

COMING OUT, COMING HOME OR INVITING PEOPLE IN?

**Supporting same-sex attracted
women from immigrant and
refugee communities**

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ACKNOWLEDGEMENTS

The Multicultural Centre for Women's Health (MCWH) acknowledges the financial support provided by the Australian Lesbian Medical Association for the implementation of the Understanding Sexuality Project.

Representatives from numerous agencies, groups, organisations and services made invaluable contributions to the Understanding Sexuality Project. Many thanks are owed to the consultation participants whose inputs have facilitated a greater understanding of the experiences and support needs of immigrant and refugee same-sex attracted women in Australia. Subsequent to the consultation was the development of a half-day training program for bicultural and bilingual workers that was delivered individually to two groups: MCWH bilingual health educators and staff members or representatives from various agencies, organisations and services that engage with, or deliver services to GLBTIQ people and/or ethnic communities. The participation of these educators and service providers has increased awareness of the initiatives required to build community and professional capacity to support same-sex attracted women from ethnic communities.

Appendix 1 lists the agencies, groups, organisations and services represented in the Understanding Sexuality Project.

DISCLAIMER

The views expressed in this report are solely those of the Multicultural Centre for Women's Health and should not be attributed to the Australian Lesbian Medical Association.

ACRONYMS

AGMC	Australian GLBTIQ Multicultural Council
AIDS	Acquired Immune Deficiency Syndrome
BHE	Bilingual health educator
CALD	Culturally and linguistically diverse
GLBTI	Gay, Lesbian, Bisexual, Transgender, Intersex
GLBTIQ	Gay, Lesbian, Bisexual, Transgender, Intersex, Queer
HIV	Human Immunodeficiency Virus
MCWH	Multicultural Centre for Women's Health

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EXECUTIVE SUMMARY

In response to the AGMC conference recommendation about the need for ethnic communities to improve their understanding of the issues facing their GLBTIQ members and so better support GLBTIQ family and community, the Multicultural Centre for Women's Health implemented the Understanding Sexuality Project. This initiative aimed to build the capacity of bicultural and bilingual community workers to support same-sex attracted women from their ethnic communities.

Initially, a consultation with key stakeholders was undertaken and available literature was reviewed to gain an understanding of the experiences and support needs of same-sex attracted women from immigrant and refugee communities in Australia. Fourteen interviews were conducted with representatives from multicultural GLBTIQ groups, as well as relevant health and community professionals. Research findings guided the development of a half-day sexuality training program, which covered diversity within sexuality; health issues of same-sex attracted women; disclosure (coming out); heterosexism and homophobia; and supporting same-sex attracted women. The training program was delivered separately to two groups: MCWH bilingual health educators and staff members of mainstream agencies, organisations and services that engaged with, or delivered services to, GLBTIQ people and/or ethnic communities. Overall, 13 BHEs and 11 service providers participated in the training program. Both groups rated the program highly.

The Understanding Sexuality training program was a small step in facilitating community and professional support of GLBTIQ people from immigrant and refugee backgrounds, but more action is needed to maintain the momentum generated, including leadership, advocacy, policy, research, professional development, resources and community education.

CHAPTER 1: INTRODUCTION

It has long been understood that same-sex attracted people from immigrant and refugee communities have a strong need for specific and culturally-appropriate support and understanding about their sexuality, both from the mainstream GLBTIQ (gay, lesbian, bisexual, transgender, intersex, queer) community as well as from their own ethnic communities. The Australian GLBTIQ Multicultural Council (AGMC) national conference in 2004 clearly sent such a message. Attended by GLBTIQ people from a range of immigrant and refugee backgrounds, a number of delegates spoke of their experiences of coming out within their own families and communities, and/or deciding not to come out due to a fear of not being accepted, or for their own safety, should they do so (AGMC, 2007).

Young women in particular were vocal about their need for support within their ethnic communities. Women spoke of the ways in which the lack of support and understanding affected them: some women distanced themselves from their families and communities, became depressed, left their family homes, relocated, considered marriage, reluctantly dated boys, and at the extreme, planned to suicide. Conversely, other women told positive stories of support and understanding and stressed how important community acceptance had been in their lives.

One clear conference outcome was an acknowledgement that immigrant and refugee communities have a responsibility to improve their understanding of the issues facing their GLBTIQ members and better support GLBTIQ family and community. One effective way for this to happen is through culturally-relevant training and education delivered to key members of ethnic communities such as bicultural and bilingual workers. Such training and education would build the capacity of bicultural and bilingual workers, who are working closely with community members on a range of issues, to break down stereotypes, address fears and offer people alternative discourses for their understanding of sexuality issues.

1.1 Background to the Understanding Sexuality Project

The Multicultural Centre for Women's Health (MCWH) is a women's health organisation committed to improving the health of immigrant and refugee women across Australia. The centre is for all immigrant women, including refugees and asylum seekers, women from emerging and established communities, and women temporarily settled in Australia.

As part of its mission to improve the ability of immigrant and refugee women to assume greater control over their health and wellbeing, MCWH provides health education and information to women in workplaces and community settings. The centre's health education program follows a holistic, peer education model known as the *woman-to-woman approach*, which is participatory in design and respects women's experiences and knowledge. Trained bilingual health educators (BHEs) conduct health education sessions for women in the preferred languages of the participants, covering a range of women's health issues, with a focus on sexual and reproductive health. The centre provides health education to women in over 20 languages.

The Multicultural Centre for Women's Health also provides cross-cultural training to health and community professionals that engage with and/or deliver services to immigrant and refugee women, with the aim of improving culturally-appropriate service delivery. Regular training is also provided to the MCWH bilingual health educators to update and expand their knowledge and skills.

In response to the AGMC conference recommendation about the need for training for bicultural and bilingual community workers, the Understanding Sexuality Project was implemented through the Multicultural Centre for Women's Health. The project's aim was to build the capacity of bicultural and bilingual community workers, including the MCWH bilingual health educators, to support same-sex attracted women from their ethnic communities. More specifically, the project's objectives were to:

- Consult with key stakeholders, including representatives from relevant GLBTIQ groups, bicultural and bilingual community workers, and lesbian health professionals, to gain an understanding about the experiences and support needs of same-sex attracted women from immigrant and refugee communities;
- Conduct a brief review of relevant training modules, where available;
- Develop a one-day training program that covers a range of topics including diversity within sexuality and sexual identity; culturally-specific approaches to understanding same-sex attraction; disclosure; supporting same-sex attracted family members and friends; and dealing with homophobia and discrimination;
- Deliver the training program to the MCWH bilingual health educators;
- Conduct evaluation of the one-day training program for the MCWH bilingual health educators; and
- Produce and disseminate a succinct report so that the outcomes of the project are widely known among key stakeholders.

