Polare

MAGAZINE OF THE NEW SOUTH WALES GENDER CENTRE

Mariela Castro

Edition 93
October-December 2012

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the Gender Centre Service Magazine

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The Gender Centre is also committed to educating the public and service providers about the needs of people with gender issues.

We offer a wide range of services to people with gender issues, their partners, families and organisations, and service providers.

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(9-5, M-F)
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Email:
reception@gendercentre.org.au
Website:
www.gendercentre.org.au

The Gender Centre is staffed 9am-4.30pm Monday to Friday

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Cover: Mariela Castro, daughter of the President of Cuba, Raul Castro, is a committed and tireless worker for the rights of LGBT and women in Cuba. Ms Castro will be in Australia as a guest of the Australian Government in October 2012, and will be participating in two sexual health conferences to be held in Melbourne. She will also be giving a public lecture at the University of Sydney on 16 October at 6.30pm (see ad. p.12)

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Having a MENTOR has changed my life ... my FUTURE is BRIGHTER than ever!

October-December 2012

No. 93

CONTRIBUTORS

anthony carlino, katherine cummings, marika, carla treloar, amy herlihy, l. gillam, matt kailey, trish kench, caitlin hall, barry deutsch

REGULAR

DEADLINE

for submissions to the next edition of *Polare* is the eighth of December 2012

Editor: Katherine Cummings
THE FINE PRINT

Polare
resources@gendercentre.org.au
PO Box 266, Petersham
NSW 2049
Phone: (02) 9569 2366
Fax: (02) 9569 1176
Email: reception@gendercentre.org.au
Website: www.gendercentre.org.au

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Unsolicited contributions are welcome although no guarantee is made by the editor that they will be published, nor any discussion entered into. The right to edit material contributions without notice is reserved to the editor. Any submission that appears in *Polare* may be published on the Gender Centre's Website.

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FEATURES

SERVICES & NOTICES

Editorial - Katherine Cummings

I had intended this edition of *Polare* to deal almost exclusively with health matters, and to use the cover to present a selection of images of the informed researchers and health workers who help us to understand the complications of our various health conditions.

These include, in this issue, Amy Herlihy and Lynn Gillam on 47,XXY (Klinefelter's Syndrome), Professor Carla Treloar on staying safe while injecting drugs over a period of years, Trish Kench on mental health nursing and a hepatitis C update from Maggie Smith. I also owe thanks to Dr Max Hopwood from the National Centre for HIV Social Research at UNSW for asking around the NCHSR for articles of interest to Gender Centre clientele, and arranging for Professor Treloar's piece to be submitted for this issue.

A few days ago, however, I received information that Mariela Castro, a dedicated activist on behalf of women and the GLBT communities in Cuba and elsewhere, is to be in Australia in October and giving a public guest lecture at the University of Sydney (see ad. on p.10). Ms Castro has done a great deal for our various communities in Cuba, including provision of free hormonal and surgical treatment for Cuban transgenders.

I took the opportunity to ask for, and received, permission to place Ms Castro's image on the cover of this issue, so that the collage of our health writers will be postponed. In the meantime you must make do with the thumbnail images associated with their various writings.

There are also two pieces dealing with the use of dexamethasone on pregnant women to reduce the *possibility* of congenital adrenal hyperplasia (CAH), a condition which *might* lead to masculinisation, tomboyism or other horrible consequences. This is dealt with by Carol Devine and Matt Kailey in separate pieces. I find it incomprehensible that doctors would take the risks associated with *in utero* experimental medication for reasons such as these. Have they all forgotten the consequences of thalidomide?

Matt Kailey also weighed in with a piece on the rights of inmates of jails to receive medical treatment, including the right to therapeutic intervention (hormonal and surgical) for transgenders. I would have liked a companion piece on the parallel situation in Australian jails but it has not arrived in time for inclusion so it, too, may turn up in No. 94.

On the positive side there is the good news that hormone implants, both estrogen and testosterone are available again, locally made and at a reasonable price.

And there is a piece on the Carmen Rupe Memorial Trust, which intends to involve itself in community based events relevant to GLBTI but also apply its energy to more generally philanthropic events, in the spirit of the late Carmen Rupe herself.

Marika has graced us with one of her columns, recording the everyday life and events of a transgender in society, enjoying life to the full and discovering new facets of her own character as each week passes. Those of us who have been there can enjoy the *deja vu* and those who are on their way can look forward to explorations every bit as exciting as Marika's.

In an earlier editorial I asked if anyone had a copy of the AAP list of definitions as amended by the SAGD (Sex and Gender Diverse) movement, but so far nobody has responded. Anybody?

I had hoped to write something for this issue on the topic of non-binary pronouns but the amount of health material available overwhelmed me and I have had to reduce my usual editorial space by two thirds. Try not to cheer, or if you do cheer, don't tell me about it.

Have a happy holiday season and I'll see you all again (or write to you) in the New Year.

Katherine

Staying Safe by Professor Carla Treloar

National Centre in HIV Social Research

How do some people who have injected illicit drugs for many years manage to avoid hepatitis C infection? What can social research with people who inject drugs tell us about how to avoid getting hepatitis C in the long-term? The 'Staying Safe' study is an innovative social research project which aims to learn from long term injectors what their hepatitis C prevention strategies are for the purpose of informing a new generation of hepatitis C prevention strategies.

Background

Hepatitis C virus infection is a leading cause of chronic illness and death related to illicit injecting drug use. More than 90 per cent of the estimated 9,700 new cases of hepatitis C infection annually in Australia are attributable to injecting drug use and up to 80 per cent of people who inject drugs (PWID) have markers of hepatitis C infection. By the end of 2005 an estimated 264,000 Australians had been exposed to hepatitis C, with 197,000 of those people estimated to be chronically infected. While only a minority of those infected will progress to advanced liver disease, chronic hepatitis C infection is now the leading indication for liver transplantation and cirrhosis in Australia, the US and other parts of the world, and these are expected to increase four-fold by 2020.

Transmission of hepatitis C among PWID primarily occurs as a result of exposure to contaminated blood during injection. In Australia, approximately 70 per cent of people who have injected drugs for over eight years have been exposed to hepatitis C. The main risk factors associated with hepatitis C infection include being older, having injected for a long time and injecting frequently. Hepatitis C transmission has also been reported in association with specific practices, such as cocaine injection (which may be a marker for frequent injection), sharing syringes and other injecting equipment and assisting others to inject. Some evidence also implicates the shared use of injecting equipment other than needles and syringes in the transmission of hepatitis C. Australian research has found that young people and people who are new to injecting appear to be at greatest risk of hepatitis C infection. Women and people who inject from culturally and linguistically diverse (CALD) backgrounds were twice as likely as PWID who were not from a CALD background to have acquired hepatitis C.

Professor Carla Treloar

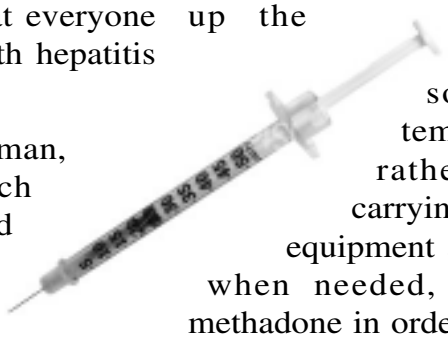
Harm reduction, HIV and hepatitis C prevention in Australia

In response to the risk of widespread transmission of HIV among people who inject drugs, in 1987 the Australian Government implemented harm reduction policies including the provision of clean injecting equipment through a variety of primary sites such as needle and syringe programme (NSP) outlets and secondary sites such as community health centres and hospital emergency departments, community pharmacies and syringe vending machines. This harm reduction strategy, combined with dedicated funding to illicit drug user groups for education and health promotion, has contributed to Australia having some of the lowest rates of HIV infection (< 2%) among PWID in the world. However, harm reduction strategies like NSP are not as good at preventing hepatitis C transmission between PWID as they are at preventing HIV transmission. This is because the hepatitis C virus is more infectious than HIV and because hepatitis C infection was already very common among populations of PWID in Australia by the time the NSP and other harm reduction strategies were first introduced in the late 1980s.

Social research and the Staying Safe study

Past social research has highlighted some of the important issues for hepatitis C prevention strategies. The ability of people who inject drugs to implement prevention strategies is limited by the illegal and stigmatised nature of drug injection. Risks of legal intervention and arrest, overdose, violence, access to money, concerns about addiction, drug withdrawal, fearing breaches of anonymity or confidentiality are some of the priorities which "compete" with

people's efforts to prevent hepatitis C infection. Studies have also found that PWID typically have little or no awareness or contact with harm reduction services at the time they begin to inject illicit drugs, and some PWID will not attend health services, or only attend them infrequently, instead preferring to get their injecting equipment from friends and associates who inject. Social research has also provided other insights, for example into how much PWID know about hepatitis C risk practices and research has highlighted people's false beliefs, such as the myth that everyone who injects ultimately ends up with hepatitis C.



Several years ago, Dr Sam Friedman, from the National Drug Research Institute in New York City designed a study called the Staying Safe study. The underpinning idea of Staying Safe is to explore the strategies used by people who have injected for long periods but who have not acquired hepatitis C infection. The idea is that these strategies will assist in developing a new generation of hepatitis C infection prevention programmes, which can help both new and experienced PWID to remain uninfected with hepatitis C over the long term. During the last five years, in-depth interviews have been conducted with PWID in many sites around the world including New York City, St Petersburg, Valencia, Prague, London, Sydney and Melbourne. These interviews have explored the lives and injecting practices of people who have remained free of hepatitis C despite many years of injecting drug use. To be eligible for participation in this study people had to have injected drugs for eight to fifteen years and they had to have had their hepatitis C negative status confirmed through blood tests. As well, long term injectors who had acquired hepatitis C were recruited. Detailed life history interviews were conducted with each participant.

Some of the main findings from the Staying Safe study

The findings from this study so far have illustrated the considerable degree of control over injecting practices that long term injectors have employed in order to avoid exposure to hepatitis C infection. A number of participants described the strategies they employed to maintain safe injecting practices in situations that were very risky. These included the marking of injecting equipment in order to identify who it belongs to, making rules about not sharing any injecting equipment whatsoever, injecting in areas that are clearly demarcated and separated from others who are also injecting, waiting until getting home before injecting, being prepared with money, drugs and equipment before injecting, being in charge of mixing up the drug solution and distributing the mixed solution to others, having temporary periods of smoking rather than injecting heroin, carrying an injecting 'kit' of sterile equipment at all times so it is available when needed, stockpiling and sharing methadone in order to prevent withdrawal, and maintaining strong protective social networks of people who will help when needed. Interestingly, for many participants the factors that may have helped them to 'stay safe' were not directly related to health promotion messages or hepatitis C transmission avoidance. These factors included the ability and inclination to maintain strong social and family supports and to 'present well' in social networks, maintaining control over the injecting situation and prioritising vein care, and avoiding track marks, by using a new needle for every injection.

Conclusion

The Staying Safe study is ongoing and new findings will emerge over the coming year. Nonetheless, the findings briefly discussed in this article illustrate how drug injecting practices and hepatitis C prevention strategies are an outcome of individual, social, cultural, environmental and drug market contexts. New generations of hepatitis C health promotion may need to engage with the multiple priorities of people who inject drugs in order to help them develop strategies to remain hepatitis C free. These new health promotion strategies will need to engage with the pleasures as well as the pragmatics of injecting drug use that are indirectly associated with becoming infected with hepatitis C. ❑❑❑❑❑

NSW Seahorse Society

is a self help group based in Sydney open to all crossdressers, their relatives and friends. We offer discretion, private monthly social meetings, social outings, contact with other crossdressers, a telephone information service, postal library service and a monthly newsletter.

THE SEAHORSE SOCIETY OF NSW INC
PO BOX 2193 BORONIA PARK, NSW 2111
Call on 0423.125.860
and our **website** is:
www.seahorsesoc.org
Email:
crossdress@seahorsesoc.org

"crossdress with dignity"

Letters to the Editor

Katherine,

XXY AND HORMONE THERAPY

Over the years of reading *Polare* I've come across a number of articles pertaining to XXY and how testosterone is recommended by the medical profession to treat these 'MEN'.

Well, I'm here to tell you, we don't all identify as men, some of us see ourselves as women and administer estrogen,while others are intersex, some of whom choose a combination of testosterone and estrogen, and others are just plain old XXY and may or may not administer sex defining hormones.

My own journey of diagnoses followed along the lines of diagnosis and immediate introduction to testosterone without any regard for how I identified.

It was a horrible experience and yet I was told by the medical profession on more than one occasion that my life would not be worth living if I stopped using that testosterone.

It didn't take long for all parties to realise that the testosterone was killing me.

What followed was my introduction to the Gender Centre and years of counselling, some of which was in-house but the bulk of it by mental health professionals as they sought to unravel the damage caused by my forced chemical sex-reassignment.

No one should ever have to experience what I went through and access to sex defining hormones should be limited to those who've passed stringent psychological assessments similar to those that transgendered people presently experience.

After all the XXY individual who is given these hormones is, in effect, transitioning from a gender neutral state, to man, to woman, to everything in between and beyond.

I'll always be thankful to the Gender Centre for the great support they've afforded me over the years and I have no doubt if it weren't for them I wouldn't be here today.

I've just passed the ten-year mark of administering estrogen and on many occasions I have been asked by XXY's who administer testosterone if I am transitioning and my reply has always been "no more than they are".

Thanks Katherine for all that you do.

Canice XXY

To the Editor, *Polare,*

A WALK TO REMEMBER

When Michael Foucault talks about sexual repression resulting from the Victorian regime in his *History of Sexuality,* I feel it's a depiction of society in India.The politically correct term "other sex" derived from the binary opposition of male and female undergoes immense discrimination in every aspect of Indian life.

The *hijras*. the name given to the transgender people of India, are tucked away from the thoroughfare of normal luife and receive glares and glances publicly. They lead an isolated life hidden from the man/woman majority and they

Hijras

are denied education, culture and the fundamental right of humanism, which is equality. Gender bias has penetrated every fabric of society and even the educated middle-class intelligentsia has not acted for the improvement of the *hijras.*

Residing in Kolkata, one of the biggest metropolitan citoes of India, I was surprised when I was invited to take part in a Pride Walk to be conducted by the stigmatised LGBT community of my city.

