely to say that their emotional and mental well being is 'neither good nor poor' (30%, n. 17), 'poor' (20%, n. 11), or 'very poor' (7%, n. 4) than the other two groups. By comparison, among those who last received a negative HIV test result, 15% (n. 59) described their emotional and mental well being as 'neither good nor poor', 15% (n. 57) as 'poor' and 5% (n. 18) as 'very poor'. 21% (n. 75) of

those who have not had an HIV test result described their emotional and mental well being as 'neither good nor poor', 16% (n. 58) as 'poor', and 2% (n. 7) as 'very poor'.

LGBT people regardless of HIV status experience similar levels of the following specific mental health difficulties in the past five years: significant emotional distress; depression; anxiety; isolation; confidence/self esteem; stress; anger management; fears/phobias; problem eating disorders; panic attacks; self harming; addictions or dependencies; suicidal thoughts or 'none of the above' mental health difficulties.

7.4.3. Housing and homelessness

(see also Browne and Davis, 2008)

Those who have tested positive for HIV are more likely (29%, $p<.05$) to have experienced homelessness than those who have received a negative test result or who have not been tested (22%). It is not possible to ascertain from this data whether homelessness resulted in living with HIV or if living with HIV resulted in homelessness.

Those who are living with HIV (14%) are more likely to have been homeless in Brighton & Hove in the past five years compared to those who are negative and/or have not been tested (11% $p = .01$). Those living with HIV (18%) are more likely than those who have not been tested for HIV or have tested negatively in their most recent test (6%) to have specialist housing needs ($p.=.002$). 30% of those who are living with HIV live in social housing compared to 8% of those who are negative or who have not had a HIV test. This indicates a reliance on state supported accommodation and housing.

7.4.4. Safety

(see also Browne and Lim, 2008)

37% of those who are living with HIV experienced discrimination on the basis of their gender and/or sexual identities in the areas where they lived. Those who are living with HIV have similar levels of experiences of all forms hate crime in the past five years except negative comments, compared to those who are not living with HIV. 39% of those who are not living with HIV and 57% of those who are ($p=.011$) have experienced negative comments in the past five years. Those who are living with HIV are more likely to say that there are places, services or facilities in Brighton and Hove where they do not feel safe, compared to those who have either tested negative or have not had a test result. 74% (n. 29) of those who had tested positive found that there were places, services or facilities in Brighton and Hove where they did not feel safe, compared to 53% (n. 290 $p = .03$) of those who had either tested negative or had not had a test result. Those who have tested positive are significantly more likely to not feel safe inside LGBT venues (14% compared to 4%) , in the 'gay village' (38% compared to 20%) and in cruising grounds than those who have tested negative or have not been tested (41% compared to 22%).

7.4.5. Sexual activity

Those who last tested HIV negative are the most likely group by HIV status to have had sex with somebody in the last three years (97%, n. 375) (p = .0005). 93% (n. 52) of those who living with HIV have had sex with someone in the last three years, a greater proportion than for those who have never received an HIV test result (90%, n. 322).

Table 7.4b: HIV test results by whether respondents have had sex with someone in the last three years

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Yes	No.	52	375	322	749
	%	**92.9**	**97.4**	**89.7**	**93.6**
No	No.	4	10	37	51
	%	**7.1**	**2.6**	**10.3**	**6.4**
Total	No.	56	385	359	800
	%	100.0	100.0	100.0	100.0

Table 7.4c: HIV test results by number of people respondents have had sex with in the last twelve months

		Taken test, result positive	Taken test, result negative	Not received a result	Total
1	No.	6	145	181	332
	%	**11.8**	**38.8**	**56.4**	**44.5**
2 - 5	No.	9	97	78	184
	%	**17.6**	**25.9**	**24.3**	**24.7**
6 - 10	No.	6	40	26	72
	%	**11.8**	**10.7**	**8.1**	**9.7**
11 - 15	No.	4	24	5	33
	%	**7.8**	**6.4**	**1.6**	**4.4**
16 +	No.	26	64	14	104
	%	**51**	**17.1**	**4.4**	**13.9**
None	No.	0	4	17	21
	%	**0**	**1.1**	**5.3**	**2.8**
Total	No.	51	374	321	746
	%	100	100	100	100

Over half of respondents who have tested positive for HIV (51%, n. 26) have had sex with 16 or more people in the last twelve months, making them much more likely to have done so than those who last tested HIV negative (17%, n. 64) and those who have never received an HIV test result (4%, n. 14) (p = .0005). No respondents living with HIV have not had sex with somebody over the past twelve months. Those who have tested HIV positive are also less likely to have had sex with only one person (12%, n. 6) or with between 2 and 5 people (18%, n. 9) in the past twelve months than those who last tested negative (39%, n. 145 have had sex with just one person in the past twelve months, 26%, n. 97 with between 2 and 5 people) and those who have not received an HIV test result (56%, n. 181 with one person, 24%, n. 78 with between 2 and 5 people). However, it is important to note

that since Count Me In Too did not ask people to specify the types of sex they are engaging in and whether or not they are practicing safe sex and using condoms, no conclusions can be drawn about risks of sex and onward transmission.

7.4.6. Disclosure of sexual and/or gender identity to GPs

85% (n. 48) of those who have had a positive HIV test result have disclosed to their GP that they are lesbian, gay, bisexual and/or trans, making them more likely to have done so than those who have last tested negative for HIV (61%, n. 234) or those who have never received an HIV test result (55%, n. 200) (p = .0005).

Table 7.4d: HIV test results by disclosure of sexual and/or gender identity to GP

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Yes	No.	48	234	200	482
	%	**85.7**	**61.1**	**55.4**	**60.3**
No	No.	8	149	161	318
	%	**14.3**	**38.9**	**44.6**	**39.8**
Total	No.	56	383	361	800
	%	100.0	100.0	100.0	100.0

7.5. Social networks and support

The questionnaire included a number of measures of social networks and support. Those who are living with HIV are less likely to participate in and enjoy the LGBT scene– and this can be seen as an indication of how well respondents are connected with other LGBT people in the city, a connectivity that can be important for individuals' well being. A more explicit question about social support in times of personal crisis was also asked in the questionnaire. Of the options that respondents could choose from, a reliance on voluntary services in times of crisis is significantly related to HIV status. Again those living with HIV are more likely to be reliant on voluntary services in times of crisis than other LGBT people.

Table 7.5a: HIV test results by 'I enjoy going to/using LGBT commercial venues and events in Brighton and Hove'

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Agree	No.	37	298	248	583
	%	**66.1**	**77.6**	**68.9**	**72.9**
Disagree	No.	8	24	21	53
	%	**14.3**	**6.3**	**5.8**	**6.6**
I don't use	No.	7	40	54	101
	%	**12.5**	**10.4**	**15**	**12.6**
Unsure	No.	4	22	37	63
	%	**7.1**	**5.7**	**10.3**	**7.9**
Total	No.	56	384	360	800
	%	100	100	100	100

Those who have tested positive for HIV are more likely (14%, n. 8) to disagree with the statement 'I enjoy going to/using LGBT commercial venues and events in Brighton and Hove' than those who last tested HIV negative (6%, n. 34) and those who have never received an HIV test result (6%, n. 21) (p = .015). They are also less likely to agree with the statement (66%, n. 37) than those who last tested HIV negative (78%, n. 298) and those who have never received an HIV test result (69%, n. 248) (see table 7.5a). This is perhaps unsurprising given the results above regarding feelings of safety in LGBT venues and events, the gay village and cruising grounds.

Respondents who have tested HIV positive are more likely (15%, n. 8) than those who last tested HIV negative (4%, n. 14) or those who have not received an HIV test result (4%, n. 12) to say that they rely upon voluntary services at a time of personal crisis (p = 002).

Table 7.5b: HIV test results by reliance on voluntary services in a personal crisis

		Taken test, result positive	Taken test, result negative	Not received a result	Total
Yes	No.	47	337	307	691
	%	**85.5**	**96**	**96.2**	**95.3**
No	No.	8	14	12	34
	%	**14.5**	**4**	**3.8**	**4.7**
Total	No.	55	351	319	725
	%	100.0	100.0	100.0	100.0

There is no significant relationship between HIV status and the likelihood of relying on other forms of formal or informal care provision or support.

7.6. Information

How to communicate information to LGBT HIV positive people is a concern of many service providers, and this section looks at data that is indicative of how this might effectively be done. Those living with HIV are just as likely as other LGBT people to prefer to get their information from the LGBT switchboard, an LGBT community centre, local LGBT media (radio, magazines), local LGBT websites, national LGBT websites, web message boards, and flyers and posters. However, they are less likely to want to get their information from national LGBT media (excluding websites), listings, and email updates, and more likely to want to get information from email.

7.6.1. National LGBT media

Those who have tested positive for HIV are significantly less likely (9%, n. 5) to prefer to get information on local LGBT news and events from national LGBT media than those who last tested HIV negative (25%, n. 94) or those who have not received an HIV test result (21%, n. 72) (p = .019).

7.6.2. Listings

Respondents who have tested positive for HIV are less likely (23%, n. 13) to prefer to get information on local LGBT news and events from listings than those who last tested HIV negative (38%, n. 141) or those who have not received an HIV test result (31%, n. 104) (p = .028).

7.6.3. Emails

Respondents living with HIV are more likely (38%, n. 21) to prefer to get information on local LGBT news and events from emails than those who have last tested negative for HIV (26%, n. 95) (p = .005). They are also a little more likely to prefer this method than those who have not received an HIV test result (36%, n. 123).

7.6.4. Email updates from local group

Respondents living with HIV are less likely, however, to prefer to get information on local LGBT news and events from email updates from local groups (9%, n. 5) than those who last tested HIV negative (20%, n. 74) and those who have not received an HIV test result (14%, n. 48) (p = .034).

7.7. Conclusion

This chapter has shown that LGBT people living with HIV represent a particular part of the LGBT communities and have specific experiences of discrimination, homelessness and fear of crime. 7% of this sample are living with HIV. 7% (n. 26) of those who do not identify as disabled/long term health impaired have tested positive for HIV, which indicates an interesting area of identification but may have implications for receiving support. Those who are living with HIV are more likely to be over 36, be male, white, either gay, bisexual or queer, they are not trans and not Deaf. Those who are living with HIV have specific support needs that differ proportionally from other LGBT people. 37% of those who are living with HIV experienced discrimination on the basis of their gender and/or sexual identities in the areas where they lived. 29% of those living with HIV have experienced homelessness to have experienced homelessness. 18% have specialist housing needs and 30% of those who are living with HIV live in social housing. In addition, people living with HIV are feel less safe in Brighton & Hove and less safe inside LGBT venues, in the 'gay village' and in cruising grounds than those who have tested negative or have not been tested. When asking about support services, respondents who have tested HIV positive are more likely (15%) to say that rely upon voluntary services at a time of personal crisis than those who last tested HIV negative (4%) or those who have not received an HIV test result (4%). This indicates a further reliance on particular agencies and groups at times of personal crisis.

8. Sex work

8.1. Introduction

Very little is known about LGBT sex work and the experiences, needs and practices of particularly men and trans people who are involved in sex work. This chapter will explore the exchanging of sex for payment, including the use of sex to find housing or somewhere to stay. The questions that form the basis of this chapter were generously provided by a female sex work project in Brighton & Hove. The chapter will firstly outline the prevalence of sex work that can be established from the Count Me In Too research, this is likely to be an undercount due to the format of the questionnaire and who is likely to have taken part. However, those that did fill in the questionnaire offer important insights into some of the needs and vulnerabilities of those who engage in sex work and exchange sex for payment. Consequently, this chapter will highlight some key issues for those who are currently or have previously exchanged sex for payment. The chapter will begin by outlining the numbers of those who have taken payment for sexual acts, it will then break this down by particular identity groupings. The chapter will examine what was exchanged for sex, and who sex was sold to. The chapter uses the frequency of engagement with sex work to define sex workers and explore specific needs associated with sex work. Finally the chapter examines exchanging sex for housing and the areas of need that can be established from the data.

8.2. Prevalence

Just under 10% (n.79) people in this sample have taken payment for sexual acts in their life times, with 6 people saying that they 'don't know'. Table 8.2a shows responses of the 99% of the sample that answered the question 'Have you ever taken payment for sexual acts?' The question is framed in order to capture single occurrences of taking payment for a sexual act in the past, as well as continuing to regularly take payment for sexual acts.

Table 8.2a: Have you ever taken payment for sexual acts?

	Frequency	Percent	Valid %
Yes	79	9.6	**9.8**
No	724	88.4	**89.5**
Don't know	6	.7	**.7**
Total	809	98.8	100.0
missing	10	1.2	
total	819	100.0	

Exchanging sex for payment varied by sexuality but not by trans identities – which indicates that trans people are just as likely as non trans people to have taken payment for sex. Those who identified as disabled or long term health impaired, those who have mental health difficulties and who are HIV positive were more likely to have exchanged sex for payment.

8.2.1. Sexual identity

Those who define as queer (18%), gay men (13%) and those who identify as 'other' in terms of sexuality (13%) are more likely to have taken sex for payment than lesbians (4%). Table 8.2b also illustrates that 10% of bi people have also taken payment for sex (p=.001).

Table 8.2b: Payment for sexual acts by sexual identity

		Lesbian	Gay	Bisexual	Queer	Otherwise coded	Total
Yes	No.	10	55	5	5	4	79
	%	**3.7**	**13**	**10.6**	**17.9**	**12.9**	**9.8**
No	No.	263	369	42	23	27	724
	%	**96.3**	**87**	**89.4**	**82.1**	**87.1**	**90.2**
Total	No.	273	424	47	28	31	803
	%	100.0	100.0	100.0	100.0	100.0	100.0

8.2.2. Disability

Those who had a disability or a long term health impairment were twice as likely (17%) to take payment for sexual acts than those who had no disability (8.6%) (p=.008).

Table 8.2c: Payment for sexual acts by disability

		Disabled	Not disabled	Total
Yes	No.	20	58	78
	%	**17.1**	**8.7**	**9.9**
No	No.	97	612	709
	%	**82.9**	**91.3**	**90.1**
Total	No.	117	670	787
	%	100.0	100.0	100.0

8.2.3. Mental Health Difficulties

Those who have experienced mental health difficulties (12%) in the past five years are twice as likely to have exchanged sex for payment than those that have not (6%, p=.014). It cannot be established from this research if taking payment for sex led to mental health difficulties or if mental difficulties resulted in taking payment for sex. However, this is an area that requires further investigation.

Table 8.2d: Payment for sexual acts by mental health difficulties

		No mental health difficulties	Mental health difficulties	Total
Yes	No.	14	62	76
	%	**5.7**	**11.7**	**9.8**
No	No.	231	469	700
	%	**94.3**	**88.3**	**90.2**
Total	No.	245	531	776
	%	100.0	100.0	100.0

8.2.4. HIV status

Those who are living with HIV (34%) are almost 3 times as likely to have taken payment for sex than those who have tested negative or have not had a test result (12%, p=.0005). A causal link cannot be ascertained as to whether living with HIV leads to taking payment for sex, or if taking payment for sex impacts on the likelihood of a person receiving an HIV positive test result.

Table 8.2e: Payment for sexual acts by HIV status

		HIV+	HIV- or untested	Total
Yes	No.	19	47	66
	%	**33.9**	**12.3**	**15.1**
No	No.	37	334	371
	%	**66.1**	**87.7**	**84.9**
Total	No.	56	381	437
	%	100.0	100.0	100.0

Those who said that they had taken payment for sex were asked questions regarding their practices and experiences.

8.3. Exchanging sex

95% (75) of those who said that they have taken payment for sexual acts, have exchanged money for sex, with 18% (14) saying that they exchanged sex for somewhere to stay (see table 8.2f). 15% (n. 12) have exchanged sex for drugs, and 8% (n. 6) have exchanged sex for alcohol.

Table 8.2f: What have you ever exchanged sex for?

	Frequency	Percent
Money	75	94.9
Somewhere to stay	14	17.7
Drugs	12	15.2
Alcohol	6	7.6
Other	3	3.8

Note: this table only includes those who have taken payment for sexual acts.

Using sex in order to have somewhere to stay has implications for homelessness and can also relate to vulnerabilities regarding domestic violence and abuse. This will be addressed below.

8.4. Types of work

Table 8.4a outlines the ways in which the sample worked. 39 people did not answer this question, perhaps indicating that they did not consider themselves to be 'working'. It may also indicate (along with the other category) a dissonance between common perceptions and understandings of sex work and LGBT comprehensions and experiences. 40% (n. 16) of those who answered the question said that they worked independently as an escort with 28% giving another answer to how they worked. 20% work for an escort agency, massage parlour, flat or sauna (8 people) with 10% saying that they work from streets/car parks. One person said that they work independently from an indoor venue.

Table 8.4a: Which of the following best describes how you work?

	Frequency	Percent	Valid %
I work independently as an escort	16	20.3	40.0
Other	11	13.9	27.5
I work for an escort agency	4	5.1	10.0
I work for a massage parlour/ flat/ sauna	4	5.1	10.0
I work from the street/ car parks	4	5.1	10.0
I work independently from an indoor venue	1	1.3	2.5
Total	40	50.6	100.0
missing	39	49.4	
total	79	100.0	

Table 8.4b: Other responses to question 'Which of the following best describes how you work?'

Depends on circumstances
non sex work
I did it once through a friend
I was a pro dominatrix
porno industry
I worked for my family
It was a very long time ago

Its occasional - with someone I like
I have not worked as an escort for over 30 years
was forced by an a abuser who profited from it
a guy offered me money for sex, so I said go on then

8.5. Clients

The questionnaire asked respondents about who they sold sex to. Table 8.5a shows that the majority of those who sold or exchanged sex had male clients (92%), with 14% reporting that they sold or exchanged sex with women, and 4% (n. 3) with those who identify as an 'other' gender. No respondents say they have sold sex to, or exchanged sex with those who identify as trans. This was then broken down by gender and sexuality.

Table 8.5a: When you sold or exchanged sex, who did you have sex with?

	Frequency	Percent
Men	73	92.4
Women	11	13.9
Trans	0	0
Other	3	3.8

8.5.1. Gender differences

Figure 8.5a shows a breakdown of, and compares the proportions of male and female respondents who said that they had had sex with men, women, and those of an 'other' gender for payment or as part of an exchange. No respondents identifying as of no gender or an 'other' gender than male or female said that they had sold or exchanged sex. The numbers in this section are small and results should be taken as indicative

Figure 8.5a: When you sold or exchanged sex, who did you have sex with? By gender

8.5.2. Selling sex to men

Table 8.5b shows that 97% of men who sold sex sold it to other men. However 78% of women also sold sex to men. Male sex work is an under investigated area of research. 97% (n. 61) of male respondents who have sold or exchanged sex have had sex with men for payment or in exchange for something. 3% (n. 2) of male respondents who have sold or exchanged sex say they have not sold or exchanged sex with men, or in other words have only ever sold or exchanged sex with women or those of an 'other' gender. However, 7% (n. 4) of male respondents who have sold or exchanged sex say they have sold sex to or exchanged sex with women. Given that 94% (n. 58) of men who have sold or exchanged sex say they have never sold sex to or exchanged sex with women, this means there is a small proportion of men who have sold sex to or exchanged sex with both men and women. A similar picture applies to men with respect of selling sex to or exchanging sex with those of an 'other' gender. 3% (n. 2) of men who have sold or exchanged sex report having done so with those of an 'other' gender, while 97% (n. 60) of men who have sold or exchanged sex report never having sold sex to or exchanged sex with a person of an 'other' gender. Therefore a small proportion of men sold sex both to men and an 'other' gender.

Table 8.5b: When you sold or exchanged sex who did you have sex with? - Men by gender

		Male	Female	No gender or 'other'	Total
Not men	No.	2	4	0	6
	%	**3.2**	**22.2**	**0**	**7.4**
Men	No.	61	14	0	75
	%	**96.8**	**77.8**	**0**	**92.6**
Total	No.	63	18	0	81
	%	100.0	100.0	100.0	100.0

8.5.3. Selling sex to women

Table 8.5c: When you sold or exchanged sex who did you have sex with? - Women by gender

		Male	Female	No gender or 'other'	Total
Not women	No.	58	10	0	68
	%	**93.5**	**55.6**	**0**	**85**
Women	No.	4	8	0	12
	%	**6.5**	**44.4**	**0**	**15**
Total	No.	62	18	0	80
	%	100.0	100.0	100.0	100.0

Whereas women sold sex to men and women, men appear to sell/exchange sex almost exclusively to/with other men. Among female respondents who have taken payment for sex or exchanged sex for something other than money, 78% (n. 14) say they have sold sex to or exchanged sex with men, while 22% (n. 4) say they have never sold sex to or exchanged sex with men. 44% (n. 8) of women who have sold or

exchanged sex report having sold sex to or exchanged sex with other women, while 56% (n. 10) report having never sold sex to or exchanged sex with other women. Women selling sex to women is an under-researched area. 6% (n. 1) of women who have sold or exchanged sex have done so with a person identifying as of an 'other' gender than male or female, while 94% (n. 16) have never sold sex to or exchanged sex with someone identifying as an 'other' gender.