This report has three chapters. This first chapter has provided a brief overview of the Multicultural Centre for Women's Health and the Understanding Sexuality Project. Presented in Chapter 2 are the project findings, while key recommendations are presented in Chapter 3.

CHAPTER 2: PROJECT FINDINGS

Very little literature is available about the experiences and support needs of same-sex attracted women from immigrant and refugee communities in Australia. Similarly, evidence of capacity-building initiatives for these communities around sexuality and sexual diversity is also lacking. Consequently, a consultation was undertaken with key stakeholders to gain the understanding required to guide development of the training program. Fourteen interviews were conducted with representatives from multicultural GLBTIQ groups, as well as health and community professionals possessing knowledge of and/or experience in working with same-sex attracted women, particularly those from ethnic communities. Overall, the consultation involved 14 participants from 12 groups, organisations and services (see Appendix 1). The main consultation questions are presented in Appendix 2. A review of available literature, which was limited at best, was also undertaken to expand on the issues and themes which emerged during the consultation.

Following the consultation, a half-day sexuality training program specifically for bicultural and bilingual workers was developed. Initially, the training program was piloted with 13 MCWH bilingual health educators. The training program was also due to be delivered to bicultural and bilingual community workers employed in ethno-specific or multicultural services, or actively involved in their ethnic communities. However, promotion of the training program generated little interest; instead, there was much interest in the training program from staff members of mainstream agencies, organisations and services that engaged with, or delivered services to GLBTIQ individuals. Consequently, the training program was slightly revised in consideration of the different target group. Overall, 11 representatives from 8 agencies, organisations and services participated in the service provider training program (see Appendix 1).

This chapter presents findings from the Understanding Sexuality Project. The main limitation of the project needs to be considered in review of this report. Funds available for project implementation were extremely limited, but welcome nonetheless. Despite this limitation, project outcomes and recommendations provide a basis for further advocacy, dialogue and action.

For the purpose of this report, the term *same-sex attracted women* is used to collectively refer to lesbian and bisexual women. The terms *immigrant and refugee* and *ethnic* are used interchangeably to minimise repetition, as are *gay-friendly*, *gay-sensitive* and *gay-supportive*. Whilst the focus of the Understanding Sexuality Project was immigrant and refugee same-sex attracted women, with this report highlighting the key issues pertinent to these women, some findings and recommendations are relevant to, and have broader implications for all GLBTIQ people from ethnic communities. So, discussion of project findings moves between matters specific to women to those relevant to all GLBTIQ individuals from ethnic backgrounds.

2.1 We don't have those people in our community

Two commonly-held beliefs in immigrant and refugee communities include: same-sex attracted people do not exist in ethnic communities and sexual diversity is specific only to Western societies. Some parents and cultural groups do accept and support their GLBTIQ children and members, with GLBTIQ people visible in their ethnic communities and able to manage their multiple identities (cultural, religious, sexual et al). Awareness of culturally-specific histories of sexual diversity, as well as lived experiences of persecution due to membership of a minority group within a minority group, appear to contribute to this understanding. Religious frameworks and cultural contexts can influence understanding of sexuality-related issues in the general community, including amongst immigrants and refugees, so it is inappropriate to suggest that ethnic communities are unwilling or unable to understand and accept divergent sexual identities. In some cases, religious teachings about compassion, fairness and social justice for all, or cultural beliefs about the importance of family and community, may facilitate acceptance.

For other immigrants and refugees, sexual diversity, including same-sex attraction, is the opposite of everything they believe and understand about women, men and family (Pallotta-Chiarolli, 1992). The expression of sexuality is believed to be symbolic of the individualism of Western societies and the antithesis of the collectivist nature of many non-Western cultures. Family is considered paramount, so gender expectations are strongly defined by traditional familial roles. Women are expected to be feminine, marry men, bear and raise children, while men are expected to be masculine, marry women, father children to continue the family line and name, and head the family unit (Jardin, 2006; Pallotta-Chiarolli, 1992). Consequently, parents of GLBTIQ people from ethnic communities may express concerns for their children's future and security, believing their children are unable to have children of their own and so will be alone and childless in their old age, without anyone to take care of them (Pallotta-Chiarolli, 1998). Parents may also fear for the hardship and discrimination their children will experience due to their sexual identity.

2.2 It has a damaging effect on health to hide part of yourself and even hide it from yourself

Sexual orientation is a social determinant of health. The discrimination and exclusion that GLBTIQ people experience can result in adverse health outcomes. Depression and anxiety commonly affect GLBTIQ individuals (Pitts et al, 2006; Smith et al, 2003). Health issues affecting same-sex attracted women include sexually transmitted infections (due to many women currently or previously engaged in sexual relationships with men), tobacco use, asthma, heart disease, high cholesterol, endometriosis and polycystic ovaries (Diamant et al, 2000; Hillier et al, 2005; McNair, 2005; Pitts et al, 2006). Same-sex attracted women are also less likely to undergo screening procedures such as Pap tests and clinical breast examinations (Diamant et al, 2000).

Evidence is limited about the health issues specific to same-sex attracted women from immigrant and refugee communities. Given that these women are a minority within a minority, and so susceptible to three levels of discrimination—sexism, homophobia (from their ethnic communities) and racism (from the GLBTIQ and general communities)—mental health issues, such as depression, anxiety and self-harming behaviours, are common (Bell and Hansen, 2009; Jardin, 2006; Jivraj et al, 2002; Mann et al, 2006). Some same-sex

attracted women who are married and disclose their sexual orientation to their husbands may experience domestic violence (Jivraj et al, 2002).

These poor health outcomes are due to women's reluctance to access health services, stemming from a fear of disclosing their sexual orientation to health practitioners:

'Our communities are reticent to access health services because they either fear or they know it will require disclosure and they don't want to disclose their sexuality or gender identity and so they would rather wait and do nothing and end up with chronic health problems than run the risk of either being forced to disclose and/or being treated insensitively.' (Consultation participant 1)

Same-sex attracted women are less likely to access mainstream health services due to health practitioner attitudes, knowledge and practices. Many women consider health practitioners working in mainstream health services to be heterosexist, homophobic, ill-informed about health issues specific to same-sex attracted women and ill-equipped to sensitively address these health issues (McNair, 2005).

Compared to Australian-born women, immigrant and refugee women are less likely to use health and community services (MCWH, 2010). For same-sex attracted women from ethnic communities, there are no figures to demonstrate health service utilisation. It is expected that, as these women are a minority within a minority, their health access would be poor (Diamant et al, 2000), even worse than for other immigrant and refugee women. Also, the health access issues for these same-sex attracted women are more complicated.