My gay friend insisted that I should go on the walk if only to experience the concept. On 29 June 2012, 1,200 members of the LGBT community walked the major roads of Kolkata,

demanding their rights and asserting their existence. I was amazed. To me, given the conservative and ignorant attitude of my society, this walk (with cross-dressers, transgenders and transsexuals) was not about rights, it was about asserting their gender identity. It was a voice against social control and hypocrisy and it was a voice celebrating nature.

India still has a long way to go to reach the point where sex, sexuality and gender are no longer the deciding factors for acceptance and a normal life. My dream will come true when a transgender woman can work in a corporate environment, wearing female clothing and nobody would even notice.

Regards,

Sayanti Chatterjee

Dear Sir/Madam

I am writing in relation to the very disturbing situation outlined in Dangerous Experiment In Fetal Engineering, a report on thecrisky prenatal use of steroids to try to prevent intersex, tomboys and lesbians

(http://www.northwestern.edu/newscenter/stories/2012/08/dreger-fetal-engineering.html)

Our organisation is extremely concerned by the usage of dexamethasone in pregnant women for the purpose of fetal sex normalisation and this drug's serious adverse events to the exposed off-spring, which include hydrocephalus, mental retardation, failure to thrive and developmental delay.

Our DES exposed members know too well the harmful impact and suffering caused when dangerous substances cross the placental barrier.

The situation described in the abovementioned document would indicate that nothing has been learned from the tragic disasters of DES and thalidomide. Disturbingly, the concern expressed about this usage by medical societies for more than ten years has been blatantly ignored.

We wish to know whether this usage of dexamethasone is occurring in Australia? We consider this to be extremely serious and would appreciate your prompt reply on this matter.

Carol Devine
Coordinator, DES Action Australia-NSW
Ph (02) 98754820
c_devine@bigpond.net.au
Blogsite: www.desnsw.blogspot.com<http://www.desnsw.blogspot.com>

If anyone can help Carol by providing further information about the use of dexamethasone in Australia, she would like to hear from you. You may contact her by phone or email. Her blogsite is also listed above.

Since the above letter was added to Polare, we have been in contact with Carol and she has sent us a very recent copy of a letter received on the topic of dexamethasone from the Therapeutic Goods Adminstration in response to Carol's letter. The TGA letter has been transcribed, with Carol's permission, and appears below.

KC

Australian Government
Department of Health and Ageing

Ms Carol Devine,

[Personal address omitted.]

Thank you for your emails of 5 and 6 August 2012 to the Therapeutic Goods Administration (TGA) and the Minister for Health, the Hon Tanya Plibersek MP, regarding off-label usage of dexamethasone. Your email was referred to the Parliamentary Secretary for Health and Ageing, the Hon Catherine King MP. The Parliamentary Secretary has asked me to reply on her behalf.

For a therapeutic product to be supplied in Australia, it must have been assessed by the TGA against applicable quality, safety and efficacy standards and included in the Australian Register of Therapeutic Goods (ARTG). When a therapeutic good is included on the ARTG, only specific indications are approved by the TGA for that particular entry. (cont. next page)

Dexamethasone is available only via a prescription from a medical practitioner and belongs to a class of medicines known as corticosteroids. It is a synthetic glucocorticoid with potent anti-inflammatory effects and is used to treat a wide range of medical conditions. There are approximately 10 products on the ARTG containing dexamethasone as an active ingredient. Information on each of these products is available by searching the Public ARTG Summary at *www.ebs.tga.gov.au/*. Further information is also publicly available by checking the Product Infomation and/or Consumer Medicines Information documents via the TGA website at *www.tga.gov.au*.

Prescribing a registered medicine for indications other than the approved indications is what is commonly referred to as "off-label" prescribing. It is a matter of medical practice that a doctor may prescribe any medication they think is suitable to treat a particular condition in a specific patient.

The practice of prescribing registered medicines outside of their approved indications is not regulated or controlled by the TGA, as it is at the discretion of the prescribing physician. In these circumstances, the TGA is unable to vouch for the quality, safety or efficacy of this unapproved product and its use is therefore regarded as experimental.

I trust this information is of assistance.

Yours sincerely,

Harry Rothenfluh,
Head, Ofice of Medicines Authorisation
Therapeutic Goods Adminstration
6 September 2012

Mariela Castro

Guest Lecture on Sexual, Gender and Women's Rights
6.30pm-8.30pm
16 October 2012
Eastern Avenue Auditorium
University of Sydney

ALL WELCOME, NO ADMISSION FEE

Hormone Implants Available Again

Following the discontinuation of hormone tablet implants on the Australian market and due at least to some extent to the efforts of Dr Jonathan Hayes, implants are now being manufactured in Australia and are available at a reasonable cost.

Many people prefer implants to injections, patches or pills for a variety of reasons. In the case of oral ingestion or skin patches the drug may be absorbed at unpredictable rates, and in the case of oral ingestion may have undesirable effects on the liver. Some people also find skin patches hard to keep in place.

Implants solve these problems as the pellet consists of a hard crystal of either estradiol or testosterone, the hormones produced by the human ovary or testicles, which is released into the blood stream, attains a steady state, and is then used by the body as the hormone is metabolised. This creates a steady hormone stream which lasts for several months.

One of the companies producing these implants is Stenlake and the price range for Estradiol or Testosterone pellets starts from $126.00. Stenlake is located at Level 1, 76 Spring St, Bondi Junction. (02 9387 3205) and produces implants in 50mg or 100mg strengths, created on a European pellet press to maintain the same size and finish as those formerly available..

A high strength testosterone pellet is being developed in a 200mg size and Stenlake will deliver Australia-wide, or customers can pick up from the Bondi Junction address.

A number of transgenders have been obtaining their hormone supplies for overseas sources but there are obvious risks involved in this process.

Above all, it is important to base your hormone therapy on the advice and prescriptions supplied by an endocrinologist with experience in our sector of the field. IT IS DANGEROUS TO SELF-MEDICATE!

Speaking Personally, by Marika

Friends have on more than a few occasions expressed surprise when I've mentioned that I regularly see a counsellor. I guess it's quite flattering to hear them express the opinion that they've long regarded me as someone who comes across as self-confident and perfectly comfortable in my gender and my relationship with the world in general. On the other hand however, I have to admit that I'm equally surprised when I'm faced with their curiosity.

It seems to me to be based on the assumption that a counsellor's role is solely to provide guidance, advice and solace to those going through major life challenges or upheavals. In our case, as gender-variant clients, these challenges might range from the stresses associated with familial rejection to difficulties of transition.

Marika

Don't get me wrong. I've experienced many of those stresses and challenges and I'm grateful to the many individuals, professionals and friends, who've seen me through some very difficult times, but my friends are also right in observing the person I am now....

So, why do I continue to see a counsellor every fortnight or so? Well, to explain, I need first of all to say something about my personality that I think we all have in common. This is a need for approbation from someone important in our lives. Someone we love, admire or respect at whatever level. When we're young children, it would most likely have been a parent or carer. As students it was perhaps a favourite teacher or even a friend. As adolescents maybe a peer group, a boyfriend or girlfriend.

The second point, more specific to myself however, is the fact that I was born with a creative bent that has served me well, especially during the more difficult phases of my life as an artist and a teacher.

Now, although in common with many other artists, I was primarily my own most exacting critic, I would invariably have someone important to me in mind during creation. Someone I needed to impress. I'm not referring to a generous patron. No, it was always someone I loved, a muse if you like or at least someone I really admired.

As well as being the motivation to perform at a high level, this same person would often invest ideas and suggestions for future works and even help me overcome technical difficulties with sound advice and support when I sought it....

Which brings me to another question raised by friends. Knowing something of my background they ask me if I'm still painting and I have to admit that, since losing my studio about two years ago, I have not. And when they ask me if I've done anything creative recently I delight in responding "Open your eyes! Look at me..".

The point being that for the last few years I've been re-recreating myself in so many different ways and with varying degrees of success. A creation that's had its ups and downs but would not have been possible had it not been for my good fortune to find a remarkable person to be my muse and my confidante.

I'm speaking of my counsellor; a person who, despite the fact that she's less than half my age has, right from the start, clearly understood her role as motivator and facilitator rather than as a shoulder to cry on. She and I have established what I believe to be a mutual respect that, in my case, has fulfilled a need to have someone whose positive evaluation of my progress motivates me.

I don't go to her with problems, at least nothing I expect her to solve for me. I simply tell her of the day to day things I've been doing since my last visit, including the status of my ongoing

social and family relationships, issues of dress and presentation and, quite often, matters totally unrelated to me and my ongoing life. She's always totally engaged with what I have to say.

She listens quietly and then, quite uncannily, will interject with an incisive comment or suggestion that is invariably helpful and, more often than not, helps me to see things more clearly.

She also provides me with materials or contacts that might be useful.

As I drive home at the conclusion of an hour or so, I always feel fortified and uplifted.

And, incidentally, if I'm to be honest, my decision to contribute a series of articles to this magazine would not have happened without her encouragement.

That's why I see her.

Recently, it was two years, to the day, since the surgery that changed my life. Since that wonderful day, my life, my world has moved so fast and so far that I've often found it difficult to believe that the person I am now could possibly be the same person I see in old photographs, or read about in saved letters.

And the truth, I now sincerely believe, is that I *have,* in fact become someone quite separate from the person I was before.

Sure, there are physical characteristics that remain as a reminder of my past, and always will, but I've never felt the need to undergo surgical changes to my looks.

Now, I can imagine how a statement like this could cause some confusion for some, especially those who've heard me talk about my journey in terms of 'gender–alignment.' 'Surely,' they might say, 'If your gender was always female, then as now, you're still the same person you always were. More so, perhaps, because your sex and gender are now aligned whereas before they were not.'

Perfectly sound reasoning if you discount the profound psychological, emotional and, dare I say, spiritual changes that can, certainly in my experience, have a remarkable effect on one's personality. Some of these effects are, no doubt, the result of drastic hormonal adjustments by way of a variety of pharmaceutical means.

Personally, however, I find it hard to believe that the changes to my psyche, my self-image, my self-confidence, my sociability and my new-found optimism about things in general are simply due to hormones.

But then...I'm neither a psychiatrist, an endocrinologist or any other kind of expert in these matters. I'm just so happy to be the person I am now, compared to the sad, sad individual I see in those pictures.

Anyway, to get back to my second 're-birthday'. I was delighted and, I have to say, quite moved, when some of the many new friends I've made since moving to the Central Coast, almost two years ago now, got together to arrange a 'surprise' party for me. I was quite amused by the fact that one or two of them found it impossible to keep the secret and would drop hints to warn me of what was going on.

On the day, we had a lot of laughs and they each went out of their way to make it memorable. It

was a lovely afternoon and one I'll remember for as long as memories remain. And it's memory that I want to say something about next. Specifically the effect that ageing is, to only a small, but nevertheless concerning, degree having on my memory.

Now, don't be alarmed if you're a friend reading this. I'm a long way from 'losing my marbles' altogether. Although..., you could argue, that happened two years ago!

At my age (71), it's not uncommon to become, what I prefer to call 'distracted'.

My GP assures me that my occasional short-term memory loss is quite normal and nothing to worry about. I might forget where I left something or, when multi-tasking, I will sometimes omit an important step from a sequence like the recipe for an elaborate dish. Infrequently required names become a problem after a period of time, especially those of people and places.

This can be quite embarrassing at times. I'm told long term memory, on the other hand, will probably be enhanced. Not really something I need, when considered in the context of what I was saying about my earlier life at the beginning of this column!

In a recent conversation with someone, I started to tell about a wonderful weekend away I'd spent with a girlfriend. Problem was, I couldn't, for the life of me, remember the name of the resort. In a combination of frustration and desperation I said:

"You know.....um.., that place in the mountains...you know.. THAT place.....!"

"What mountains?", my impatient friend asked.

"You know.....Those mountains.....Those mountains around Katoomba!"

"So was it at Katoomba where you spent the weekend?"

"Yeah, that's right! Katoomba! It was quite a memorable weekend...."

Something that has delighted me recently is the number of my friends, all of them over fifty, who are involved in activities that require a degree of spirit and considerable grit. I can't help feeling extraordinarily privileged that such people have accepted me as a friend. Their zest for life is a constant source if inspiration, and it's got me thinking about risk-taking. Why is it that when people of a 'certain age' engage in audacious or risky pursuits it's considered to be noteworthy? It seems to me that, at this age, it makes a lot more sense than it does for the young, who still have most of their lives ahead of them and a serious accident could be disastrous. We've less to lose. With that in mind, I'll be testing my own intestinal fortitude on my natal birthday later this month (September) I'll tell you all about it in the next issue.

Finally, I should say something about my quest, as an ageing lesbian, for a meaningful, and hopefully long-term, relationship with another woman. In the April edition of this magazine, I told of my disastrous attempts at finding someone via a lesbian dating site. The bad news is that I eventually gave up. The problem was not so much my gender background as my age. The good news, however, is that I'm now in a wonderful relationship with a lovely lady I've known for some time, but I never dreamed she would be interested in me. How wrong I was!

Love, *Marika*

WOULD YOU LIKE TO HEAR BY EMAIL?

The Gender Centre is compiling a list of email addresses of those clients and friends who would like to be notified of social, support, educational and other functions and events of interest.

Just email us

reception@gendercentre.org.au

Put "Email list" in the subject line and give us your first name and Email address.

Thinking Outside the Square: considering gender in Klinefelter Syndrome and 47, XXY

by Amy Herlihy and Lynn Gillam

A common genetic condition affecting males, Klinefelter syndrome (KS), is often described as 'The Forgotten Syndrome'. Although the prevalence of KS has been estimated to be as high as 1 in 450 (Herlihy et al., in press.), between 50 and 70% of males are never diagnosed (Bojesen et al., 2003). Klinefelter et al., 1942 first described KS as a syndrome in males, characterised by tall stature with eunuchoidal body proportions, gynaecomastia, small testes, hypogonadism, azoospermia and increased FSH levels (Klinefelter et al., 1942).

The cause of this syndrome was identified seventeen years later as an additional X chromosome inmales, resulting in a 47, XXY karyotype (Jacobs & Strong, 1959). Since then, there have been many advances in research concerning the biomedical aspects of KS, in addition to the cognitive and neuro-psychological features, providing a greater understanding of the variety of behavioural, learning and psychological difficulties that may be present (Bojesen & Gravholt, 2007).

"... a number of intersex organisations report more than a handful of female or nonmale identifying people who have an XXY karyotype."

We recently completed a study examining the psychosocial impact of KS (Herlihy et al., unpublished data).

