

ACON SUBMISSION TO

Senate Standing Committees on Community Affairs

Inquiry into Universal Access to Reproductive Healthcare

December 2022





About ACON

ACON is Australia's largest health organisation specialising in community health, inclusion, and HIV responses for people of diverse sexualities and genders. Established in 1985, ACON works to create opportunities for people in our communities to live their healthiest lives.

Our head office is in Sydney and we also have offices in Lismore and Newcastle. We provide our services and programs locally, state-wide, and nationally. We are a fiercely proud community organisation, unique in our connection to our community and in our role as an authentic and respected voice.

Members of Australia's sexuality and gender diverse communities experience health disparities when compared to health and wellbeing outcomes experienced by the total population. They may also face significant barriers to accessing traditional healthcare pathways.

We recognise that members of our communities share their sexual and gender identity with other identities and experiences and work to ensure that these are reflected in our work. These can include people who are Aboriginal and Torres Strait Islander; people from culturally, linguistically and ethnically diverse, and migrant and refugee backgrounds; people who use drugs; mature aged people; young adults; and people with disability.

Contact

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ACON acknowledges the Traditional Owners of the lands on which we work. We pay respect to Aboriginal Elders past and present.



Executive Summary

ACON thanks the Standing Committee on Community Affairs for this opportunity to provide evidence to the Inquiry into Universal access to reproductive healthcare.

ACON is particularly concerned with access to reproductive healthcare for the communities we work with, including people of diverse genders and sexualities. This submission comments on the particular terms of reference in the inquiry as they relate to the services we provide and the communities we work with.

Universal access to reproductive healthcare must be universal across the entire sector, and not only found in specialist or community-run services. People in our communities often value a specialist, LGBTQ+ specific service,¹ but this does not negate the importance of inclusive, affirming and safe mainstream services.

We welcome any interventions that seek to improve access to reproductive healthcare for people in our communities, who are often invisibilised in this sector, and/or subject to negative and often traumatic experiences in seeking to access vital care.

Recommendations

ACON makes the following recommendations to ensure universal access to reproductive healthcare for everyone, including sexuality and gender diverse communities:

1. Create workforce development initiatives to improve mainstream reproductive healthcare service provision for priority populations, including LGBTQ+ people.
2. Ensure that best-practice always includes a co-design approach, particularly for priority populations such as LGBTQ people.
3. Ensure education and service design for reproductive health include a trauma-informed approach.
4. All reproductive health services should implement a model such as 'Parts and Practices' for sexual and reproductive health services to best understand the bodies and needs of patients and their partner/s without assumption.
5. Specialist services should be funded to include peer navigation as part of their service model
6. Develop comprehensive sexuality education programs that are age-appropriate, evidence-based, inclusive of diversity, and committed to ending all forms of stigma.
7. Ensure that HPV prevention is available and recommended equitably, regardless of gender.



Introduction

Reproductive healthcare affects all people, including people of all genders, sexualities, bodies, and backgrounds. Despite popular or historical assumptions, all people, regardless of their gender or sexuality require access to safe and affirming reproductive healthcare.

Important work has been done in broadening education and service delivery to cisgender gay men and lesbian women, as well as in some cases to transgender men and women. However, truly universal reproductive healthcare does not require us to add two additional gender categories to our services, but is accessible and actively welcoming and affirming to people of other genders and sexualities, including non-binary people of all genders and experiences, bisexual/bi+ and pansexual people, queer people, and any other LGBTQ+ people whose identities or relationships are not visible to health providers or communities.

We detail further on in the submission the negative experiences that many LGBTQ+ people face while accessing reproductive healthcare. The provision of universal access to reproductive healthcare for all people would not only help to address these experiences for LGBTQ+ people around Australia, but can also help cisgender, heterosexual people feel more supported, comfortable, and understood by their service providers. For example, by adopting a trauma-informed approach for all patients of reproductive healthcare, not just those who have a history of sexual or other trauma, we can ensure that reproductive healthcare is always person-centred and sensitive to the individual.