8.6. Sexual identity of those who sold/exchanged sex and gender of the recipient

Sexual identity can play an important part in accessing services and support for sex workers. 98% of gay men who have sold/exchanged sex, did so with men, and 100% of those who identified as bisexual and who have sold/exchanged sex, did so with men. 90% of those who identify as 'other' in terms of sexuality and who have accepted payment for sex, sold/exchanged sex to/with men. This compares to 60% of lesbians who sold/exchanged sex to/with men. Similar to the findings regarding gender, a higher proportion of lesbians sold sex to women (60%) compared to 4% of gay men, 40% of bisexuals and 20% of those who defined as 'other' in terms of sexuality. Yet this proportion is lower than gay men who sold sex to men. However, these figures are small and should therefore be taken as indicative.

8.6.1. Selling sex to or exchanging sex with men

Figure 8.6a: When you sold or exchanged sex who did you have sex with? - Men by sexual identity

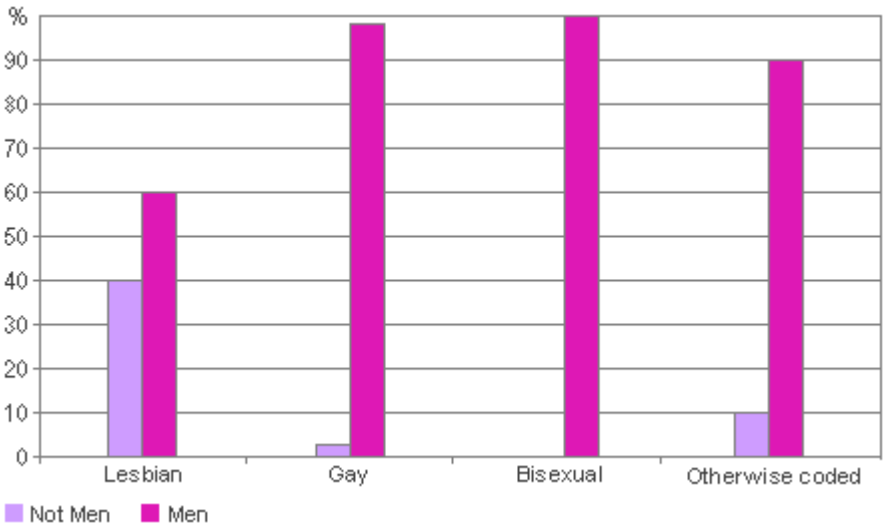
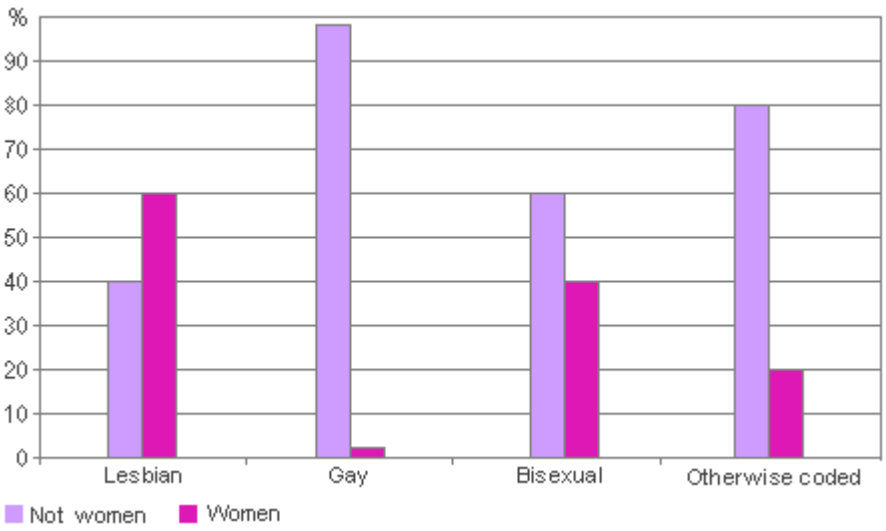


Figure 8.6a shows that 60% (n. 6) of lesbians who have had sex for payment or in exchange for goods other than money, say they have sold sex to or exchanged sex with men, while 40% (n. 4) of lesbians who have sold or exchanged sex say they have never sold sex to or exchanged sex with men. 98% (n. 55) of gay men who have sold or exchanged sex report having sold sex to or exchanged sex with other men, with only 2% (n. 1) of gay men who have sold or exchanged sex saying they have never done so with men. All bisexual respondents who have sold or exchanged sex (n. 5) have done so with men. 90% (n. 9) of those 'otherwise coded' (those who identify as queer or an 'other' sexual identity) who have sold or exchanged sex have sold sex to or exchanged sex with men.

8.6.2. Selling sex to or exchanging sex with women

Figure 8.6b shows that 60% (n. 6) of lesbians who have sold or exchanged sex report having sold sex to or exchanged sex with women, while 40% (n. 4) of lesbians who have sold or exchanged sex say they have never sold sex to or exchanged sex with other women. 96% (n. 53) of gay men who have sold or exchanged sex have never sold sex to or exchanged sex with women, but 4% (n. 2) have sold sex to or exchanged sex with women. 60% (n. 3) of bisexual respondents who have sold or exchanged sex have never done so with women, but 40% (n. 2) say they have sold sex to or exchanged sex with women. Of those 'otherwise coded' who have sold or exchanged sex, 80% (n. 8) have never sold sex to or exchanged sex with women, while 20% (n. 2) have sold sex to or exchanged sex with women.

Figure 8.6b: When you sold or exchanged sex who did you have sex with? - Women by sexual identity



8.6.3. Selling sex to or exchanging sex with those identifying as an 'other' gender than male or female

1 lesbian, 1 gay man and 1 person whose sexual identities are 'otherwise coded' have sold or exchanged sex report having sold sex to or exchanging

sex with people who identify as of an 'other' gender than male or female. No bisexual respondents report having sold sex to or exchanging sex with those of an 'other' gender.

8.7. Frequency

Table 8.7a: How often do you sell/exchange sex?

	Frequency	Percent
It is a regular source of income	3	3.8
Very occasionally, when I have to	9	11.4
It was just a one-off	20	25.3
I don't do it any more	47	59.5
Total	79	100.0

When those who have sold or exchanged sex were asked how often they sell or exchange sex, 60% (n. 47) report no longer selling or exchanging sex, and 25% (n. 20) report that doing so was 'just a one off'. 11% (n. 9) of those who have sold or exchanged sex say that they do so very occasionally when they have to, and 4% (n. 3) report that selling or exchanging sex is a regular source of income for them.

8.7.1. Defining sex workers

Table 8.7b: Frequency of selling or exchanging sex – sex workers and non sex workers

		Sex workers	Not sex workers	Total
It is a regular source of income	No.	3	0	3
	%	23.1	0	3.7
Very occasionally, when I have to	No.	10	0	10
	%	76.9	0	12.3
It was just a one-off	No.	0	21	21
	%	0	30.9	25.9
I don't do it any more	No.	0	47	47
	%	0	69.1	58
Total	No.	13	68	81
	%	100.0	100.0	100.0

Here, a distinction is made between, firstly, those for whom selling or exchanging sex is a regular source of income or for whom selling or exchanging sex is an occasional occurrence done when they need to, and secondly, those for whom selling or exchanging sex is something they no longer do or was just a one off occurrence. For the purposes of this analysis, those who use sex as a regular source of income or occasionally when 'I have to' are defined here as 'sex workers' because they are currently engaging in sex work regularly or due to circumstances. Table

8.7b shows the 23% (n. 3) of those defined here as sex workers say that selling or exchanging sex is a regular source of income for them, while 77% (n. 10) say that it is something they do occasionally when they have to. Key questions were then asked of the sex workers to explore their particular needs and vulnerabilities.

68 people who exchanged sex once or 'don't do it anymore' these are categorised as 'temporary or former sex workers'.

8.7.2. Gender

Sex workers (77%, n. 10) and those who are not sex workers but have sold or exchanged sex in the past (78%, n. 53) are more likely to be male than those who have never sold or exchanged sex (55%, n. 383) ($p = .0005$) (see table 8.7c) LGBT sex workers in this research are less likely to be women.

Table 8.7c: Sex working by gender

		Sex workers	Not sex workers but have exchanged sex	Never accepted payment for sex	Total
Male	No.	10	53	383	446
	%	**76.9**	**77.9**	**55.1**	**57.5**
Female	No.	3	15	312	330
	%	**23.1**	**22.1**	**44.9**	**42.5**
Total	No.	13	68	695	776
	%	100.0	100.0	100.0	100.0

8.7.3. Sexual identity

Table 8.7d shows that the majority of sex workers and those who have exchanged sex for payment are gay men (62%, 71% respectively), however, despite the low numbers of those who are categorised as other in terms of sexuality, these account for almost a quarter of sex workers (23%). These figures can only be indicative due to low numbers, however they point to areas of vulnerability around identifications within and outside of categories such as 'gay'.

Table 8.7d: Sex working by sexual identity

		Sex workers	Not sex workers but have exchanged sex	Never accepted payment for sex	Total
Lesbian	No.	2	8	263	273
	%	**15.4**	**11.8**	**36.3**	**33.9**
Gay	No.	8	48	369	425
	%	**61.5**	**70.6**	**51**	**52.8**
Otherwise coded	No.	3	12	92	107
	%	**23.1**	**17.6**	**12.7**	**13.3**
Total	No.	13	68	724	805
	%	100.0	100.0	100.0	100.0

8.8. Sexual health

Figure 8.8a shows when respondents had last had a sexual health check up by whether respondents are sex workers, are not sex workers but have sold or exchanged sex, or have never sold or exchanged sex. Due to the low numbers these tests are not statistically significant; however, they do indicate key areas for further investigation.

The data indicates that sex workers have had sexual health check ups (see chapter 6) more recently than those who have exchanged sex as a once off and don't do it anymore, as well as those who have never exchanged sex for payment. 46% (n. 6) of sex workers last had a sexual health check up within the past six months, compared to 39% (n. 26) of those who are not sex workers but have sold or exchanged sex and 18% (n. 129) of those who have never sold or exchanged sex. 25% (n. 180) of those who have never sold or exchanged sex have last had a sexual health check up within the last 1 to 5 years, compared to 15% (n. 2) of sex workers and 12% (n. 8) of those who are not sex workers but who have sold or exchanged sex. 15% (n. 2) of those who are sex workers last had a sexual health check up more than five years ago, compared to 12% of each those who are not sex workers but who have sold or exchanged sex and those who have never sold or exchanged sex (n. 8 and n. 83, respectively). Only 1 sex worker (8%) said that they do not need a sexual health check up, compared to 5% (n. 3) of those who are not sex workers but have sold or sold or exchanged sex, and 7% (n. 49) of those who have never sold or exchanged sex. No sex workers say they have never had a sexual health check up, although 12% (n. 8) of those who have sold or exchanged sex in the past have never had a sexual health check up. 27% (n. 191) of those who have never sold or exchanged sex have never had a sexual health check up.

Figure 8.8a: Sexual health check ups and sex working

8.9. Mental health

Sex workers are more likely (92%, n. 11) to experience mental health difficulties (see 'Key terms' section of the Introduction for a definition) than are those who are not sex workers but who have in the past sold or exchanged sex (80%, n. 53) or those who have never sold or exchanged sex (67%, n. 469) ($p = .019$).

8.10. Alcohol

All the respondents categorised as sex workers (n. 12) say they drink alcohol. They are more likely to do so than those who are not sex workers but have sold or exchanged sex in the past (73%, n. 48) or those who have never sold or exchanged sex (86%, n. 598) ($p = .007$).

8.11. Drugs

75% (n. 9) of sex workers have taken 'illegal drugs' in the past five years, making them more likely to do so than those who are not sex workers but who have sold or exchanged sex in the past (69%, n. 46) or those who have never sold or exchanged sex (48%, n. 344) ($p = .001$).

8.12. HIV status

18% (n. 2) of sex workers have tested HIV positive, 25% (n. 17) of those who are not sex workers but who have sold or exchanged sex in the past have tested HIV positive, while 5% (n. 37) of respondents who have never sold or exchanged sex have tested HIV positive. Although the numbers in this analysis are too low for a reliable chi square test to be carried out, the following statistics are indicative and should be used to inform future research. 82% (n. 9) of sex workers have tested HIV negative, compared to 56% (n. 38) of those who are not sex workers but who have sold or exchanged sex in the past, and 47% (n. 334) of those who have never sold or exchanged sex. No sex workers have never been tested for HIV, compared to 19% (n. 13) of those who have sold or exchanged sex in the past and 48% (n. 345) of those who have never sold or exchanged sex. It is not possible to ascertain a casual relationship between these variables (i.e. whether sex work results in testing positive for HIV, or if testing positive for HIV can lead to sex work), however, work in these areas should account for the potential of multiple needs.

8.13. Sexual assault

Those who have taken payment for sex (including sex workers, people who have sold or exchanged sex on a one off basis, and those who have sold or exchanged sex in the past but no longer do so) are more likely to have experienced sexual assault (15%, compared to 4%, $p. <.0001$). All of these respondents have sold or exchanged sex on a one off basis or have sold or exchanged sex in the past but not doing so any longer.

8.14. Sex working and homelessness

Sex workers are more likely to have been homeless in Brighton & Hove on the past five years. Three people (5% of those who have been homeless in Brighton and Hove, 23% of sex workers) who have been homeless in Brighton & Hove in the past five years have regularly taken payment for sex or have done so occasionally as necessary (these are defined as 'sex workers', n. 13). These were all male sex workers. Experiences of homelessness in the past 5 years vary across groups. 23% (n. 3) of those who regularly sell sex, 19% (n. 13) of those who did it once or do not do it any more, compared to 10% of those who have not sold sex and have been homeless in Brighton & Hove in the past five years ($p < .0001$). 13 people who exchanged sex once or 'don't do it anymore' have been homeless in Brighton & Hove in the past five years (these are categorised as 'temporary or former sex workers', n= 68). Conversely, those who have been homeless are more than 3 times as likely to have exchanged sex for payment (22%) than those who have never experienced homelessness (7%). This indicates an area of vulnerability both sex workers who are more likely to experience homelessness and those who are homeless engaging unwillingly in sex work. These findings need further investigation, including exploring the needs of sex workers and temporary sex workers.

8.15. Reasons for selling sex

Table 8.15a: What were/are your reasons for selling sex?

	Frequency	Percent
Other	36	45.6
I needed money for housing	18	22.8
I wanted to work in the sex industry	12	15.2
I needed money for drugs/ alcohol	12	15.2
The hours/ money suited me better than other jobs	12	15.2
I couldn't get any other job	8	10.1
Someone else forced me to do it	5	6.3

The majority of people who responded to this question indicated that their reasons for selling sex were/are other that those offered in the question responses. These are examined below. As mentioned above sex workers were more likely to experience homelessness; therefore, it is perhaps unsurprising that housing was a key reason for exchanging sex (23%, n. 18). Wanting to work in the sex industry, needing money for drugs and alcohol, and the hours and money all followed housing at 15% (n. 12) as a reason for exchanging sex.

23% of those who exchanged sex for payment said that they did so because they needed the money for housing. Of these 18 people, 5 were under 26, 7 were aged between 26 and 35 and 6 were in the 36-45 age group. These results can only be taken as indicative as we do not know their age when they exchanged/sold sex. In the qualitative data (see tables 8.15a and 8.15b), reasons for selling sex included domestic violence and abuse, mental health difficulties and, in some cases, in response to very difficult

circumstances. Although some people said they sold sex to 'try it' or 'for fun', most of these answers point to selling sex as something that was forced by circumstances rather than something that was chosen:

> **Problems with my mental health left me unable to work and with no money in my early 20's**
>
> *(Questionnaire 48)*

> **I was living on the streets and needed to eat (aged 14 years)**
>
> *(Questionnaire 70)*

Among those who said that they exchanged sex because of a need for money for housing, other reasons sometimes also played a part. Needing to escape abuse because of gender/sexual identities or other reasons may increase the likelihood of engaging in sex work.

> **needed money because i needed to pay rent to avoid an abusive home**
>
> *(Questionnaire 185)*

Having to pay study fees can also influence a decision to engage in sex work.

> **had little money for rent and food and study fees**
>
> *(Questionnaire 165)*

Table 8.15b: Major categories from qualitative data: What were/are your reasons for selling sex?

Categories	No. of responses
I wanted to experience it/I enjoy(ed) it	7
Need(ed) extra money (in addition to other employment)	7
Needed money for:	
Housing/rent/shelter	4
Food	2
Bills	1
Study fees	1
I like extra spending power/gifts/going places I couldn't otherwise afford	4
Someone offered payment or gifts	4
Opportunity/because I could	3
It was a one off	2
Mental health difficulties	2
Of Which: *Unable to work*	1
Self-harm	1

Notes:
1. Where responses fall into more than one category they are counted in each category that they fall into.
2. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.
3. In this table, subsets of a major category (marked by 'Of Which') are mutually exclusive.

Table 8.15c shows the 3 responses that were given by only one person each.

Table 8.15c: Other responses: What were/are your reasons for selling sex?

persuaded by friend
emotional comfort
Learning curve of life
It was a hardcore porn shoot
It was a mutual arrangement

8.16. Sex for somewhere to stay

As described above, sex workers and those who have exchanged sex for payment are more likely to experience homelessness compared to other LGBT people. It can also be seen that housing was a key reason for exchanging sex. The questionnaire also asked about using sex to have somewhere to stay. Respondents may have perceived this differently than taking payment for sex as is shown below.

4% of LGBT people (n. 31) have had sex or made themselves available to have sex in order to have somewhere to stay in the past 5 years. A further 4% (n. 28) have done so earlier than in the last five years. There is a statistically significant relationship between homelessness and having sex for somewhere to stay ($p < .0001$ see table 6.9b). 18% of those who have been homeless had sex or made themselves available to have sex in order to have somewhere to stay (12% in the last 5 years, 6% outside the last 5 years) compared to 4% of those who have not been homeless (2% in the last 5 years, 3% outside the last 5 years).

Table 8.16a: Homelessness by have you had sex or made yourself available to have sex with someone so that you had somewhere to stay within the last 5 years

		Never been Homeless	Experienced Homelessness	Total
Have made themselves available (last 5 yrs)	No.	11	20	31
	%	**1.8**	**11.8**	**4.0**
Have made themselves available (not in the last 5 yrs)	No.	16	11	27
	%	**2.6**	**6.5**	**3.5**
Did not make themselves available (last 5 yrs)	No.	586	138	724
	%	**95.6**	**81.7**	**92.6**
Total	No.	613	169	782
	%	100.0	100.0	100.0

10% of young people (n.12) have had sex or made themselves available to have sex for somewhere to stay (see also Browne, 2007; Harris and Robinson, 2007). Other research has pointed to the vulnerabilities of young LGBT people who experience abuse, discrimination and homelessness because of their gender/sexual identities (see Browne, 2007; Cull et al., 2006). Those in the peak earning ages (26-46) are less likely than young people to have made themselves available or had sex in order to have somewhere to stay in the past 5 years. 3 people over 55 (4%) have also

made themselves available to have sex for somewhere to stay in the past five years.

Those who have exchanged sex for payment regularly or occasionally when they need to, are more likely ($p < .0001$) to have had sex or made themselves available to have sex in order to have somewhere to stay (46%, n. 6). (These sex workers were all male, indicating a group that has particular needs regarding housing). This compares to 5% of LGBT people who have never accepted payment for sex and 25% of temporary/former sex workers- as defined earlier (see also chapter 5). However, this indicates that the majority of those who said that they have had sex or made themselves available to have sex in order to have somewhere to stay do not identify this as 'taking payment for sex'. Although these figures are small, they are indicative of housing support needs for those who may be vulnerable. In particular, services catering for sex workers should be aware of their potential need to exchange sex for somewhere to stay and those in housing should be suitably trained to cater for LGBT people who engage in sex work. This is an area that needs further investigation to explore the range of needs of LGBT sex workers.

8.17. Conclusion

This chapter has shown that 10% of LGBT people in this sample have taken part in sex work in their life times. Some groups were more likely to engage in sex work, including those who identified as disabled or long term health impaired, those who have mental health difficulties and who are living with HIV. The chapter identified particular patterns of exchange, clients and work practices identified. 95% (75) of those who said that they have taken payment for sexual acts, have exchanged money for sex. The majority of those who sold or exchanged sex had male clients (92%), with 14% reporting that they sold or exchanged sex with women. Women sold/exchanged sex to men and women, men sold/exchanged sex almost exclusively to/with other men. Similar trends were found in relation to lesbian/gay men. 40% (n. 16) of those who answered the question said that they worked independently as an escort with 28% giving another answer to how they worked. 20% work for an escort agency, massage parlour, flat or sauna (8 people) with 10% saying that they work from streets/car parks. 60% report no longer selling or exchanging sex at the time of the research and 25% report that doing so was 'just a one off'.