The recruitment material called for adult males diagnosed with KS at any age, but now aged eighteen years and older. Our inclusion criterion was any individual who had a karyotype consisting of more than one X chromosome and a single Y chromosome (e.g. XXY, XXXY), including mosaic variations (e.g. XY. XXY) and those with XX testicular disorder of sex development, but excluding those with a female cell line (e.g. XX. XXY). This seemed at the time to be a clearly defined subpopulation; however, it soon became apparent that things were not so straightforward.

Over the course of our recruitment period, from November 2008 to December 2009, a number of inquiries came through, some from clinicians, but mostly from the support group Organisation Intersex International Australia Ltd. Were we looking for male XXY participants only? Or were we also interested in XXY participants who were female, intersex, or at least did not identify as male? This initially caused some concern among the research team – we certainly had not intended to exclude anyone with XXY chromosomes, regardless of his or her gender identity, and we had lacked awareness of the possibility of this occurring, by assuming that all XXY individuals are male.

Amy Herlihy

None of the health professionals involved inthe planning of this study, however, had encountered this before and so it had not been raised as a possibility. In addition, there was, and still is, very limited evidence in the literature regarding the prevalence of non-male individuals amongst those with an XXY karyotype. The information that is available usually concerns an XXY karyotype found in conjunction with an additional genetic variation, such as a mutation in the androgen receptor gene (Girardin et al., 2009).

Follow-up studies of XXY individuals diagnosed through newborn screening surveys would suggest that almost all of these babies will be phenotypically male and identify as male. However, although probably only a small minority, individuals with XXY who do not identify as male do indeed exist, and a number of intersex organisations report more than a handful of female or nonmale identifying people who have an XXY karyotype.

Ultimately, it remains unknown what proportion of individuals born with XXY will identify as female, intersex or other.

This caused us to consider carefully the definition of KS and of XXY, not only within our own research but also in terms of healthcare provision for these individuals.

In our experience, both in research and in clinical practice, the two terms – KS and XXY – are almost always used interchangeably. Yet the study inquiries that we received highlighted an interesting issue: Should there be a distinction between XXY and KS? Males diagnosed with KS will generally have an XXY karyotype, or variation thereof. Perhaps not everyone with an XXY karyotype should be diagnosed with KS. KS defines character-isticsthat are only unusual if found in a male.

Common symptoms, such as low testosterone and breast development, are not unexpected features (or symptoms) if identified in a female. Therefore, for an individual with an XXY karyotype who does not identify as male, KS may not be a suitable diagnosis.

This line of thinking may even be extended to individuals who identify as male, but whose concept of masculinity may not align with that of their health professional or societal norms.

Lynn Gillam

For example, take two individuals with an XXY karyotype, one who clearly identifies as male, the other who does not identify as female, but who views the XXY-related breast development as a part of who they are, not as a symptom. In these examples, KS is an appropriate diagnosis for the first individual, but may not be for the second.

To provide patients with the most appropriate care and treatment, it is important to understand these potential differences amongst those diagnosed with an XXY karyotype. The role of testosterone replacement therapy in KS has numerous benefits, both medical and psychosoci (Simpson *et al*., 2003*)*.

For some men, especially those who have not fully virilised in puberty, it can be life-altering treatment. The reality, however, is that it may not work for everyone, and especially for those individuals who may not consider themselves female, but do not wish to me more 'male' either.

While it may be argued that choosing not to have testosterone treatment could have a number of negative long-term medical consequences (Bojesen and Gravholt; Maggi *et al*., 2007), this may not be the most important consideration for those who feel they are being medicated to change them into people they do not feel themselves to be.

This situation is unlikely to present major problems for fertility specialists, who usually see men in heterosexual relationships seeking reproductive advice. It is possible, however, that not all individuals, especially those who are diagnosed outside this context, will identify with typical notions of gender, sexual identity and, therefore, masculinity (Noble, 2003).

As awareness of KS and other sex chromosome variations grows, it may become more important that these distinctions are clear,and that the spectrum of possible human variation is reflected in the medical information available to families and the general public. There are two reasons for this; the first is so that people with XXY who do not identify as male are not considered 'weird', and so that informed decision-making regarding the most appropriate regime for them is encouraged. The second reason is that men with KS are not constantly struggling to dispute beliefs that they are intersex, or half female, which is a common messgae among media reports, and can be a source of uncertainty, stress and shame for these men (Herlihy *et al*., unpublished data).

Ultimately, we decided that the goal of our research was to look at KS as a genetic condition affecting males, and not just the karyotype XXY, which may manifest in different ways for a small number of people. With little evidence in the literature to guide clinicians as to the gender profiles of people with XXY, the best practice to approach each patient with an open mind (Gillam *et al*., 2010). This, issue, however, needs further exploration. Should individuals with an XXY karyotype who do not identify as male be considered to have KS? In addition, how should individuals with an XXY karyotype who do identify as male, but do not wish to become more masculine, be informed of the possible consequences of lifeliong testosterone deficiency, while maintaining respect for the patient's choice? This is an area of

endocrinology that would benefit from further discussion and collation of clinical experience. Research into the range of karyotypes and their possible corresponding phenotypes, in addition to the current difficulties experienced by these people, would be beneficial.

References

Bojesen A & Gravholt CH. (2007) Klinefelter syndrome in clinical practice. *Nat Clin Pract Urol* 4, 192–204.

Bojesen A, Juul S & Gravholt CH. (2003) Prenatal and postnatal prevalence of Klinefelter syndrome: a national registry study. *J Clin Endocrinol Metab* 88, 622–626.

Gillam L, Hewitt J & Warne G. (2010) Ethical principles for the management of infants with disorders of sex development. *Horm Res Paediatr* 2010; doi: 10.1159/000316940.

Girardin CM, Deal C, Lemyre E, Paquette J, Lumbroso R, Beitel LK, Trifiro MA & Van Vliet G. (2009) Molecular studies of a patient with complete androgen insensitivity and a 47, XXY karyotype. *J Pediatr* 155, 439–443.

Herlihy AS, McLachlan R, Cock M & Halliday J. (2010) The prevalence and diagnosis rates of Klinefelter syndrome: an Australian comparison. [In press.]

Jacobs PA & Strong JA. (1959) A case of human intersexuality having a possible XXY sex-determining mechanism. *Nature* 183, 302–303.

Klinefelter H, Reifenstein E & Albright F. (1942) Syndrome characterized by gynecomastia, aspermatogenesis without a-leydigsm and increased secretion of follicle-stimulating hormone. *J Clin Endocrinol Metab* 2, 8.

Maggi M, Schulman C, Quinton R, Langham S & Uhl-Hochgraeber K. (2007) The burden of testosterone deficiency syndrome in adult men: economic and quality-of-life impact. *J Sex Med* 4, 1056–1069.

Noble M (2003) Representations of Klinefelter Syndrome (revised 2010). Accessible from http://oiiaustralia.com/media/articles/representations-klinefelter-syndrome/.

Simpson JL, De La Cruz F, Swerdloff RS, Samango-Sprouse C, Skakkebaek NE, Graham JM Jr et al. (2003) Klinefelter syndrome: expanding the phenotype and identifying new research directions. *Genet Med* 5, 460–468.

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The Women's Group meets for discussion and mutual support, and the sharing of experiences and opinions.

The meetings are normally held on the last Monday of each month at the Gender Centre from 1.30 to 3.30 pm.

October 29: Anthony Carlino on "Bullying".

Katherine Cummings, Convenor

OVER 55's GROUP

A Mature Person's Group

Thursday 11th October.

Discussion Topic: **Our Hobbies and Leisure Activities Through Life; have they changed with Transition or age?**

Led by Phia.
Location - Gender Centre
1.30pm-3.30pm

Thursday 8th November

Discussion Topic: **Evolution to a Woman. The discussion will be preceded by a major presentaion titled "The Evolution of Jessica"**.

Led by Jessica
Location - Gender Centre
1.30pm-3.30pm

Thursday 13 December
Lunch as an end-of-year- gathering

Location - Petersham RSL
12.30pm onwards
NB Note the change of time and venue!

This Group provides an opportunity for the sharing of experiences and talking about our future goal as individuals.

Come and enjoy participation in this interesting Group.

The Michelle Kosilek Decision: More Than the Needs of One by Matt Kailey [tranifesto.com/2012/09/06]

Michelle Kosilek, a convicted murderer in a Massachusetts jail, has caused some controversy in both the transgender and general population. Kosilek by winning her appeal for her reassignment surgery to be paid for by the State, based on the Eighth Amendment (which forbids "cruel and unusual punishment"). This column comes from FTM Matt Kailey's always interesting and often brilliant blog called Tranifesto and has some relevance to Australian convicts and their rights to publicly-funded treatment for their gender issues.

Matt says:

I recognise the anger and frustration of those who have worked three jobs, sold their possessions and still can't afford to pay for this surgery They think, "I have been a law-abiding citizen all my life and I can't afford the surgery, but a convicted murderer can get it for free? How fair is that?"

Probably not all that fair, actually. But in my opinion, the Michelle Kosilak decision is about far more than one person - one murderer, even - getting her transition surgery covered by the State. I think there are some points that we have to look at with regard to this decision, all of which take Kosilek out of the equation entirely.

1. First of all, we have to examine whether or not Federal or State governments should pay for medical care for their prisoners. If the answer is yes, then the decision could go no other way. If transition is, in fact, medically necessary and if, in fact, a civilised government provides health care to those whom it incarcerates, the the government must provide medically necessary care to all its prisoners. It cannot discriminate on the basis of some false morality, or on the "worthiness" of the individual receiving the care. We either treat our prisoners humanely or we don't, and providing necessary health care is the humane thing to do. It's not a matter of who "deserves" it and who doesn't. It's a matter of whether or not we are going to provide it to those prisoners who are medically eligible - period.

2. Next we have to look at legal decisions that work in our favour as trans people. Regardless of the unpopularity of this decision among some in the trans community and some in the general public, the fact is that any legal decision upholding the view that transition surgery is a medical necessity can only benefit us in the long run.

The more legal rulings we have under our belt, the closer we get to eliminating this whole "choice" misconception, the closer we get to insurance coverage for transition procedures, and the closer we get to transition being seen as a medical, rather than a psychiatric, solution for a medical, rather than a psychiatric, condition.

3. And finally, we have to weigh the significance of this decision against the possible setback it represents for us in the minds of the general public. Certainly it can, and probably will, have some negative repercussions with regard to the "hearts and minds" that we hope to change. But hearts and minds are always slow to come around. And they can turn on a dime when something like this happens.

For these reasons, legal intervention must often come first. Then if the hearts and minds don't change, it doesn't matter as much, because the law is working for us. And when the law recognises us as legitimate human beings with legitimate human rights, that often *does* serve to change hearts and minds over time. At the very least it forces the hands of those hearts that are resistant.

So, while I completely understand the arguments, anger and animosity within our own community regarding this controversial decision, I think we have to put Kosilek as an individual aside and look at the larger picture with regard to what this means to us as trans people and this means for a larger society that either will or will not provide necessary medical services to everyone in its care - no judgement calls and no exceptions. ❑❑❑❑❑

Mariela Castro Comes to Town

by Katherine Cummings

Mariela Castro, who is the daughter of Raul Castro, President of Cuba and Vilma Espin, feminist and revolutionary, has concerned herself with sexual health matters and the rights of women and LGBT in Cuba for a number of years. She will be visiting Australia in October as a guest of the Australian Government.

She has campaigned for AIDS prevention and for the recognition and advancement of homosexuality, bisexualism, transvestism and transgender human rights.

Ms Castro is Director of the Cuban National Center for Sex Education of Havana and President of the Cuban Multidisciplinary Centre for the Study of Sexuality, President of the National Commission for Treatment of Disturbances of Gender Identity, a member of the Direct Action Group for Preventing, Confronting and Combatting AIDS and an executive member of the World Association for Sexual Health (WAS).

She is a also a director of the journal *Sexologia y Sociedad* and has published thirteen scholarly articles and nine books.

One of Ms Castro's most significant revisions from the transgender point of view was a bill to legalise gender reassignment surgery and hormonal therapy as well as providing new documentation appropriate to their affirmed gender. Since June 2008, Cubans diagnosed as gender dysphoric have been able to obtain free state-sponsored gender affirmation surgery.

We thought that Mariela Castro was offering the hand of friendship to Barack Obama, but it turned out that she was demanding the return of five Cuban intelligence agents, jailed by the United States ... a feisty lady!

For some years, Cubans and visitors to Cuba who were HIV-positive were re-stricted to treatment centres. These laws were relaxed in 1989 to allow movement between treatment centres and home.

There is still public antipathy towards GLBT Cubans, fuelled by social mores and religion, but due significantly to the efforts of Ms Castro, reform is taking place.

Ms Castro is also campaigning on behalf of marriage equality.

Please note the ad. on p. 10 for the lecture to be given by Ms Castro at the University of Sydney on 16 Oct.

Transgender Day of Remembrance November 20

Observance of the Transgender Day of Remembrance sponsored by the Gender Centre and the City of Sydney will this year again be held in Parliament House, in the Macquarie Room, on Tuesday, November 20, commencing at 10.00am for 10.30am and concluding at 12 noon.

There will be invited speakers and those present will be invited to contribute relevant experiences from the floor. We will be glad to receive suggestions for the conduct and content of the proceedings. All welcome. Light refreshments will be served.

This year the use of Parliament House is being sponsored by politicians representing the Labor party, the Nationals and the Greens.

Katherine Cummings, Convenor ***[resources@gendercentre.org.au]***

The Counsellor's Column

by Anthony Carlino

I recently included in the Transtopia youth group the topic of bullying and how best to deal with it. While bullying is often thought of as an experience most likely to be encountered by children and adolescents, it is also a reality in adult life for those unfortunate enough to encounter adult bullies. We know that bullies exist everywhere - in our school system, in universities and workplaces.

Probably the widest and most inclusive definition is that bullying is any act or words that make another person feel less than who they truly are. Most people are likely to experience bullying which is characterised by a number of examples including but not limited to:

*Mocking

*Putting someone down

*Making threats

*Belittling

*Ignoring

*Intimidating someone

*Physical Violence

While most workshops focus on the valid importance of how to deal with a bully, many of them fail to address an important reality for many victims - namely that advising a victim of bullying to "ignore" the bully is often impractical (especially if you see them regularly) and more importantly it does not make them stop.