In our clinical and research work, ACON has seen our communities struggle to find services that are affirming or able to provide accurate reproductive health information. The practice of accessing reproductive care for people in our communities is commonly harmful, including experiencing ignorance, stigma, or having assumptions made about them or their partners that delay or prevent care.

Reproductive healthcare is not solely the domain of those who are seeking to reproduce, or even those who are sexually active. Most people will interact with reproductive healthcare at least at some point in their lives.

The research shows, and our communities tell us, that all kinds of people not only desire children, but are able to conceive and carry children to term, require access to family planning, contraception and abortion services, and will interact with services for reproductive care. However, we also know that if those services are not affirming and universally accessible, this contributes to poorer health outcomes in the patient and a barrier to accessing further care.

This submission will address the relevant terms of reference as they relate to the experiences of our communities with regard to reproductive healthcare. While we acknowledge the importance of assisted reproductive technology for many in our communities, this submission does not detail these experiences. We endorse the recommendations of Rainbow Families with regard to expanding access to assisted reproductive technologies.

We understand that this inquiry is regarding universal access to reproductive health care, but note that at times the terms of reference refer to sexual health care and literacy. As an organisation committed to improving health outcomes for communities affected by HIV, as well as improving sexual health wellbeing for all marginalised genders and sexualities, it is our understanding that what is intended by



the terms sexual healthcare in the inquiry are as an extension of reproductive healthcare (ie. relating to sexual organs or sexual practices that relate to reproduction).

Sexual health is a much broader field than reproductive health, and if the inquiry desires, we can provide a wealth of information on the sexual health experiences, needs and best practices for LGBTQ+ communities.

(c) workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals

The development of health services and health workers remains a key activity in making reproductive healthcare more accessible and affirming.

ACON develops and regularly trains a wide range of clinical and non-clinical services on inclusive practice for our communities, via our Pride Training service and our Pride in Diversity networks, including our Pride in Health and Wellbeing program. These training services are developed by LGBTQ+ people, and aim to ensure that services understand our health needs. Workforce development is a critical component of improving access to healthcare for LGBTQ+ people, as it allows for a broader range of services to be accessible for our communities.

Recommendation:

1. Create workforce development initiatives to improve mainstream reproductive healthcare service provision for priority populations, including LGBTQ+ people.

(d) best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

ACON has a long history of providing sexual healthcare and education, and more recent history in providing reproductive healthcare to LGBTQ+ people of all genders and sexualities. This health provision has been developed in response to research showing that mainstream service providers and health systems struggle to or have not attempted to include service delivery that is appropriate and affirming for people of diverse genders, sexualities, and cultures.

Through our service provision experience, which has been built on community and international research, we have designed and implemented a range of practices and processes that help provide care to communities in a best practice way.



This service history includes the set up and running of ACON's successful range of a[TEST] clinics around Sydney, the CheckOUT sexual and reproductive health screening clinic, and the trans[TEST] sexual health screening clinic, as well as a wide range of peer interventions across mental health, sexual health, and wider wellbeing.

For this submission, we draw strongly on the experience of designing and running the CheckOUT service in partnership with Family Planning NSW, which sought to provide affirming and trauma-informed sexual and reproductive healthcare to all LGBTQ+ people, with funding specifically to deliver Cervical Screening to all LGBTQ+ people with a cervix. Client feedback for this service, obtained via anonymous online surveys emailed to clients, has been consistently positive, with almost 98% of clients satisfied with the service. 98% of clients said they would recommend the service to others and 63% had already done so.

A key part of universal access is using language and terms in a clear and simple way throughout the reproductive health sector. This can include removing titles or terms that refer to gendered health settings, such as women's or men's health services, and instead referring to the specific service being offered. While language can seem like a small issue, it is viewed by many LGBTQ+ people as an immediate indicator of whether or not a service will be affirming and, as a result, safe.