15% were defined here as sex workers: these are people who said that selling or exchanging sex is a regular source of income or something that they do when they have to. Sex workers and those who are not sex workers but have sold or exchanged sex in the past are more likely to be male than those who have never sold or exchanged sex. The majority of sex workers and those who have exchanged sex for payment are gay men. 46% of sex workers last had a sexual health check up within the past six months, compared to 39% of those who are not sex workers but have sold or exchanged sex and 18% of those who have never sold or exchanged sex. Sex workers in this research had identifiable vulnerabilities. They are more likely to experience mental health difficulties, sexual assault and

homelessness. They are more likely to drink alcohol, take 'illegal drugs' than are those who are not sex workers but who have in the past sold or exchanged sex (80%) or those who have never sold or exchanged sex (67%). 18% (n. 2) of sex workers have tested HIV positive, 25% (n. 17) of those who are not sex workers but who have sold or exchanged sex in the past have tested HIV positive, while 5% (n. 37) of respondents who have never sold or exchanged sex have tested HIV positive.

4% of LGBT people (n. 31) have had sex or made themselves available to have sex in order to have somewhere to stay in the past 5 years. A further 4% (n. 28) have done so previous to the last five years. 10% of young people (n.12) have had sex or made themselves available to have sex for somewhere to stay. Those who have exchanged sex for payment, regularly or occasionally (46%, n. 6) when they need to, are more likely ($p < .0001$) to have had sex or made themselves available to have sex in order to have somewhere to stay.

9. Trans Health

9.1. Introduction

It is clear from the Count Me In Too research that trans individuals are one of the most vulnerable groups within the LGBT collective (see Browne and Lim, 2008a, b, Browne and Davis, 2008, Browne, 2007a). As has already been shown in chapter 2, trans respondents are more likely to have poor physical health in the 12 months prior to the research than other LGBT people. They are also less likely to see information on sexual health as relevant to them. Trans engagements with health services can be difficult, yet in order to physically transition, trans people must approach health professionals either privately or through the National Health Service. The findings presented here should be considered in conjunction with those of West (2004) which investigated trans engagements with health services. This chapter will address both qualitative and quantitative data from the Count Me In Too research that focused specifically on the area of trans health. It will explore the questions that trans people were routed too, many of which focused on health. The questions were proposed to the researchers by trans support groups and trans people indicating that this area is a priority area for these stakeholders. The chapter will firstly address experiences with GPs. It then moves on to examine the Gender identity clinic and how experiences of transition can be improved, finally the chapter addresses the absence of information and the need for ongoing care.

9.2. GPs

As this research has already shown almost the entire trans sample was out to their GP (88%), perhaps because of necessity rather than reflecting feelings of safety. GPs can act as an initial point of contact for trans people seeking to transition, or in need of support regarding their trans identities. They can be invaluable in supporting trans people to access appropriate services. Experiences with GPs can make trans people wary of the health system and disengage from services that exist to support them.

Table 9.2a shows that the majority of trans people think that their current GP is good or very good 68%, with 16% saying that their GP is poor or very poor. Interestingly 7% said that the question was 'not applicable' indicating a disengagement from these services.

Table 9.2a: Overall, how do you rate the quality of care delivered by your GP?

	Frequency	Percent	Valid %
Very good	11	25.0	25.6
Good	16	36.4	37.2
Neither good nor poor	6	13.6	14.0
Poor	3	6.8	7.0
Very poor	4	9.1	9.3
Not applicable	3	6.8	7.0
Total	43	97.7	100
Missing	1	2.3	
Total	44	100	

The qualitative data offers important insights into this data and how experiences with GPs can lead to finding safe GPs, as well as 'lucky' moments:

Alice: **I was very fortunate in that I got pointed to probably one of the best GPs in Brighton in terms of knowledge-ability on trans health issues so I pretty much fell on my feet there. But prior to moving to Brighton my GP was very helpful and when I came out to her I didn't have any change in reaction, in the way that I was treated towards. It wasn't a negative, you know, it wasn't kind of... "I can't deal with this patient any more". So I was fortunate there that in how that was how smoothly that went really. There were definitely to me LGBT friendly. Coming back to the present now - the NHS obvious always had me as, you know, male since birth really. But my current practice [they] put me down in their files as being female and so kind of all the stuff they send out to me was, you know, ensured that it was the title when it was addressed to me was appropriate and also sort of ask me what did I want to be referred to as Miss, Ms, etc. which I think is [part of] taking trans issues [into account] more. They had to kind of swiftly get things changed on my NHS card, which I was slightly surprised about but they were able to kind of help get things amended without you having to kind of write up loads and loads of letters or give any weird explanation there to help you through that.**

(Trans focus group 1)

For Alice a reaction that 'wasn't negative' was considered 'LGBT friendly'. It is clear that she experienced these interactions with her GP as positive and she considers herself 'lucky'. They asked about pronouns which is a key area of recognition for some trans people and Alice found that they were helpful and did not require 'weird explanations'. In many ways this can be seen as an example of good practice. A consistency of GP care for trans people was lacking, and finding 'safe' GPs is a key issue. Trans people can thus search for friendly GPs, finding them through social networks and services for trans people:

Sarah: **She [our GP] was recommended to me by [name] at Gender Trust and it's basically it's a question of who you know, and it's not as if there's some central point, just have a list of friendly GPs, friendly consultants and things like that. When I went to my own GP, my own GP at the time was [name] her reaction was somewhat negative to say the least**

I think she just genuinely understands, because [Gender Trust worker] was acutely aware of how little support trans people had from other general practitioners and she [name of doctor] decided [that] she wanted to take these trans people under her wing. She studied and read up as best she could, so she knew what it was all about, but when it became clear in fact that trans people in her previous practice in [name of place] were not too happy with general attitude of reception staff there and other patients, what does she do? She sets up her own practice in [name of street] and that's a big step, it's a big step, it's a relatively small practice compared to the one in [name of place], it has made a big difference. I'm much happier there...

Anne: **I don't think she picks out trans people and offers them extra care, but she just treats everybody the same, you know, and that comes across in the way she talks to you, you know.**

(Trans focus group 2)

Being treated 'the same' is something that not all trans people experience. Sarah experienced discrimination both from her GP and from reception staff at her 'friendly' GP office. For many trans people, such experiences with their GPs can be alienating, with health professionals being unaware of how to deal with trans issues and acting in inappropriate ways towards trans people. The selection of a trans friendly GP may not be an option:

Kate: **[There] was a GP in this case, who I assume was a quite strong Roman Catholic who told me 'why couldn't I just be an ordinary gay man instead of wanting to be trans-gendered?' as if I had a choice about it. Another one who had to examine my legs and proceeded to cover my body with the white bit that we normally lie on because she couldn't actually look at my genital areas which, you know, my penis hadn't been removed at that stage, and then proceeded to tell me that I was a sinner, etc. Since I've been in Brighton most of the people I've related to either at the front desk or the GPs have actually been relaxed about me being trans-gendered on the service. My major concern is access. When I go to GP surgery I had absolutely no choice at all of whether I can investigate, is this GP friendly to me or are they not friendly. It's rather like playing Russian Roulette and we've already explained twice I got shot in the head and maybe an equal amount of times I got**

lucky. I was fortunate in that I could afford to pay for my transition privately, if I hadn't and I had to stay with one of my negative experiences then I think it would have been incredibly painful and very stressful and maybe damaging to my transition.

(Trans focus group 1)

Trans people are more likely to experience mental health difficulties, suicidal distress as well as having particular physical health needs. When Kate says that 'it's like playing Russian Roulette', the impact of not identifying trans friendly GPs becomes clear. Choosing an inappropriate and ill-informed GP can, for some trans people, be a horrific experience. Although Kate has been 'lucky' she knows the risks she is taking. She is also aware of her previous experiences and how these inform her current use of services.

GPs cannot directly refer patients to the gender identity clinic and there are particular procedures that have to be followed in order to engage with NHS services. These stages can be unknown to local services who are educated by their trans clients, who are in turn informed by trans support groups:

Anne: **As I was about to say, in my case when I mentioned to the local psychiatric team what the problem was, they said 'I hadn't a clue about this, don't know anything about gender identity problems, what can they do to help you?' Now, that is so rare that I actually get asked that question by medical profession, "what can I do to help you", it is very, very rare. And if I hadn't have known from [Gender Trust worker] about Charing Cross and about how to get into the national health system I wouldn't have had a clue but I said, right, what I need is for you to refer me up to Charing Cross hospital, explained, no problem. But I also needed the support of my GP who was not willing to give that support, so I changed GP, and [name of Gender Trust worker] said to [name of doctor] has pushed, pushed and pushed and I got an appointment eventually at Charing Cross. But again [name of doctor] had to write to the local mental healthcare team to prompt them, and then I had another psychiatrist at Brighton...**

(Trans group 2)

Rather than offering an informed service regarding trans care, Anne discusses an ill-informed service who relied on the patient. Anne herself acquired the information from the Gender Trust, however, even at this stage she had to change her GP in order to be supported in receiving appropriate care.

As trans people are forced out of areas, they move into and through different health systems, this has implications for the quality and consistency of care that they receive:

Sarah: **Every time I moved address my psychiatrist changed. So I moved from [name of town] to Brighton, I moved there because people were coming round my friends' houses with baseball bats, because they were associated with me. They were threatening my friends because of their association with me and they were wanting to find out where I lived, so I moved to Brighton very quickly indeed. It was a real, real risk that I would be at home and so I literally abandoned a lot of my possessions, grab what I could get and in a week gone. Once I went to Brighton I thought, 'okay, we'll carry on', and they said 'you've got to have an appointment with the Brighton health team now'. All that and then I moved to Hove, I moved, moved to Hove and I got told I have to have an appointment with the Hove mental health team. It was ridiculous. [It] is a postcode lottery, it's flipping ludic... it's ridiculous.**

(Trans focus group 2)

Due to her experiences of hate crime that targeted her friends as well as threatened her own personal safety, Sarah had to move Brighton 'quickly'. Not only does hate crime have implications for mental health (see Browne and Lim 2008 a, b), for trans people it can result in a set back in terms of care and transitioning processes. Even this does not account for the need for trust that is paramount when accessing health services (see chapter 11). Therefore, experiences of hate crime, which trans people are more vulnerable to (see Browne and Lim, 2008a) can have direct implications on the care given to trans people, and effect their transition. It also makes them once again vulnerable to the 'Russian Roulette' choices in terms of GP care.

9.3. Gender Identity Clinic

Table 9.3a: Overall, how do you rate the quality of care delivered by your NHS Gender Identity Clinic?

	Frequency	Percent	Valid %	% without the 'not applicable category'
Very good	2	4.7	4.8	9
Good	2	4.7	4.8	9
Neither good nor poor	3	7.0	7.1	13.6
Poor	5	11.6	11.9	22.7
Very poor	10	23.3	23.8	45.4
Not applicable	20	46.5	47.6	100.0
Total	42	97.7	100.0	
Missing	1	2.3		
Total	43	100.0		

People who seek to transition who cannot afford private services rely on NHS gender identity clinics. Table 9.3a illustrates that 48% of trans people said that a question regarding the quality of care delivered by NHS gender identity clinic was 'not applicable', indicating a use of private services and/or a disengagement from health services by trans people. Of those who used NHS gender identity clinics, 45% said that the quality of care was very poor with a further 23% saying that it was poor. Consequently, over 68% of trans people who engaged with the gender identity clinic said that the quality of care they received was poor/very poor.

The qualitative data supported the key quantitative findings regarding gender identity clinics. Some trans people did not access services, poor health use of alcohol and cigarettes can mean trans people are not treated:

Susan: **I've never really accessed any services at all really with regards [PAUSE] transition, well, no that's not strictly true, I did, I did go to some doctors in London and I did have a date for surgery but I'm going back about 11 or 13 years now, and but I chickened out is the word I suppose, quite at the last minute, you know. So, I've never really accessed services only up to that point, and I mean I did take hormones for a while but they wouldn't prescribe them to me, because I was drinking, you know, really heavily and still smoking and so they wouldn't prescribe them. So I bought them myself but that was too expensive, so I packed that up. So I don't... from when I left London I hadn't accessed any services whatsoever, you know.**

(Trans focus group 1)

Sustained supported for transitioning is clearly absent from Susan's narrative. She accessed services in the past but then chose not to engage with health services buying hormones privately until they became unaffordable. Her narrative points to an absence of care for her health both from Susan and other health care providers who refused treatment due to smoking and alcohol. Her disengagement from services meant that for over ten years she has not accessed health care services.

For those who have used health care services and particularly those dealing with Gender Identity, Charing Cross was frequently mentioned, and never in a positive way:

Soraya: **Yeah, and the thing is that I recently asked the head of the Claybrook Centre [Charing Cross Gender Identity Cinic] if he considered me to be mentally ill and he said, basically yes; and also...**

Sarah: **And they're the people who are supposed to be looking after us. It's a reason why a lot of people take off to other distant countries and get through the operation and all the rest of it and some of them don't pick the right person and then they have all sorts of complications. And, you know, it's why a lot of people won't go through Charing Cross, you know, they're**

rather sort of take chances like, go to Thailand and find a half cheap, you know, back street surgeon, like, you know.

Soraya: **Absolutely, so the thing is that this... the system that's in place now damages people, quite extensively. That's the truth of it, it isn't even that we are not cared for, we are damaged by the system. So despite that I think that if we had a special centre then at least it would be somewhere where people could always go and know that they would get decent treatment, if they weren't just sent off to Charing Cross all the time. To be sent off 70 miles to go and see some unsympathetic jerk, I mean...**

Georgina: **I admit, I've had trouble at Charing Cross, [name of doctor] there he's a complete arsehole to be honest.**

Soraya: **There's consistency of consultants, one tells one thing, one tells the next. I mean what is it? Society is really, really very cruel often and the thing is it's not... and going to Charing Cross to meet somebody like [Names a doctor] is, makes it worse, not better.**

Sarah: **We keep beating on about Charing Cross but that is, that is a big, big, big sticking point in the trans community.**

(Trans group 2)

The inappropriateness of equating trans identities with mental health 'illness' was a common theme throughout the focus group. Participants argued that their that trans identities were not mental health difficulties and mental health difficulties were not necessarily related to their trans identities. Services such as Charing Cross are avoided because these philosophy of these services collapse mental health into trans issues. As the sole NHS provider in the South of England, Trans people have no option other than to use this service, or seek private care in at times unsafe overseas locations. More than this, Soraya argues that the system itself is damaging with doctors that do not care for trans individuals, instead considering them 'mentally ill', because of their trans status. The lack of adequate care and the reliance on one facility can mean that Trans people must comply with 'arsehole' doctors or risk losing their care. Charing Cross as the key provider for transitions is perceived to have damaging effects on trans people, lacking consistency. This can relate to inappropriate procedures as well as poor care:

Sarah: **[Charing Cross] doesn't seem to be looking out for our health. No, I had the exact opposite experience [compared to with my GP] in that the first piece of correspondence that I got from them was all in my now new name as it were, since I changed it and was appropriately addressed to me and they wanted me to send back a copy of my change of name and from the moment they got a copy of my change of name they**

have referred to me with my old name but as "Ms" and I'm kind of like don't quite understand where they're coming from on that one and after the first piece of correspondence I spoke to them about it in person and they said "I'll, right, okay, speak to the receptionist, we'll make sure that gets done". Well, my next piece of correspondence I've had from them since then nothing's happened and so they still refer to me as "Ms" but with my old name. I think it's kind of appalling for someone who's supposed to be there the whole [PAUSE] significant part of my transition and healthcare provider that they can't even get something like that right [PAUSE] and it kind of… it does reflect upon their services that they're providing

(Trans group 1)

Using the correct names are important in recognising gender identities and enabling a trans person to live in their chosen gender. Experiences such as this from the very service that is supposed to be helping Trans people are not only inappropriate, they undermine the service and support being offered. Perhaps unsurprisingly then, trans people perceived Charing Cross as unhelpful, damaging and not actually dealing with 'the problem':

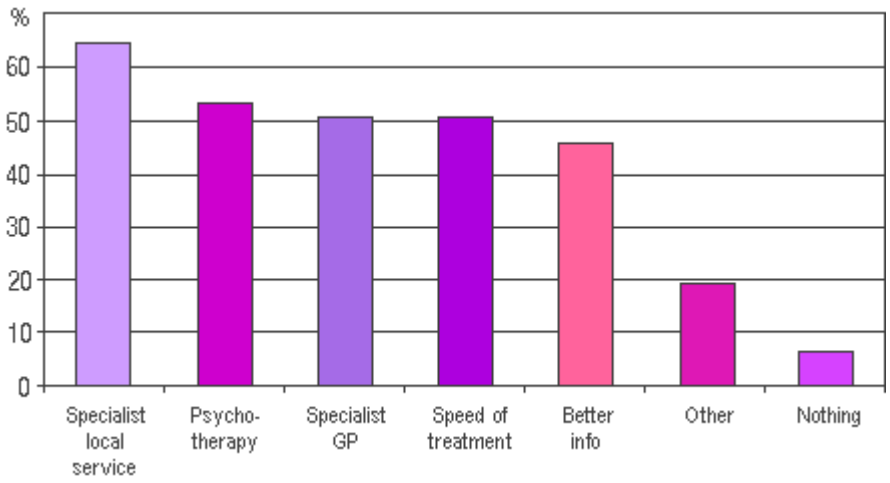
Anne: **The only mainstream services that I've kind of experienced in terms of my gender identity would be Charing Cross and they deemed my transsexuality to be a mental disorder, yet they don't actually seem to be doing anything to help if, you know, as a mental disorder and as in treating it as a mental disorder, as they kind of pointed out last week, just kind of measuring how you are fairing up in society and whether you are kind of taking an active role within society, they're not actually bothering to deal with sort of what you're there for really, you know, if it's a mental disorder why aren't they giving you the appropriate treatment for that? You know, to me it's not a mental disorder, it's a physical one, but they're not taking that on board.**

(Trans group 2)

9.4. Improving transition

Trans respondents were asked what could have been done to improve their transition. Over 65% said that a specialist local service was needed with 51% asking for a specialist GP.

Figure 9.4a: What do you feel could have been done to improve your transition?



The desire for local services was apparent throughout the trans focus groups. The absence of local services was seen as one of the main reasons for the failings of the gender identity clinic and trans individuals taking risks with their health.

Soraya: **The way the NHS treats us in this... from this community. But I don't think it's just the NHS I think that the PCT should work with the council to provide an overall consciousness of needs for trans people in this community. At the moment the services aren't joined up, they're not joined and, you know, for example in housing, you know, it's not everybody that needs housing but because the... but it's to understand, like [Sarah] said during transition people can be very, very vulnerable as well as being in an unsafe place and just to know that is true could... maybe would help some people. Do you know what I mean, because generally we come out and we come out and live lives, you know what I mean.**

Researcher: **What would you like to see in Brighton and Hove, what would you like to change?**

Sarah: **Have our own centre, nothing to do with Charing Cross.**

Anne: **Well, yes, that would be better,**

Sarah: **Nothing to do with Charing Cross, we should have our own medical professionals with the knowledge.**

(Trans group 2)

However, although location is very important, there is a desire to see change in how trans people are treated and the focus of the engagement with trans issues:

Kate: **One of the really key factors that needs to be dealt with, as to what needs to be changed, is how the equivalent of the gender clinics, whether it be at Charing Cross or wherever else it is, in how they deal with our medical condition and not treating it as a psychiatric illness and not being this kind of gender dysphoria but actually treating it as the condition that it is, because to me gender dysphoria is something wrong with the person's mind as to how they perceive them to be, rather than actually have them accepting the possibility that it could be an actual physical condition rather than a mental condition and how they and kind of in the service that they provide us at the gender clinic and they way they provide it.**

(Trans group 1)

Rethinking the services provided to trans people could improve trans medical care as well as the health and wellbeing of trans people. Kate argues that this is the key to developing health services for trans people.

9.5. Information

Throughout the qualitative research it was clear that information on health care was being passed through social groups and networks in order to enable trans people to access non-discriminatory services that would adequately care for their needs. The lack of information regarding trans issues is a key area of need. 47% of trans people in this research said that their transition would have been improved by better information:

Susan: **For me there was very, very little information, I had to find a lot out myself, I don't even know to this I don't know how I found my way to [name of doctor], which I did. So for my personal experience there isn't easily or readily available information that I can go and pick things up about trans.**

(Trans focus group 2)

The lack of available information has in part been addressed buy internet access, however, there still continues to be a need to develop information for trans people to support them throughout their lives, including their period of transition.