Whilst some women prefer to access mainstream health services, primarily for confidentiality purposes or because of familiarity with these services, others are reluctant because of perceptions that health practitioners in these services lack understanding of cultural issues, or hold racist views (Jivraj et al, 2002). Conversely, access to gay-friendly health services is also problematic. Women do not access these services because they lack awareness of these services, or women are still confused about their sexual identity and may not perceive gay-friendly health services as being equipped to assist them in their identity development, or women fear family, friends or community members will see them accessing these services (Jivraj et al, 2002). Mainstream and gay-supportive health practitioners' lack of cultural awareness around the intersections of sexuality, culture, ethnicity and religion, and the consequential multiple identities, may result in practitioners being unprepared for women who are same-sex attracted *AND* from immigrant and refugee backgrounds. In order to assist these patients, health practitioners may try to force choices that women do not want to make. For women who do not want to, or do not know how to access mainstream or gay-friendly health services, alternatives include ethno-specific or multicultural services, such as bilingual health practitioners. These services may be preferable for women who are seeking culturally-appropriate support, particularly those women who are newly-arrived, but accessing service assistance around sexuality issues can be difficult. Women with children may not wish to disclose their sexual orientation to bicultural or bilingual community workers in these services out of fear that workers will deem them unfit mothers and so facilitate removal of their children from their custody (Jivraj et al, 2002). Other women do not trust community workers in these services to respect their confidentiality and so fear their sexual orientation will be revealed to all in their communities. There are bicultural and bilingual community workers, including health

practitioners, who are culturally-aware and gay-friendly, but for many of these health and community professionals, fear of discrimination from their communities means there is a reluctance to publicly demonstrate their support of, and willingness to provide health care and assistance to GLBTIQ people.

The lack of information for same-sex attracted women about gay-sensitive, culturally-aware health professionals and community workers affects their access to health care. Whilst there is information available about health professionals, including general practitioners, medical specialists and dentists, who are considered competent in addressing the health needs of same-sex attracted women (DocList website), there is no indication of the level of cultural awareness or competence of these health service providers.

2.3 Coming out, coming home or inviting people in?

Same-sex attracted women from immigrant and refugee communities have complex, intersecting identities (cultural, religious, sexual et al). Many women feel torn between these identities. Some women make compromises, while others manage their multiple identities.

Disclosure of sexual orientation to families and communities is a difficult process for many same-sex attracted women from immigrant and refugee backgrounds. For some, cultural identity, with its emphasis on family, is more important than their sexual identity:

'They set a very high price on that capacity to interact and have acceptance and their sense of belonging is much more in that community than it probably is in the gay and lesbian community, particularly when they're young, so to give that up in exchange for the other one is just too hard. It doesn't limit their capacity to interact because they don't tell.' (Consultation participant 2)

As a result, disclosure may never occur. This scenario may be more likely in cultures where attitudes towards sexual diversity are so rigid that families would refuse to accept members who are same-sex attracted. For others seeking to manage their multiple identities and disclose their sexual orientation, there is fear that the disclosure will result in family rejection and loss of family support. In some instances, disclosure has resulted in withdrawal of family support (including financial support), forced marriage, domestic violence, homelessness and exclusion from communities (Bell and Hansen, 2009; Jardin, 2006; Jivraj et al, 2002; Reeders, 2010). For women with children, there is a fear that children will be removed from their custody, or that their children will reject them if they disclose their sexual orientation (Jivraj et al, 2002). However, not all family reactions to disclosure of sexual orientation are extreme, but compromises may have to be made (Mann et al, 2006). Family acceptance may occur on the condition that same-sex attracted women are guarded or selective in their expression of their sexual identity in public or at family gatherings. For example, partners may be introduced to extended family members as 'friends'.

On the contrary, some same-sex attracted women from immigrant and refugee backgrounds do experience complete acceptance from their families and communities. Family responses to disclosure of sexual orientation can be better than expected. This may be due to greater understanding of sexual diversity, either based on culturally-specific histories of sexual diversity, or because of higher levels of acculturation,

or growing community acceptance of divergent sexual identities. Lived experiences of persecution due to membership of a minority group within a minority group may also facilitate acceptance. Box 1 presents the 'coming out' stories of four same-sex attracted women. These stories represent learning opportunities for building the capacity of immigrant and refugee communities to support their GLBTIQ members. The belief that parents will not understand lesbianism has prevented or delayed some women from disclosing their sexual orientation to their parents (Pallotta-Chiarolli, 1992), but the stories in Box 1 suggest families may be more aware and supportive than anticipated. Capacity-building initiatives need to emphasise the importance of family, draw on culturally-specific histories of sexual diversity to facilitate understanding, and encourage supportive bicultural and bilingual community workers, such as health professionals, to challenge parental and community attitudes towards sexual diversity and to encourage acceptance.

Concern has been expressed about the pressure applied to same-sex attracted individuals from immigrant and refugee backgrounds from mainstream and GLBTIQ communities in Western societies to 'come out', without any understanding of the importance of family in many cultures, the risks involved in the process, or the non-Western perspectives on 'coming out'. Criticism of 'coming out' suggests the process is an individualist Western practice that is not culturally-appropriate and is more of a threat to the collectivist nature of many non-Western cultures (Pallott-Chiarolli, 1998; Reeders, 2010).

'Inviting people in' and 'coming home' are considered more culturally-appropriate alternatives to 'coming out':

'Coming out tends to be a really narrow way of looking at sexuality and thinking about coming into your sexuality. It tends to be a very dominant Western perspective. Inviting people in into your life reframes thinking. It is about feeling good about who you are, what you do and how you identify and how you want to be actually letting people into your world. Coming home—which is about finding a place where you can fit and a place where you feel you've come home—it's about a place where you feel comfortable, safe and happy.' (Consultation participant 3)

Inspiration for 'inviting people in' comes from 'coming in', a term created after conversations with GLBTIQ people from a Muslim background in Australia (Hammoud-Beckett, 2007; Moore, 2011). 'Coming in' and 'inviting in' are considered more representative of the experiences of GLBTIQ people from an ethnic background; remove the pressure associated with publicly disclosing one's sexual identity; and instead encourage and empower GLBTIQ people to choose with whom they share their life and from whom they can gain support (Hammoud-Beckett, 2007; Moore, 2011). As such, 'coming home' involves introducing one's sexuality into the family through the gradual introduction and integration of one's partner via relevant family-kin categories (Chou, 2000 as cited in Reeders, 2010).

Box 1: Immigrant women's stories of 'coming out'

Disclosure of sexual orientation to families can be a positive or better than expected experience for same-sex attracted women from immigrant and refugee communities. Joo-Inn, born to an Anglo-Australian mother and Malaysian Chinese father, experienced minimal difficulty when introducing her new partner to her family. Despite initial concerns that life would be difficult for her as a lesbian and her father's cultural beliefs about same-sex attraction, Joo-Inn felt her family accepted her and her relationship.