*"If I did this [came out] and still got treated as a woman it would be more heartbreaking."*²

Based on community consultation and co-design, ACON provides a [clear and simple language guide aimed at health services](#), as well as [a general one for use by other services and the public](#). However, it is important to note that affirming language is one part of a larger approach.³

Accurate and affirming reproductive healthcare also requires us to not make assumptions, such as asking what sexual (or reproductive) organs a patient has when beginning a clinical relationship, and confirming what sexual organs their partners have, regardless of their gender. A model for doing so, named the 'Parts and Practices' model, was used by ACON in the CheckOUT clinic, and refers to learning about the body parts of patients and their partner/s, and the practices they engage in, in order to provide accurate and evidence-based sexual health information or testing.

By learning about the sexual organs a patient and their partner/s have, it is possible to provide not only accurate but also affirming health information, ie. for a woman in a lesbian relationship who has a vagina and uterus, and her partner has a penis and testes, penetrative vaginal sex carries the risk of pregnancy, whereas if either partner did not have a uterus or testes respectively, that penetrative vaginal sex would not carry a pregnancy risk. In this situation, merely knowing the gender and gender assigned at birth for each patient would not provide all the necessary information to provide accurate healthcare.

Universal access to reproductive healthcare must also include preventative care such as screening for cancer of sexual organs. Many LGBTQ+ people, especially lesbian cis women and trans people with a cervix, report much lower screening rates than their cisgender heterosexual peers.⁴

Many LGBTQ+ populations experience much higher rates of sexual violence and coercion than their heterosexual and cisgender peers, in some cases nearly four times higher than found in the general public.^{5,6} This number is highest among non-binary people of all genders assigned at birth, but is not insignificant for other trans people, and cisgender bisexual and lesbian people.⁷



Considering the alarming rates of sexual violence experienced by people of all genders and sexualities, and the potential for accessing reproductive healthcare to negatively impact patients with a history of sexual violence⁸ such that “the act of walking into a clinic is traumatic,”^a there is a need for all reproductive health services to be trauma-informed.

Trauma-informed health spaces are also helpful for mitigating other forms of trauma that LGBTQ+ people face, including trauma obtained through previous interactions with medical services.⁹ Reproductive healthcare spaces have the potential to be sites of this medical trauma,

“one of the worst times for me was when I was in, I was getting a vaginal smear or something. [...] And the pathology lady announced to the entire waiting room, they were like, ‘Oh, this is, can’t be for you. You don’t have a vagina.’”¹⁰

By treating the disclosure of gender or sexuality diversity as a form of trust, and not a formality or data collection, LGBTQ+ patients are shown that at the least, their service access will not be a site of further trauma or harm.

Best practice must be incorporated into all aspects of practice provision, and not just the interactions between patient and health practitioner. This includes patient interfacing with websites, social media and reception staff, forms and data collection, patient history and diagnoses, follow up care, and referrals to other services or practices. This was achieved at the Check OUT clinic through its strong partnership, co-design approach between Family Planning NSW and ACON, who together were able to develop a trauma-informed and community-centred model of care for the service.

The role of peers

A critical way that the CheckOUT clinic ensured a best-practice approach that was affirming, trauma-informed, and person-centred was the critical role of peers in the service delivery. ACON has a long history of peer work, recognising the central role that lived experience can play in ensuring informed care.¹¹

At CheckOUT, Peers and Registered Nurses (RNs) attend together, training each other across trauma-informed care; LGBTQ+ bodies, identities and sexual practices; Sexually Transmitted Infections (STIs) and testing protocols; cervical cancer, HPV and Cervical Screening Tests; and the unique practices and policies of Check OUT.