9.6. Ongoing care

Although transitioning is often understood as a finite period of time, the trans focus groups acknowledged the continued need for health care beyond the period of 'transition':

Soraya: **I'd like to talk about, about... the other thing is about the system now, it's heading for surgery and once you've had surgery there's nothing and the... that for example, through Dr [name] I get a yearly endocrine check. But I was told by the PCT that this would be finishing soon. Now the endocrinologist considers it vital that this sort of regular look at my body to see whether... to see my blood pressure's good, to see whether I have the right levels of various things in my system. In other words the post-surgical, it's not finished then, we still need a maintenance programme of simple care...**

Susan: **It's not like having your appendix out, you're given some pain killers and that's it on you go.**

Soraya: **Right, yeah. And often there's even later complications with surgery...**

Susan: **This is a life long thing, this goes on till the day you die, you know.**

Anne: **The other problem I think is that if a trans person has some problems and doesn't tell anybody about them, or just holds them in I mean it's not just trans people, it's everybody who has health problems and is reluctant to actually say anything, the system only acts when it all explodes in their faces.**

(Trans group 2)

Ongoing care for trans people relates to physical and mental health care. Support for those who have transitioned and are living in their chosen gender is clearly as important as supporting those who are transitioning. The full extent of these needs have yet to be established and further work is needed to examine the ongoing health and wellbeing needs of trans people.

9.7. Conclusion

This chapter has highlighted some of the key areas of health care for trans people. There are key issues for trans people regarding GP access, namely finding safe GPs and engaging in referral systems to ensure that appropriate care is received. However, the chapter has addressed one of the main failings of the NHS system that of Gender Identity Clinics,

particularly Charing Cross, that overly focus on mental 'illness' equating this with trans experiences as well as , in the opinion of service users who contributed to this research, failing to demonstrate respect for clients. It has been shown that engagements with mental health services and other services that should support trans people are hugely problematic, and these services are blamed for poor mental health and further stigmatising trans individuals. Trans individuals seek improved local services that cater for them, specialist GP services, psychotherapy and better information to improve their transition. There is also a need to provide ongoing and potentially lifetime support for trans people, in terms of their physical and mental health needs (see Browne and Lim, 2008b).

10. Deaf, hard of hearing, deafened or deaf-blind people

10.1. Introduction

Contrary to some – mainly medical – models of disability, deafness as it affects the lives of deaf people is not primarily an issue relating to their health. Rather, their experience of how deafness affects their lives lies in the negotiation of everyday social and institutional settings, service provision, and buildings and environments – whether these are accessible and whether they face exclusion and discrimination in such contexts. Deaf people, then, may have particular issues when engaging with health services and may have specific needs pertaining to both their deafness and their LGBT identities and experiences. Twenty eight people (4%) in the sample identified themselves as deaf, hard of hearing, deafened or deaf-blind. This chapter addresses the particular issues that emerged as significant for this group and that are of concern for the provision of health services to this group. It will firstly look to sexual health and then address issues of multiple marginalisation for Deaf LGBT people, including marginalisation and domestic violence and abuse. It will then examine specific aspects of health that were identified in the research before moving on to changes LGBT people who identified as deaf, deafened, hard of hearing and deaf-blind identified. The aim of this chapter is to highlight issues that need further attention and offer the findings of Count Me In Too for services to use and to begin the research that is needed in this area.

10.2. Deaf identities/definitions

As table 10.2a shows the category of 'D/deaf' can be too narrow to describe the range of experiences people have with auditory impairment. For the purposes of this research, the term deaf was used as advised by deaf people on the steering group, however, as one participant noted, Deaf is also a sociolinguistic minority and not a medical category.

Table 10.2a: Major categories from qualitative data: 'What do you think about the term 'deaf'? Is the label too specific? Does it capture your identity?'

Categories	No. of responses
I am 'hard of hearing'/'hearing impaired' etc., not deaf	15
'Deaf' is ok	3

This chapter uses the term Deaf in order to explore the experiences of auditory difference, recognising the issues and heterogeneity of this grouping. Table 10.2b emphasises some of the differences identified by the respondents.

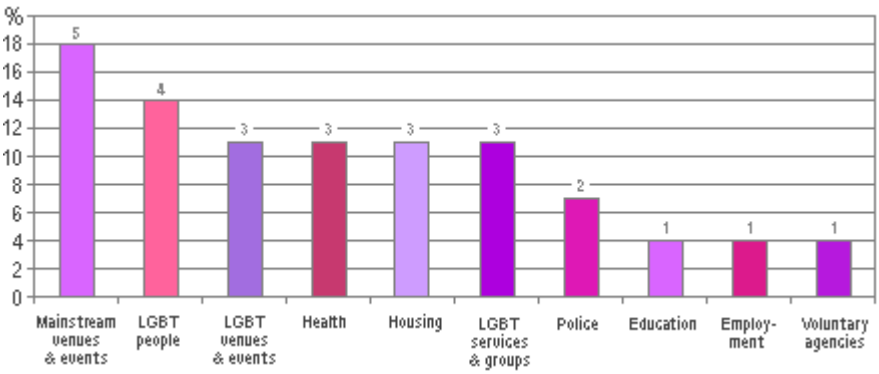
Table 10.2b: Examples of responses where broader issues are raised

Not really as my disabilities are wider. First arch syndrome means I was born deformed and so have no right ear and no sight to right eye, so it is much deeper than merely deafness.
It is not my identity. I have Menieres Disease which makes me partially deaf in one ear. People do not perceive me as deaf
I do not identify as specifically "Deaf" - I am deaf in that I cannot hear properly and was born that way. Any limitations, restrictions and political connotations of the usage of the word "deaf" are due to the deaf community - I suspect ALL minorities marginalise other members in this way.

10.3. Deafness and marginalisation

The questionnaire asked respondents who identified as deaf whether they have experienced bullying, abuse, discrimination or exclusion from a variety of sources, or whether they had been unable to access any of these services, venues or events. Figure 10.3a shows that 18% (n. 5) of deaf respondents report experiencing bullying, abuse, discrimination, exclusion or not being able to access mainstream venues and events. 11% (n. 3) reported experiencing bullying, abuse, discrimination, exclusion or not being able to access health services, LGBT venues and events, housing, and LGBT services and groups.

Figure 10.3a: As a LGBT deaf person, have you experienced bullying, abuse, discrimination, exclusion from and/or been unable to access the following in Brighton & Hove in the last five years?



(% is of all who identified as deaf – numbers above columns refer to actual frequencies)

As figure 10.3a shows mainstream venues and events are the most cited source of bullying, abuse, discrimination and exclusion. The deaf focus group pointed to the difficulties faced that can be faced by LGBT deaf people in everyday environments.

James: **Would feel unsafe kissing and hugging in the street. Can't hear comments, threats and shouting but through a hearing partner can see his reactions. Also nervous on St. James's street at night.**

(Deaf focus group)

James points to how experiences of hate crime can be experienced through a partner's reactions. This means he adjusts his behaviour and avoids displays of affection, even in apparently 'safe' areas. The questionnaire also asked about fear of crime as a deaf person. 30% (n. 7) of those who answered the question said that as a deaf person they feared abuse and physical attack (table 10.3a).

Table 10.3a: Fear of abuse and physical attack as a LGBT deaf person

	Frequency	Percent	Valid %
Yes	7	25.0	**29.2**
No	17	60.7	**70.8**
Total	24	85.7	100
Missing	4	14.3	
Total	28	100	

Marginalisation is experienced through abuse, violence or discrimination and also through feelings of safety and exclusion from mainstream and everyday spaces. The Deaf community can also be problematic:

I don't necessarily feel more marginalised by mainstream society than straight deaf people, but I do feel marginalised by straight deaf people!

(Questionnaire 651)

In addition to this data, table 10.3b shows that, among the deaf respondents who answered the question, almost a third (32%, n. 7) feel marginalised because of their LGBT deaf identity.

Table 10.3b: Marginalisation because of LGBT deaf identity

	Frequency	Percent	Valid %
Yes	7	25.0	**31.8**
No	15	53.6	**68.2**
Total	22	78.6	100
Missing	6	21.4	
Total	28	100	

The second and third areas identified as sites of abuse, violence, discrimination and exclusion were LGBT specific. In order to understand Deaf LGBT lives, there is a need to explore both mainstream and LGBT exclusions. The questionnaires explained how LGBT Deaf people can experience a double marginalised with respect to both LGBT communities and Deaf communities:

> [in response to the question Why do you feel marginalised by this aspect of your identity?]
>
> **Because I am not accepted by Deaf people because I am Gay and I am not accepted by LGBT because I am Deaf.**
>
> *(Questionnaire 654)*

This chapter will now explore some of the ways in which these marginalisations are felt and experienced.

10.4. Living in Brighton & Hove

Table 10.4a: How easy is it for you to be a LGBT deaf person in Brighton & Hove?

	V. easy		Easy		Neither		Difficult		V. Difficult	
	No.	%	No.	%	No.	%	No.	%	No.	%
To be a LGBT deaf person in Brighton and Hove?	1	4	6	21	12	43	5	18	1	4

Table 10.4a shows that 22% (n. 6) of deaf respondents find it difficult or very difficult being an LGBT deaf person in Brighton and Hove. This compares to 5% in the overall research, when they were asked solely about their LGBT identities and living in Brighton & Hove. Furthermore, 25% (n. 7) of deaf respondents say that they find it easy or very easy to be an LGBT deaf person in Brighton and Hove compared to 76% in the overall research.

10.5. Help/information

Table 10.5a: How easy is it for you to find information about what help/assistance is available to you?

	V. easy		Easy		Neither		Difficult		V. Difficult	
	No.	%	No.	%	No.	%	No.	%	No.	%
To find information about what help/assistance is available to you?	3	11	4	14	8	29	7	25	3	11

Table 10.5a also shows that 36% (n. 10) of deaf respondents find it difficult or very difficult to find information about what help or assistance is available to them, while a further 29% (n. 8) find it neither easy nor difficult

to find such information. There was a request for further specific information for those who are hard of hearing:

More info on services for hard of hearing

(Questionnaire 124)

The Deaf focus group pointed to a problem when deaf services in Brighton and Hove are run or led by particular Churches that are not accepting of LGBT identities. These services are not perceived as being welcoming or accessible, and priori experiences can inform these understandings:

Alex: **There's the Sussex Deaf Association, which is our sort of local association, but I wouldn't go there because it's a very church-led organisation, just to let you know that, and has a real sort of history of being quite discriminatory against LBGT people, it's run very strongly by, you know, the straight community and there was a sort of big, very strong, sort of uprising about three years ago where basically, you know, members of that community who were LBGT were pretty much told to sort of take a hike really, so, and they're the service the provider that the council would first look to if they wanted to access the deaf community within Brighton, and yet they're not welcoming for LBGT people.**

(Deaf focus group)

Where services for Deaf people are influenced and controlled by hostile church based groups, this can mean that LGBT people find themselves asked to leave key social and support organisations because of their gender/sexual identities. Alex expresses a concern with the use of these services to access the Deaf community by significant public bodies such as the council.

10.6. Services for LGBT Deaf people

Table 10.6a: How easy is it for you to access services specifically for LGBT deaf people?

	V. easy		Easy		Neither		Difficult		V. Difficult	
	No.	%	No.	%	No.	%	No.	%	No.	%
To access services specifically for LGBT deaf people?	3	11	10	36	8	29	0	0	3	11

Conversely, however, 47% (n. 13) of deaf respondents find it easy or very easy to access services specifically for LGBT deaf people. While 29% (n. 8) find it neither easy nor difficult to access such services, 11% (n. 3) find it very difficult to access these services (see table 10.6a). The health service was pointed to as a problem by one participant:

The Health Service for deaf persons in Brighton & Hove is very poor

(Questionnaire 160)

Service providers need to be aware of the difficulties that they may present to deaf people who are trying to communicate with them, such that these services become unavailable:

Deaf people can have problems accessing support services and even knowing which ones are available. Support has to come from deaf friendly people and can't be accessed only through the phone. For example, police didn't have communication access and so that service could not be used.

(Deaf focus group)

10.7. LGBT pubs, clubs and organisations

Table 10.7a: How easy is it for you to find LGBT pubs/clubs and organisations who are also deaf friendly?

	V. easy		Easy		Neither		Difficult		V. Difficult	
	No.	%	No.	%	No.	%	No.	%	No.	%
To find LGBT pubs/clubs and organisations who are also deaf friendly?	0	0	3	11	8	29	9	32	4	14

No one in this research said it was very easy to find Deaf and LGBT friendly pubs/clubs and organisations. Only 11% (n. 3) of deaf respondents find it easy to find LGBT pubs, clubs or organisations that are deaf friendly, 46% (n. 13) find it difficult or very difficult to find deaf friendly LGBT pubs, clubs or organisations. From many respondents' perspective, LGBT communities and spaces are inaccessible because of their assumptions regarding the normality of hearing. As a result, many LGBT deaf respondents feel excluded from such communities and spaces.

James: **From the Deaf community's perspective, the LGBT community is a hearing community. So Deaf LGBT person can still see the LGBT community as primarily hearing and therefore different to 'me'.**

(Deaf focus group)

Marginalisation and exclusion on the basis on these identities can have very practical implications in using LGBT scenes.

Researcher: **Do you ever feel you've been unfairly treated or left out on the scene?**

Alex: **Yeah, absolutely, left out, loads of examples of that, because of communication, trying to make overtures**

and people not really wanting to engage with it, that happens an awful lot. You know, there are people, some deaf awareness who have learnt to sign a bit and it's just great as an in, then, but if there's absolutely nothing then it just becomes impossible and that feels quite excluding at times. But then I don't really go for it, you know, I like make the overtures and if I see the attitudes not open then I go off, that's my way, I don't stick to it, you know, I don't force it as an issue.

Researcher: **How about you?**

James: **I feel all right really. I'm quite an assertive person so if there's a problem I would ask people to make a change or, you know, as a deaf person you don't expect it to be accessible, you don't expect there to be a service, you just think "Oh, it's a hearing organisation so of course it's going to be like that?"**

(Deaf focus group)

The expectation of hearing organisations is such that they are not 'expected' to be accessible. James expects to have to negotiate access and force change. Finally, it should be noted that the hard of hearing have different needs in this respect from some other Deaf people.

As a hard of hearing person I find it difficult in most gay venues and many straight places because of the high ambient noise levels

(Questionnaire 153)

The noise levels in 'gay places' and in straight pubs/clubs can make these environments inaccessible to LGBT deaf people and those who cannot tolerate ambient and/or loud noise/music particularly in the evenings. The absence of non-scene safe LGBT space in Brighton & Hove has been discussed above (in relation to a healthy living centre) and elsewhere (see Browne and Lim, 2008; Browne, 2007a)

10.8. Domestic violence and abuse

Deaf and hard of hearing people who have experienced domestic violence and abuse are more likely (54%, n. 7) than non-deaf people who have experienced violence and abuse (35%, n. 56) to have been abused by people other than partners or family members. This suggests a particular vulnerability that people who are deaf or hard of hearing might have with respect to friends, neighbours and others whom they know. It cannot be ascertained if deafness leads to vulnerabilities around domestic violence and abuse or if these are related to gender and sexual identities. However, alongside the potential hostility received from Christian run Deaf organisations, this data indicates that Deaf people may also experience violence and abuse from those close to them. Although these figures are low, they should be taken as indicative and addressed both within Deaf communities and services and LGBT communities and services.

10.9. Health

The Deaf focus group indicated some of the difficulties deaf people face in trying to access health service:

James: **I find accessing sexual health is sometimes difficult. If I go to the clinic and I have to wait and hearing when they say for me to come in, sometimes communication with the doctor is okay and having to say, "I'm deaf, but I can hear a little bit in this ear so if you sit there…" and so on.**

(Deaf focus group)

Even where sexual health services recognise and track the fact that patients are D/deaf, this information is only useful if it is used to alter how health services are delivered to deaf people.

Alex: **When I go to the reception and I say "Please, don't get somebody just to shout out, could somebody wave." It has just has never happened. It's like a note gets passed around on my folder and in huge capital letters "HE IS DEAF" is there, right on the folder. But they don't do anything with that information. Still it's exactly the same service as hearing people, so there's no addition, it's you know. Like I was talking with the counsellor and saying, you know, "I don't like this sort of, you know, that I'm deaf written there," and he was saying "Well, it's important." And I was saying "But only if you actually do something with that information." But that point was slightly lost on him.**

(Deaf focus group)

For all Deaf people there can be particular issues in access health services locally. Small networks and scenes can mean LGBT deaf people may not have the anonymity or confidentiality that other people feel using these services:

Alex: **I would use mainstream services but I wouldn't be comfortable, I wouldn't feel that there was the rapport really, it's too many times I've been sort of labelled, you know, sort of the medicalisation, it becomes all about my deafness and all about audiology and so on, you know.**

James: **I think it's probably more difficult for deaf people also as well because they know the interpreters within the area and there's a concern about confidentiality and so do you need to bring in interpreters from outside of the community, but then there's an issue of them not knowing you and if you're seeing those interpreters within sort of clinical situation or at the doctors, I often find that quite difficult.**

Alex: **I use my partner, so I avoid that, but then what happens if you want to talk to someone privately without your partner there? Yeah, it's very difficult. We'd have to sort of try and use spoken language rather than sign language. I tried that for a while and there's a guy now who I've been seeing for quite a considerable time, so we're getting used to each other, but it's not that easy really. But if it's an unknown person then that would be almost impossible.**

(Deaf focus group)

Health service providers can face a particular challenge in clinical situations when interpreters are being used. In some circumstances, interpreters who are known to the patient (including a partner) can be comforting and can help foster a comfortable environment. In other circumstances, however, this can present problems regarding confidentiality. This is especially the case if interpreters are employed from within a relatively small LGBT deaf community in Brighton and Hove.

10.10. Change in Brighton & Hove

When the respondents who identified as Deaf, deafened, hard of hearing or deaf-blind, were asked about what they would like to change in Brighton and Hove, there were five clear categories (see table 10.10a).

Table 10.10a: Major categories from qualitative data: 'As a LGBT deaf person, what would you most like to see change in Brighton and Hove?'

Categories	No. of responses
Less prejudice/more understanding	6
Less loud music in venues	3
Better access (generally)	3
More/better information	2
Wider use of BSL	2

Similar to disabled people below, 6 people asked for less prejudice and more understanding, this was in some cases generic:

Greater understanding of deaf people, and not to be treated as idiots

(Questionnaire 116)

In other cases there was a desire to see change amongst LGBT people:

Less prejudice by the LGBT community to disabled LGBT people in general

(Questionnaire 651)

3 people mentioned the loud music in venues which made them inaccessible to them:

I'm not that deaf but do wear hearing aid. Less obtrusive background music would make it easier for me to participate more fully in conversations when out in social settings

(Questionnaire 11)

Being able to participate can be a very important part of socialising, developing social and support networks and feeling part of LGBT lives and communities. Questionnaire 654 perhaps puts it best when they discuss integration, services and social events:

Greater Deaf Awareness, more professionals who target Deaf LGBT e.g. community police, medical services, more people who use BSL, more deaf and hearing integrated events, more events less focussed on music which is not accessible.

(Questionnaire 654)

10.11. Conclusion

This chapter has shown that issues of multiple marginalisation are key to understanding Deaf LGBT people's lives and experiences. It has illustrated that issues of marginalisation, exclusion and discrimination pertain both to Deaf communities not accepting LGBT people and LGBT people marginalising Deaf people. Of the twenty eight people who identified themselves as deaf, hard of hearing, deafened or deaf-blind, a third feel marginalised by their LGBT identity. Bullying, abuse, discrimination, exclusion or access issues were experienced by 18% in mainstream venues and events, and 36% (n. 10) of deaf respondents find it difficult or very difficult to find information about what help or assistance is available to them. There were specific health, safety and housing issues associated with experiences of LGBT deaf people. The Deaf focus group indicated some of the difficulties deaf people face in trying to access health services, in particular communication with health professionals and access to services more generally. Yet the data also shows that whilst LGBT Deaf respondents feel that there is some services for LGBT Deaf people, there is a lack of pubs/clubs and organisations who are LGBT *and* Deaf friendly. 22% (n. 6) find it difficult or very difficult being an LGBT deaf person in Brighton and Hove. Deaf and hard of hearing people who have experienced domestic violence and abuse are more likely (54%, n. 7) than non-deaf people who have experienced violence and abuse (35%, n. 56) to have been abused by people other than partners or family members. Consequently, this research has highlighted specific issues pertaining to Deaf LGBT lives and experiences as well as an area that needs further exploration in relation to the use of services, experiences of hate crime, use of LGBT networks, social spaces and support groups. It has also shown that LGBT deaf people would like venues to be more accessible.

11. Physical disability & long term health impairment

11.1. Introduction

As with deafness in the chapter above, disability is understood here not within a medical model, but rather as a socially constructed phenomenon. However, due to the way the disability question was asked, it is not possible to separate out long term health impairments from physical disabilities to ascertain similar/different needs for LGBT people. In addition, as can be seen from the chapter addressing HIV, those who might be defined as long term health impaired did not always identify in this category. The data in this research can provide key areas for further investigation of LGBT disability issues, as well as offer insights into LGBT lives. This report has already shown that LGBT people who identify as disabled or long term health impaired are more likely to rate their physical health in the past 12 months as poor, to have engaged in sex work, to be out to their GPs and to want a specialist LGBT GP. In order to ensure that the information provided by participants is not lost and can be used by future work in this area, this chapter outlines the key findings for those who are disabled/long term health impaired in this study. It should be noted that disability has been woven into all aspects of this project and this chapter serves as a central reference point for this area as well as presenting some data not covered elsewhere. Furthermore, the placing of this chapter within the health report does not indicate a medicalisation of disability, rather a desire to report the key findings in this area. This chapter will firstly outline the sample that is addressed in this chapter/research, before exploring measures of marginalisation and exclusion experienced by LGBT people who are disabled. It will examine socialising, and key areas of risk and need for LGBT people who are physically disabled and/or long term health impaired. Finally the chapter will address the ways that respondents identified they could feel more included.