It is important to realise that even a single act can be bullying and have a massively detrimental effect to someone's mental health. The effects of bullying are the same for children and adults. Often though, it is more difficult for adults to talk about how they feel or report it. Sometimes even when an adult commits suicide due to the cumulative effects of bullying, family or loved ones might not even know the person was being bullied at all.

Never forget that bullying is a crime and bullies are criminals. Their actions, whenever practical and possible, need to be reported and action taken. Suicide is a very real outcome for some victims of bullying and as such its incidence needs to be taken seriously both in terms of getting support for the victim AND the bully.

Anthony Carlino

On October 29, starting at 1.30pm, I will be running a workshop during the monthly Women's Group at the Gender Centre, on bullying that focuses on the experience as adults. More specifically, I will seek to create a safe space for participants to discuss the following:

- Their own experience of bullying

- Who becomes a bully and why?

- How do I keep myself safe and stop the bullying?

- The digital and connected world - the new avenue for bullies.

I hope to see many friendly faces there and until then, I hope the world is smiling at you all!

Into The Mirror: A New FTM Play

Shelley Wall has written a new play that deals with problems brought on by the transgender protagonist, Sally, who transitions to become Kendall. Sally's daughter arrives home after eighteen months in Britain and resists the change ("I've already got a father. I want my mother at my wedding, not some freak.")

Penny Day as Sally/ Kendall

The play will be shown at the King Street Theatre, cnr King and Bray Streets, Newtown from 21 November to 16 December. Tickets: Full $33, Concession $28.

Bookings www.kingstreettheatre.com.au or call 9119 3739.

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PARENTS OF TRANSGENDER CHILDREN

The Gender Centre will be hosting an information and support group for parents who have children (any age) who are transgender or gender diverse).

Meetings will be held on the second Monday of each month from 6.00pm to 8.00pm. A clinical psychologist will co-facilitate these meetings.

A light supper will be available.

$500 To Be Given Away!!!

The Sex and Gender Diversity (SGD) Human Rights and Dignity Conference held in Sydney in December 2011 has $500.00 to give to a disabled person from one of the SGD groups.

To enter, send your name and eligibility and contact details to Tracie O'Keefe at:

info@tracieokeefe.com

The draw will be at the end of October.

Sex and Gender Education (SAGE) Needs You!

SAGE is a grassroots organisation that educates, campaigns and lobbies for the rights of **all sex and gender diverse people in Australia:** transsexual, transgender, intersex, androgynous, without sex and gender identity

Membership is FREE!

SAGE no longer sends out printed newsletters - instead we send out occasional news and updates via email, and also post news items, articles and documents on the SAGE website.

To join SAGE, and receive occasional news updates, go to

http://lists.cat.org.au/mailman/lisinfo/sage

and sign up to our low-volume mailing list
For more information visit our website
www.sageaustralia.org

SAGE - campaigning for your rights!

Barbecues and other events 2012

Xmas Barbecue,
Dec. 8, Noon - 4.00pm
Joseph Sargeant Community Centre
60 Prospect St, Erskineville
Watch the Gender Centre Website, Twitter and Facebook for details

News Items of Interest

"MATRIX" DIRECTOR COMES OUT AS TRANSGENDERED

Larry Wachowski

Larry Wachowski, director of the three Matrix films, has come out as transgendered and will from now on be known as Lana Wachowsky.

Lana outed herself in a promotional video about her new film "Cloud Atlas" which is said to include amazing special effects and a cast of well respected British actors, including Jim Broadbent and Hugh Grant.

Lana's wife filed for divorce in 2002 after her then husband was photographed in an S&M club in Los Angeles.

Lana Wachowski

The only possible film-director claimant to being 'out' before Lana is Ed Wood, who may or may not have been transgendered but certainly took a number of cross-dressed roles.

SA TO DEVELOP NEW STRATEGY FOR LGBTIQ

The South Australian Minister for Social Inclusion, Ian Hunter, has announced the establishment of an advisory council to deal with issues relating to the LGBTIQ community and the initiation of a survey for LGBTIQ South Australians.

The Council is designed allow participation in discussions and provide advice on policies, programs, services and processes for LGBTIQ within Government.

Ian Hunter

The Department is seeking sixteen representatives from the LGBTIQ community to become members of the advisory council, which will report directly to the Chief executive of the Department for Communities and Social Inclusion. The council will meet at least six times over the next eighteen months.

Hunter also suggested that people log on and complete the online Rainbow Survey (*www.sa.gov.au/lgbtiq*), targeted towards LGBTIQ South Australians and intended to create topics for discussion by the council.

FEDERAL GOVERNMENT FUNDS PROJECT FOR AGEING LGBTI

Mark Butler

The Hon. Mark Butler, Minister for Mental Health and Ageing put out a press release on 24 July predicting a large increase in demand for aged care service for LGBTI clients. He stated that it is important to recognise LGBTI in the same way as the needs for other diverse groups are recognised, for people from culturally and linguistically diverse communities.

Butler said that the Federal Government will work with the LGBTI Health Alliance to develop a comprehensive strategy to ensure that the needs of LGBTI Australians are addressed, and forecast a $3.7 billion aged care reform package. In April Butler had announced $2.5 million to support staff training sensitive to the needs of ageing Australians in these communities.

Mark Butler said the project was no different from offering appropriate services for migrant retirees from non-English speaking background, or for indigenous senior citizens.

The Shadow Treasurer, Joe Hockey, derided the idea of funds to train carers for LGBTI residents of facilities for the aged, calling it "silly" and a waste of money.

He suggested that the Coalition, if elected, would cancel the funds. He did not respond to questions about the parallel with aged care for similar groups

Joe Hockey

NEEDLE EXCHANGE

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PETERSHAM
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Monday to Friday
A confidential free service for people with gender issues *(Ask for the Outreach Worker)*

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Water
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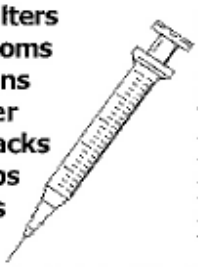

Syringes
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or phone the Alcohol and Drug Information 24 hr advice, information and referral service. Sydney 02 9331 2111
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Pay-It-Forward Binder Program

is a used binder serice that provides used donated binders to:

***** guys in the Australian and New Zealand region who need a chest binder and are struggling financially or cannot obtain a binder through regular channels e.g.: Centrelink recipients, students, individuals who do not have an income, or do not have the support of their families to access binders.**

The aim is to alleviate some of the dysphoria experienced by FTMs and to improve their quality of life.

The Pay-It-Forward program accepts donated binders, which are cleaned, sized and passed on to those in need.

The service is based on honesty and should not be accessed by those who are just looking to save money.

Our website is:

http://binderprogram.ftmaustralia.org or you can email: binderprogram@ftmaustralia.org

FTM Australia

2012

FTM Australia is a membership-based network which has offered contact, resources and health information for men identified *female* at birth, their family members (partners, parents, siblings and others), healthcare providers and other professionals, government and policymakers since 2001.

Newsletter

Our newsletter - *Torque* is published four times a year for the benefit of members, their families and service providers. *Torque* is available as a pdf document which is emailed to you or available on our website. All the information about *Torque* is on the website at *www.ftmaustralia.org/resources/torque.html*

OzGuys Discussion List

Our e-mail discussion list is called OzGuys.

OzGuys - is open to FTM Australia members living in Australia and New Zealand.

Goals of the discussion list include:

- To encourage friendships and information sharing amongst members
- To empower members and their families in understanding transsexualism
- To encourage members to adopt positive images of being men in society and achieve anything and everything they dream of.

For more information please visit *http://groups.yahoo.com/group/ozguys/*

To find out more or read our resources please visit our website at *www.ftmaustralia.org*

LGBT and Mental Health Nursing Care

by Trish Kench RN, BN, BSc.Psych (Hons), Grad. Dip. Mental Health Nursing, MA

Trans and other sexuality and/or gender diverse-identified (LGBT) people[1] experience higher than average rates of some mental health issues. It is not surprising that ongoing and widespread socio-cultural stigmatisation and marginalisation can have enduring personal consequences.

These include anxiety and depression - up to and including suicidality. What may be surprising is that it is not uncommon for LGBT people who access mental health services to report the experience of active discrimination and consequently unsatisfactory care. Readers may remember the ads in recent issues of *Polare* that invited mental health nurses to participate in my research into what sort of mental health nursing care we provide to LGBT people and how we might contribute to improving the care experience. This article provides a brief and preliminary look at the progress of the research project.

Trish Kench

Bad environments contribute to bad health. Marginalised social status, poor social support structures and abuse ranging from verbal attacks up to a lifetime experience of oppression and the possibility of being murdered are the kinds of psychosocial health determinants with which LGBT people are familiar - at the very least as sub-cultural anecdotes and, for many, from personal experience (e.g. Dysart-Gale, 2010).

The most commonly reported associated mental health problems for LGBT people include substance misuse, depression, and stress and anxiety disorders (e.g. Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002). It is important to remember that identification as being sexuality and/or gender diverse is not the problem.

Some LGBT people attribute their mental health issues to psychosocial problems associated with their sexuality and/or gender. Examples include the gay person who internalises social stigmatisation as self-hatred, or the trans person who becomes seriously depressed having been rejected and ostracised by family and friends. It should also be noted that unrelated mental health problems such as schizophrenia can also affect LGBT people. Such people can be doubly stigmatised. Not only do they represent a marginalised socio-cultural sex/gender minority, they can also be rejected by, and isolated from, other LGBT people who, like elements of the rest of the population, stigmatise them for being mentally unwell.

Negative experiences of mental health care reported both anecdotally and in the health research literature by LGBT people include various expressions of homonegativity on the part of health professionals (Fish, 2006). Obviously this is counter-productive to delivering better health outcomes in a system that describes itself as providing holistic, individualised care.

Predictably, the consequences of continuing to experience stigmatising and discriminatory behaviour in health care environments include LGBT people feeling unsafe, invalidated and unsupported (Platzer, 2006). But then, how could a care environment be therapeutic for individuals who fear to disclose important aspects of their lives? Even if sexuality and/or gender diversity is of no immediate relevance, recognition, understanding and accommodation of sub-cultural aspects of a person's life will need to be incorporated into mental health recovery plans to improve their quality of life.

Typically the behaviour of individual health professionals is singled out for criticism by LGBT people, perhaps because subjectively people interact with other people, not systems. Little is written about the lack of organisational or institutional support for staff that could, perhaps, counteract the attitudes and behaviours they bring into the health care milieu from the wider, discriminatory socio-cultural environment. Similarly, there is very little support for LGBT people at the level of health policy that could require and inform competent health care practices[2].

There is a lack of guidance and a limited supply of educational materials available for the members of multi-disciplinary health care teams to help them to become better informed on how to support competently LGBT people. For example, in my own profession, neither the Royal College of Nursing Australia nor the Australian College of Mental Health Nurses (ACMHN) provides specific guidance on how best to support LGBT people who access health services.

My aim with the current qualitative research project is to explore the role and views of the mental health nurses who provide care to LGBT people. Mental health nurses work in the full range of mental health services available in Australia, yet they have not previously been asked to contribute to research on this topic. In this project, participants have been asked to reflect on their practice experience in working with LGBT clients and to suggest what institutional and organisational improvements they believe might improve the experience of care for LGBT people.

To date, there are nineteen mental health nurses participating in this research. Their expertise ranges from having spent years and even decades in mental health nursing in a variety of health care environments, ranging from community case management to crisis intervention as well as acute and chronic in-patient care. They include several nurses who responded to the ads in *Polare*.

Project participants are a diverse bunch of dedicated and determined clinicians who personify the ACMHN values of honesty, caring, trustworthiness and the pursuit of excellence. They are of many ages, genders and sexualities and other socio-cultural differences. They are city- and rurally-based, Indigenous and non-Indigenous, non-English-speaking and English-speaking migrants and people born in Australia.

They identify as lesbian, gay, bisexual, transgender, heterosexual and other. Their participation has required an intensive involvement and a major commitment of time and energy, including lengthy semi-structured interviews, taped group discussions, and the review of interviews and group discussion transcripts.

As health care professionals, the mental health nurses in this project see themselves as responsible for the development of therapeutic alliances with individuals. They describe tailoring their care to suit individuals' needs and working with the over-arching objective of helping people to improve their quality of life. It is still early in the research process, yet some interesting themes are emerging. As might be expected there were some differences between the thoughts expressed by the LGBT participants and by the heterosexual participants.

Many of the heterosexual nurses in the project struggled with the idea that it is not unusual for LGBT people to report feeling unsafe and unsupported and therefore reluctant to disclose their sexual and/or gender diverse status. It was well recognised by these research participants that such reluctance would compromise their ability to develop a therapeutic alliance with clients.

Many were able to recall instances where the behaviour of a colleague had made them pause for thought. Yet, seeing themselves as caring, competent professionals, they could not see their own practice as potentially problematic. Sometimes we know that we are dealing with something about which we know little; other times we do not know that we do not know (Ehrlinger, Johnson, Banner, Dunning, & Kruger, 2008).

In the private interview stage of the research, the participating nurses expressed their intention to reflect on their practice, and on the processes and structures in their workplaces that might need to be changed to promote a more inclusive therapeutic approach that was conscious of LGBT people's issues with health care.

Several nurses spoke with frustration about having limited access to relevant information and suitable sources of referral for their clients.

Some also expressed discomfort in caring for trans people - not because they felt negatively towards them but rather because they knew

themselves to be unfamiliar with, and ignorant about, any trans-specific needs. These nurses also tended to comment that while they knew and worked with and cared for LGB people, they very rarely had the opportunity to interact with the much smaller population subset of trans people and that this contributed to their unfamiliarity with trans needs.

These ideas translated in the group discussion stage of the research into a recognition that what is missing is readily available information that could be used to support culture-specific needs of LGBT people, and also education materials that would enable a more nuanced approach to caring for LGBT people.

The LGBT nurses who participated in the project described their own efforts to educate their colleagues and create culturally welcoming and inclusive environments. Some spoke of their own struggles in working with homonegativity - up to and including their own fears of disclosure and the experience of being bullied.

Their strategies range from advising peers when their comments or practices appear discriminatory to ensuring their workplaces are stocked with relevant brochures and pamphlets from LGBT peak bodies.

In the private interviews several commented that they worried that giving the impression that a mental health care environment was inclusive - for example, by having information materials on display - could give misleading impressions to LGBT people that they would be dealing with culturally competent service providers when this was not necessarily so.

This idea was integrated in the group discussions with the consensus view that education for health care professionals in how to provide culturally competent care to LGBT people should be mandatory.