The benefit of training and sharing knowledge between clinicians and community is well-documented, and Check OUT encourages a collaborative approach between RNs, Peers and clients: “With the support of peers and clinicians, individuals become active participants in their healthcare, and their knowledge, confidence and wellbeing improves.”¹²

The peer role is well-defined, to work in close concert with the both the client and the RN. The peer’s primary role is providing a sense of a ‘soft landing’ before clients engage with the RN, providing information about the consultation and noting patient preferences. When considering the trepidation

^a Quote sourced from the online, anonymous Check OUT Feedback survey, which is emailed to all clients after their appointment.



clients may feel in approaching medical contexts due to past negative experiences within healthcare, the shared lived experience of the peer worker creates a safe space and increases access to care:

When it comes to marginalised populations, such as those most affected by HIV and people of diverse sexualities and genders who may have had poor experiences with mainstream health services, this is a real strength of peer-based approaches...Because peers exist within and are part of the stigmatised group, people who utilise services delivered by peers are less likely to experience stigma in these settings.¹³

Once a client has been greeted and filled out a registration form (which allows clients to select their pronouns as well as gender, sex assigned at birth and intersex status), they are asked if they would like to have a Peer Consult: the contents and purpose of the consult is explained, and clients are reassured it is not mandatory.

“This was probably the easiest and best STI check/cervical screening I have ever experienced- the questions I was asked felt a lot less judgmental compared to things I've been asked at previous consultations. Very much appreciated this non-judginess as well as just the general chill and queer friendly atmosphere, also very much appreciated the use of non-gendered language when asking about past partners etc.”^a

“The peer worker made a huge difference to me feeling comfortable and able to go through with the cervical exam (which I've had bad experiences with before and was very anxious about). She was kind, sympathetic and responsive. The consultation made me feel confident and respected.”^a

Through the service history of the CheckOUT clinic, patient surveys indicated that while the experience of the clinic was overall very sensitive and affirming and an example of best-practice, it led to worse experiences in other health services that were not affirming, as patients realised that poor service was not the only form of care they could receive.

While reproductive healthcare for trans and gender diverse people requires a specific skillset that is aware of the unique needs of this population, trauma-informed, and mindful of the negative experiences of marginalisation,¹⁴ we believe that this skillset is not a difficult one to acquire through best practice training, especially that provided by LGBTQ+ educators, and by exploring the role of peers in service provision.

Recommendations:

2. Ensure that best-practice always includes a co-design approach, particularly for priority populations such as LGBTQ people.
3. Ensure education and service design for reproductive health include a trauma-informed approach.
4. All reproductive health services should implement a model such as ‘Parts and Practices’ for sexual and reproductive health services to best understand the bodies and needs of patients and their partner/s without assumption.
5. Specialist services should be funded to include peer navigation as part of their service model



(e) sexual and reproductive health literacy

Comprehensive sexuality education is required to build sexual and reproductive health literacy.^{15,16} However, school-based sexuality education is often inadequate for people of diverse genders and sexualities, who are then required to develop this health literacy outside of school settings.^{17,18} ACON provides opportunities for people in our communities to develop their health literacy and take control of their health and wellbeing, in recognition of the fact that this information has been missing from formal or mainstream education sources.

For decades, ACON has provided comprehensive health promotion and education around the prevention of HIV and other STIs to gay, bi+ and queer men in NSW. ACON's peer education programs are a flagship component of our work, and have been critical in developing the sexual health literacy of people, especially men, in our communities since the mid-1980s.¹⁹

As well as our peer education programs, ACON provides digital health promotion across our communities. ACON's award-winning community education and mobilisation initiative [Ending HIV](#) continues to educate gay, bisexual and other men who have sex with men on what they can do to help prevent new HIV transmission in NSW. Since its launch in 2013, we've improved our communities' understanding on the importance of frequent HIV testing, the effectiveness of HIV prevention strategies such as PrEP, the benefits of starting HIV treatment early and having an undetectable viral load. In 2021-22, *Ending HIV* had over 1.1 million page views.