For Nilgün, born to Turkish parents, family acceptance stemmed from an unlikely source. Nilgün was reluctant to tell her mother she was a lesbian, despite her mother's suspicions and constant interrogation. Upon confirmation of her suspicions, Nilgün's mother turned to her own mother for support and sympathy, only to be reprimanded:

'What are you worried about? Lots of married Turkish women have women on the side. Are you so surprised? Get used to it! Do you want her to be in an unhappy marriage? If she's happy, you have to accept that! Grow up!'

Culturally-specific histories of sexual diversity also emerged in Melina's story about 'coming out' to her mother. When Melina's mother asked Melina if she was more comfortable with women than with men, Melina confirmed she was a lesbian. Melina's mother was totally accepting and promised to inform other family members of Melina's sexual identity. Upon and after disclosure, Melina learnt about Italy's history of sexual diversity from her mother and other Italian women, some of whom had their own experiences of same-sex relationships. Melina experienced complete familial acceptance of her sexual identity.

For Gina, her Greek mother asked her if she was gay after finding 'incriminating' evidence. Gina confirmed she was a lesbian, only to be taken to the family doctor to be 'cured'. The family doctor told Gina's mother that sexual diversity was natural and instead tried to cure her anxiety instead. Despite always being comfortable with her sexuality, Gina had always been concerned about disclosing to her strict Greek father. Gina promised her mother she would not tell her father that she was a lesbian, but when Gina's father was finally told - after he had expressed concern about his wife's anxious behaviour - Gina was shocked, but pleasantly surprised by his response:

'Is that all? Jesus, I thought she was dying or something. Stop crying woman.'

Gina subsequently learnt that the son of her father's best friend in Greece had committed suicide because he was gay.

References: Chew, 1999; Güven, 1999; Lambropoulos, 1999; Pallotta-Chiarolli, 1992

2.4 Our culture grounds us: it tells us who we are, where we come from

Same-sex attracted women from immigrant and refugee backgrounds possess a strong desire for family and community acceptance. Often, women feel confused, believing they have to choose between their multiple identities. Affirmation from bicultural and bilingual community workers is crucial to women accepting themselves after disclosure (Jivraj et al, 2002). However, there are few bicultural and bilingual community workers who are culturally-aware AND understanding of sexuality-related issues:

'Ideally, we would all like to have services that are both culturally-sensitive and aware and being gay-friendly, but a lot of people experience homophobia and discrimination, so the majority of times they haven't been able to find a balance where the person or service provider is both queer-friendly and also sensitive to cultural issues.' (Consultation participant 3)

Using consultation findings, a half-day sexuality training program specifically for bicultural and bilingual workers, including the MCWH bilingual health educators, was developed. Limited resources meant the proposed one-day training program was reduced to a half-day (four hours) program. Five modules were incorporated into the training program, including diversity within sexuality; health issues of same-sex attracted women; disclosure (coming out); heterosexism and homophobia; and supporting same-sex attracted women. Table 1 provides an overview of the training program for the bilingual health educators. The MCWH Project Officer responsible for the Understanding Sexuality Project delivered the training program in May 2010 and 13 BHEs participated.

The training program was also due to be delivered to bicultural and bilingual community workers employed in ethno-specific or multicultural services. Staff members in relevant services across Melbourne were invited by email to participate in the training program, but this targeted approach generated little interest. The training program was also promoted on relevant websites and via email lists and generated much interest from staff members of mainstream agencies, organisations and services that engaged with, or delivered services to GLBTIQ people. Consequently, the training program was slightly revised in response to the different target group. The five modules from the BHE training program remained in the service provider program, but more information designed to improve cultural awareness and competence was included. Table 2 provides an overview of the service provider training program. In August 2010, the MCWH Project Officer co-facilitated the training program with the assistance of a same-sex attracted woman from an immigrant background. The additional facilitator was involved in the training program after the MCWH Project Officer experienced difficulties in delivering the training program to the BHEs, namely an inability to provide insights that only a same-sex attracted woman from an immigrant and refugee background could provide. All participants were also given a detailed list of multicultural GLBTIQ groups, and gay-supportive health and counselling services. Overall, 11 representatives from 8 agencies, organisations and services participated in the service provider training program.

Evaluation of the training program was undertaken (see evaluation surveys in Appendices 3 and 4). Both groups of participants rated the training program highly, with ratings of **8.7** and **8.2** (on a scale of 1 to 10, with 1 being 'poor' to 10 being 'excellent') by BHEs and service providers respectively. As the training program was specifically tailored to bicultural and bilingual community workers, the BHEs gave higher overall ratings for the program than service providers. Whilst revisions were made to the training program in consideration of a different target group, time did not allow for a thorough modification as the level of service provider interest in the program was not anticipated. Consequently, elements of the BHE training program remained in the program for service providers and proved too familiar for service provider participants. This finding suggests a separate training program should be developed for mainstream service providers to improve their capacity to support same-sex attracted women from immigrant and refugee communities. Nonetheless, the training program provided an informative introduction to the service providers about the intersections of sexuality, culture, ethnicity and religion. Table 3 provides overall ratings for the Understanding Sexuality training program for BHEs and for service providers.

The Understanding Sexuality training program has since been incorporated into the MCWH professional training program and in the future will be delivered to bicultural and bilingual community workers employed in ethno-specific or multicultural services, or actively involved in their ethnic communities.

Table 1: Overview of the Understanding Sexuality training program for bilingual health educators