Participants formed the view that education should be included in course curricula at the university and college level and supported in workplace training programs.

They concluded that these programs should be mandatory for all the members of the multi-disciplinary health care team because of the importance of the topic, the high turnover of health staff, and the increasing inclusion of culturally diverse migrants in the health workplace.

Participants also commented that leadership was required at the level of national and state governments' health policies and from nursing representative bodies such as the Australian College of Mental Health Nurses to ensure provision of the resources necessary to support such training and education.

The research project is ongoing. I am up to the stage of collating and analysing the results of interviews and group discussions. At this stage it appears that a belief in the need for education and the development of political support to develop practice guidance and an appropriate allocation of organisational resources to support mandatory workforce education are the predominant views of the research participants. The idea that this education should focus on teaching people how to respond helpfully to cultural difference rather than simply arming them with facts and figures about particular cultural sub-groups demonstrates the nurses' commitment to providing therapeutic individualised care to LGBT people who need to access mental health services.

References

Dysart-Gale, D. (2010). Social Justice and Social Determinants of Health: Lesbian, Gay, Bisexual, Transgendered, Intersexed, and Queer Youth. *Canada Journal of Child and Adolescent Psychiatric Nursing*, 23(1), 23-28.

Ehrlinger, J., Johnson, K., Banner, M., Dunning, D., & Kruger, J. (2008). Why the unskilled are unaware: Further explorations of (absent) self-insight among the incompetent. *Organizational Behavior and Human Decision Processes*, 105, 98-121.

Fish, J. (2006). *Heterosexism in Health and Social Care.* Basingstoke: Palgrave.

Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *British Journal of Psychiatry*, 180, 423-427.

Platzer, H. (2006). *Positioning Identities: Lesbians' and Gays' experiences with Mental Health Care*. Edmonton: Qual Institute Press.

Endnotes

1. I acknowledge that the terminology used to identify and describe people of diverse sexual identification, sexual orientation and gender is likewise diverse - and disputatious. I also recognise that the acronym LGBT implies a commonality of issues and a coalition of purpose that may not exist among the various groups and individuals who have an interest in the field.

I am using the acronym LGBT because it is inclusive and historically familiar. Finally, the 'I' often used to signify an at least nominal inclusion of issues relevant to intersex people is perhaps noticeable by its absence. This is because a consideration of the issues faced by intersex people who access mental health services is not included in this research project.

2. This situation is the current focus of national policy discussions and readers are referred to the work of the National LGBTI Health Alliance *www.lgbthealth.org.au* for further information.

Trish Kench

Mental Health Nursing Care

with people of diverse sexuality and/or gender

Research Project

What do you think?

As a mental health nurse, what is your role in caring with people of diverse sexuality and/or gender (S/G)?

S/G diverse people often experience marginalised social status and poor social support. They also experience higher than average rates of mental health problems such as anxiety and depression, up to and including suicidality.

Are S/G diverse people disadvantaged in mental health services - for example, because they are minorities, or because care providers do not feel knowledgeable about their issues?

AIM This research explores the role of the mental health nurse in caring with S/G diverse people. Nurses who participate in the research will have the opportunity to reflect on and gain alternative perspectives to develop their practice. They will also have the opportunity of sharing their ideas on how institutional settings and organisational environments might usefully be modified to improve the care experience.

YOU are invited to participate, whatever your own sexuality and/or gender. This project has ethics approval from the University of Canberra Human Research Ethics Committee.

If you would like to participate please contact me via the details below:

Trish Kench, RN, BN, BScPsych, Grad. Dip. Mental Health Nursing
Tel: (02) 6563 1789 Mob: 0431 833 634
Email: trish.kench@internode.on.net

UNIVERSITY OF CANBERRA
AUSTRALIA'S CAPITAL UNIVERSITY

Change of Mailing Details?

☐ Different Name?

☐ Different Address?

☐ Different gender?

☐ Don't want *Polare* any more?

My OLD details:

My New details:

Mail to: The Editor, Polare, PO Box 266, Petersham, 2049

RPA SEXUAL HEALTH CLINIC

25 Lucas Street, Camperdown, NSW, 2050 BUT SEE COLUMN ON RIGHT

WHAT DOES THE SEXUAL HEALTH CLINIC DO?

- ☐ Testing, treatment and counselling for sexually transmissible infections, including HIV
- ☐ Gay men's sexual health check-ups
- ☐ Sex worker health checks
- ☐ Men's and women's sexual health check-ups
- ☐ Advice on contraception
- ☐ Pregnancy testing and counselling
- ☐ Free condoms and lubricant
- ☐ Needle and syringe program and sexual health check-ups for people who inject drugs
- ☐ Hepatitis testing and vaccination
- ☐ Post-exposure Prophylaxis (PEP) for HIV

WHAT HAPPENS WHEN YOU VISIT THE CLINIC FOR THE FIRST TIME?

You will be asked to fill out a registration form.

The information you give us will remain confidential and will be put in a numbered file. Keep this number and quote it for any test results and when making future appointments.

A nurse will determine whether you need to see a doctor or nurse for a medical issue or a counsellor to discuss information on sexual health, safer sex or relationship issues.

SOME COMMONLY ASKED QUESTIONS

Do I need an appointment? *Yes, appointment is preferable.*

Do I need a Medicare card? *No, you don't need a Medicare card.*

Do I need to pay? *No, all services are free.*

Do I need a referral from a doctor? *No, simply call 9515 3131 for an appointment.*

(Interpreters available)

NOTE!!

RPA Sexual Health is moving to new premises at 24 Marsden Street, Camperdown, NSW, 2050

The new clinic phone number will be:

(02) 9515 1200

Clinic bookings will close from Wenesday 3 October 2012 and will reopen in the new premises on Wednesday 10 October 2012

For more information on our services see:

www/slhd.nsw.gov.au/CommunityHealth/pdfs/Central/RPASH.pdf

or call the NSW Sexual Health Infoline 1800 451 624

Central Coast Transgender Support

The CCTS is a totally free and unfunded service to all with gender issues. It offers guidance to all who are contemplating commencement of the medical and psychological requirements that are involved in full MTF transition under the Harry Benjamin Standards of Care.

The Centre also provides access to high quality, subsidised and certified permanent hair removal and offers alternative direction and instruction for the control and management of problem hair or chronic hirsutism.

CCTGS operates Monday to Saturday 10am-10pm

0404 054 000
Email:smh101@exemail.com.au

Hepatitis C Update by Maggie Smith

Hepatitis C is an infectious disease affecting the liver, caused by the hepatitis C virus (HCV) which is passed from one person to another through blood to blood contact. (i.e. sharing needles or injecting equipment or through unsafe tattooing or piercing methods).

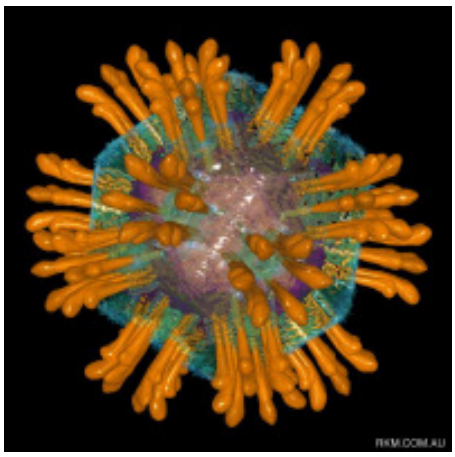
Acute hepatitis C refers to the first six months after infection. Between 60% to 70% of people infected develop no symptoms during this acute phase. In the minority of people who experience acute phase symptoms, they are generally mild and nonspecific, and because of this rarely lead to a specific diagnosis of hepatitis C.

Chronic hepatitis C is defined as infection with the hepatitis C virus persisting for more than six months.

The virus persists in about 85% of people infected. Chronic infection can progress to scarring of the liver (fibrosis), and advanced scarring (cirrhosis) which is generally apparent after many years. In some cases, those with cirrhosis will go on to develop liver failure or possibly liver cancer.

Hepatitis C is tested for with a blood test. The first part of testing is an antibody test. If this is positive a hepatitis C viral load / PCR test and genotype will be done.

There are six main genotypes (strains) of hepatitis C. Each genotype contains numerous subtypes, labeled a, b, or c. Genotypes 1a and 1b (55% prevalence) and 3a (37% prevalence) are the most common genotypes in Australia.



hep C virus

In Australia, it is estimated that approximately 291,000 people have been exposed to the hepatitis C virus and have hepatitis C antibodies, of whom around 217,000 were living with chronic hepatitis C.

Current Treatment for HCV is normally 'combination therapy" which is pegylated interferon and ribavirin. Pegylated Interferon can be given on its own, "monotherapy", but combination therapy has a higher success rate. Treatment is interferon given as an injection subcutaneously, (under the skin into the fat) once a week and taking ribavirin tablets daily for 6 or 12 months. The length of treatment depends on the genotype infecting a person .

Being a current injecting drug user does not prevent a person from going on treatment. The main thing for a person still injecting drugs is to be mindful that treatment can clear the strain of virus they are infected with, but if injecting habits still expose a person to a blood-borne virus, it is possible to be infected with another strain of HCV.

It's also important for a person to be aware that treatment needs to be continuous. Which means there has to be the commitment that once a person starts treatment they need to stay on it. Be aware of the possible side effects of treatment, some people have no side effects, some get mild flu like symptoms and others may get possible emotional disturbances like being short tempered, tired or depressed. These side effects may only last for the first few months of treatment or they may continue for the whole time a person is on treatment. As a rule these side effects stop once a person completes their treatment.

There are two new drugs most likely going to be available in Australia by the end of next year and a number of others in final stages of research for the treatment of hepatitis C. The two new drugs will be used in conjunction with the current combination therapy. They will not totally change hepatitis C treatment; they will, however, shorten the length of treatment and increase the chance of a cure for people with genotype 1.

The two new drugs are called Incivek (telaprevir) and Victrelis(boceprevir). They are both a type of drug called protease inhibitors. A problem with the current types of treatment is that the drugs do not specifically target HCV. Interferon stimulates the immune system and

ribavirin is an antiviral, but not specifically for HCV.

Protease inhibitors are directly acting antivirals and Incivek (telaprevir) and Victrelis (boceprevir) directly target the reproduction of HCV. They inhibit (block) HCV cells from multiplying.

Victrelis has been approved and has been released for public use by the TGA in Australia. It is yet to be listed on the Pharmaceutical Benefits scheme, so cost is still a problem for many people, but this is being reviewed. To access treatment talk to your doctor.

Summary:
* hepatitis C is a virus that causes liver inflammation and liver disease
* hepatitis C is spread through blood-to-blood contact
* it is a slow-acting virus, and for most people does not result in serious disease or death
* approximately 291,000 Australians have been exposed to hepatitis C virus and 217,000 are living with chronic hepatitis C
* there is a treatment for hepatitis C called Pegylated Interferon and Ribavirin
* viral genotype is the most important predictor of response to treatment
* there is no vaccination currently available for hepatitis C.

(Courtesy of Hepatitis Australia)
Useful and reliable websites are
Hepatitis NSW: *www.hepatitisc.org.au/*
and Hepatitis Australia:
www.hepatitisaustralia.com/
Hepatitis helpline number is 1800 803 990

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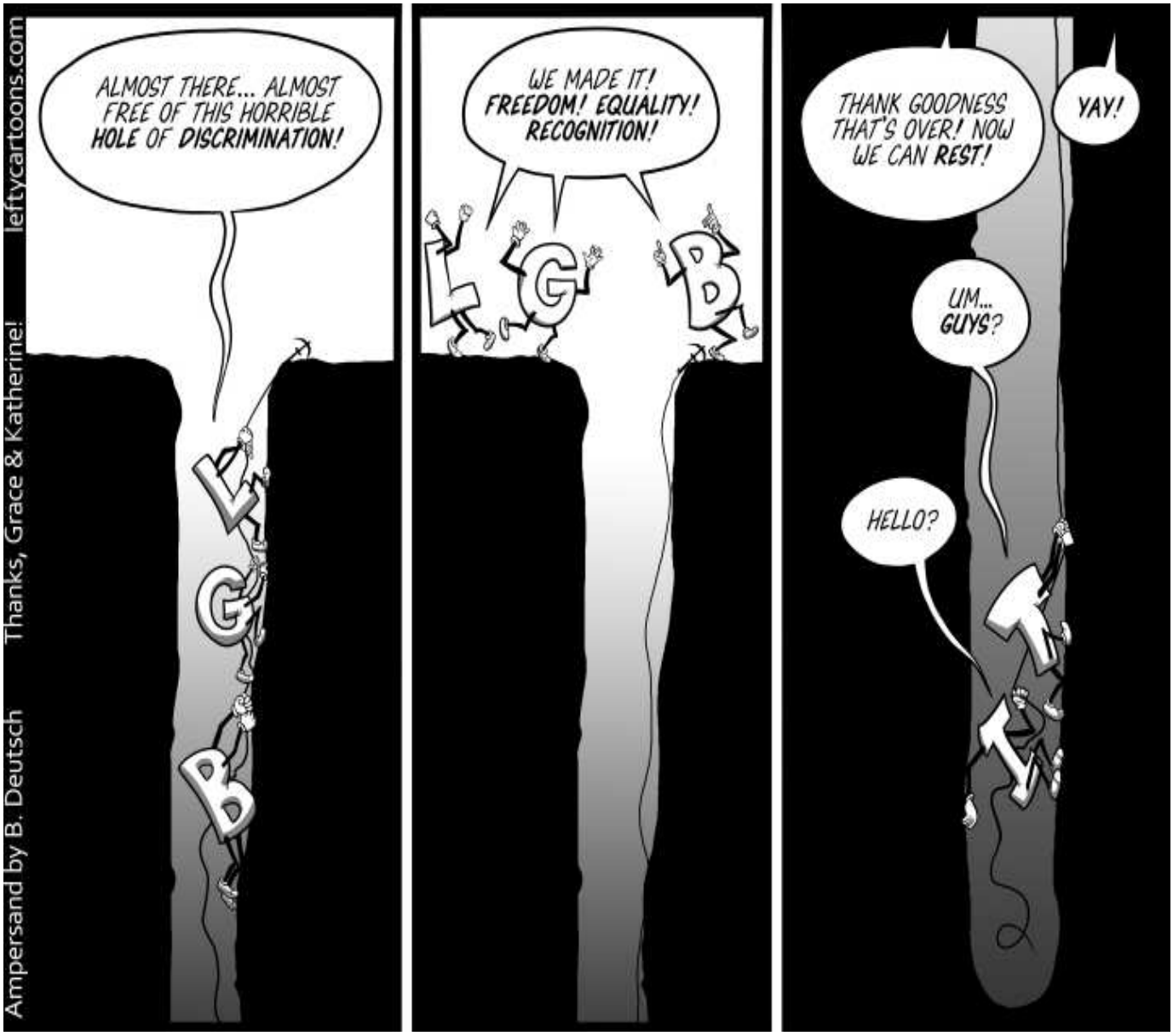


Transgender Anti-Violence Project (TAVP)

The mission of the Transgender Anti-Violence Project is to provide education, support, referrals and advocacy in relation to violence and oppression based on gender identity.