11.2. Sample

15% of the sample identified as having a long term health impairment or physical disability. This is slightly less than Count Me In where a quarter of the sample had a physical disability or long term health impairment (Webb and Wright, 2001).

Table 11.2a: Those who identified as having a long-term health impairment or physical disability

	Frequency	Percent	Valid %
Yes	119	14.5	**14.9**
No	681	83.2	**85.1**
Total	800	97.7	100

Of the 56 who indicated they had tested positive for HIV, 26 did not identify as disabled or as having a long term health impairment (see chapter 6); or, as questionnaire 285 suggests, some of those living with HIV might consider themselves as having a long-term health impairment but not to be disabled.

> **Hold on! I answered YES to the previous question [Are you or do you identify yourself as having a long-term health impairment or physical disability?] because, being HIV+, I have a long-term health problem. Disability is not an issue.**
>
> *(Questionnaire 285)*

Not all who identified as having mental health difficulties identified as disabled or as having a long-term health impairment. Questionnaire 122 asserts that all labels – including 'disabled' – can be stigmatising, and that care should be taken when applying labels that individuals might not agree describe their experiences or conditions.

> **It's not a helpful expression for me. I have had long term mental health problems and the term 'disabled' has been applied by government organisations. Certainly it is a form of disability but the labelling stigmatises and is not helpful. People start to perceive you differently and at times this comes across as annoyingly patronising. If labels have to be used, I prefer 'a person with mental health problems', although such issues are deeply personal and should only be revealed when absolutely necessary.**
>
> *(Questionnaire 122)*

Personal issues that are 'only revealed when absolutely necessary' can be stigmatised through the use of labels. This respondent is clear in their rejection of such categories.

Those who have long-term physical health impairments might not always identify with the label 'disabled', as questionnaire 11 demonstrates.

> **I have a physical problem (lymphoedema in my arm) which I'm aware of & which I have to be careful with but which does not disable me as such. I wouldn't class myself as disabled as this would seem to cover more severe problems. I have a condition which impacts on my life rather than a disability**
>
> *(Questionnaire 11)*

This qualitative data indicates some of the issues with quantifying disability, and the range of experiences and identities LGBT people have regarding this label. This is in spite of other people and services' understandings of the category and who sits within it.

11.3. Experiences of being an LGBT person who is disabled/long term health impaired

Those who answered 'yes' to the question 'do you identity as having a long term health impairment or disability?' were routed through to a section that asked about socialising, identities, marginalisation and experiences of being a disabled LGBT person in Brighton & Hove. This section will outline the key findings.

11.3.1. Living in Brighton & Hove

Table 11.3a shows that a quarter (25%, n. 29) of respondents who identify as disabled say they find it difficult or very difficult to be an LGBT disabled person in Brighton and Hove. This compares to 5% in the overall research pertaining just to LGBT identities (see Browne, 2007a). 41% (n. 48) of respondents who identify as disabled say they find it neither easy nor difficult to be an LGBT disabled person in Brighton and Hove. However, over a third of respondents (34%, n. 39) who identify as disabled say that they find it easy or very easy to be an LGBT disabled person in Brighton and Hove.

Table 11.3a: How easy is it for you to be a LGBT disabled person in Brighton & Hove?

	Frequency	Percent	Valid %
Very easy	14	11.8	12.1
Easy	25	21.0	21.6
Neither easy nor difficult	48	40.3	41.4
Difficult	26	21.8	22.4
Very difficult	3	2.5	2.6
Total	116	97.5	100
Missing	3	2.5	
Total	119	100	

For some Brighton & Hove is seen to be unwelcoming for those who do not fit stereotypical desirable gay lifestyles:

Stan: **You just get a feeling that the … the gay scene is wonderful to have in Brighton, it brings in a lot of money, the pink pound and what have you, I get the feeling, I just get the feeling off of them that we are being used simply because it is an attraction here … its, and if you ask anything of them other than to bring the pink pound here and have a good time. Don't! …**

The message is that you are welcome to come to Brighton but if you come to Brighton you must have money, you must have somewhere to live and you must have a job, don't come here unemployed, don't come here disabled, do not come here if you have got mental health issues, they don't want to know, that is the general sort of attitude, that the feeling from the members of staff of Brighton & Hove Council over the last 15 years, that is the attitude that I have received from all of them. They don't want us here, they don't care if you've lived here all your life, go and find somewhere else, you are disabled, go and retire to Bognor or somewhere else, they don't want you because they can't cope with you in Brighton and Hove city, in this town.

(Disabled focus group)

For Stan, although LGBT people are welcomed in Brighton & Hove, this is related to money and the gay scene. Those who are not rich or able bodied are in Stan's opinion made to feel unwelcome and he feels that 'they' can't cope and don't want you.

Those who were routed through the disability section of the questionnaire and were asked about their experiences in Brighton as a disabled person. Table 11.3b shows that there were 15 positive responses with many explorations of difficulties and problems.

Table 11.3b: Major categories of response from qualitative data: 'Please tell us about your experiences of Brighton & Hove as a disabled LGBT person'

Categories		No. of responses
Positive		15
Of Which:	*Groups*	2
	Mind Out	2
	LGBT Switchboard	1
	LGBT care/healthcare workers	1
	Bus services	1
	Supportive/accepting LGBT spaces	1
	Acceptance/tolerance in Brighton & Hove	1
Isolation/not fitting in / exclusion from many LGBT social activities / difficulty meeting other LGBT people		8

Of Which:	Can't afford to socialise	1
Difficulties with accessibility		6
Of Which:	*To venues*	4
	Toilets	1
	Seating	2
	Parking	1
Indifference/lack of care / undervalued		6
Subject to prejudice / discrimination / stigma / ridicule / abuse		6
Hidden/invisible illness or disability		5
Of Which:	*I hide illness or disability*	3
Lack of understanding		4
Of Which:	*Of mental health difficulties*	2
	Of disabilities in LGBT communities	2
	Of disabilities by public bodies	1
Difficulties with LGBT cultures (incl. on LGBT scene)		3
Difficulties with disability service providers and groups		2
Of Which:	*Mainly targeted at those with 'obvious' disabilities*	1
	Discrimination from religious service providers and/or groups	1
Not in work/living on benefits		2
Difficulties with housing/lack of help from the council/GPs		3
Lack of/poor/poorly resourced support		1

Notes:
1. Where responses fall into more than one category they are counted in each category that they fall into.
2. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.
3. Subsets of a major category (marked by 'Of Which') are not mutually exclusive with respect to other subsets of the same major category: a single response (counted only once under the major category) may fall into more than one subset of the major category.
4. The total of the subsets (marked by 'Of Which') for any major category do not necessarily enumerate the total number of responses for that major category.

Those who had positive experiences in Brighton and Hove as LGBT disabled people mentioned LGBT specific services, venues and spaces that they valued and enjoyed:

I belong to a group for lesbians with ME – a good space. On the whole the networks I'm in are reasonably good around this.

(Questionnaire 041a)

switchboard been helpful, just started mindout and has been easier exploring my sexuality when I was unsure as my cpn is a lesbian and my day centre worker. i found i could only confide in my uncertainty about my sexuality with people that I knew were gay or lesbian because I knew they would understand and be accepting.

(Questionnaire 16)

However, even where there were some positive attributes found with the city, isolation, exclusion and access issues were key areas mentioned by 8 people where LGBT people who identified as disabled or long term health impaired had significant difficulties:

> **- bus service is v. prompt and great when my condition is exhausting - Brighton & Hove Council and the LGBT community both tend towards an emphasis on the city as the place for young people who are fit, healthy and always up for going clubbing all night! Good for tourism, no doubt, but the city's diversity does encompass many more people who deserve more funding into alternative means of socialising, clubs and alcohol-free activities. We have such beautiful surroundings and parks - I'd like to meet the LGBT community out there too!**
>
> *(Questionnaire 38)*

Questionnaire 38 points to some of the improvements in Brighton & Hove that have made the city more accessible. They also address some continuing needs, including (as has been mentioned throughout this report and will be addressed in this chapter) alternative social spaces and a desire to meet the 'LGBT community'. Isolation is a key issue for LGBT people. Disabled LGBT people can feel isolated due to accessibility, lack of support as well as stigmatisation and exclusion from the LGBT community.

> **The support services are extremely poor and underfunded. I feel isolated and alone because I cannot join in a lot of LGBT activities**
>
> *(Questionnaire 48)*

> **While most high street stores have good disabled access the more interesting places, i.e. the north lanes do not, similarly many of the gay bars are only accessed by stairs or steps**
>
> *(Questionnaire 505)*

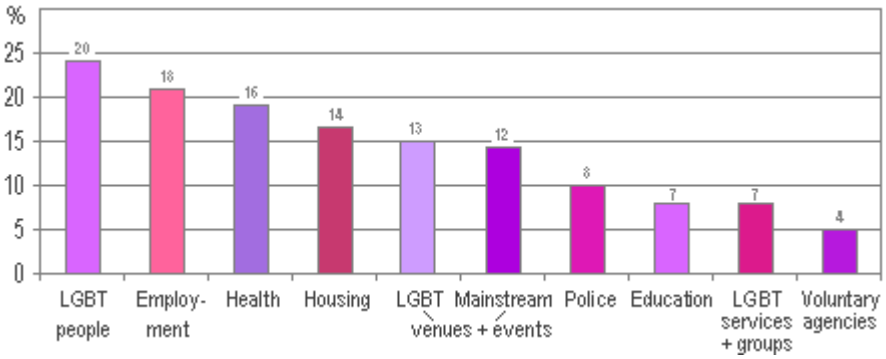
11.4. Marginalisation

This research asked particular questions regarding marginalisation and exclusion that addressed experiences of bullying, discrimination, abuse and exclusion as well as asking LGBT disabled people if they felt marginalised.

Figure 11.4a below shows that 24% (n. 20) of those who identify as disabled report having experienced bullying, abuse, discrimination or exclusion from other LGBT people. The qualitative data (see table 11.3b) supports this with 3 people indicating that LGBT people can lack understanding/acceptance. 21% (n. 18) report having experienced bullying,

abuse, discrimination or exclusion in employment or not being able to access employment because of their disabled LGBT identity.

Figure 11.4a: As a disabled LGBT person, have you experienced bullying, abuse, discrimination, exclusion from and/or been unable to access the following in Brighton & Hove in the last five years?



(% is of all who identified as disabled – numbers above columns refer to actual numbers)

A combination of LGBT lives and lack of employment can be key to understanding marginalisation amongst LGBT disabled people as questionnaire 274 and 30 outline:

> **The commercial gay scene seems to be centred around youth and money. The latter can be in short supply if you are unable to work because of you health conditions.**
>
> *(Questionnaire 274)*

> **I can't work or participate in many social activities. I am very poor, living off benefits, which affects all aspects of my life. i have trouble getting appropriate care from my GP and i do not have the energy to fight for it. My housing opportunities are limited. I feel particularly affected by the lack of money that i have coming in.**
>
> *(Questionnaire 30)*

Questionnaire 30 also indicates that services can be key to LGBT people, and that poverty, health care, housing and socialising can all be interlinked such that marginalisation and exclusion happen on a number of different levels. In the quantitative data, health services and housing were noted as key areas of bullying, abuse, discrimination or exclusion. 19% (n. 16) report such experiences with respect to health services, while 17% (n. 14) report such experiences with respect to housing. In the qualitative data, these services were identified as problematic:

> **The disability adaptation the council have made to my flat does not work. The manager refuses to meet with me to discuss it to find the solution to the problem the council has created.**
>
> *(Questionnaire 841a)*

I get support from my partner (i.e. housing, and stuff that needs doing, like cooking). I have had lots of problems with my GP who has not done even the minimal to help me: I've had to complain to the practise twice out of immense frustration. Living off benefits is difficult. I can't afford to socialise on the gay scene.

(Questionnaire 30)

Table 11.4a shows that almost half (49%, n. 48) of LGBT disabled respondents feel that they are marginalised because of their identity as an LGBT disabled person.

Table 11.4a: Feelings of marginalisation because of LGBT disabled identity

	Frequency	Percent	Valid %
Yes	48	40.3	49.0
No	50	42.0	51.0
Total	98	82.4	100
Missing	21	17.6	
Total	119	100	

Table 11.4b: Major categories from qualitative data: Why do you feel marginalised by this aspect of your identity [Disability]?

Categories		No. of responses
Lack of understanding/acceptance		11
Of Which	*By LGBT people*	3
	Of mental health difficulties	2
Discrimination/stigma/prejudice		10
Of Which:	*re: Mental health difficulties*	3
Difficulties with/exclusion from socialising/LGBT scene		7
Of Which:	*Exclusion from money oriented LGBT scene*	1
	Exclusion because of expectations regarding appearance	1
Most people/spaces/organisations do not/are unwilling to make allowances for disabilities		6
Miscellaneous marginalisation with respect to:		
	Employment	5
	Mainstream disabled groups	1
Hidden/invisible disabilities		5
Unable to do things used to be able to do		3
Poverty		2
Of Which:	*Exclusion from socialising/LGBT scene*	2
Difficulty getting appropriate care		1
Housing difficulties		1
Mention of mental health difficulties		6

Notes:

1. Where responses fall into more than one category they are counted in each category that they fall into.
2. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.

3. Subsets of a major category (marked by 'Of Which') are not mutually exclusive with respect to other subsets of the same major category: a single response (counted only once under the major category) may fall into more than one subset of the major category.

4. The total of the subsets (marked by 'Of Which') for any major category do not necessarily enumerate the total number of responses for that major category.

The qualitative data asked why people felt marginalised by this aspect of their identity and table 11.4b above outlines the main categories. These answers have in part been used to explore and understand the quantitative data above. Other issues such as socialising and the LGBT scene will be addressed below.

11.5. 'Not just a dyke, but one with special needs': Socialising and LGBT disabled identities and bodies

Table 11.5a: Do you regularly socialise/take part in:…

	Yes		No		Unsure	
	No.	%	No.	%	No.	%
LGBT communities, activities, events and groups elsewhere in the UK?	44	**39**	66	**59**	2	**2**
Disabled groups, activities, events and groups in other areas of the UK?	21	**19**	88	**79**	3	**3**
LGBT communities, activities, events and groups in Brighton & Hove?	14	**14**	86	**84**	2	**2**
Disabled groups, activities, events and groups in other areas of the UK?	4	**4**	99	**94**	2	**2**

Note: % = valid %

LGBT disabled people in this research regularly participate in national LGBT groups and local disabled groups more than in national disability groups or local LGBT groups. Perhaps because of the paucity of specific LGBT groups in Brighton & Hove, LGBT disabled people have to access UK wide groups. Among respondents who identify as disabled and who answered the question, 19% (n. 21) said that they regularly participate in disabled groups, activities, events and/or groups in Brighton and Hove. Although a this is a not particularly large minority of these respondents, this is still a greater proportion than either the 4% (n. 4) of respondents who take part in disabled groups, activities, events and/or groups in other areas of the UK or the 14% (n. 14) who take part in LGBT communities, activities, events and/or groups in Brighton and Hove. Respondents who identify as disabled are more likely (39%, n. 44) to participate in LGBT communities, activities, events and groups elsewhere in the UK than they are in Brighton and Hove. The converse is true with respect to disabled groups, activities, events and groups.

11.6. Disabled groups

Over half (51%, n. 55) of respondents who identify as disabled say that they do not feel they fit well or at all into disabled activities, events and groups in Brighton and Hove, supporting the contention that there is a lack of accessible/welcoming services in Brighton & Hove. This could also explain the low percentages that regularly socialise or take part in these events. A further 28% (n. 31) report being unsure how well they felt they fit into such activities, events and groups (table 11.6a).

Table 11.6a: How do you feel you fit into disabled activities, events and groups in Brighton & Hove?

	Frequency	Percent	Valid %
Very well	6	5.0	5.5
Reasonably well	17	14.3	15.6
Not sure	31	26.1	28.4
Not that well	26	21.8	23.9
Not at all	29	24.4	26.6
Total	109	91.6	100
Missing	10	8.4	
Total	119	100	

11.7. LGBT events/activities

Table 11.7a: How do you feel you fit into LGBT activities, events and groups in Brighton & Hove?

	Frequency	Percent	Valid %
Very well	13	10.9	11.6
Reasonably well	29	24.4	25.9
Not sure	28	23.5	25.0
Not that well	24	20.2	21.4
Not at all	18	15.1	16.1
Total	112	94.1	100
Missing	7	5.9	
Total	119	100	

In 2000 Count Me In found that 1 in 5 disabled people had been prevented from using LGBT venues (Webb and Wright, 2001). Table 11.7a shows that 38% (n. 42) of respondents who identify as disabled say they do not fit that well or do not fit at all into LGBT activities, events and groups in Brighton and Hove. This is a smaller proportion than those who say they do not fit that well or fit at all into disabled activities, events and groups in Brighton and Hove. The 38% (n. 42) who say they fit very well or reasonably well into LGBT activities, events and groups in Brighton and Hove is also greater than the 21% (n. 23) who say they fit very well or reasonably will into disabled activities, events and groups in Brighton and Hove.

As section 11.4 above indicated disabled LGBT people can feel isolated and excluded from LGBT scenes and 24% say that they have experienced abuse, marginalisation, bullying and/or exclusions from LGBT people. The qualitative data in the focus groups pointed to accessibility issues in the LGBT scene:

> **With pubs & clubs being the main venues for socialising, I am very limited as I need decent seating or suffer pain. It's easier often not to go out to pubs etc.**
>
> *(Questionnaire 80a)*

> **Having to stand when I need to sit, being physically pushed around at venues because I cannot rush around (LGBT venues). Seen as a bit of a pain – not just a dyke, but one with extra needs!**
>
> *(Questionnaire 20a)*

Questionnaire 80 identifies the physical restrictions of pubs and clubs that do not cater for those who need decent seating. Questionnaire 20 points to issues of multiple marginalisation 'not just a dyke, but one with special needs' that means that she thinks she is perceived as a 'pain' and in need of assistance in venues and events.

In the focus group data accessibility and the lack of a welcome in the gay scene for 'visible' disabilities was addressed:

Dave: **I mean the times I've been in the gay places or going to the sauna say but you can't see the stick in the sauna or when I'm getting dressed and going out and they see the stick and you can see the look of absolute horror, think oh I've had sex with a cripple [laughter] you see that look which makes me laugh. I've been pubs, people are stare at you like.**

[Laughter] No there's a difference [laughter] but to me I'm, I mean I met somebody once who he wouldn't go to a gay club because people were staring at him because he had a stick. I'm not as sensitive about that. I mean there are folk around who must be quite sensitive to obvious disabilities whether they be walking sticks, wheelchairs assistants, dogs who get you know as I say gawped at and I think in the gay scene you know particularly gay men it is just the body, the body perfect culture and I think touched on what you were saying earlier about if you are a bit different you know you are not, you don't seem … a lot of places in Brighton it can be worse for that.

Dan: **I think Brighton is … it has a huge gay population and yet I can't think of a venue that is accessible apart from Café 22 at most but I mean most of the pubs/clubs**

have got steps so if people aren't visible then people are not going to get used to it.

(Disability focus group)

Dan points to accessibility as an issue for LGBT people, Dave notes the cultures of the gay scene that can be exclusionary focusing on the 'body perfect culture'. The desirability of particular bodies can mean that certain bodies are seen as 'crippled' and can mean that some LGBT people will not go to gay places.

Those with disabilities that are less 'visible' and those who are able to hide their disabilities may encounter different problems when socialising such as a lack of understanding and consideration upon the part of others, and an unwillingness of other individuals, organisations or venues to make allowances for their disabilities.

I constantly have to explain my condition to people who have never heard of it, or who don't believe me because I 'don't look ill or disabled'.

(Questionnaire 38)

Yes, I am visually impaired it is extremely difficult for anyone to know this as I don't look visually impaired at all, I don't even wear glasses (they don't help). However, in the sometimes highly shallow aspects of Gay life the 'visual aspects' are all important. People judge you on how you look, I don't look any different but this does mean I am judged to be like anyone else which most of the time I want - but sometimes this puts me at a significant disadvantage as people assume I am able to see them perfectly, or see them at a distance or read a sign. I am often accused of ignoring people or not recognising people so this sometime makes people think I am rude or aloof.

(Questionnaire 217)

Understanding disability as only something that can be 'seen' from people's physical appearance can be disempowering and undermine the experiences of disabled people.

