Policy Document

Transgender Health and Access to Care (2021)

Position Statement

The Australian Medical Students Association (AMSA) believes that:

1. Gender is distinct from biological sex that is assigned at birth, and sexuality.
2. Gender and its expression exist on a spectrum, not within a male/female binary.
3. While many experiences of transgender, gender diverse and nonbinary (hereafter respectfully referred to as TGD) individuals mirror the difficulties faced by the LGBTQIA+ community as a whole, the TGD community faces unique challenges to their health and overall wellbeing.
4. Healthcare systems should not discriminate against individuals on the basis of their gender.
5. Systemic change within Australian society is required so as to acknowledge the diversity of gender.
6. All TGD individuals should have access to gender-affirming care.
7. More research needs to be conducted on the health needs of the TGD community.
8. TGD health is an intrinsic part of healthcare. All health practitioners and health students should have mandatory training into providing holistic healthcare to TGD patients.

Policy

AMSA calls upon:

1. The Commonwealth Government of Australia to:
    a. Include gender-affirming healthcare under Medicare and the Pharmaceutical Benefits Scheme (PBS) to improve access to gender affirming care.
        i. Create medicare items specific to specialist gender affirming services including, but not limited to, surgical procedures and post surgical care
        ii. To improve access to testosterone prescriptions for transgender men and gender-diverse assigned female at birth individuals.
    b. Increase transparency and accessibility to healthcare, education and support services to TGD individuals in rural and regional areas.
    c. Collect population data on numbers, demographic features and health statuses of TGD individuals in Australia through avenues such as the Census.

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d. Facilitate increased research and reliable data collection into TGD individuals, with disaggregation of collected data into the following communities, including, but not limited to:
    i. Rural and regional residents
    ii. Aboriginal and Torres Strait Islander peoples
    iii. Refugee and asylum seekers
    iv. Individuals experiencing homelessness
    v. People of culturally and linguistically diverse backgrounds.

2. Australian State & Territory Governments to:
    a. Establish health strategies and guidelines to cater for the specific needs of TGD peoples, in addition to those outlined for LGBTQIA+ health.
    b. Work with healthcare professionals to develop more inclusive TGD tailored health programs including, but not limited to:
        i. Moving away from the use of cis- and hetero-normative language within public health campaigns
        ii. Educational campaigns for TGD populations, including health screening and family planning
        iii. Increased support for community run peer support programs, such as providing resources to streamline access to gender affirming care.
        iv. Facilitating increased research and reliable data collection into TGD individuals in areas like family planning
    c. Prioritise the expansion of funded services, including family planning and screening programs, that cater to the specific needs of TGD individuals in consultation with organisations that represent TGD individuals in all relevant stakeholders and communities such as:
        i. Rural and regional residents
        ii. Aboriginal and Torres Strait Islander peoples
        iii. Refugee and asylum seekers
        iv. Individuals experiencing homelessness
        v. People of culturally and linguistically diverse backgrounds.

3. State Departments of Education to:
    a. Train teachers in the use of supportive language and inclusive behaviour towards TGD students and staff.
    b. Provide supportive environments for students to feel safe to advocate for their own rights and represented, including:
        i. Expand sex education to include sexuality education and for the curriculum to be more inclusive of TGD individuals.
        ii. Educate all students on pronouns use
        iii. Incorporate gender inclusive facilities, such as all gender toilets
        iv. Create inclusive administrative systems which allow students and staff to formally change name and gender markers.
    c. Engage with representatives from community peer support programs to improve awareness and understanding of the challenges faced by the TGD community and incorporate these into secondary school curricula.

d. Provide clear guidelines on the provision of inclusive preferred names and pronouns in school records.

4. Australian Universities and Medical Schools to:
   a. Provide inclusive TGD health education with acknowledgement of the variety of health and non-health related challenges unique to this community, including:
      i. Training educators in culturally safe practice, TGD content and facilitating safe classroom environments for TGD students.
      ii. Providing teaching programs which address the clinical and non-clinical aspects of gender affirming care
      iii. Incorporating TGD representation within teaching and examination, such as practical case-based learning (PBL) and objective structured clinical examinations (OSCEs).
   b. Create a safe, inclusive, and holistic learning environment for students who identify as TGD by:
      i. Providing opportunities for students to provide feedback on gender inclusive teaching such as through student evaluation surveys
      ii. Working with placement organisations to ensure they create a safe space for students who have diverse genders
      iii. Upholding individuals' pronouns and preferred names
      iv. Providing all gender toilets.
   c. Ensure administrative support processes are inclusive, safe and produced with consultation from the LGBTQIA+ community, particularly with regard to:
      i. Students who may need to alter gender markers on official documents;
      ii. Providing areas on official forms for students to indicate their pronouns and preferred name
      iii. Altering names in university records.