The Project addresses all forms of violence that impact on the transgender, gender diverse and gender-questioning community, including (but not limited to) domestic violence, sexual violence, anti-transgender harassment and hate crimes.

Transphobic crimes affect many gender-diverse people in Australia each year.

The Transgender Anti-Violence Project provides a range of free, confidential services and has already helped a number of people who have experienced incidents that include verbal abuse, physical attacks, bullying, harassment and discrimination.

The TAVP needs to know about your experiences to be able to help you personally and to document the event in order to stop it from happening to others.

What can I report?

You can report anything to the TAVP. Some examples follow:

- Physical assaults
- Verbal abuse and threats
- Sexual assualts
- Stalking
- Domestic violence
- Family violence

When making a report to the TAVP you will be asigned a support worker, to asess the nature and level of support you may require. The Project will then provide you with ongoing assistance and referral services, including support when reporting to police, counselling, legal support, court support and medical support and follow-up support.

To make a report, call the Transgender Anti-Violence Project on 9569 2366 or 1800 069 115 or report online at *www.tavp.org.au*

Do You Believe You Are Intersexed?

If so and you would like to know more and meet others like yourself then contact:

OII Australia [Organisation Intersexe Internationale]
at PO Box 1553, Auburn, NSW, 1835 or at:
oiiaustralia@bigpond.com
or visit our website at www.oiiaustralia.com

QUEENSLAND GENDER CENTRE

The Queensland Gender Centre is run solely by a transsexual in Brisbane, Queensland, Australia with the aim of assisting those in need of accommodation and assistance. It is open to all those who identify as transsexuals and who are mentally stable and drug and alcohol free.

The location of the shelter is kept confidential to protect the tenants. The accommodation is in an upmarket suburb on Brisbane's upper north side.

You can stay either up to six months or twelve months and we can house up to six people at a time.

If you want more information or are interested in assisting with the project, please telephone, write or email the Queensland Gender Centre. Contact details on the Directory pages.

PLEASE READ THIS!

If you are moving, or changing your email address, please tell us. Undeliverable copies of Polare waste money that could be used for other services.

The Gender Centre Has Joined Twitter!!!

For those who don't know, Twitter is an Internet text-based social networking system a bit like SMS. Messages are restricted to 140 characters but if you want to keep up to date daily (or more frequently) with what is going on at the Gender Centre, you can do so on Twitter.

Go to the Internet, and type in *www.twitter.com/thegendercentre* to see the latest Twitter news. Note that this is one-way information. You can't respond or ask questions on Twitter. If you need further information you will need to phone (02) 9569 2366

or email *reception@gendercentre.org.au* or *resources@gendercentre.org.au*.

LEGAL PROBLEMS?

The Inner City Legal Centre will be providing advice sessions for clients of the Gender Centre.

The ICLC can advise in the following areas:

family law | criminal matters | fines | AVOs | victim's compensation | employment | identity documents | police complaints | discrimination | domestic violence | sexual assault | complaints against government | powers of attorney | enduring guardianship | wills | driving offenses | credit and debt | neighbourhood disputes

Dates for 2012 have not been set but sessions will be held monthly. To make an appointment please contact a Gender Centre Staff member on 9569 2366 or email *reception@gendercentre.org.au*. Bookings are essential

Gender Centre Events, Workshops and Group Meetings May-Dec 2012

	May 2, 9, 16,23, 30 Yoga							
		Jun 19. hep C What does it mean for you?						
1.30pm		Jun 25 Women's Group	July 30 Women's Group	Aug 27 Women's Group	Sep. 24 Women's Group	Oct 29 Women's Group	Nov 26 Women's Group	
1.30pm **NB except Dec. see p.16**	May 10 Over 55 Group	Jun 14 Over 55 Group	Jul 12 Over 55 Group	Aug 9 Over 55 Group	Sep 13 Over 55 Group	Oct 11 Over 55 Group	Nov 8 Over 55 Group	13 Dec Over 55 Group
5.00pm	May 30 Youth	Jun 27 Youth Group	Jul 25 Youth Group	Aug 29 Youth Group	Sep 26 Youth Group	Oct 31 Youth Group	Nov 28 Youth Group	Dec 19 Youth Group
6.00pm		Jun 1 FTM Connect	Jul 6 FTM Connect	Aug 3 FTM Connect	Sep 7 FTM Connect	Oct 6 FTM Connect	Nov 2 FTM Connect	Dec 7 FTM Connect
6.00pm	May 14 Parents' Group	June 11 Parents' Group	Jul 9 Parents' Group	Aug 13 Parents' Group	Sep 10 Parents' Group	Oct 8 Parents' Group		

The Carmen Rupe Memorial Trust

The Carmen Rupe Memorial Trust (CRMT) is inviting transpeople with a passion for making a difference to join their Advisory Committee.

The CRMT is being established as a registered charity to further Carmen's interest in GLBTI education and social justice through philanthropy and community service. We are looking for talented, motivated people happy to work in a positive team environment to build an organisation capable of achieving great things in Carmen's memory.

The Advisory Committee will provide the Trustees with input on policy and strategy, will lead or coordinate projects initiated by the Trust, and will ensure the CRMT's decision-making processes are informed by the wider community through ongoing consultation. They are especially interested in hearing from members of the transgendered community, the wider GLBTI community and the Maori and Pacific Islander communities.

Former Gender Centre Counsellor, Elizabeth Riley, one of CRMT's foundation trustees, says:

"We're setting out to build a charitable organisation that will educate and empower transgendered people to take greater control of their own lives while helping others, ultimately to educate and engage the wider society in support of all gender-diverse individuals.

For further information please contact Kelly on 0452 454 965

A Call To Arms in the Spirit of Carmen Rupe

by Caitlin Hall, CRMT Advisory Committee

Can one person make a difference?

Carmen Rupe certainly thought so and through a remarkable life's work has left us a legacy of courage and inspiration - a road map to how one transgender person made a positive difference in the lives of so many and greatly empowered herself in the process.

Through political action and the power of celebrity, Carmen worked for decades to challenge the all-pervasive ignorance and occasionally brutal homophobia and trans-phobia common from the 1950s to the 1980s. Through volunteer work within the GLBTI community and for other disadvantaged groups, Carmen demonstrated the power of human kindness as a force for social change.

Understanding the potential of her legacy, Carmen's Will and Testament envisaged a charity that could continue this work - a volunteer-based organisation in Carmen's name that would harness the energy of the entire transgender community as a force for positive social change.

A small group of Carmen's friends and family have been very busy working to make Carmen's final wish a reality. Preparations are now under way to launch the Carmen Rupe Memorial Trust (CRMT) as a registered charity as part of the 2013 Sydney Mardi Gras Festival.

The main launch event will take place at Slide on Oxford Street on February 26th 2013. The CRMT's broader program launch will include participation in Mardi Gras Fair Day, creating a multimedia performance piece for Queer Thinking and once again entering a float in honour of Carmen in the Mardi Gras Parade, aiming to continue the success of the CRMT launch team's Carmen Sea of Love Float (pictured) in this year's Mardi Gras Parade, which was nominated for a 2012 Mardi Gras Award.

Helen Tapilau leads the CRMT float Mardi Gras 2012

A number of transgendered people have already come forward to help the CRMT by working on various committees and production teams. The CRMT is very keen to hear from others who may wish to get involved.

Former Gender Centre Counsellor Elizabeth Riley, one of the CRMT's foundation Trustees, wrote "We're setting out to build a charitable organisation that will educate and empower transgendered people to take greater control of their own lives while helping others, and ultimately to educate and engage the wider society in support of all gender diverse individuals."

The CRMT's primary aim will be the promotion of the principles of social inclusion and greater appreciation of human diversity and universal human rights in Australia, with a special focus on SGD and GLBTI related issues. To achieve this goal, the CRMT will design and implement strategies to improve the social status, social integration and social welfare of disadvantaged individuals and communities, both our own community and others who confront even greater problems. To this end, the CRMT Deed of Settlement, the legal instrument that defines how the charity will operate, has been carefully drafted to allow the long-term strategic focus of the CRMT the necessary flexibility to evolve as new ideas and energy are brought to the project by the broader community.

Garry Pammer, the Senior Partner at accounting firm Clark and Jacobs has taken on the important role of the CRMT's foundation Chairman to help navigate the Trust to full status as a registered

charity. Carmen's favourite niece Chanette Hemopo, who was the major beneficiary of Carmen's Will, is also a foundation trustee member of the CRMT trust.

Kelly Glanney, Carmen's long-time friend and neighbour who shared legal guardianship with Chanette during the period Carmen was unwell prior to her passing, now directs the CRMT Advisory Committee. This committee will provide the Trustees with input on policy and strategy, leading and/or co-ordinating projects initiated by the Trust and ensuring the CRMT's decision-making processes are informed by the wider community through ongoing consultation.

Kelly says that while several appointments are already made, a number of committee vacancies remain open to members of the trans-gendered community, the wider GLBTI community and the Maori and Pacific Islander communities.

Anyone similarly passionate about making a positive difference in the lives of others, is invited to contact Kelly on 0452 454 965.

Already the CRMT has created promising alliances with organisations such as the Community Brave Foundation *www.thecommunity/bravefoundation.org*), with whom the CRMT will be working to develop long term solutions to tackle and ultimately eradicate online bullying, homo/bi/transphobia and youth suicide. The CRMT has already initiated a number of its own projects, including one based on the idea that received broad support during the CRMT's community consultation process.

TransAction will become a service organisation operating under the auspices of the CRMT that will bring our community and its friends together in the spirit of Carmen to work on a range of community and charitable activities in a safe and supportive environment.

Community members can volunteer their time to be involved in various charity and community based projects, some that will benefit the GLBTI community directly and others that will support the broader humanitarian goals of the CRMT.

Two past presidents of Sydney Kiwanis, a global community service organisation, are currently helping the CRMT bring this idea to fruition. In keeping with CRMT's broader vision, a primary aim of TransAction will be to engage members of our community to become involved in activities that not only benefit society but will also empower participants, enabling them to develop a stronger social support network, build self-esteem, compassion and empathy while at the same time developing practical life and professional skills.

Carmen drew tremendous personal pride from opening her heart to others in this way, learning to rise above the hurt that is all too common in our community and reach out and touch the lives of others less fortunate in a positive and meaningful way.

Haka for Carmen, Mardi Gras 2012

If one person can make a difference, imagine what our community, working hand in hand can do.

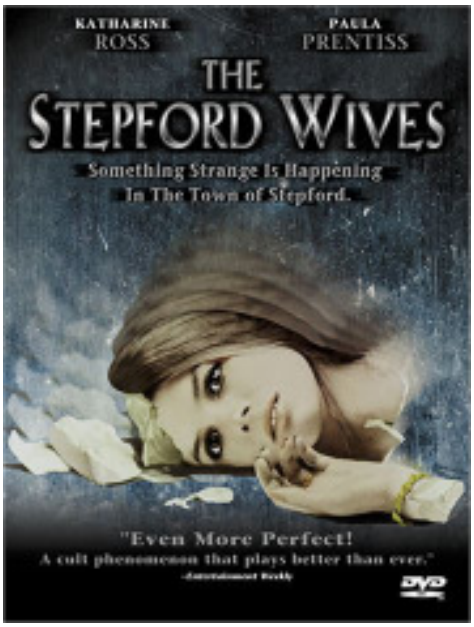
We now have an opportunity to honour the legacy of Carmen and bring our community together by opening our hearts to the healing power of love, not only for ourselves but also for this precious planet we all live on.

For further information on the CRMT contact Kelly Glanney on: 0452 454 965 or via email at *kmg@carmenrupe.org*.

Stepford Comes to the 21st Century: Preventing 'Masculinity' in Females by Matt Kailey, August 9, 2012

If you're too young to remember the original movie "The Stepford Wives", here's a brief synopsis. Women in Stepford love housework. They dress as it they're going to the Academy Awards just to go to the grocery store. They don't age, their boobs are firm and tghey love to have sex, even with their ageing, sagging husbands. And even with all the sex and glamour, they still keep their homes spotless.

The women in Stepford are ultra-feminine, according to the standards of the day (the film was made in 1975 from a book published in 1972).



The women do these things because the men have created robots that look just like their wives and have some of their wives' sensibilities but not all of them - not the ambitious, rebellious ones that make women want to pursue careers and maybe leave the breakfast dishes unwashed for a while.

For the times it was a movie that made a strong statement, and maybe that statement needs to be made again. A paper from Northwestern University's Feinberg School of Medicine, appearing in the *Journal of Bioethical Inquiry* and reported in the *Advocate*, claims that US physicians are "using a synthetic steroid to prevent female babies from being born with 'behavioural masculinisation', or rather a propensity toward lesbianism, bisexuality, intersexuality and tomboyism," [quoted from the *Advocate* report].

In other words, doctors are creating Stepford wives in the womb. Pregnant women who are at risk of having a child born with congenital adrenal hyperplasia (CAH), an endrocrinological condition that can result in female fetuses being born with intersex or more male-typical genitals and brains, are being given dexamethosone, a synthetic steroid, to try and "normalise" the development of those fetuses. Note that the report says women "who are at risk" of having a child born with CAH - the medication is being received by fetuses who do not have CAH and, even by male fetuses.