Module	Information provided/Key messages
<p>Diversity within sexuality</p>	<ul style="list-style-type: none"> • Beginning with a question: how do you know that same-sex attracted people do not exist in your community? • Introduction to sexuality: general definition, no universal culturally-acceptable definition, key terms, diversities, fluidity, sexual orientation (contributing factors, emergence) • Culturally-specific histories of sexual diversity; sexual diversity is universal and does not only occur in Western societies • Discussion of the opening question: the only way to know another’s sexual orientation is when they tell you, but many people keep their sexual orientation hidden for fear of discrimination • <u>Implications for advocacy, education and support:</u> Refer to cultural and religious frameworks to help people in the community to better understand sexuality
<p>Health issues of same-sex attracted women</p>	<ul style="list-style-type: none"> • Relationship between sexuality, or sexual orientation, and health • Lack of research into health of same-sex attracted women from immigrant and refugee communities • Women’s health issues are universal, irrespective of sexual orientation, but some experiences of health issues may be different • Mental health issues in same-sex attracted women from immigrant and refugee communities due to sexism, homophobia and racism (from GLBTIQ and general communities) • Key health issues: sexual and reproductive health; mental health; chronic disease; health service access and utilisation • <u>Implications for support:</u> understand mental health impacts of intersecting discriminations and invisibilities; provide a breadth of information about health issues (multilingual and in relevant cultural contexts, where possible); recognise importance of an appropriate referral (mainstream OR ethno-specific)
<p>Disclosure (coming out)</p>	<ul style="list-style-type: none"> • Disclosure: definition, stages, levels, ongoing process, risks, difficulties • GLBTIQ members of immigrant and refugee communities desire acceptance from their communities • <u>Implications for support:</u> be non-judgemental; communication of acceptance whether there is disclosure or not; use of language such as ‘lesbian’ can be confronting for a woman who is newly-identified or unsure; acceptance of a woman’s level of disclosure; respect for confidentiality so do not disclose sexual orientation to others without woman’s consent; appropriate referral but only with woman’s permission; do not force choices or assume that a woman must choose between her culture/community and her sexuality
<p>Heterosexism and homophobia</p>	<ul style="list-style-type: none"> • Definitions of heterosexism and homophobia and their similarities to racism • Discrimination on basis of sexual orientation is illegal in Victoria • <u>Implications for advocacy, education and support:</u> consider intersecting discriminations and multi-faceted identities; recognise racism in the GLBTIQ community and homophobia in general and ethnic communities; challenge the myths and misconceptions about sexual diversity that exist in your community
<p>Supporting same-sex attracted women</p>	<ul style="list-style-type: none"> • <u>Implications for education and support:</u> understand sexual diversity and know about the issues affecting same-sex attracted women from immigrant and refugee communities; challenge your own personal beliefs and misinformation about sexual diversity and same-sex attraction; be aware of appropriate social supports for same-sex attracted women (AGMC website lists multicultural GLBTIQ social support groups; health and community services)

Table 2: Overview of the Understanding Sexuality training program for service providers

Module	Information provided/Key messages
Diversity within sexuality	<ul style="list-style-type: none"> • Introduction to sexuality: general definition, no universal culturally-acceptable definition, key terms, diversities, fluidity • Culturally-specific histories of sexual diversity, well-known GLBTIQ members of immigrant and refugee communities, global gay rights activism • <u>Implications for service delivery</u>: don't assume person's identity = behaviour; accept diversity in identity and behaviour; don't assume older immigrants will not have a history or understanding of sexual diversity; when referring to same-sex attracted people to service providers in their community, don't assume they will not be supportive, even if they are not openly so
Health issues of same-sex attracted women	<ul style="list-style-type: none"> • Relationship between sexuality, or sexual orientation, and health • Lack of research into health of same-sex attracted women from immigrant and refugee communities • Women's health issues are universal, irrespective of sexual orientation, but some experiences of health issues may be different • Mental health issues in same-sex attracted women from immigrant and refugee communities due to sexism, homophobia and racism (from GLBTIQ and general communities) • Key health issues: sexual and reproductive health; mental health; chronic disease; health service access and utilisation • <u>Implications for service delivery</u>: understand mental health impacts of intersecting discriminations and invisibilities; provide a breadth of information about health issues (multilingual and in relevant cultural contexts, where possible); recognise importance of an appropriate referral (mainstream OR ethno-specific)
Disclosure (coming out)	<ul style="list-style-type: none"> • Disclosure: definition, stages, levels, ongoing process, risks, difficulties • Positive experiences of disclosure: Joo Inn-Chew and Nilgun • Non-Western perspectives of 'coming out': coming home, inviting people in • <u>Implications for service delivery</u>: be non-judgemental; communication of acceptance whether there is disclosure or not; use of language such as 'lesbian' can be confronting for a woman who is newly-identified or unsure; acceptance of a woman's level of disclosure; respect for confidentiality so do not disclose sexual orientation to others without woman's consent; appropriate referral but only with woman's permission; do not force choices or assume that a woman must choose between her culture/community and her sexuality
Heterosexism and homophobia	<ul style="list-style-type: none"> • Definitions of heterosexism and homophobia • Preventing heterosexism and homophobia in immigrant and refugee communities will move at different rates across communities because of variability in level of understanding and willingness to accept • <u>Implications for service delivery</u>: consider intersecting discriminations and multi-faceted identities; recognise racism in the GLBTIQ community and homophobia in general and ethnic communities; use community notions of solidarity and support for brothers/sisters to generate understanding of discrimination to combat racism and homophobia
Supporting same-sex attracted women	<ul style="list-style-type: none"> • Consolidation and discussion of information presented • Participant case studies and personal experiences • Appropriate social supports for same-sex attracted women (AGMC website lists multicultural GLBTIQ social support groups; health and community services)

Table 3: Overall ratings for the Understanding Sexuality training program

	Bilingual health educators*	Service providers**
Overall quality¹	8.7	8.2
Comprehensive²	8.5	8.0
Informative²	8.7	8.1
Clear/understandable²	9.0	8.7
Relevance of information provided to women from your community* AND/OR women accessing your service**²	8.5	8.3
Extent to which the training program increased your knowledge and understanding of sexuality-related issues* OR issues relevant to same-sex attracted women from immigrant and refugee communities**³	8.5	7.8
Level of confidence to support same-sex attracted women from your community* AND/OR same-sex attracted women from immigrant and refugee communities accessing your service**²	8.5	8.6
Strategies¹	8.6	8.2
<ul style="list-style-type: none"> • <i>Extent the strategies reinforced understanding of information provided and issues discussed³</i> • <i>Effectiveness of the involvement of a same-sex attracted woman from an immigrant background in the delivery of the training program²</i> 	9.1 NA	8.3 8.2
Amount of information provided during training program	90% of evaluation participants reported that sufficient information was provided, while 10% indicated that more information was required	87.5% of evaluation participants indicated sufficient information was provided, while 12.5% suggested that more information was required

¹ On a scale of 1 to 10, 1 is 'poor' and 10 is 'excellent'

² On a scale of 1 to 10, 1 is 'not at all' and 10 is 'extremely'

³ On a scale of 1 to 10, 1 is 'not at all' and 10 is 'completely'

2.5 Where to from here?

The AGMC national conference in 2004 was a starting point for the articulation, analysis and comprehension of the lived experiences of GLBTIQ people from immigrant and refugee communities. Since the conference, several forums have been held across Australia (Melbourne, Sydney, Brisbane) to further discuss and interpret the issues and conflicts arising from the intersections of sexuality, culture, ethnicity and faith (AGMC website; Chan and Costaras, 2010). Whilst examination of these issues is necessary, significant action to encourage acceptance and support of GLBTIQ people from ethnic communities is long overdue. The time for action is now. The Understanding Sexuality Project training program was a small step in the right direction, but is insufficient in the long-term to create the cultural change required to enable ethnic community acceptance and support of GLBTIQ members. A concerted, multi-faceted approach is needed, involving leadership, advocacy, policy, and research to increase visibility of GLBTIQ members of immigrant and refugee communities; professional development to build community and professional capacity to support GLBTIQ members of ethnic communities; culturally-appropriate resources to inform about sexuality-related issues; and community education to generate acceptance of GLBTIQ members of ethnic communities.