The absence of a local LGBT disabled space is perhaps why national organisations are relied upon. However, there used to be local LGBT groups that supported disabled people. These both closed before the start of this research:

Madeline: **it's interesting because that's one of the reasons I moved down as well, was because there was a group, ironically for disabled lesbians, which no longer doesn't exist [LAUGHS]. I laugh because I was quite involved, very involved in it, I think I ran it single-handedly, but, the problem was I was running it virtually single-handedly and I can't do that, you know…. I mean the**

problem is that, you know, disabled people want to run the groups themselves…but the people that we attract maybe don't have the energy, because of their disability, to run the group. So it ends up falling down to those of us that have got energy but also have full time jobs because we've got that energy to work, do you know what I mean, so it's a vicious circle.

(Pilot Focus group)

Madeline highlights the 'vicious circle' for LGBT people who seek to facilitate LGBT disabled space. The absence of support from non-disabled people can mean a loss of autonomy, but those within the group may not have the capacity to cope with the diverse range of needs that LGBT disabled people may have, including isolation and a lack of support networks and systems. This can mean a burden is placed on some LGBT disabled people to support each others in ways that drains their own resources and is beyond their capacity, in order to provide LGBT disabled spaces.

11.8. Key areas of Risk/Need

LGBT people who identify as disabled are more likely to have serious thoughts of suicide, to have exchanged sex for payment and to feel uncomfortable using services because of their gender/sexual identity. Those who identified as having a disability (54%) were over twice as likely as those without a disability (25%) to have had serious thoughts of suicide. Those who had a disability or were long term health impaired were twice as likely (17%) to take payment for sexual acts than those who had no disability (8.6%). Those with a physical disability or who have long term health impairments feel uncomfortable using services because of their sexuality and gender identity (20%) and have higher feelings of discomfort for reasons other than their sexuality (29% compared to 13%).

11.8.1. Housing

LGBT people who identify as disabled or long term health impaired can have specific housing needs and experiences that differ from the rest of the LGBT population, but that are still related to their LGBT identities. 19% of those who identify as physically disabled/long term health impaired report having experienced bullying, abuse, discrimination or exclusion from housing. LGBT people in the sample who are disabled or who have a long term health impairment are more likely to struggle obtaining accommodation, to have experienced homelessness, to report having specialist housing needs and to live in social housing.

Those who are disabled or have a long term health impairment are over twice as likely (48%) to struggle getting accommodation as those who do

not (21%, p. <.0001). The lack of suitable properties can affect moving from areas of hate crime as well as obtaining suitable properties in the first instance. Of those who identify as disabled or have long term health impairment, 21% (n. 6) live in social housing compared to 9% (n.67) of those who did not identify as disabled or as having a long term health impairment. 36% privately own their own homes compared to 48% of those who are not disabled. A third of those who defined as disabled have been homeless compared to 20% of those who are not disabled. Those who identify as disabled or long term health impaired are more likely to report having specialist housing needs (37%, compared to 2%) than those who are not disabled. This is perhaps to be expected, yet it should still be noted that the majority of LGBT disabled people do not live in social housing (79%), indicating a reliance on other sources of financial and social support and, possibly, a lack of engagement with services.

11.8.2. Domestic violence and abuse

Those who identified as disabled or having a long term impairment were more likely to have experienced abuse, violence or harassment from a family member or someone close to them than other respondents ($p<0.05$). Half (51%) of those who defined as physically disabled or long term health impaired had experienced this compared to just over a quarter (27%) of those who did not identify in this category (see table 3.6a). This indicates an area of vulnerability that may have been caused by domestic violence and abuse, or may be exploited by perpetrators of violence.

Table 11.8a: Domestic violence and abuse by physical disability or long term health impairment

Disability		DV survivor	Not DV survivor	Total
Yes	No.	57	56	113
	%	**50.4**	**49.6**	**100**
No	No.	182	484	666
	%	**27.3**	**72.7**	**100**
Total	No.	239	540	779
	%	30.7	69.3	100

P<0.0005 (Continuity Correction)

This is consistent with the limited research that has been conducted into the experiences of disabled women, which shows that disabled women are twice as likely to experience domestic violence as non-disabled women (1995 British Crime Survey, also confirmed by data from other countries). They are also likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence. Further research should explore LGBT experiences of domestic violence and abuse in relation to disability.

Disabled people are also more likely to have experienced abuse from others (39%) than non-disabled people who have experienced domestic violence and abuse (23%). Although some of these others included friends and family, there is a need to investigate the vulnerability of this grouping within LGBT populations.

11.8.3. Safety

Those who identified as physically disabled or long term health impaired are more likely to have experienced hate crime, to have safety fears and to think the police service had not improved.

39%, (n. 34) of disabled LGBT people reported an incident of hate crime in this survey compared to 23% (n.112) of those who did not identify as disabled ($p = .001$). Those with a disability or long-term health impairment were less likely to feel very safe or safe and more likely to feel unsafe/very unsafe at home and outside in Brighton in the day and at night. Only 3% (n. 3) of those with a disability or long-term health impairment felt very safe outside in Brighton at night, and only 25% felt safe (n. 30). This compares with 9% (n. 61) of people without a disability or long-term health impairment who felt very safe outside at night, and 41% (n. 276) of this group who felt safe. Of those with a physical disability or long-term health impairment, 22% (n. 26) felt unsafe outside at night in Brighton, and 12% (n. 14) felt very unsafe. This compares with respective figures of 12% (n. 82) and 2% (n. 15) for respondents without a disability or long-term health impairment ($p < .0005$).

While less than one percent of those without a disability or long-term physical impairment (n. 4) felt unsafe or very unsafe at home, 5% of those with a disability or long-term physical impairment felt unsafe or very unsafe at home. While 96% of those without a disability or long-term physical impairment (n. 619) felt safe or very safe at home, somewhat fewer – 86% (n. 102) – of those with a disability or physical impairment felt safe or very safe at home ($p < .0005$).

10% (n. 12) of those with a disability or long-term impairment felt unsafe or very unsafe outside in Brighton during the day, compared to 1% (n. 8) of those without a disability or long-term health impairment. 69% (n. 81) of those with a disability or long-term impairment felt safe or very safe outside in Brighton during the day, compared with 90% (n. 604) of those without a disability or long-term physical impairment ($p < .0005$).

65% (n. 54) of those who identified as disabled felt unsafe in relation to places, services or facilities in Brighton and Hove, compared to 52% (n. 255) of those who did not identify as disabled. This difference is statistically significant ($p = .03$).

18% (n. 10) of disabled respondents did not feel safe inside LGBT venues, compared to 2% (n. 6) of respondents who did not identify as disabled ($p < .0001$).

Those who were disabled were more likely to at times avoid going out at night: 67% (n. 58) compared to 26% (n. 127) of those who were not disabled.

Those with a disability are over twice as likely to think the police service had not improved (8% compared to 3%, $p=.006$), compared to those without a disability. They were also slightly more likely to think it had improved (57%, compared to 50%) and less likely to answer 'not sure'. This shows a diversity of opinion that needs to be investigated further.

Table 11.8b: Have the services the Police provide to LGBT people improved by Disability (whole sample included as numbers are small)

Disability		Yes	No	Not sure	Total
Yes	No.	65	9	40	114
	%	57.0	7.9	35.1	100
No	No.	338	20	314	672
	%	50.3	3.0	46.7	100
Total	No.	403	29	354	786
	%	51.3	3.7	45.0	100

P=0.006

Those who identify as disabled or have a long term health impairment are almost twice as likely (42%, n. 36 compared to 22%, n. 108), to say that there is prejudice against LGBT people in the police service.

11.9. Developing inclusion for LGBT disabled people

Those who identified as disabled or long term health impaired in this research were given the opportunity to offer suggestions as to what could change to make those who answered the question feel more included in LGBT or disabled communities, activities, events and groups in Brighton & Hove. The major categories can be seen in table 11.9a.

Table 11.9a: Major categories from qualitative data: 'Is there anything that could change to make you feel more included in Disabled or LGBT communities, activities, events and groups in Brighton and Hove?'

Categories		No. of responses
No; Don't want special provision or to be treated differently		11
Better accessibility and more/better facilities		10
Of Which:	*To venues*	3
	Toilets	3
	At Pride	2
	Lifts (that work)	1
	Flooring	1
	Parking	1
	Seating	1
Better understanding/acceptance		9
Of Which:	*Re: hidden/invisible disabilities*	2
	Re: multiple identities	1
	From the police	1
	From medical professionals	1
Better information		3
Of Which:	*Re: disabled and LGBT activities, events and/or groups*	2

Re: accessibility at activities, events and/or groups	1
Greater variety of kinds of socialising	3
More support for LGBT people with mental health difficulties	3
Greater equality; measures against discrimination/stigma/prejudice	2

Notes:

1. Where responses fall into more than one category they are counted in each category that they fall into.
2. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.
3. Subsets of a major category (marked by 'Of Which') are not mutually exclusive with respect to other subsets of the same major category: a single response (counted only once under the major category) may fall into more than one subset of the major category.
4. The total of the subsets (marked by 'Of Which') for any major category do not necessarily enumerate the total number of responses for that major category.

As can be seen from table 11.9a, there were 11 responses which indicated that nothing could be changed or that there was no desire for special provision.

> **I have no particular wish to be included in ANY sort of group. I regard myself as being queer, but heterosexual.**
>
> *(Questionnaire 177)*

> **No I used to go to LGBT Mind group at the Allen centre, but I felt I was giving my energy to other people who had problems, and was not actually getting any benefit for myself. Also I want to keep in with `normal` society.**
>
> *(Questionnaire 207)*

> **No I don't expect to be treated any differently to anyone else.**
>
> *(Questionnaire 473)*

The desire in questionnaire 207 to 'keep in' with 'normal' society and not wanting to fit in with LGBT communities offers a different perspective to that of the focus groups (perhaps because these targeted LGBT people). The wish to not be treated differently is interesting and is set alongside the data above that suggests LGBT people who have long term health impairments or are disabled are treated differently by LGBT people and do not access local disability groups.

However, for ten people more accessibility was desired and 9 people wanted to see better understanding/acceptance.

> **For clubs etc to realise that identity goes beyond sexuality into race and disability as well. And for medical profession to be more clued up about the dual nature of disability and sexuality**
>
> *(Questionnaire 342)*

The desire for clubs and pubs as well as health services to recognise issues of multiple marginalisation and be 'more clued' up, illustrates that for some, there are specific needs associated with LGBT disabled identities, experiences and lives. These needs should be addressed across service provision as well as in venues for socialising.

> **access to buildings or venues, that say have a disabled lift but its broken or a club venue is up stairs and there is no lift, or the floor is uneven**
>
> *(Questionnaire 13)*

> access descriptions on publicity for events. More loos at Pride :)
>
> *(Questionnaire 76)*

The desire for alternative venues, activities and events came across clearly with 3 people specifically mentioning this (in addition to the data above):

> **many of the LGBT events are focused on clubbing and drinking, which I would only do occasionally. More alternatives would be nice, e.g. book group, film club. - disabled groups seem to exist primarily for fund-raising purposes. I would like to meet other disabled people to socialise more.**
>
> *(Questionnaire 38)*

11.10. Conclusion

This chapter has shown that issues of multiple marginalisation are pertinent for LGBT people who identified as having a physical disability or long term health impairment. 15% of the sample identified as having a long term health impairment or physical disability. Of these a quarter of respondents who identify as disabled say they find it difficult or very difficult to be an LGBT disabled person in Brighton and Hove. Yet there was some evidence of positive experiences in Brighton & Hove with LGBT specific services, venues and spaces being valued and enjoyed. However, the qualitative data also pointed to isolation, exclusion and access issues as key areas where LGBT people who identified as disabled or long term health impaired had significant difficulties. Supporting this, those who identify as disabled report having experienced bullying, abuse, discrimination or exclusion from other LGBT people (24%), in employment (21%), from health services (19%). Almost half of LGBT disabled people in this research regularly participate in national LGBT groups, this figure is much less for local disabled groups and local LGBT groups, indicating that these are not available or accessible. Supporting the lack of accessibility for LGBT people in disabled groups, over half of disabled/long term health impaired respondents say that they do not feel they fit well or at all into disabled activities, events and groups in Brighton and Hove and 38% of respondents who identify as disabled say they do not fit that well or do not fit at all into LGBT activities, events and groups in Brighton and Hove.

This research has shown that LGBT people with physical disabilities/long term health impairments have specific areas of need. LGBT people who identify as disabled are more likely to have serious thoughts of suicide, to have exchanged sex for payment and to feel uncomfortable using services because of their gender/sexual identity. LGBT people who identify as disabled or long term health impaired can have specific housing needs and experiences that differ from the rest of the LGBT population, but that are still related to their LGBT identities. Those who identified as disabled or having a long term impairment were more likely to have experienced abuse, violence or harassment from a family member or someone close to them than other respondents. Those who identified as physically disabled or long term health impaired are more likely to have experienced hate crime, to have safety fears and to think the police service had not improved.

Qualitative data suggested that LGBT people wanted to be treated 'normally' with some asking for little change. However, many requested improved accessibility, acceptance, understanding and information.

12. GPs and healthy living centre

12.1. Introduction

This chapter will explore some of the key areas of engagement with health services and the desire for LGBT centred services. GPs are an important point of initial contact for a wide range of services, yet they can be used differently according to perceptions and experiences of stigmatisations and prejudice. This chapter will examine the complexities of coming out to GPs relating to gender and sexual identities, as well as differences between LGBT people. The chapter will then discuss the desire for an LGBT specific service, before addressing the question of an LGBT healthy living centre.

12.2. GPs

The majority of the sample have disclosed their sexual/gender identities to their GPs (60%) (table 12.2a). Those who are trans, lesbian, older people, those with mental health difficulties and those who are living with HIV are more likely to be out to their GPs. This is a slight rise from the 47% who said they had disclosed their sexual/gender identity to their GP in the Count Me In research in 2000 (Webb and Wright, 2001). Yet, Count Me In also found that less than half of the sample were confident that their GP would be non-judgemental. Disclosures in this research did not mean that LGBT people were confident in using their GP services.

Table 12.2a: Have you disclosed to your GP that you are Lesbian, Gay, Bisexual and/or Trans?

	Frequency	Percent	Valid %
Yes	488	59.6	**60.2**
No	323	39.4	**39.8**
Total	811	99.0	100.0
Missing	8	1.0	
Total	819	100.0	

The disclosures by particularly vulnerable populations were discussed in the focus groups, and strategies for finding 'safe' and 'friendly' GPs were identified. There were fears expressed regarding attending a GP who was hostile, unsympathetic, insensitive and / or generally unfriendly towards LGBT people. There was evidence in the focus groups of participants seeking out friendly GPs who they felt safe with:

Greg: **My GP's gay but I deliberately sought to get a gay GP and because in the past… I mean I think there is an issue with LGBT people and GPs definitely. I have had a GP in the past who's been really, really, you know, homophobic and it makes such a difference because you just feel so vulnerable when you go to your GP anyway, that if you get like crap, which I did from a GP who wouldn't even look at me, you know, wouldn't even say my name, you know, would say 'you' but, do you know what I mean, oh just wouldn't get up and, you know, shake hands when you walked in the consulting room, nothing. Anyway, … from then I thought, right, I'm never, ever, ever going to have a homophobic GP ever again and so I deliberately chose to have a gay GP and it makes such a difference. Luckily I don't go to the GP that often, but when I do I know that because he's gay, you know, that… my sexuality will not be an issue.**

(Hate crime focus group)

Others, whilst they may/may not be out to their GP avoided disclosing particular information and some were able to use alternative services, particularly for sexual health concerns. This illustrates a continuing concern with GPs' friendliness on the basis of sexual activities and the need for alternative services for some LGBT people.

Fred: **…every now and then it occurs to me that I'm not actually out to my doctor because if there is anything sexual health related, I don't go to my GP because I don't want it on my record … And it's not because I'm concealing it and I only go to him for sore throats and aching limbs and whatever, and so you know I'm one of those many people who technically isn't there for my doctor.**

I would always go there [Wilde clinic] because it's a gay space … And people wouldn't make assumptions and in the past when the waiting list has been … wait two months for a check up, there is a drop-in in Shoreham and I've been there and it is generic and I'm sitting there in the waiting room thinking you all look straight, I'm sure you are not but I look straight, the Doctor is going to assume I'm straight, I've got to come out and I don't mind coming out to a doctor and but it's, it is just nice, you know – it is more relaxing

just to go to gay space and know that people aren't going to make assumptions.

(Parents focus group)

Using specific doctors and clinics for particularly illnesses is afforded to some sections of the LGBT population and this is appreciated. A number of male participants mentioned that there was no need to disclose their sexuality or gender identity to their GP. Where issues of sexual health were concerned they used specific clinics and the Lawson Unit and GUM clinics were mentioned as examples of good practice (except for the stereotypical 'gay' music!). In these environments coming out is not something that has to be negotiated with doctors who assume heterosexuality and whose sexual identity is 'other'.

However, female and trans participants noted that they often have to come out to their GP, due to specific questions regarding transitioning or contraception (see chapter 9). The lack of choice and previous experiences can lead participants to use social networks to find LGBT friendly GPs. For those who had yet to create these networks, the fear of their GP not being LGBT friendly meant that they often did not disclose their sexual orientation to them. Along with a fear regarding the friendliness of GPs, there was also a perceived lack of knowledge about specific LGBT issues and concerns.

Susan: **The only health issues that I really know about for lesbians are like breast cancer. I know little about that, but I do know that it's an issue for women who don't have children. I'm very ignorant, woefully ignorant, maybe that's an issue. If there was a poster on the wall (in my GPs surgery) saying 'look for a leaflet in our racks about your lesbian health', I would go and look for it.**

(Women's focus group)

The desire to be represented on the information racks at doctors' surgeries was about more than gaining information. Another focus group spoke of how these visible signs could make them feel welcome. While Susan comments on the lack of available information on issues that may affect lesbians / gay women, Ruth notes that there is nothing that specifically addresses her as a bisexual woman, both because of the focus on the sexual health of straight women and because of the limited amount of information available on lesbian health.

Ruth: **I know the Claude Nicol - I've heard nothing but good about them. On top of that there's the Wilde Clinic for gay men. There isn't so much here but in London there was things specifically aimed at lesbians. But there's nothing aimed at bisexual people and that's a whole different thing on its own. I'm poly-amorous anyway, so I'm sleeping with people from both genders. There isn't any information that's specifically aimed at bisexual people and about the issues around that and it's like if you look at the stuff that's aimed at straight women it**

doesn't really mention herpes, the chances of like contact between say women and oral sex with herpes and that sort of thing, so it's like it gets ignored. You either go to a straight one or you go to gay one, there isn't anything in between.

(Bisexual focus group)

For others, LGBT identities may be important in their diagnosis and treatment:

Rosa: **I've got a whole part of mind stream which is not heterosexual, part of it that's bisexual, but there's a bit of it that's trans. So unless the heath providers understand that and they understand the issues around that, it's very hard for them to diagnose what the hell's wrong with me. I think respect talks about do they take into account in their diagnosis, you know, the fact that I'm trans-gendered and that fits other parts of my health system. They don't take that into account and even when I tell them it's important they still don't take it into account.**

(Trans focus group 2)

Rosa highlights how trans needs should be taken into consideration where they are identified as important in the treatment of medical conditions. It should be emphasised, however, that Rosa and other trans participants did not want all their physical and mental health difficulties to be reduced to only to their trans status. They were clear that whilst this should be taken into account, it should not be taken as the reason for all physical and mental health difficulties.

12.2.1. Sexual identity

In 2000 women were found to be more likely to be out to their GP's than men (Webb and Wright, 2001). Those who describe themselves as queer have the highest proportion of disclosure, at 71% (n. 20), followed by lesbians (68%, n. 188). However, less than a quarter of bisexuals (23%, n. 11) have made this disclosure. This compares to 58% (n. 248) of gay men (see table 12.2a; p = .0005).

Table 12.2a: Disclosure of sexual or gender identity to GP by sexuality

		Lesbian	Gay	Bisexual	Queer	Otherwise coded	Total
Yes	No.	188	248	11	20	21	488
	%	**67.6**	**58.1**	**23.4**	**71.4**	**67.7**	**60.2**
No	No.	90	179	36	8	10	323
	%	**32.4**	**41.9**	**76.6**	**28.6**	**32.3**	**39.8**
Total	No.	278	427	47	28	31	811
	%	100.0	100.0	100.0	100.0	100.0	100.0

12.2.2. Trans

Almost the entire trans sample (88%, n. 37) have disclosed their sexuality / gender identity to their GPs, a significantly greater proportion than the rest of the sample (58%, n. 440) (p = .0005) (see chapter 9). Trans people may have to disclose their gender identity in order to be treated and have their medical needs understood. However, as Rosa illustrates, this may not be a positive experience.

12.2.3. Disability

Three quarters (76%, n. 90) of those with a disability have disclosed their sexual identity to their GP, compared to just under three fifths (57%, n. 385) of the rest of the sample (p = .0005). Disabled LGBT people may have to rely on specific services, which can mean that they are forced to out themselves in order to receive particular forms of care- this area needs further exploration.