And even if the female fetus *does* have the condition it appears that little is known about the long-term risks to the women and unborn children treated with this drug. The doctors who are administering this drug, and the women who are accepting it, are obviously more concerned about the "feminin-ity" of these female children than they are about potential health hazards. I don't blame the pregnant women. Because of our culture's reverence for doctors, along with the woman's vulnerability (she wants to do what is right for her child), many of these women will listen to and do what their doctor says. Invoking fear in a pregnant woman by discussing 'problem' of having a 'masculine', lesbian or intersex daughter, could result in that woman agreeing to take an experimental drug, on the grounds that the doctor knows best. I don't even completely blame the doctors, although they are far more culpable than their patients. I blame the culture that insists that:

- ☐ 'Masculine' gender characteristics are superior to 'feminine' gender characterisitcs, but only to a point - and that point comes when a female starts developing them. (We need an 'inferior' class - 'feminine' women - in order to maintain a 'superior class' - 'masculine' men.)
- ☐ All girls and women must be 'feminine', both in appearance and in expression, and all boys and men must be 'masculine'.
- ☐ Marrying a man, having heterosexual sex, and bearing children are goals that all women *should* have. (Females with CAH have been shown to be less interested in traditional female roles, marriage and child rearing than control groups, says the report.)

☐ No girl or woman could possibly *want* to be a lesbian, bisexual, or even a 'tomboy', and if she found out that this could have been prevented in the womb, she would be upset that it hadn't been.

☐ An intersex condition is a bad thing. Having non-standard genitalia is a bad thing. Imperfection is a bad thing. 'Normal' is not only desirable, it's worth substantial risk to achieve - and 'normal' is whatever the culture says it is.

Find a 'gay gene' and you can certainly win the argument that sexual orientation is not a choice - but you can also succeed in eliminating gay, lesbian and bisexual people altogether. Find a 'trans gene' and you win your argument that transition is not a choice - but how long will it be before any kind of gender diversity disappears from the gene pool?

Certainly doctors need to be looking for any real health problems associated with CAH and figuring out how to manage or mediate these. But *in utero* experimentation to prevent 'masculine' or 'imperfect' females smacks of Stepford. I had hoped we were beyond that.

Matt Kailey is an FTM who writes a great blog at *tranifesto.com*. He answers questions sent in by his readers and others are given the opportunity to add their opinions. Matt has given *Polare* to reprint his columns with attribution.

Directory Assistance

Note: As foreshadowed in *Polare 90*, the Directory Assistance section has been reduced in order to free up space for other material. The directory information has changed only in minor details and at long intervals and *Polare* is no longer sent interstate in significant numbers. Interstate entries have, therefore, been removed and only New South Wales, Interstate and International entries have been retained. The full Directory is still available on the Gender Centre website at www.gendercentre.org.au.

New South Wales Gender Centre

Counselling
Provides counselling to residents and clients living in the community. For more information or an appointment contact the Counsellor on Monday, Tuesday, Wednesday or Thursday 10am - 5.00pm.

Outreach service
Available to clients in the inner city area on Tuesday nights from 6.00pm to 2.00 a.m. and on Thursdays from 10am - 5.30pm by appointment only. Monday and Wednesday afternoons and Friday 10am - 5.30pm. Also available to clients confined at home, in hospital or gaol - by appointment only. For an appointment contact Outreach Worker - 9569 2366.

Social and support service
Provides social and support groups and outings, workshops, forums and drop-ins. For more information contact the Social and Support Worker. 9569 2366

Resource development service
Produces a range of print resources on HIV/AIDS, medical and other information relevant to people with gender issues and their service providers. We provide printed information including a quarterly magazine *Polare* and a regularly updated website at:
www.gendercentre.org.au .
For more information contact the Information Worker on Monday or Wednesday 9569 2366

Drug and alcohol service
Provides education, support and referral to a broad range of services - By appointment only. For an appointment contact the Outreach or Social and Support Worker 9569 2366

Residential service
Provides semi-supported share accommodation for up to eleven residents who are sixteen years of age or over. Residents can stay for up to twelve months and are supported as they move towards independent living. A weekly fee is charged to cover household expenses.

Assessments for residency are by appointment only and can be arranged by contacting the Counsellor, Outreach Worker or Social and Support Worker 9569 2366.

For partners, families and friends

Support, education and referral to a wide range of specialist counselling, health, legal, welfare and other community services are available for partners, families and friends of people with gender issues. For more information contact the Social and Support Worker 9569 2366.

For service providers, employers and others

Advice, support and workshops are also available to employers, service providers, students and other people interested in gender issues. For more information contact the Manager, Gender Centre, 7 Bent Street or PO Box 266, Petersham NSW 2049
Tel: (02) 9569.2366
Fax: (02) 9569.1176
manager@gendercentre.org.au
http://www.gendercentre.org.au

NOTE
For after-hours counselling contact Lifeline on 131 114 or Gay and Lesbian Counselling Service 5.30pm-10.30pm seven days on (02) 8594 9596 or 1800 105 527 www.glcsnsw.org.au

Directory Assistance

2010 - TWENTY10/GLBT YOUTH SUPPORT

Twenty10 provides support to young transgender, lesbian, gay and bisexual people who are having trouble at home or are homeless. We provide accommodation, support, counselling, case management and social support as well as information and referrals for young GLBT people and their families. We run community education programs throughout NSW.
PO Box 553 Newtown, NSW, 2042
Youth callers needing help:
Sydney local: (02) 8594 9555
Rural NSW: 1800 652 010
All other callers:
(02) 8594 9550
Fax: (02) 8594 9559
Email: infor@2010.org.au
www.twenty10.org.au

ACONHEALTHLTD

Information and education abourHIV/AIDS, caring, support for living living with HIV/AIDS.
41 Elizabeth St, Surry Hills, NSW 2011 or POBox 350 Darlinghurst, NSW 1300
Ph: (02) 9206 2000
Fax: (02) 9206 2069
tty: (02) 9283 2088

ACON-HUNTER

129 Maitland Road or PO Box 220, Islington, 2296
Ph: (02) 4927 6808
Fax: (02) 4927 6845
hunter!acon.org.au
www.acon.org.au

ACON-ILLAWARRA

47 Kenny Street. Wollongong, PO Box 1073, Wollongong, NSW, 2500
Ph: (02) 4226 1163
Fax: (02) 4226 9839
www.acon.org.au

ACON-MID-NORTH COAST

Shop 3, 146 Gordon St
Port Macquarie NSW 2444
Tel: (02) 6584 0943
Fax: (02) 6583 3810
mnc@acon.org.au
POB 1329, Port Macquarie, 2444

ACON - NORTHERN RIVERS

27 Uralba Street
Lismore NSW 2480
PO Box 6063
South Lismore NSW 2480
Tel: (02) 6622.1555
or 1 800 633 637
Fax: (02) 6622 1520
northernrivers@acon.org.au

AFAO (AUSTRALIAN FEDERATION OF AIDS ORGANISATIONS)

National AIDS lobby and safe sex promotion organisation.
PO Box 51
Newtown 2042
Tel: (02) 9557 9399
Fax: (02) 9557 9867

ALBION STREET CENTRE

HIV testing, clinical management, counselling and support, treatment and trials for HIV/AIDS.
Tel: (02) 9332.1090
Fax: (02) 9332.4219

ANKALI

Volunteer project offering emotional support for People Living with HIV/AIDS, their partners, friends and carers. One on one grief and bereavement service.
Tel: (02) 9332.1090
Fax: (02) 9332.4219

BOBBY GOLDSMITH FOUNDATION (BGF)

Provides direct financial assistance, financial counselling, employment support and supported housing to people in NSW disadvantaged as a result of HIV/AIDS
Ph: (02) 9283 8666
free call 1800 651 011
www.bgf.org.au
bgf@bgf.org.au

BREASTSCREEN

Phone 132050

CENTRAL TABLELANDS TRANSGENDER INFORMATION SERVICE

Provides information and directions for anyone seeking medical or psychological assistance in changing gender. Provides information on gender friendly services available in the Bathurst, NSW Area. Provides support and understanding for families and friends in a non-counselling atmosphere.
Operates 9 am - 8pm Mon - Fri
Tel: 0412 700 924

(CSN) COMMUNITY SUPPORT NETWORK

Transport and practical home based care for PLWHA. Volunteers welcome. Training provided.
Sydney Mon-Fri 8.00am-6.00pm
9 Commonwealth St, Surry Hills
Tel: (02) 9206.2031
Fax: (02) 9206.2092
csn@acon.org.au
PO Box 350 Darlinghurst NSW 1300

Western Sydney and Blue Mountains

Mon-Fri 9.00am-5.00pm
Tel: 9204 2400
Fax: 9891 2088
csn-westsyd@acon.org.au
6 Darcy Rd, Wentworthville, 2145
PO Box 284, Westmead, 2145

Hunter

Mon-Fri 9.00am-5.00pm
Tel: 4927 6808\Fax 4927 6485
hunter@acon.org.au
129 Maitland Road, Islington, 2296
PO Box 220, Islington, 2296

MacKillop Centre - Hunter

Training and development opportunities for PLWHA
Tel: 4968 8788

Illawarra

Mon-Fri 9.00am-5.00pm
Tel: 4226 1163:Fax: 4226 9838
illawarra@acon.org.au
47 Kenny St, Wollongong, 2500
POB 1073, Wollongong, 2500

Mid North Coast

Outreach project: by appointment
Tel: 6584.0943
Fax: 6583.3810
4 Hayward Street, Port Macquarie, 2444
POB 1329, Port Macquarie, 2444

FTMAustralia

Resources and health information for all men (identified *female* at birth), their partners, families and service providers. For information contact FTMAustralia, PO Box 488, Glebe, NSW, 2037.
www.ftmaustralia.org
mail@ftmaustralia.org

GAY AND LESBIAN COUNSELLING SERVICE OF NSW (GLCS)

A volunteer-based community service providing anonymous and confidential telephone counselling, support, information and referral services for lesbians, gay men, bisexual and transgender persons (LGBT) and people in related communities.
Counselling line open daily from 5.30pm-10.30pm daily (02) 8594 9596 (Sydney Metro Area - cost of local call, highe for mobiles)
1800 184 527 (free call for regional NSW callers only)
Admin enquiries: (02) 8594 9500 or admin@glcsnsw.org.au
website: www.glcsnsw.org.au

HIV AWARENESS AND HIV AWARENESS AND SUPPORT

For HIV positive IDUs and their friends. Meets on Wednesdays. Contact Sandra or Tony at NUAA.
Tel: (02) 9369.3455
Toll Free: 1800.644.413

HOLDEN STREET CLINIC

Sexual Health Clinic is staffed by doctors, sexual health nurses, a clinical psychologist and an administration officer.
Mon, Tue, Wed. 9.00am-5.00pm
(closed 12.15pm-1.00pm for lunch)
Men's Clinic Thursday evenings 5.00pm-8.00pm
Appointments preferred (02) 4320 2114
Ground Floor 69 Holden St, Gosford 2250
Tel:(02) 4320 2114
Fax: (02)4320 2020

INNER CITY LEGAL CENTRE

Available to discuss any legal matter that concerns you.
Ph: (02) 9332 1966

INTERSECTION

Coalition group of lesbian, gay, transgender and other sexual minority groups and individuals working for access and equity within local community services and their agencies.
Christine Bird (02) 9525.3790

The Anti-Violence Project can be contacted on (02) 92062116 or 1800 063 060

KIRKETON ROAD CENTRE

Needle exchange and other services
Clinic Hours:
Monday to Friday, 10am - 6pm
Saturday to Sunday, 2pm - 6pm
Outreach Bus - Every Night
100 Darlinghurst Road
(Entrance above the Kings Cross Fire Station Victoria Street, Sundays
345 Crown Street, Surry Hills, 2010
PO Box 22, Kings Cross, NSW, 2011
Tel: (02) 9360.2766
Fax: (02) 9360.5154

LES GIRLS CROSS-DRESSERS GROUP

An independent peer support group for transgender people. Free tuition, job assistance, friendship and socials, general information. Bi-monthly meetings.
Coordinator,
PO Box 504 Burwood NSW 2134

(MCC) METROPOLITAN

MCC Sydney is linked with MCC churches in Australia as part of an international fellowship of Christian churches with a secial concern for any who feel excluded by established religious groups. MCC deplores all forms of discrimination and oppression and seeks to share God' unconditional love and acceptance of all people, regardless of sexual orientation, race or gender.
96 Crystal St, Petersham, 2049
Phone (02) 9569 5122
Fax: (02) 9569 5144
Worship times:
10.00 am and 6.30 pm
office@mccsydney.org
http://www.mccsydney.org.au/

MOUNT DRUITT SEXUAL HEALTH CLINIC

Provides free, confidential and respectful sexual health information, assessment, treatment and counselling.
Tel: (02) 9881 1206
Mon 9.00am-4.00pm
Wed 9.00am-1.00pm
Fri 9.00am-1.00pm

NEWCASTLE SWOP

SWOP at Newcastle has a Mobile Sexual Health Team
4927 6808

NORTHAIDS

A community based organisation providing step down and respite care for PLWHA on the Northern Beaches.
Tel: (02) 9982 2310

PARRAMATTA SEXUAL HEALTH CLINIC

provides free, confidential and respectful sexual health information, assessment, treatment and counselling.
Level 1, 162 Marsden (cnr.eorge St) Parramatta, 2150
Ph: (02) 9843 3124
Mon, Wed, Fri, 9.00am-4.00pm
Tue 9.00am-1.00pm
Fri 9.00am-4.00pm

PLWHA (PEOPLE LIVING WITH HIV/AIDS)

PO Box 831, Darlinghurst, NSW, 2010
Ph: (02) 9361 6011
Fax: (02) 9360 3504
www.plwha.org.au
Katoomba
PO Box 187,
Katoomba, NSW, 2780
Ph: (02) 4782 2119
www.hermes.net.au/plwha/
plwha@hermes.net.au

POSITIVE WOMEN

Can offer one-on-one support for HIV positive transgender women. Contact Women and AIDS Project Officer or Women's HIV Support officer at ACON.
Ph: (02) 9206 2000
www.acon.org.au/education/womens/campaigns.htm

REPIDU

Resource and Education Program for Injecting Drug Users
Mon - Fri, 9am - 5pm Sat & Sun, 1 - 5 Deliveries Tue, Fri 6 - 9
103/5 Redfern Street, Redfern, NSW, 2016
(Redfern Community Health Centre, enter via Turner Street)
Tel: (02) 9395 0400
Fax: (02) 9393 0411

RPA SEXUAL HEALTH CLINIC

provides a free and confidential range of health, counselling and support services. Ph: 9515 3131

SAGE FOUNDATION (Sex and Gender Education Foundation)

A voluntary lobbying organisation made up of gender variant people to lobby the government to ensure equal treatment in all respects of life. Sage is non-profit. All welcome.
Ph: 0421 479 285
Email:
SAGE_Foundation@yahoogroups.com