[TransHub](#) provides accurate, evidence-based and accessible information to support the health of trans and gender diverse people, including information about sexual and reproductive health, social, medical and legal gender affirmation, mental health, cancer screening, substance use, domestic violence and rights. This resource is a critical component in informing trans and gender diverse people, their loved ones and their allies about their health needs. In 2021-22, the site amassed 1.4 million page views. The site is now being developed to expand to a national audience, with additional reproductive health information to be included in the expansion.

TransHub also produces printable resources that can be displayed in clinical settings, including [this brochure](#), produced in partnership with Family Planning NSW, to provide information on contraception to trans and gender diverse people.

ACON is currently developing an additional digital health promotion resource, *Word on the Sheets*, to promote sexual and reproductive health and wellbeing and healthy relationships for LGBTQ women and their partners, due for publication in 2023.

Alongside our best-practice models of clinical care, ACON strives to provide our communities with the best opportunity for adequate sexual health and reproductive health literacy and access to safe and appropriate sexual and reproductive healthcare. However, building sexual and reproductive health literacy requires tailored interventions for different members of our communities, and ongoing and sustained efforts as our communities and approaches to prevention, testing, treatment and reproductive health evolve.



U=U, or Undetectable = Untransmittable, refers to the idea that when someone living with HIV has an undetectable viral load (UVL), there is zero risk of HIV transmission. Studies from 2016 and 2017²⁰ have confirmed this result, and since then, community awareness of the U=U message has been building.

A recent study of gay and bisexual men found that almost 79% were familiar with the U=U message.²¹ Of those who were familiar with the message, 67% believed it was accurate,²² yet just 39% were willing to have condomless sex with a partner with an undetectable viral load.²³ Despite the familiarity and understanding of the accuracy of the message, this did not necessarily translate to trust in practice.

This example demonstrates that knowledge of sexual and reproductive health practices may not always translate into action. National and state-based HIV Strategies recognise the role that stigma plays in our response to HIV, and the need to end stigma in order to further prevent HIV transmission, promote good quality of life among people living with HIV, and build health literacy.

Sexual and reproductive health literacy must therefore occur alongside efforts to reduce stigma, around HIV but also around broader sexual and reproductive health, and the many diverse populations who engage in sexual practices who experience forms of stigma such as homophobia, transphobia, racism, ableism, and ageism.

Specialist services like ACON are able to provide strengths-based, empowering and non-judgemental information for our communities, by our communities, largely thanks to the NSW government's longstanding recognition of the importance of partnerships in delivering messages tailored to our communities.

However, our communities should have more avenues to access information that is relevant to their health needs, and non-stigmatising – in mainstream settings as well as specialist ones. Access to safe mainstream services and information, as outlined earlier in this submission, promotes the idea that our health can and should matter to all health services, thereby de-stigmatising our health needs, elevating our access to information, and services.

For this reason, ACON supports the work of Family Planning NSW in promoting the need for age-appropriate, evidence-based comprehensive sexuality education for all people across the lifespan.

Recommendation:

5. Develop comprehensive sexuality education programs that are age-appropriate, evidence-based, inclusive of diversity, and committed to ending all forms of stigma.



(g) experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare

Historically, trans and gender diverse people were viewed as being automatically excluded from having children or needing reproductive healthcare services.²⁴ However, with increased visibility of trans people and experiences in public life and the health sector, so too has the need for reproductive healthcare to meet the needs of gender diverse people and their partners.

A growing body of research shows that trans and gender diverse people (including trans men, trans women, and non-binary people) are more likely to have negative experiences when accessing healthcare of all kinds than their cis peers.^{25,26} This can stem from a range of factors, including misuse of terms or language, incorrect assumptions about their bodies and/or desires, being given incorrect medical advice, refusal of service or being directed to gendered services that do not align with their identity, and outright discrimination or transphobia by health workers.