Leadership, advocacy, policy and research

Sexuality and sexual diversity is taboo, sensitive and hidden in many cultures. Peak government and non-government bodies (national, state/territory) representing multicultural affairs and immigrant and refugee communities provide covert support in limited amounts to multicultural GLBTIQ groups (usually in the form of financial grants), but fail to publicly acknowledge the existence of GLBTIQ people in ethnic communities. This perpetuates the invisibility of GLBTIQ members within these communities. Failure to acknowledge sexual diversity in immigrant and refugee communities may stem from fear of community backlash, but such a stance can be perceived to be homophobic. If these peak bodies are to be truly representative of ALL individuals in immigrant and refugee communities, leaders within these bodies who are supportive of GLBTIQ people need to be courageous and willing to endure and challenge any criticism or hostility (within and external to these peak bodies), and publicly demonstrate their support of, and advocate for, GLBTIQ members via culturally-appropriate methods (such as ethnic media, community forums and events). Previous peak body leaders have publicly acknowledged and demonstrated support in the past (Nguyen, 2008), but support needs to be regular and ongoing, and not just a one-off occurrence.

Government bodies and academic researchers also perpetuate the invisibility of GLBTIQ people from immigrant and refugee communities. In 2009, the Victorian Government's Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing produced a guide, *Well Proud*, about GLBTI-inclusive practice for health and human services. In this 50-page A4-sized document, only two sentences highlight the issues affecting GLBTIQ people from ethnic backgrounds. Future editions of the guide should acknowledge the cultural diversity within the GLBTIQ community and highlight the issues of members from different cultural groups. Government policy around gay and lesbian issues should also draw more attention to concerns relevant to GLBTIQ individuals from immigrant and refugee communities.

Academic researchers also need to acknowledge cultural diversity within the GLBTIQ community. Research into gay and lesbian issues is highly monocultural, primarily conducted with well-educated, middle-class Anglo-Australians and focused only on sexual identity, thereby failing to consider the multiple identities of

many in the GLBTIQ community. Whilst this research renders the GLBTIQ community visible, the focus on sexual identity alone simultaneously renders ethnic members of this community invisible (Murdolo, 2008). Research has been conducted into the prevalence of same-sex attraction in Australia and found that men and women from non-English speaking backgrounds were less likely to report same-sex attraction (Smith et al, 2003), but this finding highlights the need for academic researchers to undertake more inclusive research into sexual diversity. Research methods requiring high-level English proficiency (written and/or spoken), as well as access to and capacity to use the internet or email, are culturally-inappropriate and exclude many GLBTIQ members of immigrant and refugee communities (Murdolo, 2008). Other GLBTIQ people from ethnic backgrounds may be reluctant to disclose their sexual orientation to researchers who may lack cultural awareness. Thus, research findings indicate the lack of cultural diversity in the GLBTIQ community, serving to perpetuate the invisibility of ethnic GLBTIQ people.

Peak bodies representing multicultural affairs and ethnic communities, together with mainstream government agencies and academic researchers create dual invisibilities for GLBTIQ people from immigrant and refugee backgrounds: they are invisible in ethnic *AND* GLBTIQ communities. These dual invisibilities are mutually reinforcing. The failure of peak bodies to publicly acknowledge sexual diversity in ethnic communities supports the monocultural views and practices of government agencies and academic researchers engaged with the GLBTIQ community. Consequently, government policies and academic research findings perpetuate the views of peak body representatives that sexual diversity does not occur in ethnic communities. There is a need to draw attention to GLBTIQ people from ethnic backgrounds through acknowledgement of sexual diversity in immigrant and refugee communities, as well as to recognise cultural diversity in the GLBTIQ community. Culturally-appropriate research into the prevalence of sexual diversity in ethnic communities is required, as is research into the health issues affecting GLBTIQ members of these communities. With regard to research into lesbian and bisexual women's health, oversampling of women to allow for analysis of sub-groups, such as those from ethnic communities, has been suggested (Diamant et al, 2000).

Professional development

The Understanding Sexuality Project training program was a pilot professional development exercise developed specifically for bicultural and bilingual community workers. The training program was delivered to MCWH bilingual health educators. The BHEs responded positively to the program, and there was much animated and insightful discussion throughout the exercise. Resource constraints meant that the training program could only be delivered over four hours. Ideally, the training program needs to be expanded into a one-day program so that the five modules can be covered more comprehensively. Some BHEs also expressed a need for greater discussion about engaging in public advocacy for same-sex attracted women in their communities without experiencing community backlash. In this regard, the training program needs to be revised to include additional information about effective and culturally-appropriate advocacy strategies on sensitive issues. Promotion of the training program also needs to be reconsidered. A promotional flyer with details of the training program was distributed via email to staff members employed in ethno-specific or multicultural services, or actively involved in their ethnic communities, but this approach generated little interest. Future promotional activities should include advocacy, such as direct communication with managers of ethno-specific or multicultural services, to provide detailed explanation of the training program's relevance to their employees and their work in ethnic communities. The training program could also be delivered on-site to all staff members of individual services.

The high level of mainstream service provider interest in the Understanding Sexuality training program highlights the need for cross-cultural professional development initiatives specifically tailored to health and community professionals employed in mainstream and gay-friendly services. A one-day training program for mainstream and gay-supportive service providers that elaborates on the intersections of sexuality, culture, ethnicity and religion, and that enables the delivery of culturally-appropriate support to same-sex attracted women from ethnic communities, is needed. The training program should cover the following topics:

- Culturally-specific understanding and histories of sexual diversity, including gay rights activism;
- Health issues of same-sex attracted women from immigrant and refugee communities, including links between sexual identity, domestic violence, forced marriages and child custody issues; barriers to accessing health and community services;
- Disclosure: Western (*coming out*) versus non-Western perspectives (*coming home* and *inviting people in*); risks of disclosure in different cultures; importance of not forcing choices and respecting choices made about level of disclosure; positive stories of disclosure, family and community acceptance;
- Heterosexism and homophobia (in GLBTIQ and ethnic communities): minimising heterosexist assumptions;
- Supporting same-sex attracted women from immigrant and refugee communities: communication and interpersonal skills that demonstrate acceptance and inclusion and that facilitate safe disclosure of sexual orientation; culturally-appropriate referral to gay-supportive bicultural and bilingual community workers, including health professionals; positively challenging homophobic attitudes in culturally-appropriate ways (Jivraj et al, 2002; McNair, 2003; Parks et al, 2004).