5. Medical, Nursing, and Allied Health Professionals and Students to:
   a. Be respectful, sensitive, and open-minded in acknowledging diverse gender identities and understand the unique healthcare challenges in which TGD individuals face.
   b. Provide safe spaces for TGD patients to express their health concerns by:
      i. Encouraging a safe, judgement-free space for TGD individuals
      ii. Reducing personal and workplace stigma surrounding TGD individuals, including challenging bias and stereotyping of TGD patients
      iii. Increasing visibility of TGD care within healthcare settings such as through displays which support and educate on TGD health.
      iv. Challenging attitudes and behaviours rooted in bias and stigma that are harmful to TGD individuals
      v. Tailoring services and resources which are required to address the specific and complex needs of TGD individuals, including the use of inclusive language, raising awareness for screening tests and family planning.

vi. Respecting the autonomy of TGD individuals on issues like fertility preservation

c. Incorporate greater systemic change within administrative and referral systems which are inclusive of, and acknowledge, the broad spectrum of gender which allow patients' freedom to express preferences regarding:
   i. Preferred name
   ii. Gender
   iii. Pronouns

6. Specialist Colleges and the Australian Medical Council (AMC) to:
   a. Support practitioners providing gender affirming care by providing guidelines on family planning and their work as allies and advocates for the TGD community.
   b. Provide training and support to general practitioners to provide sensitive and individualised care to TGD people seeking to access gender-affirming care via the informed consent model including:
   c. Expand specialist training pathways to incorporate modules to cater to the specific needs of TGD individuals
   d. Develop guidelines to cater to the specific healthcare needs of TGD including but not limited to contraceptive for TGD individuals
   e. Address gaps in TGD healthcare through endorsing medical curricula which are more inclusive of TGD healthcare provision.

Background

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia. AMSA is committed to promoting transgender, gender diverse and non-binary (TGD) health and ensuring that all patients have access to safe and effective medical care. AMSA seeks to advocate on issues that may compromise access to care or create avenues for healthcare discrimination.

The following working definitions, as they are in rapid and constant flux, will be used with respect to their meanings as defined by the Australian Institute of Family Studies [1].

- **Gender**: the socially constructed categories assigned to individuals on the basis of their assigned sex at birth.
- **Sex**: anatomical, chromosomal and hormonal characteristics which classify individuals as male, female or intersex at birth.
- **Gender identity**: An individual's perception of self as male, female, a combination of both, or neither. One's gender can be the same or different from their sex assigned at birth, and may change over time.
- **Transgender, or trans**: an umbrella term used to describe people whose gender does not exclusively align with the one they were assigned at birth.
- **Gender diverse**: an umbrella term encompassing a range of genders expressed in different ways, including, but not limited to genderfluid, genderqueer, agender, and gender non-conforming individuals.
- **Non-binary**: a term used to describe gender identity that does not conform to traditional gender norms and may be expressed as other than woman or man, including gender neutral and androgynous.

- **Cisnormativity**: the view that everyone is cisgender and that all people will continue to exclusively identify with the gender they were assigned at birth. This view invalidates the existence of TGD people.
- **Heteronormativity**: the view that heterosexual relationships are the only natural, normal and legitimate expressions of sexuality and relationships, and that other sexualities or gender identities are unnatural and/or a threat to society.

It should be noted that Sistergirl and Brotherboy are terms used by Aboriginal and Torres Strait Islander people to describe gender diverse people that have a female or male spirit respectively, and take on respective roles within the community [2].