12.2.4. Age

Young people are considerably less likely to disclose their sexual identity to their GP, with less than two fifths (38%, n. 46) of under 26 year olds doing so, compared to three fifths overall. The likelihood rises with age, to 73% (n. 92) of 46 – 55 year olds doing so, and a slight drop in the over-55's, to 69% (n. 52) (p = .0005).

12.2.5. Mental health difficulties

Those with mental health difficulties are also more likely to have disclosed their sexual / gender identities to their GP (62%, n. 333), compared to 54% (n. 133) of those who do not experience mental health difficulties (p = .032).

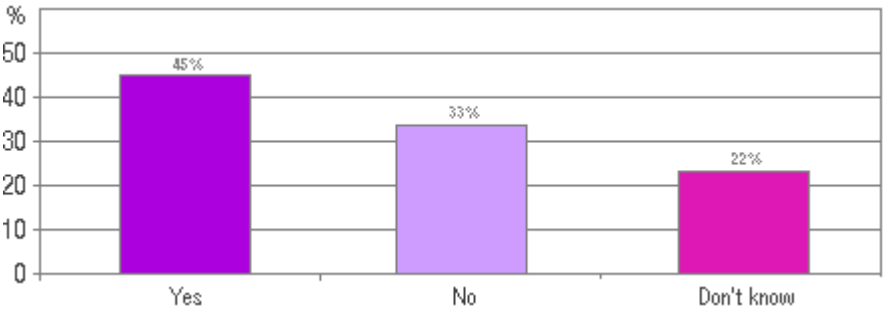
12.2.6. Living with HIV

Those who are HIV positive (86%, n. 48) are also more likely to have disclosed their identities to their GPs than those who last tested HIV negative or who have not had a test result (61%, n. 234) (p = .001). This may relate to the need to recieve treatment and/or the sourcing of friendly GPs.

12.3. Specific LGBT service

Although 60% of people are out to their GPs, 45% (n. 363) would like a GP / clinic that is specifically for LGBT people, 22% (n. 179) are unsure and 33% (n. 264) say they would not like a specialist GP/clinic service (see figure 12.3a). This figures are small drop from Count Me In in 2000 (Webb and Wright, 2001), when 51% said they would prefer to use an LGBT GP service Those who are disabled, isolated or have mental health difficulties are more likely to want a specialist GP service.

Figure 12.3a: Would you prefer to use a GP / clinic service that was specifically for you as an LGBT person?



One focus group respondent expressed his support for LGBT facilities succinctly with the observation:

Chris: **Brighton should have a gay centre. They should have a centre to go to that specifically deals with your wellbeing, health. I mean it's the biggest gay community in Europe and we don't have what you might call our own place.**

(Disability Focus Group)

12.3.1. Disability and/or long term health impairment

Table 12.3b: Preference for a GP/clinic service specifically for LGBT people by disability

Disability		Yes	No	Total
Yes	No.	62	295	357
	%	**54.9**	**43.6**	**45.2**
No	No.	35	221	256
	%	**31**	**32.7**	**32.4**
Don't know	No.	16	160	176
	%	**14.2**	**23.7**	**22.3**
Total	No.	113	676	789
	%	100.0	100.0	100.0

Those who identify as long term impaired or disabled are more likely (55%, n. 62) to prefer a clinic specifically for LGBT people than those who do not

identify as disabled or long term impaired (44%, n. 295) (p = .035). However, the proportions not preferring a specific clinic are similar for both those with a disability and those without (see table 12.b above).

12.3.2. Isolation

Just over half of those who feel isolated (51%, n. 133) prefer a GP / clinic specifically for LGBT, compared to just over two fifths (43%, n. 220) of those who do not feel isolated (p = .025). Similar proportions of both groups do not express a preference (22%, n. 59 of those who feel isolated and 21%, n. 109 of those who do not feel isolated).

12.3.3. Mental health

Almost half (49%, n. 259) of those with mental health difficulties would prefer to use a GP / clinic specifically designed for LGBT people, compared with 39% (n. 95) of those who do not experience mental health difficulties (p = .025). Those with mental health difficulties are less likely than those without mental health difficulties to not want a GP / clinic specifically designed for LGBT people (30%, n. 161 against 37%, n. 92).

12.4. Healthy living centre

In contrast to the divided opinion regarding specialist GPs, the vast majority supported an LGBT healthy living centre with a range of LGBT health and community services (see table 11.7). 91% of those who answered the question (85% of the entire sample) would like to see such a centre.

The desire for a healthy living centre varied by income with those earning under £10,000 almost unanimously agreeing with the statement (97%), compared to those earning over £40,000 who were less supportive (87%). Those who are isolated (96%) are more likely to want a healthy living centre than those who are not (87%). Those who experience mental health difficulties (93%) are more supportive of this idea than those who do not experience mental health difficulties (85%).

Table 12.4a; Would you like a LGBT Healthy Living Centre providing a range of LGBT health and community services?

	Frequency	Percent	Valid percent
Yes	697	85.1	**90.5**
No	73	8.9	**9.5**
Total	770	94.0	100.0
Missing	49	6.0	
Total	819	100.0	

Many of the focus groups enthusiastically embraced the idea of a healthy living centre, which would provide a range of services (including exercise, yoga, meditation, a welcoming café, safe space and a swimming pool!). There was also a clear link between this and the alternative social spaces and central information points that are seen to be needed in the city. For many a healthy living centre could offer a health service and more:

Evan: **And it's about those words 'LGBT Healthy Living' rather than "I'm a doctor but I can talk to you about LGBT issues", because you can't. I wouldn't want to go to the doctor and say "Oh my partner ain't half playing up, or he's making me feel really low." I would do, but I'd probably think "Well, not going to get much joy out of it". So I think if it's 'healthy living' people will start… that name has been… around quite a bit now, people are used to healthy living centres and daily living centres and they'd be more inclined to go along and maybe about something … that maybe can't be directly dealt with at the daily living centre or the healthy living centre, but they can be, you know, signposted to somewhere else who can help them, so I think that would be a good idea.**

Andy: **Those services could be offered, anything from mental health to physical health to social activities, they're all in one place so that there's an interest in me being a gay man, rather than me having to go somewhere and tell them who I am and then [they] try and engage with me.**

(Outlying estate focus group)

However, those in the focus groups also expressed some caution about the ghettoisation of specialist services. The healthy living centre was understood to operate in addition to continued development of mainstream services that respond appropriately and effectively to LGBT needs. It was felt that the healthy living centre should offer some outreach and education to GPs and other service providers. This would work against the potential ghettoisation of LGBT people and also offer a centre of excellence that could reach nationally (and potentially internationally):

Martin: **You need specialist centres that can do the research and carry things forward and advise the frontline people, but the frontline service should be able to cater for everyone.**

(BME focus group 1)

The breadth of vision for a healthy living centre is clear in this quote. Yet Natasha highlights how these specialisations can result in mainstream services passing on clients to specialist services where available, and therefore being more difficult settings in which to raise LGBT issues. Healthy living in this sense is not simply about the delivery of health services, but about improving LGBT healthy living and social spaces outside the LGBT scene.

Natasha: **I think the idea of having something like this would be highly beneficial, but it shouldn't be something that we would have to rely upon. I think we should be able to go to, no matter where we are, our local GP and be able to receive the services that we need without having to be told 'Oh, well, if you go down to the community centre you'll be able to get yourself sorted out there'. Although it would be good to have it as a specialist kind of centre for health purposes and also for those people who kind of don't feel they can pluck up the courage to talk about these sorts of problems to their GP, but are able to go somewhere and talk about the problems that they face**

(Trans focus group 2)

12.5. Conclusion

This chapter has shown that there have been some changes since 2000, in proportions of LGBT people coming out to GPs however there is a strong desire to have a healthy living centre that caters for LGBT people. Although a slim majority of LGBT people in this research are out to their GP about their gender identity/sexuality, there continues to be difficult negotiations and discriminatory experiences when using GPs. Many LGBT people spoke of finding safe and LGBT friendly GPs that they felt comfortable with and of using alternative services in order to deal with particular issues. There is a desire for an LGBT specific GP service, however the vast majority of LGBT people want a healthy living centre that provides a range of services to cater for LGBT health and wellbeing.

13. Monitoring and future priorities and services

13.1. Introduction

Monitoring is seen as an important tool in ensuring the equity of service provision and enabling services to find where gaps exist in relation to their provision for the diverse communities of Brighton & Hove. Although census data is not available regarding sexual or gender identities to offer what are often seen as 'base level' statistics, monitoring can still be an important tool in emphasising equity issues. Sexual and gender identities are often perceived to be 'too personal' to monitor. This results in an absence of sexuality/gender identity data and thus limit understanding of how these communities use or interact with particular services. This chapter will address whether LGBT people are happy to be asked about their gender/sexual identities and the geographical variations in this data collection. The local government duties to consult with the diverse populations of cities are then addressed and then the sample responses to the questions regarding how these consultations should occur. This chapter will outline the areas identified by those in the research as key priority areas in the next five years.

13.2. Monitoring

As reported in Count Me In Too, the majority (85%) of LGBT people are happy to give information about their gender/sexual identities if they believe the service is LGBT friendly and the data is confidential and anonymous (Browne, 2007a). 85% of LGBT people will give information regarding their sexual/gender identities if they believe the service is LGBT friendly and the data is confidential and anonymous (see table 13.2a).

However, the qualitative data on the questionnaire noted that for some the small networks of LGBT Brighton & Hove are problematic when attempting to ensure anonymity.

Table 13.2a: Are you willing to give information about your sexual orientation / gender identity when using or accessing services for monitoring purposes?

		Total
Yes, always	No.	311
	%	40.1
Yes, if the information was anonymous and confidential	No.	152
	%	19.6
It would depend on how LGBT friendly I thought the service was	No.	198
	%	25.5
Sometimes	No.	76
	%	9.8
Never	No.	15
	%	1.9
Don't know	No.	16
	%	2.1
Other (please specify)	No.	8
	%	1.0
Total	No.	776
	%	100.0

In 2007 Spectrum produced a paper that addressed trans need and the possibilities of monitoring the trans communities. Recommendations included basing monitoring gender identities on:

- Policy support
- Understanding of the reasons behind monitoring
- clarity around what will happen as a result of monitoring
- prior consultation with the communities
- training for the monitoring organisation
- guaranteed confidentiality of the monitored information

This is clearly relevant here and should be pursued in order to ensure monitoring is accurate and acceptable for LGBT people.

13.3. Modes of consultation

61% of respondents would like to see consultations by the police, Council and NHS undertaken by questionnaire, perhaps unsurprising as this was the tool used to collect this data. A smaller proportion would like to have open public meetings (47%), LGBT community forums (38%), community events (38%) and LGBT focus groups (36% see table 12.4 c). The citizen's panel was the least popular option (24%).

Table 13.3a: How would you like service providers to consult with you?

	Frequency	Percent
Questionnaires	500	61.1

Open public meetings	388	47.4
LGBT community forums	312	38.1
Community events	311	38.0
LGBT focus groups	294	35.9
Citizens panel	194	23.7
Don't know	87	10.6
Other	18	2.2

However, the qualitative data on the questionnaire also suggested internet chatrooms, surveys (this, again, may reflect the techniques use for Count Me In Too) and emailed surveys from LGBT groups would be positively viewed. There was a mention of the need for these 'consultations' to be co-operative such that authorities take 'proper notice of LGBT desires and wishes' (questionnaire 168). There was also a desire to consult broadly with the general LGBT public, beyond the 'usual suspects' and those who are most vocal in open meetings, perhaps through the internet.

13.4. Priority areas for LGBT health

Table 13.4a outlines the key priorities identified in the questionnaire, with mental health (45%), sexual health (39%), drug use (37%), alcohol use (34%) and LGBT friendliness of the health service (24%) being the top five priorities for LGBT people.

Table 13.4a: What in your opinion should be the top three priorities for improving Health and Well-being for LGBT people in Brighton and Hove in the next 5 years?

	Frequency	Percent
Mental health	371	45.3
Sexual health	321	39.2
Drugs use	302	36.9
Alcohol use	281	34.3
LGBT friendliness of health services	199	24.3
Stop smoking	194	23.7
Access to counselling/group work	183	22.3
Emotional support	181	22.1
LGBT friendliness of leisure / fitness / physical health activities	168	20.5
Physical health	121	14.8
Access to GPs	101	12.3
Eating distress	32	3.9
Other (please specify)	19	2.3

In the focus groups LGBT friendliness was addressed. This augmented discussions of GP clinics and access as well as highlighting some key

changes that could make LGBT people feel more welcome in surgeries and health services:

Ian: **I certainly seemed to develop a sort of sixth sense about who you are going to be a problem with and who you are not going to be up front with. And to be perfectly honest I have not been upfront with my surgery, you know my doctor. It has never been an issue yet, something in my health hasn't yet occurred where I need to say to them look you know I'm a gay man, whether that's relevant or not I don't know, I just don't know, I just feel slightly …**

Researcher: **Do you know what you need for your sixth sense to kick in to say yes?**

Jo: **What would make the difference would be, they've got posters about anything else down there, if they had some posters about we're a sort of gay friendly surgery, bring your gay health issues to us or whatever you know and it's not there.**

(Older persons focus group)

The desire for signage that indicates that gay/LGBT issues could be dealt with in surgeries is illustrated by Ian. To him, this would make the surgery more LGBT friendly and he would be more able to discuss issues that could relate to his sexuality. His 'sixth sense' can have practical clues and indications of inclusion.

However, the emphasis is not just with mainstream services there was also a desire to develop LGBT community networks and bonds:

Ian: **I was listening to a programme this morning, I think it was on Woman's Hour, I don't know what it was on but it was about the development of health visitors in Salford back in God knows when you know, 1920 or whenever it was, they decided that it would be absolutely impossible for lots of well meaning middle class women to go into working class homes and dispense advice and I can understand that and so what they did was to work out a system of employing, to start with anyway, employing working class women to become Advisors to their community and so they sort of built up a network and eventually that become almost like an unofficial network so everybody could, was in touch with one another, giving advice about children, about health and so … and it seems to me that something like that for people of our age would be rather good but I mean that it was generated from us and that we have a network of people who at least kept in you know fortnightly**

(Older focus group)

The other category in the answer for top three priorities elicited some responses, the major categories are detailed in table 13.4b with future responses being outlined in table 13.4b.

Table 13.4b: Major categories from qualitative data: What, in your opinion, should be the top 3 priorities for improving Health and Well-being for LGBT people in Brighton and Hove in the next 5 years?

Categories		No. of responses
LGBT specific services		6
Of Which:	*Counselling/support*	2
	Women's only clinic	1
	GP	1
	Disability group	1
	Miscellaneous	1
Services should not be LGBT specific		2
HIV/AIDS specific services		2

Table 13.4c: Other responses: 'What, in your opinion, should be the top 3 priorities for improving Health and Well-being for LGBT people in Brighton and Hove in the next 5 years?

Everything should be easier for LGBT.
Information in directories (e.g. phone book).
A dentist
more activities that do not surround alcohol
speed of medical services
Self control, moderation, keeping out of debt
all of the above are important
Reducing waiting lists
and drug use
Physical/Mental/Emotional/Sexual Abuse
These services are not relevant to me personally but I do believe they are important to the LGBT community
Access to GUM Clinic
spiritual well-being and more holistic affordable healthcare
discorage them from sleeping around so much
LGBT-friendly schools
get rid of NHS
social/community space
Don't know
Community self-esteem development

13.5. Conclusion

LGBT people are willing to engage with statutory services in their efforts to monitor in order to improve their services. However, these monitoring procedures need to ensure the confidentiality of the information in addition to being LGBT friendly. Trans issues need to be addressed and monitoring gender identities is an area of work that is being developed and needs to be understood in this context. Consultation data suggests that consultations use a variety of different measures in order to explore the views and needs of the LGBT populations in Brighton & Hove.

The top five priorities for health for LGBT people are mental health (45%), sexual health (39%), drug use (37%), alcohol use (34%) and LGBT friendliness of the health service (24%). The focus groups indicated that signage could help with perceptions of LGBT friendliness and a willingness to address LGBT issues with GPs. There was also a desire to build community networks to support LGBT people, which may tie into a healthy living centre.

14. Conclusions

14.1. Introduction

The conclusions will offer an overview of all the chapters. Although previous Count Me In Too in depth analysis reports have discussed key areas of marginalisation in the conclusion, specific chapters of this report have addressed sex work, trans identities, HIV, Deaf people, those who are physical disabled/long term health impaired in. Therefore this conclusion will summarise the main aspects of this research, including these groups.

14.2. Summary of the chapters

14.2.1. General physical health

This report addressed general physical health by examining measures of physical health in the past 12 months, the prevalence of smoking and physical activity. It identified key differences between LGBT people and the general population, as well as within the LGBT groupings.

The report began by showing that compared to the 2003 lifestyle survey measure of general health, LGBT people rate their physical health over the past 12 months poorer than the general population. Those who are disabled and long term health impaired and older in the 2003 survey were more likely to rate their health as poor than the rest of the population. LGBT people in these categories had higher proportions in the poor/very poor categories in relation to physical health than the 2003 survey. Moreover, less than half of trans respondents rated their physical health as good/very good (compared to 78% of the general population). Similarly, those living with HIV, respondents living in rented council accommodation, and respondents living in temporary accommodation or who are homeless were less likely than other LGBT people to say that they had good physical health in the previous year.

33% of LGBT people in this sample smoke. Male respondents and those identifying as an 'other' gender are more likely to smoke than women. Younger people are also more likely to smoke although this varies with

gender: women aged between 36 and 45 are more likely to smoke than other women. Those living with HIV, those who use 'illegal drugs', and those who consider their physical health to be neither good nor poor, poor or very poor are more likely to smoke than the rest of the sample in each respective case. The majority (61%) of smokers say that they keep smoking because they are addicted to it. Over half (53%) of smokers also indicate that enjoyment is a reason for continuing to smoke. 90% of LGBT smokers are concerned about the effects that smoking has on their health. 71% of LGBT smokers would like help to stop smoking. Only 52% of LGBT smokers are aware of the free Stop Smoking Service in Brighton. The questionnaire was carried out shortly before the smoking ban in public buildings and workplaces came into effect. The prospect of a smoking ban was the most popular response when people were asked what would motivate them to give up smoking (48% of LGBT smokers). Further research needs to be carried out to assess the impact that the smoking ban has had on levels of smoking. 26% of LGBT smokers said that an LGBT stop smoking service would motivate them to give up smoking, but 19% said that nothing would motivate them to give up smoking. Those over 55 are the most likely age group to say that nothing would motivate them to give up smoking.

Almost 4 out of 5 respondents (79%) indicated that they would like to be more physically active. Amongst those who would like to be more physically active, 44% indicated that a lack of time and 30% indicated that cost stopped them from being more physically active. 43% of the trans respondents who would like to be more physically active cite a lack of trans spaces as something that stops them from achieving this desire. 8% of men indicated that a lack of male-only spaces stops them from being more physically active, while 22% of women indicated a need for women-only spaces. Those who feel isolated are more likely (33%) than those who do not feel isolated (23%) to say that having no one to be physically active with stops them being more physically active. Stating that homophobia or trans-phobia stops them being more physically active varies by gender and age. Those aged 36 to 45 are more likely to give this as a reason than other age groups for both male and female respondents. The other most frequently used reasons for not being able to be more physically active are laziness and lack of motivation or willpower.

14.2.2. Sex

This report addressed sex and sexual health in depth identifying key areas of need and the practices and experiences of LGBT people. It also addressed issues such as living with HIV and sex work.

The majority of LGBT people in this sample have had sex in the past 3 years, most have had sex with under 5 partners in the past 12 months. The number of sexual partners varies by sexual identity, with gay men having more sexual partners in the past twelve months than any other grouping. The majority of those who have not have sex in the past 3 years believe that not having sex is not respected in LGBT culture. The majority of young people have anxieties around sex. Where young people are not receiving support in schools that address sexual and gender diversity, LGBT specific services and resources can be key for those under 26.

The report moved on to illustrate that the majority of LGBT people have had sexual health check ups, although a significant minority (25%) have never had a sexual health check up, with 7% of respondents saying that they do not need one. 39% of LGBT people in this research said that they did not know where to find help around sex and relationships. There are differences between LGBT people on the basis of having sexual health check ups, relevance of sexual health information and knowledge or availability of support around sex and relationships. These could be related to the emphasis on particular forms of sexually transmitted diseases and perceived risks amongst LGBT people. Female respondents, lesbians, trans respondents, those who are disabled/long term health impaired, those who have not tested positive for HIV are less likely to have sexual health check ups than other LGBT people. Older LGBT people are more likely to say that they do not need sexual health check ups and younger people are more likely never to have had a sexual health check up. Those who are most sexually active are the most likely to get sexual health check ups. In addition, there is evidence to suggest that being out (perhaps finding a friendly GP) is linked to sexual health check up as those who are not out to their GP are less likely to have had sexual health check ups in the past 12 months and more likely to say that they have never had a sexual health check up. This varies between LGBT people with queer, lesbian or 'other' in terms of sexuality, those who are trans, who are on a low income, who feel isolated, who have not tested positive for HIV and have experienced sexual assault being more likely to say that they would not know where to find help around sex and relationships. Although the majority (71%) of respondents thought that information on sexual health in Brighton & Hove is easy to read and understand, and thought that the quality is good, respondents are less likely to agree that the information available in Brighton and Hove on sexual health is appropriate to their sexual practices and/or their sexual and gender identity and is diverse and caters for all groups.