While research reports poorer experiences in reproductive health services across LGBTQ+ communities, it also shows that broadly gender identity was respected by health professionals less frequently than sexual orientation across all health services.²⁷

The poor experiences of trans and gender diverse people can be broadly categorised into three areas: incorrect or a lack of clear reproductive health information, access to services, and ongoing or follow up care.

The first major barrier for trans and gender diverse people face is a lack of accurate and gender affirming information about reproductive healthcare. Often times, trans and gender diverse people are made to make decisions about their reproductive choices or reproductive futures based on inaccurate or incorrect information.

This may have long term health implications (such as being told a cervical screening test is not required for people who do not have vaginal intercourse with a natal penis and not discovering cervical cancer cells), or potentially immediate effects (such as being told that exogenous testosterone acts as a contraceptive and becoming pregnant).

This may also occur when information is provided, but in a way that can perpetuate further harm, such as framing all pregnancy related information as about “women’s health”. This can result in people who are not women and can get pregnant not seeking out vital health information, or to access the information and in doing so expose themselves to potential harm.²⁸

Actual access to services is also made more difficult when they are not openly affirming of diverse genders and sexualities. The existence of a binary of reproductive health services, that is women’s health and men’s health, excludes not only women who do not have breasts, vaginas, ovaries and uteruses and men who do not have penises, testes and prostates, but people of all other genders who have either set, or a combination of these organs.



Trans and gender diverse people report that accessing ‘incorrectly’ gendered health services feels like a choice between accessing potentially life-saving healthcare and being seen in a way that is harmful and could contribute to poor mental health, if they are able to get an appointment at all.²⁹

A further barrier is the expectation and apprehension that comes from continuing service access. For most people, reproductive healthcare happens in an ongoing relationship with healthcare providers and services, especially across reproductive events such as a pregnancy or trying to conceive. If the experience of a service is a negative or harmful one, but a patient knows they have to continue to access the service for a set period of time (such as for pre-natal care) or indefinitely (such as for cervical screening tests), this can result in negative outcomes for mental and physical health.³⁰ In some instances this also results in the decision to not access desired care due to it being seen as too complicated, or too much of a compromise for safety or wellbeing.

The implementation of LGBTQ+-affirming care throughout the reproductive healthcare sector is important because trans and gender diverse people all have reproductive healthcare needs across the lifespan, whether or not they are planning to reproduce. Universal access should mean access to specialist LGBTQ-services, such as ACON’s CheckOUT, but also access to safe and affirming mainstream services.

In addition, reproductive healthcare affects parts of the body that, while for many people may be uncomfortable or embarrassing, for trans and gender diverse people these parts can be a site of self-hate, trauma, or other complex and strong emotions. This impacts lower rates of screening, care access, and worse ranked outcomes than their cisgender peers, if services are accessed.

Fertility preservation can form part of a trans person’s gender affirmation journey, and this option, in line with WPATH’s Standards of Care, should be discussed with people intending to start gender-affirming treatments that could impact fertility.³¹ Research has demonstrated that trans and gender diverse people are not given enough information about fertility preservation, and in some cases, have expressed concern that it be made a requirement of access to hormones.³² It is essential that while these options are provided, they should not be a requirement of gender affirmation, as this constitutes another form of medical gatekeeping.³³

We discuss in section (d) the higher rate of sexual assault and medical assault experienced by trans and gender diverse communities, and the need for trauma-informed care. However, it is also worth noting that, for some trans and gender diverse people, the process of accessing reproductive healthcare of any kind, even care that is trans-affirming in nature, can be a difficult experience and in some cases exacerbate dysphoria or other negative experiences.³⁴

A trans-affirming healthcare system must allow for the possibility that not all interactions are able to be made entirely free from harm or discomfort, and to provide additional care and support to trans and gender diverse people if necessary.

Finally, it must be recognised that trans people are in relationships with people of all genders, and those relationships are diverse in their sexual practices, their requirement for contraception or lack thereof, their reproductive intent or desire, and their inherent configuration (such as whether the relationship is between a couple, or more than two people).