The involvement of same-sex attracted women from immigrant and refugee communities as facilitators in both kinds of training programs is important as their stories will provide much-needed insights into their lived experiences; enable better understanding of the issues affecting women and their support needs; and may generate community acceptance of GLBTIQ members.

Health and community professionals also need to be informed about other service providers who are culturally-aware *AND* gay-sensitive to whom they can appropriately refer same-sex attracted women from ethnic communities. Bicultural and bilingual community workers, including health practitioners, willing to be promoted as gay-supportive need to be identified and listed through appropriate channels, such as the DocList website or other relevant health and community service directories. Interested multicultural GLBTIQ groups could also be listed through these channels, as could mainstream health and community services that are culturally-aware *AND* gay-sensitive, and gay-specific services that are culturally-sensitive.

Resources

Culturally-appropriate education resources (written and audio-visual) on sexual identity for same-sex attracted women from ethnic communities are not available. Nor are there multilingual education resources for parents, families and communities about supporting GLBTIQ members, including same-sex attracted women. There is a need for multilingual resources in various formats that use cultural frameworks to explain sexual identity and sexual orientation to women, particularly those who are discovering their sexual identity and are confused about it (Jivraj et al, 2002), similar to information provided via The Safra Project, an online resource project that informs Muslim women about sexuality, gender and Islam (The Safra Project website).

Women also need to be informed about comfortably managing their complex identities. Multilingual resources about lesbian and bisexual women's health, including parenting, are also required, as are multilingual resources in different formats for parents, families and communities that explain sexual diversity in a culturally-appropriate manner and promote acceptance and support of GLBTIQ people. The SSAFE (Same Sex Attracted Friendly Environments) in Schools Project guide for parents, families and friends of GLBTIQ young people, *Making sense*, could be used as a template for the development of culturally-appropriate materials. These resources could be made available through mainstream, gay-specific, ethno-specific and multicultural health and community services. Bicultural and bilingual community workers who are gay-sensitive can also distribute resources as part of their advocacy and community education efforts.

Community education

Community education is integral to generating support of GLBTIQ members of ethnic communities. Given the sensitive nature of sexuality and sexual diversity in many cultures, community education directed at these communities needs to gradually introduce key issues in a non-confrontational and positive manner. Education strategies should initially be family-specific, concentrating on the importance of harmonious and respectful family relationships. This suggestion has also been made for education efforts addressing another culturally-sensitive issue: violence against women (Poljski, 2011). Ethnic communities are more likely to respond to affirmative messages about family. As community understanding increases, only then should education strategies highlight diversities within the family unit, including sexual diversity, and the importance of embracing all these diversities. Discussion about sexual identities could refer to culturally-specific histories of sexual diversity and/or cultural and religious frameworks that promote love, companionship and social justice for all (Jivraj et al, 2002; Pallotta-Chiarolli, n.d). Building on discussion about diversities within family, the illegality of discrimination on the basis of sexual orientation needs to be highlighted. Education strategies should also demonstrate that GLBTIQ people lead regular lives like anyone else: they study, work, have families of their own, and positively contribute to society. Community education also needs to challenge homophobic attitudes. The majority of immigrants and refugees have undoubtedly experienced racism, so comparing homophobia with racism, and asking education participants to contemplate their own experiences of discrimination, may enable or consolidate understanding of the need to accept and support GLBTIQ family and community members.

2.6 Conclusion

The Multicultural Centre for Women's Health implemented the Understanding Sexuality Project, an initiative that aimed to build the capacity of bicultural and bilingual community workers to support same-sex attracted women from their ethnic communities. The main outcome was a half-day sexuality training program delivered separately to two groups: MCWH bilingual health educators and staff members of mainstream agencies, organisations and services that engaged with, or delivered services to GLBTIQ people and/or ethnic communities. The training program was a small step in facilitating community and professional support of GLBTIQ people from immigrant and refugee backgrounds, but more action is needed to maintain the momentum generated, including leadership, advocacy, policy, research, professional development, resources and community education.

CHAPTER 3: KEY RECOMMENDATIONS

Improving ethnic communities' understanding of the issues facing their GLBTIQ members, and building their capacity to support these members, will require a major shift in cultural attitudes. Progress towards this matter will be challenging, the most considerable issue being the diversity across and within immigrant and refugee communities. The level of understanding about sexuality and sexual diversity, and the ability and willingness of individuals and communities to engage in dialogue about, and to address this issue, will differ significantly. Efforts designed to change the status quo will need to consider this disparity if they are to be effective in the long term, and will most likely begin at different points and progress at different rates across communities. The Understanding Sexuality Project was a small step in the right direction, but this initiative alone cannot generate the shift in attitudes required to facilitate greater acceptance and support of GLBTIQ members of immigrant and refugee communities. A concerted, multi-faceted approach is required to capitalise on the findings of the Understanding Sexuality Project, and should include the following actions:

1. Peak government and non-government bodies (national, state/territory) representing multicultural affairs and ethnic communities must acknowledge and respect ALL forms of diversity, including sexual diversity, in these communities. Leaders within these peak bodies who are supportive of GLBTIQ people should publicly demonstrate their support of, and advocate for, GLBTIQ members of immigrant and refugee communities.
2. The visibility of GLBTIQ people from immigrant and refugee backgrounds should be increased in government policy about GLBTIQ health and wellbeing, as well as academic research focused on sexuality, sexual diversity and the health issues affecting the GLBTIQ community. Culturally-appropriate research methodologies should be employed to fully capture the extent of sexual diversity in ethnic communities and the health issues affecting the GLBTIQ members of these communities.
3. The Understanding Sexuality training program needs to be rolled out widely and provided to bicultural and bilingual community workers who are employed in ethno-specific or multicultural services, or who are actively involved in their communities. This professional capacity-building exercise needs to:
 - a. be delivered as a one-day program to cover all modules comprehensively;
 - b. include discussion on effective advocacy strategies on culturally-sensitive issues;
 - c. provide details of culturally-aware, gay-sensitive health and community service providers, as well as multicultural GLBTIQ groups, to enable appropriate referral;
 - d. provide details of culturally-appropriate education resources (written, audio-visual) about sexuality-related issues for same-sex attracted women from immigrant and refugee communities, their families and community members;
 - e. involve a same-sex attracted woman from an immigrant or refugee background, and who is open about her sexual identity, in the delivery of the training program to provide much-needed insights into the lived experiences of GLBTIQ members of ethnic communities; and
 - f. be offered in community languages for community workers not proficient in English.