LGBT people living with HIV (7% of the overall sample) represent a particular part of the LGBT communities and have specific experiences of discrimination, homelessness and fear of crime. 7% of those who do not identify as disabled/long term health impaired have tested positive for HIV, which indicates an interesting area of identification but may have implications for receiving support. Those who are living with HIV are more likely to be over 36, be male, either gay, bisexual or queer, and white. They are not trans, and not Deaf. Those who are living with HIV have specific support needs that differ proportionally from other LGBT people. 37% of those who are living with HIV experienced discrimination on the basis of their gender and/or sexual identities in the areas where they lived. 29% of those living with HIV have experienced homelessness. 18% have specialist housing needs to have specialist housing needs and 30% of those who are living with HIV live in social housing. In addition people living with HIV are feel less safe in Brighton & Hove and less safe inside LGBT venues, in the 'gay village' and in cruising grounds than those who have tested negative or have not been tested. When asking about support services, respondents who have tested HIV positive are more likely (15%) than those who last tested HIV negative (4%) or those who have not received an HIV test result (4%) to say that rely upon voluntary services at a time of personal crisis. This indicates a further reliance on particular agencies and groups.

10% of LGBT people in this sample have taken part in sex work in their life times. Some groups were more likely to engage in sex work, including those who identified as disabled or long term health impaired, those who have mental health difficulties and who are living with HIV. The research identified particular patterns of exchange, clients and work practices identified. 15% were defined here as sex workers; these are people who said that selling or exchanging sex is a regular source of income or something that they do when they have to. Sex workers and those who are not sex workers but have sold or exchanged sex in the past are more likely to be male than those who have never sold or exchanged sex. The majority of sex workers and those who have exchanged sex for payment are gay men. Sex workers in this research had identifiable vulnerabilities. They are more likely to experience mental health difficulties, sexual assault and homelessness. They are more likely to drink alcohol, take 'illegal drugs' than are those who are not sex workers but who have in the past sold or exchanged sex (80%) or those who have never sold or exchanged sex (67%). 4% of LGBT people (n. 31) have had sex or made themselves available to have sex in order to have somewhere to stay in the past 5 years. A further 4% (n. 28) have done so outside the last five years. 10% of young people (n.12) have had sex or made themselves available to have sex for somewhere to stay. Those who have exchanged sex for payment, regularly or occasionally (46%, n. 6) when they need to, are more likely ($p < .0001$) to have had sex or made themselves available to have sex in order to have somewhere to stay.

14.2.3. Marginalisation

This report has looked at marginalisation in part through the experiences of health services. It has also contested the medical model of disability, exploring issues of marginalisation for LGBT people who are deaf, deafened, hard of hearing and/or deaf-blind and those who identified as physically disabled or long term health impaired.

This research has highlighted some of the key areas of health care for trans people adding to research undertaken by West (2004) and Whittle et al., (2007). There are key issues for trans people regarding GP access, finding non-prejudicial GPs and engaging in referral systems to ensure that appropriate care is received. However, the chapter has addressed one of the main failings of the NHS system that of Gender Identity Clinics, particularly Charing Cross, that overly focus on mental 'illness' equating this with trans experiences. Engagements with mental health services and other services that should support trans people has been shown to be hugely problematic and these services are blamed for poor mental health and further stigmatising trans individuals. Trans individuals sought to have improved local services that catered for them, specialist GP services, psychotherapy and better information to improve their transition. There is also a need to provide ongoing life time and potentially lifetime support for trans people in terms of their physical and mental health needs.

Issues of multiple marginalisation are key to understand Deaf LGBT people's lives and experiences. This report has illustrated that issues of marginalisation, exclusion and discrimination pertain both to Deaf communities not accepting LGBT people and LGBT people marginalising Deaf people. Of the twenty eight people who identified themselves as deaf,

hard of hearing, deafened or deaf-blind, a third feel marginalised by their LGBT identity. Bullying, abuse, discrimination, exclusion or not being able to access was experienced by 18% in mainstream venues and events and 36% (n. 10) of deaf respondents find it difficult or very difficult to find information about what help or assistance is available to them. There were some safety issues associated with experiences of hate crime that were particular to LGBT deaf people. The Deaf focus group indicated some of the difficulties deaf people face in trying to access health services, in particular communication with health professionals and access to services more generally. Yet the data also shows that whilst LGBT Deaf respondents feel that there is some services for LGBT Deaf people, there is a lack of pubs/clubs and organisations who are LGBT *and* Deaf friendly. 22% (n. 6) find it difficult or very difficult being an LGBT deaf person in Brighton and Hove. Deaf and hard of hearing people who have experienced domestic violence and abuse are more likely (54%, n. 7) than non-deaf people who have experienced violence and abuse (35%, n. 56) to have been abused by people other than partners or family members. Consequently, this research has highlighted specific issues pertaining to Deaf LGBT lives and experiences as well as an area that needs further exploration in relation to the use of services, experiences of hate crime, use of LGBT networks, social spaces and support groups.

15% of the sample identified as having a long term health impairment or physical disability. Of these, a quarter of respondents who identify as disabled say they find it difficult or very difficult to be an LGBT disabled person in Brighton and Hove. Yet there was some evidence of positive experiences in Brighton & Hove with LGBT specific services, venues and spaces being valued and enjoyed. However, the qualitative data also pointed to isolation, exclusion and access issues as key areas where LGBT people who identified as disabled or long term health impaired had significant difficulties. Supporting this, those who identify as disabled report having experienced bullying, abuse, discrimination or exclusion from other LGBT people (24%), in employment (21%), from health services (19%). Almost half of LGBT disabled people in this research regularly participate in national LGBT groups, this figure is much less for local disabled groups and local LGBT groups, indicating that these are not available or accessible. Supporting the lack of accessibility for LGBT people in disabled groups, over half of disabled/long term health impaired respondents say that they do not feel they fit well or at all into disabled activities, events and groups in Brighton and Hove and 38% of respondents who identify as disabled say they do not fit that well or do not fit at all into LGBT activities, events and groups in Brighton and Hove. This research has shown that LGBT people with physical disabilities/long term health impairments have specific areas of need. LGBT people who identify as disabled are more likely to have serious thoughts of suicide, to have exchanged sex for payment and to feel uncomfortable using services because of their gender/sexual identity. LGBT people who identify as disabled or long term health impaired can have specific housing needs and experiences that differ from the rest of the LGBT population, but that are still related to their LGBT identities. Those who identified as disabled or having a long term impairment were more likely to have experienced abuse, violence or harassment from a family member or someone close to them than other respondents. Those who identified as physically disabled or long term health impaired are more likely to have experienced hate crime, to have safety fears, and to think the police service had not improved.

Qualitative data suggested that LGBT people who identified as having a long term health impairment or physical disability wanted to be treated 'normally' with some asking for little change. However, many requested improved accessibility, acceptance, understanding and information.

14.2.4. Services, Monitoring and the Future

The final aspect of the report addressed some contemporary problems and future priorities. GP's were the focus as they offer insights into the experiences of LGBT people of front line health services. The report addressed issues such as specific GP services and the healthy living centre. Monitoring is a key issue in understanding the LGBT friendliness of services. However, effective monitoring can only occur in LGBT friendly settings. Finally the report identified key priority areas for LGBT people in the city.

Although a slim majority of LGBT people in this research are out to their GP about their gender identity/sexuality, there continues to be difficult negotiations and discriminatory experiences when using GPs. This is an increase from the 2000 Count Me In survey. However, in the qualitative data there was evidence of experiencing and negotiating GPs in order to find 'safe' and 'friendly' doctors and surgeries. There continued to be some apprehension when using GP services and for some alternative services such as sexual health clinics were used in order to avoid particular things being recorded or known to generic GP practices. There was a desire for an LGBT specific GP service, although this was slightly less than in the 2000 research. However, physically disabled/long term health impaired people, those who are isolated or have mental health difficulties are more likely to want a specialist GP service. Nevertheless, the vast majority of LGBT people want a healthy living centre that provides a range of services to cater for LGBT health and wellbeing.

The top five priorities for health for LGBT people are mental health (45%), sexual health (39%), drug use (37%), alcohol use (34%) and LGBT friendliness of the health service (24%). The focus groups indicated that signage could help with perceptions of LGBT friendliness and a willingness to address LGBT issues with GPs. There was also a desire to build community networks to support LGBT people, which may tie into a healthy living centre.

LGBT people are willing to engage with statutory services in their efforts to monitor in order to improve their services. However, these monitoring procedures need to ensure the confidentiality of the information in addition to being LGBT friendly. Trans issues need to be addressed and monitoring gender identities is an area of work that is being developed and needs to be understood in this context. Consultation data suggests that consultations use a variety of different measures in order to explore the views and needs of the LGBT populations in Brighton & Hove.

14.3. Conclusion

This report has shown that LGBT people have particular health needs that differ from the mainstream population. It has illustrated that whilst sex and sexual health is important, it is also necessary to address physical health, GPs, and smoking amongst LGBT people. The research has identified particular areas of need pertaining to HIV. This report highlighted key issues for Trans people and LGBT people who are deaf, deafened, hard of hearing and deaf blind, and those who identified as disabled/long term health impaired. These issues need to be addressed across the range of services including mainstream health related services and LGBT scenes. Finally, the report identified key issues with access to GPs as the main point of contact for health services and the importance of monitoring in establishing LGBT friendliness and accessibility.

15. Recommendations

(These recommendations should be read with Browne and Lim, 2008b)

Local NHS Trusts and the City Council should respond to this report and the recommendations below under the duties specified in the Equality Act (Sexual Orientation) Regulations 2007, Employment Equality (Sexual Orientation) Regulations 2003 and Disability Discrimination Act 2005.

Under these duties, monitoring must be undertaken by all NHS Trusts and the City Council to evidence achievements and areas of further development. Reporting to, and consulting with LGBT communities must be undertaken regularly in order to meet this aim.

15.1. General recommendations

It is recommended that:

- relevant findings and recommendations from Count Me In Too are built in to the individual (and proposed City-wide) Single Equality Scheme LGBT action plans being developed by the NHS Trusts and City Council.
- continued funding is provided by Brighton and Hove Teaching Primary Care Trust (PCT) and Brighton and Hove City Council (BHCC) for key LGBT services and groups, in order that they can action these recommendations and use the evidence presented in this report to develop good practice.
- The LGBT community, voluntary and business sector organisations focus on making their services, facilities and events more accessible for LGBT people with physical and sensory disabilities.

15.2. Health services in general

It is recommended that the Primary Care Trust (PCT) should work with LGBT people and groups to ensure that:

- All commissioned primary care related services are accessible to the LGBT community so that LGBT people feel able to disclose their sexuality without fear of discrimination. This should be addressed by the through the PCT's contracts with GP, Dental, Optician and Pharmacy practices.
- All primary care related services obtain knowledge and understanding of LGBT lives and issues via their continuing professional development. This should be addressed by the through the PCT's contracts with GP, Dental, Optician and Pharmacy practices.
- GP, Dental, Optician and Pharmacy practices' administrative staff are offered awareness training so that they are equipped to cater sensitively for LGBT people's health needs, including addressing discrimination and abuse from other patients.
- GP and health related services that have undertaken training and demonstrated inclusiveness and then advertise that they have been trained in LGBT awareness to all patients, so as to promote the safety of LGBT people using the service,
- all commissioned health related services are accessible to the LGBT community, so that LGBT people feel able to disclose their sexuality without fear of discrimination. This should be addressed via their contracts with NHS Trusts and the voluntary and private sectors.
- Monitoring is undertaken, gathering data on the use of health services by LGBT people and their experiences, and feedback is given to LGBT communities.
- Monitoring is undertaken into LGBT carers' issues, for example, by including placing LGBT questions in GP surveys of carers in order to identify such LGBT carers and their needs. The PCT should work in partnership with the Carers' Centre.

It is recommended that Brighton and Sussex University Hospitals NHS Trust (BSUH), South Downs Health NHS Trust (SDH), Sussex Partnership NHS Trust (SPT) and South East Coast Ambulance Service NHS Trust (SECA) should work with LGBT people and groups to ensure that:

- Their clinical staff obtain knowledge and understanding of LGBT lives and issues, via their continuing professional development.

- Their administrative staff are offered awareness training, so that they are equipped to cater sensitively for LGBT people's health needs.

15.3. Specialist Health services for LGBT people

It is recommended that the PCT should:

- Support an LGBT healthy living centre. This centre should address health in a broad range of contexts and support those who are most marginalised in the LGBT communities. This centre should offer LGBT training on guidance and good practice for health services, both locally and nationally, helping GPs and other health related services become LGBT friendly, thus ensuring that this provision does not ghetto-ise health provision for LGBT people.
- Consider commissioning/supporting the development of a local specialist GP service particularly for marginalised LGBT people.

15.4. Smoking

It is recommended that the PCT continues to support work that seeks to reduce the prevalence of smoking amongst LGBT people. This should include:

- Exploring the reasons for the prevalence of smoking amongst LGBT people,
- Offering stop smoking services that are targeted at LGBT people,
- Investigating LGBT-specific stop smoking services and offering these where these are needed

15.5. Physical activity

It is recommended that the PCT and BHCC should support further work to make physical activity opportunities safe for LGBT people. This should:

- Address the concerns of Trans people and their partners in accessing spaces for physical activity,
- Seek to offer low cost and cost effective physical activity provision for LGBT people,
- Address the concerns of LGBT women and their partners in accessing spaces for physical activity.

15.6. Sex and sexual health

It is recommended that the PCT, the Children & Young Peoples' Trust (CYPT) and BSUH, along with the LGBT community, voluntary and business sectors (including Spectrum) should:

- Undertake to address the stigma and discrimination experienced by LGBT people resulting from the sexualisation of LGBT identities, and the association of sexuality with sex, understanding that LGBT health is not simply located in sexual health. This is especially pertinent for those LGBT people who choose not to be sexually active.
- Commission and provide more information and support to LGBT young people around issues of sex and relationships. This should be addressed by mainstream services and particularly in educational settings such as schools, as well as by LGBT specific services. Funding should be offered to key LGBT services to support this work.
- Commission and provide public health campaigns promoting the importance of regular sexual health check ups for all sections of the LGBT community, with campaigns aimed specifically at lesbians, trans people, those who are disabled/long term health impaired, those who have not tested positive for HIV, and older and younger LGBT people. These campaigns should be undertaken with involvement from LGBT people and groups.
- Commission and provide sexual health literature that caters for and is inclusive of the full breadth of LGBT people, particularly lesbians, other female LGBT people , bisexual people, trans people, and BME people, recognising the diversity of sexual practices and relationship forms within some of these groups.

- Ensure that services offering support and information around sex and relationships are accessible to the LGBT community, by making this a condition of contracts with service providers of any sector.

- Commission and provide sexual and health clinic/s specifically for LGBT women.

- Commission and provide strategies and campaigns to develop sexual health literature targeted at lesbians and women who have sex with women, to develop support services for lesbians regarding their sexual health, and to encourage lesbians to seek regular sexual health checks. These should be undertaken in partnership with LGBT people and groups.

- Ensure that the needs of LGBT sex workers are taken into account in the commissioning and provision of services. This includes the need for cross service and sector work to support those who have engaged/are engaging with sex work.

- Ensure that services recognise the risk factors that can lead to the unwanted engagement with sex work, without stigmatising those who seek to engage in sex work.

15.7. HIV Services

These recommendations should be read in association with those presented in 'Making it Count' (Hickson et al., 2003) and 'The National Strategy for Sexual Health and HIV' (Department of Health, 2001)

It is recommended that BSUH, BHCC and the community and voluntary sector HIV services with LGBT community, voluntary and business sectors should:

- Continue to endeavour, individually and in collaboration, to access and engage with LGBT people living with HIV in order to meet their complex support needs of this group; reduce the incidence of onward transmission; and reduce the stigma and discrimination experienced by people living with HIV.

- Make efforts to increase support for men who have sex with men who have tested negative for HIV, in order to reduce the potential for HIV infection

- Continue to ensure that services promote of the importance of regular HIV testing and knowledge of your HIV status amongst.

15.8. Trans health service delivery

It is recommended that the PCT, BSUH and SPT should work with Trans people and groups to:

- Consider Trans health in a broad context that does not pathologise all trans people as 'mentally ill'.
- Ensure that all health professionals and services develop a greater awareness of both clinical & non clinical issues affecting trans people. Awareness training and services should recognise ongoing needs of trans people, not just consider those Trans people who wish to have a full gender transition.
- Address transphobia, prejudice and discrimination against trans people. This includes the PCT addressing the lack of knowledge and awareness apparent in GP staff, through its contracts with GPs. This should stem the numbers of trans people who suffer through delay and deferral, which may result in mental health difficulties.
- Ensure that health services offer appropriate support to trans people, including those who may not want or are not sure if they want hormone therapy and ultimately gender re-assignment surgery. Support for these individuals should not be seen as less important than that required for the trans person who desires hormone therapy and sex re-assignment surgery.
- Monitoring is undertaken in sensitive and respectful ways to assess the use of health services by trans people and their experiences.

15.9. Commissioning services for trans people

It is recommended that the PCT, BSUH and SPT should:

- Ensure that all commissioned services are required to demonstrate that they are trans friendly as a condition of funding.
- Ensure that safe health services for trans people are provided and publicised. This should be undertaken with key trans and LGBT services.
- Address the deep distrust of Charing Cross and the treatment pathway provided therein, in association with and after consultation with trans people, groups and services. This should enable trans people are to proceed with proper support and avoid self-medication.

- Commission and provide alternatives to Charing Cross (including local services) through partnership working between the NHS Trusts, and trans people and services.

15.10. Deaf, hard of hearing, deafened or deaf-blind

It is recommended that the PCT, BHCC, the LGBT community and LGBT businesses should:

- Commission and provide services for deaf people that are LGBT friendly as a condition of funding, and ensure that the providers' achievement in this area is monitored. Service providers should be asked to demonstrate that they have clear equality polices and procedures that are evidenced through LGBT friendly practices.
- Ensure that the issues the deaf LGBT community identified in this research are taken to the cross-sector City Disability Equality Scheme Steering Group, to ensure that concerns are added to the PCT and BHCC Disability Equality Scheme action plans.
- continue encourage Deaf LGBT people to join the City Disability Equality Scheme Steering Group to work with health providers, in order to ensure that improvements are made.
- LGBT communities, voluntary groups and businesses should undertake work to become more deaf friendly and provide inclusive spaces.

15.11. Physical disability / Long term health impairment

It is recommended that the PCT, BSUH, SPT, SDH, SECA, BHCC, Federation of Disabled People and LGBT community, voluntary and business sector organisations and forums should:

- Ensure that services commissioned and provided recognise the multiple and diverse needs of LGBT people who have long term health impairments and physical disabilities. This includes cross service working to support LGBT people by those who work with disabled people, and LGBT groups.

- Ensure that work is undertaken to provide local LGBT spaces for disabled people, that do not rely on the limited resources of LGBT disabled people, but are still controlled by LGBT disabled people.

- Ensure that work is undertaken within LGBT communities and with LGBT venues and businesses to make these spaces more accessible for LGBT people with disabilities.

- The Federation of Disabled People should explore with the LGBT communities and businesses the possibility of adding LGBT friendly accessible venues to their web based City Guide.

- PCT BSUH SPT BHCC should support the Federation of Disabled People and Spectrum to improve opportunities for LGBT disabled people to engage with NHS Trust and City Council consultation and involvement processes, to that they can help to shape City services.

15.12. Research

It is recommended that local stakeholders including the PCT, BHCC, the University of Brighton, Sussex University, the Carers Centre and LGBT community, voluntary and business sector organisations and forums should consider participating in the commissioning of/bidding for funding for and undertaking:

- Further research to investigate the specific needs of LGBT carers and carers of LGBT people (including adults and young people).

- Further research regarding young LGBT people's anxieties around sex, including LGBT young people in its design and delivery.

- Further research to address specific issues pertaining to LGBT people who are physically disabled and long term health impaired, and LGBT people who are deaf, deafened, hard of hearing, deaf-blind. This work should be done using a participatory action research framework that empowers LGBT people.

- Further research into the area of LGBT sex work, particularly in relation to male sex work, as very little research currently exists at local or national level. This should include investigations regarding needs for support among male sex workers, due to the multiple vulnerabilities highlighted in this report.

- Further research should explore LGBT experiences of domestic violence and abuse in relation to physical and sensory disabilities.

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Your feedback

We welcome any comments and suggestions.

Please email your feedback to us at:
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or by post to:

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www.countmeintoo.co.uk

Downloadable copies of this and other resources are available from the Count Me In Too website including a directory of local LGBT support organisations and groups.