SEAHORSE SOCIETY OF NSW

The Seahorse Society is a non-profit self-help group funded by members' contributions. Open to all crossdressers, their relatives and friends. We offer discretion, private monthly social meetings, outings, contact with other crossdressers, a telephone information service, postal library service and a newsletter.
PO Box 2193 Boronia Park,NSW, 2111 or Ph: 0423 125

SOUTH COAST of NSW

from Ulladulla to the VIC Border. We are a group of like-minded people trying to establish a social and support group. Jen Somers, Sexual Health Counsellor, Narooma Community Health Centre, Marine Drive
Narooma, NSW 2546
Tel: (02) 4476.1372
Mob: 0407 214 526
Fax: (02) 4476 1731
jenni.somers@sahs.nsw.gov.au

(SWOP) SEX WORKERS OUTREACH TRANSGENDER SUPPORT PROJECT

Provides confidential services for people working in the NSW sex industry.
69 Abercrombie Street
Chippendale NSW
PO Box 1354
Strawberry Hills NSW 2012
Tel: (02) 9319 4866
Fax: (02) 9310 4262
infoswop@acon.org.au
www.swop.org.au

SYDNEY BISEXUAL NETWORK

Provides an opportunity for bi-sexual and bisexual-friendly people to get together in comfortable, safe and friendly spaces.
Pub social in Newtown on 3rd Sunday of every month followed by a meal. All welcome.
PO Box 281 Broadway NSW 2007
Tel: (02) 9565.4281 (info line)
sbn-admin@yahoogroups.com
http://sbn.bi.org

SYDNEY BISEXUAL PAGANS

Supporting, socialising and liberating bisexual pagans living in the Sydney region.
PO Box 121, Strawberry Hills NSW 2012

SYDNEY MEN'S NETWORK

Welcomes FTM men.
PO Box 2064, Boronia Park, 2111
Tel: 9879.4979 (Paul Whyte)
paulwhyte@gelworks.com.au

SYDNEY SEXUAL HEALTH CENTRE

Provides free, confidential health services, including sexuality, sexual function, counselling and testing and treatment of STDs including HIV.
Level 3, Nightingale Wing,
Sydney Hospital, Macquarie St,
Sydney, NSW, 2000.
Tel: (02) 9382 7440 or freecall from outside Sydney 1800 451 624 (8.30am-5.00pm) Fax:(02) 9832 7475
sshc@sesahs.nsw.gov.au

SYDNEY WEST HIV/HEP C PREVENTION SERVICE

Needle and syringe program
162 Marsden St, Parramatta,
NSW 2150
Ph: (02) 9843 3229
Fax: (02) 9893 7103

TOWN & COUNTRY CENTRE

Drop In Centre - Weekly Coffee Nights - 24 hour ph line - regular social activities - youth services - information, advice and referral - safer sex packs and more! - for bisexual, transgender folks and men who have sex with men80 Benerembah Street, GriffithPO Box 2485, Griffith, NSW 2680
Tel: (02) 6964.5524
Fax: (02) 6964.6052
glsg@stealth.com.au

WOLLONGONG TRAN

Transgender Resource and Advocacy Network.A service for people who identify as a gender other than their birth gender. Providing a safe and confidential place to visit, phone or talk about gender issues.
Thursday AND Friday 9am - 5pm
Tel: (02) 4226.1163

WOMENS & GIRLS DROP IN CENTRE

is a safe, friendly drop-in Centre in inner Sydney for women with or without children. Shower, relax, read the paper, get information, referral and advice.
Monday to Friday - 9.30 - 4.30pm177 Albion Street, Surry Hills, NSW 2010
Tel: (02) 9360.5388

Directory Assistance

National

(ABN) AUSTRALIAN BISEXUAL NETWORK

National network of bisexual women and men, partners and bi- and bi-friendly groups. ABN produces a national magazine, houses a resource library and is a member of the International Lesbian and Gay Association (ILGA).
PO Box 490, Lutwyche QLD 4030
Tel: (07) 3857 2500
1800 653 223
ausbinet@rainbow.net.au
www.rainbow.net.au/~ausbinet

AIS SUPPORT GROUP (AUSTRALIA)

Support group for Intersex people and their families. We have representatives in all Australian States.
PO Box 1089
Altona Meadows, VIC, 3028
Tel: (03) 9315 8809
aissg@iprimus.com.au
www.vicnet.net.au/~aissg

AUSTRALIAN WOMAN NETWORK

Australian WOMAN Network is primarily a lobby and health support group for people who experience the condition of transsexualism, their families, friends and supporters. There are email discussion lists for members as well as a bulletin board for both public and member-only access.

www.w-o-m-a-n.net

CHANGELING ASPECTS

organisation for Transsexual people, their partners and families. For information, please write or call.
email:knoble@iinet.net.au
www.changelingaspects.com

FTM Australia

Resources and health information for all men (identified *female* at birth), their partners, family and service providers. Contact FTM Australia for more information.
PO Box 488, Glebe, NSW, 2037
www.ftmaustralia.org
mail@ftmaustralia.org

TRUE COLOURS DIVERSITY

True Colours represents young people who experience transsexualism and a network of their parents, families throughout Australia. Whether you are a parent, a family member, a carer, a friend or a young person experiencing the diversity in sexual formation called transsexualism, you have come to a friendly place. TRUE Colours offers mutual support and advocacy for young people with transsexualism and their families. We also offer a parents/caregivers email discussion group.
Web: www.trucolours.org.au
Email: Mail@truecolours.org.au

International

AGENDER NEW ZEALAND

A caring national support organisation for Cross/Transgender people, their partners and families. For a detailed information pack, please write or call:

PO Box 27-560,
Wellington, NewZealand

Tel: (64) 0800 AGENDER
Email: president@agender.org.nz
www.agender.org.nz

BEAUMONT SOCIETY

Non-profit organisation for crossdressers throughout Great Britain. Social functions, counselling and a contact system for members. Provides a magazine - Beaumont magazine
BM Box 3084
London WCIN 3XX
England
www.beaumontsociety.org.uk/

BEAUMONT TRUST

The Trust is a registered charity, the aim of which is the support of transvestites, transsexuals, their friends and families. It fosters research into both psychological and social aspects of transvestism and transsexualism and can provide speakers to address other organisations. It produces literature and arranges workshops, develops befriending facilities and assists with conferences.
The Beaumont Trust, BM Charity, London WC1N 3XX.
http://www3.mistral.co.uk/gentrust/bt.htm

CROSS-TALK

The transgender community news & information monthly.
PO Box 944,Woodland Hills CA 91365U.S.A.

FTM INTERNATIONAL

A group for female to male transgender people. Provides a quarterly newsletter - FTM.
160 14th St
San Francisco, CA, 94103
http://www.ftmi.org/
info@ftmi.org

FTM NETWORK UK

A support group for female to male trans people. Provides a newsletter - *Boys' Own*
FTM Network, BM Network, London, WC1N 3XX, England.
www.ftm.org.uk

GENDERBRIDGE Inc.

Support and Social Society for people with gender identity issues, their families, partners and professionals involved in care, treatment and counselling.
PO Box 68236, Newton, 1145, New Zealand
Phone: (64) (09) 0800 TGHELP (0800.84.4357) (24 hrs)
www.genderbridge.org
info@genderbridge.org

GENDER TRUST (THE)

A help group for those who consider themselves transsexual, gender dysphoric or transgendered. Provides trained counsellors, psychologists and psychotherapists and a there is a referral procedure to a choice of other therapists.
The Gender Trust
PO Box 3192, Brighton
BN1 3WR, ENGLAND
http://www3.mistral.co.uk/gentrust/home.htm
gentrust@mistral.co.uk

INTERNATIONAL FOUNDATION FOR ANDROGYNOUS STUDIES (IFAS)

Support, information, advocacy and social events. An incorporated body established to advance the health, well-being, basic rights, social equality and self-determination of persons of any age or cultural background who are transgender, transsexual, transvestite or intersex, or who are otherwise physically or psychologically androgynous as well as gay, lesbian and bisexual people.
PO Box 1066
Nedlands, WA, 6909, Australia
Mobile ph: 0427 853 083
http://www.ecel.uwa.edu.au/gse/staffweb/fhaynes IFAS_Homepage.html
www.IFAS.org.au

IFGE INTERNATIONAL FOUNDATION FOR GENDER EDUCATION

Educational and service organisation designed to serve as an effective communications medium, outreach device, and networking facility for the entire TV/TS Community and those affected by the Community. Publisher of materials relevant to the TV/TS theme. Produces TV/TS journal -*Tapestry*.
PO Box 229, Waltham, MA 02254-0229 U.S.A.
http://www.ifge.org/
info@ifge.org

IKHLAS

IKHLAS drop in centre is a community program by Pink Triangle Malaysia. Provides an outreach project, HIV/AIDS information, counselling, medication, workshop and skill building for transgender people in Kuala Lumpur Malaysia.
PO Box 11859, 50760
Kuala Lumpur Malaysia
Tel: 6.03.2425.593
Fax: 6.03.2425.59

ITANZ INTERSEX TRUST AOTEAROA OF NEW ZEALAND

Registered non-profit charitable trust to provide a number of educational, advocacy and liaison services to intersexuals, their parents, caregivers, family, friends and partners within the Community and those affected by the Community.

PO Box 9196, Marion Square
Wellington, New Zealand
Tel: (04) 4727 386 (machine only) Fax: (04) 4727 387

PROSTITUTES COLLECTIVE OF AUCKLAND - NEW ZEALAND

PO Box 68 509,
Newton, Auckland,
New Zealand

PROSTITUTES COLLECTIVE OF CHRISTCHURCH-NEW ZEALAND

Provides a confidential service for trannies working in the sex industry.
PO Box 13 561
Christchurch,
New Zealand

PROSTITUTES COLLECTIVE OF WELLINGTON - NEW ZEALAND

Provides a confidential service for trannies working in the sex industry.
PO Box 11/412, Manner St
Wellington New Zealand
Tel: (64) 4382-8791
Fax: (64) 4801-5690

Every effort has been made to include accurate and up-to-date information in this directory. To amend your listing fax (02) 9569 1176 or email the Editor on resources@gendercentre.org.au

Are You Embarrassed by Ugly and Unwanted Facial or Body Hair?

You are not alone, and there is a permanent solution. Everywhere people are raving about the results of this amazing method!

It is medically and scientifically proven safe to permanently remove your unwanted hair so that it NEVER grows back. This process (called Multi Probe Electrolysis) has 130 years of tried, tested and proven safe and effective guaranteed permanent hair loss results.

Multi Probe Electrolysis is suitable for:

All areas of the body
All skin types and skin colours
All hair types and hair colours

Comments from satisfied clients

My skin feels so soft now; I am not embarrassed to be kissed anynore; I just feel so free; I thought I would have to live with this hair, now I know I don't - thank you; I can talk to people and look at them again; 12 years and nothing has grown back - you changed my life; I have so much more confidence; I wish I knew about Permanence a long time ago

Our Guarantee

Our treatment has transformed the appearance of thousands of people. We are so confident in our results we put our 100% money back Guarantee behind our work! If in the unlikely event you are not truly satisfied with your treatment, then we insist on givimg you back your money - NO QUESTIONS ASKED!

So phone Sydney's most sought after Hair Removal Specialists for Results **NOW**. Say goodbye to your ugly unwanted hair forever and let us focus on achieving what you want, and this we do every day. The first 27 people to call and mention this ad will receive our special introductory offer - ***you pay only $99*** *for $165 of Value* ***- a saving of $66.***

Consultation	**Valued at $60**
30 Minute Treatment	**Valued at $75**
Melfol Aftercare cream	**Valued at $30**

City
Dymocks Building,
Level 3
428 George St, Sydney
9221 8595

Drummoyne
170 Victoria Road,
Drummoyne
9719 1391

www.permanence.com.au

PERMANENCE

The permanent hair removal specialists

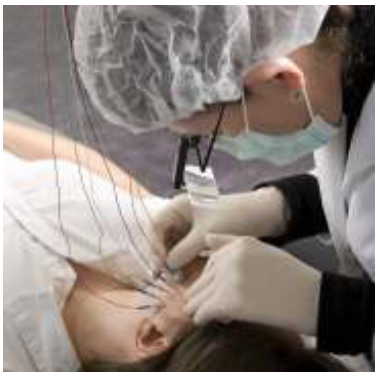
The Permanent Solution...

in Permanent Hair Removal

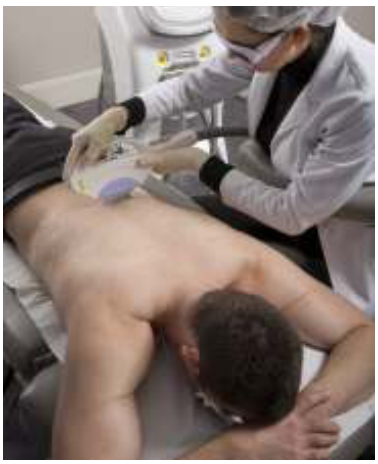
For those who are embarking on the transition from male to female, the permanent removal of hair is vital. However, with so many clinics and procedures to choose from, it's crucial that your chosen solution is reliable, safe and permanent.

At Advanced Electrolysis Centre, we have been specialising in permanent hair removal since 1996, continually improving the methods and the technologies that deliver the best results. You'll be in the hands of our experienced and qualified specialists, where you'll receive the ultimate level of personal care and attention.We also offer on-site parking for our 3hr clients subject to availability.

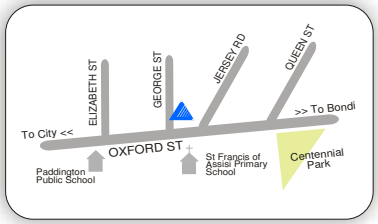
Galvanic electrolysis is a scientifically proven technique that is effective no matter what type of hair you have, and no matter what colour skin. It works perfectly, even if you have blonde or grey hair. However if you have dark hair this can be treated by laser or IPL, or in many cases a combination to achieve a true permanent result.



So, whether you are in need of some general information, or you have already decided on a method that best suits your needs, come in for a chat and get expert advice on how to effectively be free of your unwanted hair FOREVER!



- Multi probe galvanic 16, 32 and 64 (Dual operator) follicle treatment
- Guaranteed Permanent Results
- Skin Rejuvenation
- Pigmentation Reduction
- Red Veins & Rosacea



advanced
ELECTROLYSIS CENTRE

Phone: (02) **9362 1992**
9 George Street (just off Oxford St), Paddington
aecsydney.com.au