Any attempt to assign broader categories to trans populations (ie. people with and without natal genitals, or people who can and cannot become pregnant) will mean that we miss out on learning information that allows the best possible care to be provided.

The study of trans and gender diverse health and populations, while well established, is not without significant gaps in the data. Utilisation of further education services and networks such as communities of practice to stay up to date on trans and gender diverse health information is a valuable part of ongoing healthcare delivery.

The recommendations outlined in this submission, across workforce development, comprehensive sexuality education, trauma-informed care, specialist peer services, and parts and practices models all seek to improve access to reproductive healthcare for trans and gender diverse people.

We note that research shows similar negative experiences for accessing reproductive healthcare experienced by people with variations of sex characteristics, but defer to Intersex Human Rights Australia for their professional experience in this area.

(i) any other related matter

It is our understanding that there are unequal age limits to access the Gardasil vaccine, and that government funding for the vaccine is limited to 20 years of age, whereas efficacy for the vaccine far exceeds that age. HPV and the related risk for cancers are relevant to all members of LGBTQ+ communities, and access and equity is an issue currently – with evidence showing trans and gender diverse populations leaving school with much lower rates of vaccination. Moreover, LGBTQ+ populations engage in cervical screening at rates lower than the general population.^{35,36} There is low levels of understanding among cisgender men in LGBTQ+ communities about HPV and perceptions exist that vaccination is only for ‘women’ (people assumed to have a cervix).

Current guidelines create gendered disparities in the provision of the vaccine, and there is a need to clarify and remove barriers for all LGBTQ+ people in accessing prevention. Universal access to reproductive healthcare also requires equitable access to prevention and health promotion. ACON supports any move to ensure more equitable access to HPV prevention.

Recommendation:

6. Ensure that HPV prevention is available and recommended equitably, regardless of gender.



References

- ¹ Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia*. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University
- ² Gibson, A. F., Drysdale, K., Botfield, J., Mooney-Somers, J., Cook, T., & Newman, C. E. (2022). Navigating trans visibilities, trauma and trust in a new cervical screening clinic. *Culture, Health & Sexuality*, 24(10), 1366-1379.
- ³ Moseson, H., Zazanis, N., Goldberg, E., Fix, L., Durden, M., Stoeffler, A., ... & Obedin-Maliver, J. (2020). The imperative for transgender and gender nonbinary inclusion: beyond women's health. *Obstetrics and Gynecology*, 135(5), 1059.
- ⁴ Kerr, L., Fisher, C.M., Jones, T. (2019). *TRANScending Discrimination in Health & Cancer Care: A Study of Trans & Gender Diverse Australians*, (ARCSHS Monograph Series No. 115), Bundoora: Australian Research Centre in Sex, Health & Society, La Trobe University.
- ⁵ Callander D, Wiggins J, Rosenberg S, Cornelisse VJ, Duck-Chong E, Holt M, Pony M, Vlahakis E, MacGibbon J, Cook T. (2019). *The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings*. Sydney, NSW: The Kirby Institute, UNSW Sydney. Available: https://kirby.unsw.edu.au/sites/default/files/kirby/report/ATGD-Sexual-Health-Survey-Report_2018.pdf
- ⁶ Australian Study of Health and Relationships (2014). *Sex in Australia 2*. Available: https://www.ashr.edu.au/wp-content/uploads/2015/06/sex_in_australia_2_summary_data.pdf
- ⁷ Hill et al. (2020)
- ⁸ Gibson et al. (2022)
- ⁹ Gibson et al. (2022)
- ¹⁰ Gibson et al. (2022)
- ¹¹ Molyneux, A., Delhomme, F., Mackie, B. (2021) *It's Who We Are: Exploring the Role, Impact and Value of Peers*. Sydney: ACON. Available: <https://www.acon.org.au/wp-content/uploads/2021/10/Its-Who-We-Are-Exploring-the-Role-Impact-and-Value-of-Peers.pdf>
- ¹² Molyneux, Delhomme & Mackie (2021)
- ¹³ Molyneux, Delhomme & Mackie (2021)
- ¹⁴ Bartholomaeus, C., & Riggs, D. W. (2020). Transgender and non-binary Australians' experiences with healthcare professionals in relation to fertility preservation. *Culture, Health & Sexuality*, 22(2), 129-145.
- ¹⁵ Waling, A., Bellamy, R., Ezer, P., Kerr, L., Lucke, J., & Fisher, C. (2020). 'It's kinda bad, honestly': Australian students' experiences of relationships and sexuality education. *Health Education Research*, 35(6), 538-552.
- ¹⁶ Family Planning NSW (2021). Comprehensive sexuality education: A framework.
- ¹⁷ Ezer, P., Kerr, L., Fisher, C. M., Heywood, W., & Lucke, J. (2019). Australian students' experiences of sexuality education at school. *Sex Education*, 19(5), 597-613.
- ¹⁸ Ezer, P., Kerr, L., Fisher, C. M., Waling, A., Bellamy, R., & Lucke, J. (2020). School-based relationship and sexuality education: what has changed since the release of the Australian Curriculum?. *Sex Education*, 20(6), 642-657.
- ¹⁹ Molyneux, Delhomme & Mackie (2021)
- ²⁰ Ending HIV, (n.d), About Undetectable and HIV. Available: <https://endinghiv.org.au/treat-early/about-undetectable/>
- ²¹ MacGibbon, J., Bavinton, B.R., Broady, T.R., Kolstee, J., Power, C., Molyneux, A., Ellard, J., Murphy, D., Heslop, A., Clackett, S., de Wit, J., & Holt, M. (2022). *Trends in attitudes to biomedical HIV prevention among gay and bisexual men: Key findings from the PrEPARE Project 2021*. Sydney: Centre for Social Research in Health, UNSW Sydney. DOI: <http://doi.org/10.26190/jpap-4w04>
- ²² MacGibbon et al.(2022)
- ²³ Riley, B. (2022) The revolution will not be biomedicalised. September 7. Available: <https://benjaminriley.com.au/2022/09/07/the-revolution-will-not-be-biomedicalised/>
- ²⁴ Bartholomaeus & Riggs (2020)



- ²⁵ Hill et al. (2020)
- ²⁶ Callander et al. (2019)
- ²⁷ Hill et al. (2020)
- ²⁸ Moseson et al. (2020)
- ²⁹ Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT health*, 3(6), 434-442.
- ³⁰ Kerr, Fisher & Jones (2019)
- ³¹ Coleman, E., Radix, A. E., Bouman, W.P., Brown, G.R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F.L., Monstrey, S. J., Motmans, J., Nahata, L., ... Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, 23(S1), S1-S260. <https://doi.org/10.1080/26895269.2022.2100644>
- ³² Bartholomaeus & Riggs (2020)
- ³³ Bartholomaeus & Riggs (2020)
- ³⁴ Cooper HC, Long J, Aye T (2022) Fertility preservation in transgender and non-binary adolescents and young adults. *PLoS ONE* 17(3): e0265043. <https://doi.org/10.1371/journal.pone.0265043>
- ³⁵ Tracy, J., Schluterman, N., & Greenberg, D. (2013). Understanding cervical cancer screening among lesbians: a national survey. *BMC Public Health*, 13(1). doi: 10.1186/1471-2458-13-442; Tracy, J., Lydecker, A., Ireland, L. (2002) Barriers to cervical cancer screening among lesbians. *Journal of Women's Health*, 19(2), p.229-237
- ³⁶ Johnson, Michael J ; Nemeth, Lynne S ; Mueller, Martina ; Eliason, Michele J ; Stuart, Gail W. (2016) Qualitative Study of Cervical Cancer Screening Among Lesbian and Bisexual Women and Transgender Men. *Cancer Nursing*, 39(6), p.455-463