4. A comprehensive cross-cultural training program with a focus on sexuality should be developed specifically for health and community professionals employed in mainstream and gay-friendly services. This professional capacity-building exercise needs to:
 - a. include the modules from the Understanding Sexuality training program, but in a revised form so they are tailored to health and community professionals;
 - b. be delivered as a one-day program to cover all modules comprehensively;
 - c. provide details of culturally-aware, gay-sensitive health and community service providers, as well as multicultural GLBTIQ groups, to enable appropriate referral;
 - d. provide details of culturally-appropriate education resources (written, audio-visual) about sexuality-related issues for same-sex attracted women from ethnic communities, their families and community members; and
 - e. involve a same-sex attracted woman from an immigrant or refugee background, and who is open about her sexual identity, in the delivery of the training program to provide much-needed insights into the lived experiences of GLBTIQ members of ethnic communities.
5. Culturally-appropriate education resources about sexuality-related issues (sexual diversity, sexual identity, lesbian and bisexual women's health) for same-sex attracted women from immigrant and refugee communities need to be developed. Cultural frameworks should underpin discussion about these issues. It is essential that resources are: translated into community languages; available in different formats (written, audio-visual); and distributed through mainstream, gay-specific, ethno-specific and multicultural health and community services, or via bicultural and bilingual community workers engaged in community education and advocacy efforts.
6. Culturally-appropriate education resources about sexuality-related issues (sexual diversity, sexual identity, importance of acceptance and support of GLBTIQ members) need to be developed for parents, families and communities. Cultural frameworks should underpin discussion about these issues. It is essential that resources are: translated into community languages; available in different formats (written, audio-visual); and distributed through mainstream, gay-specific, ethno-specific and multicultural health and community services, or via bicultural and bilingual community workers engaged in community education and advocacy efforts.
7. Community education is essential to encourage acceptance and support of GLBTIQ members in ethnic communities. Education strategies, delivered via culturally-appropriate methods such as ethnic media and bilingual health education, should initially be family-focused and emphasise the importance of harmonious and respectful family relationships. Discussion about diversities within the family unit, including sexual diversity, should be gradually introduced into these strategies. Culturally-specific histories of sexual diversity, as well as cultural frameworks, should be used to explain sexuality-related issues, while connection between homophobia and racism could facilitate acceptance of GLBTIQ members.
8. Bilingual health education for immigrant and refugee women could also be used to inform women about sexuality-related issues (sexual identity, sexual diversity, lesbian and bisexual women's health).

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APPENDICES

Appendix 1: Project participants - agencies, groups, organisations and services represented in the consultation and the training program

Consultation

A consultation was undertaken with representatives from various groups, organisations and services, (multicultural and mainstream) to gain an understanding of the experiences and support needs of same-sex attracted women from immigrant and refugee backgrounds. Represented in the consultation were:

1. ALSO Foundation
2. Arcilesbica
3. Australian GLBTIQ Multicultural Council
4. Beit el Hob
5. Bfriend (program of UnitingCare Wesley in Adelaide, South Australia)
6. Carlton Clinic
7. Gay and Lesbian Health Victoria
8. Jewish Lesbian Group of Victoria
9. Relationships Australia (South Australia)
10. Shine SA (South Australia)
11. Victorian AIDS Council
12. Yellow Kitties

Training program

The Understanding Sexuality training program was individually delivered to two groups: MCWH bilingual health educators and staff members or representatives from various agencies, organisations and services engaging with, or delivering services to GLBTIQ people and/or ethnic communities. Thirteen MCWH bilingual health educators participated in the BHE training program. For confidentiality purposes, they are not listed here. Agencies, organisations and services represented in the service provider training program were:

1. Australian GLBTIQ Multicultural Council
2. Centre for Multicultural Youth
3. Gay and Lesbian Switchboard
4. Hanover Welfare Services
5. Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing
6. Victoria Police
7. Victorian Arabic Social Services
8. Women's Health in the South East

Appendix 2: Consultation questions

The main consultation questions included:

1. What are the main experiences of same-sex attracted women from immigrant and refugee communities with regard to their sexuality (considering health issues, disclosure, capacity to live authentically and participate in their families and communities)?
2. What is the current level of understanding (including beliefs and stereotypes) in ethnic communities (families, wider community networks, bicultural and bilingual community workers) about sexuality and sexual diversity?
3. What are the dynamics of cultures that create a supportive environment for people to disclose their sexual orientation and live authentically?
4. What difficulties might same-sex attracted women from immigrant and refugee communities experience in accessing ethno-specific services and mainstream services?
5. What difficulties might bicultural and bilingual community workers experience in engaging and/or delivering services to same-sex attracted women from their ethnic communities?
6. What difficulties might health and community professionals experience in engaging and/or delivering services to same-sex attracted women from immigrant and refugee communities?
7. What information needs to be provided to ethnic communities to facilitate a better understanding and acceptance of diversity within sexuality and sexual identity? How could same-sex attraction be explained to these communities in a culturally-appropriate and specific manner?
8. How else can same-sex attracted women from immigrant and refugee communities be better supported by their families and communities?
9. What action needs to be taken to improve the capacity of ethnic communities to support their GLBTIQ members, to generate environments where all are included, irrespective of their sexual identity?
10. Any other comments?

Appendix 3: BHE training program evaluation survey

This is the evaluation survey for the Understanding Sexuality training program for bilingual health educators.

Overall

1. How would you rate the overall quality of the training program?

1 2 3 4 5 6 7 8 9 10
Poor *Good* *Excellent*

2. How comprehensive was the training program?

1 2 3 4 5 6 7 8 9 10
Not at all *Somewhat* *Extremely*

3. How informative was the training program?

1 2 3 4 5 6 7 8 9 10
Not at all *Somewhat* *Extremely*

4. How clear or understandable was the information in the training program?

1 2 3 4 5 6 7 8 9 10
Not at all *Somewhat* *Extremely*

5. How relevant was the information in the training program to women from your community?

1 2 3 4 5 6 7 8 9 10
Not at all *Somewhat* *Extremely*

6. To what extent did the training program increase your knowledge and understanding of sexuality-related issues?

1 2 3 4 5 6 7 8 9 10
Not at all *Somewhat* *Completely*

7. Did the training program provide:

Too much information Sufficient information Not enough information

8. How would you rate the strategies (discussions, activities, quotes) used in the training program?

1 2 3 4 5 6 7 8 9 10
Poor *Good* *Excellent*

9. To what extent did these strategies reinforce your understanding of sexuality-related issues?

1 2 3 4 5 6 7 8 9 10
Not at all *Somewhat* *Completely*