Mental and Physical Health

The mental and physical health of TGD people is inextricably linked to societal stigma and discrimination driven by a cisnormative culture. Unfortunately, experiences of transphobia remain common, with nearly two-thirds of TGD people in Australia reporting some form of abuse or social exclusion within a 12-month period [3]. This stigma leaves TGD people feeling unsafe and unsupported, which can exacerbate existing health inequities. Within TGD populations, there is a higher prevalence of negative social determinants of health, such as homelessness, underemployment or unemployment, and a much higher rate of experiencing verbal, physical, and sexual abuse compared to the general Australian population, thus leading to a greater risk of being trapped in a cycle of poverty [4]. Most studies show that TGD mental health is significantly worse than that of the general population in Australia, however, exact numbers often vary significantly across studies. According to a survey of 1527 young TGD Australians, over 90% of participants reported high or very high levels of psychological distress, compared to the moderate or high levels reported by the overall population [5]. They were also fifteen times more likely to attempt suicide, and over 53% of TGD adults have self-harmed [5]. Though specific population data for Australia is unavailable, globally, TGD people share a higher burden of disease, with higher comorbidities [6].

TGD people may also face many unique mental health challenges such as gender dysphoria and distress caused by the inability to affirm their gender. Gender dysphoria describes the psychological distress that may be experienced when one's gender identity is incongruent with their sex assigned at birth [7]. It is recognised as a formal medical diagnosis in the DSM-V and is almost exclusively experienced by either TGD people or by people who are intersex. It is important to note that not all TGD people experience gender dysphoria. Medical consensus states that gender dysphoria can be alleviated through mental healthcare and gender-affirming therapies. Gender affirmation may be social, legal, medical or surgical, and different TGD people will have different preferences for the forms of affirmation they desire [7]. Social affirmation can come in the form of using a chosen name and pronouns, or even changing the way individuals present themselves. Legal affirmation may involve updating names, pronouns or other gender markers on official documentation so that legal and legislative systems affirm the individual's gender. Medical affirmation describes the use of hormones, puberty blockers, or speech therapy whilst surgical affirmation usually involves breast or genital reconstructions, facial plastic surgeries or laryngeal shaves, though, this is not an exhaustive list of the forms of gender affirmation that TGD people may choose to use [8]. A recent survey indicated that only 24% of TGD youth in Australia felt supported in their gender affirmation process with the remainder feeling that their affirmation was denied, delayed or controlled [4]. Denial of access to gender-affirming care increases the risk of depression and anxiety which may then manifest as self-harm, or suicidal ideation and attempts [6]. It also

causes many TGD people to access hormones illegally, which carries serious medical, social and financial implications [3]. For example, hormone use without medical input increases the risk of cardiovascular complications such as VTE [9] and may also impact bone health by increasing the risk of osteoporosis [10]. The financial burden of illegally accessing hormones may also increase the risk of homelessness or participation in high-risk occupations.

Stigma also creates physical health inequities for TGD people. Large gaps exist in the provision of sexual healthcare due to its currently cisnormative nature; while there is a lack of data for TGD people in Australia, there is evidence that TGD people face a higher HIV risk globally [7, 11]. Reference ranges for several measurements, such as kidney function, are based on sex. Furthermore, current medical systems often fail to account for TGD patients and the impacts of long-term hormone use on these variables, hence further complicating their healthcare due to a lack of inclusion within medical research [12]. Globally, cisnormative language also creates significant barriers to access to screening programs, such as breast, prostate or cervical cancer screening, potentially worsening health outcomes for many TGD people [13]. This is exemplified through a survey undertaken by BreastScreen Victoria where TGD individuals who were eligible for breast cancer screening expressed that the material surrounding breast cancer screening was often triggering due to its highly feminised language and heavy use of feminised imagery such as the bright pink logos [14].

While the evidence for inequity is overwhelming, a clear picture of its extent in Australia cannot be drawn due to the lack of population data which would enable comparisons between the TGD and the general Australian population to be made [15]. Such population data would be best obtained through avenues such as the national census data by the Australian Bureau of Statistics, however, the most recent census failed to achieve this as it only asked questions regarding sex and omitted any mention of gender identity [16]. Additionally, current research does not disaggregate TGD people from the rest of the LGBTQIA+ population. Research needs to account for the diversity within the TGD community, as the unique barriers faced by Aboriginal and Torres Strait Islander [17], rural and regional [18, 19], refugee [20], homeless, low income, migrant or disabled [21] TGD populations are currently not acknowledged [22, 23].

Barriers

In Australia, TGD people continue to experience numerous barriers in accessing safe health care [24]. One of the most significant being a lack of access to providers sufficiently knowledgeable in providing gender-affirming care [4, 25]. Gender-affirming care can include hormonal treatments, genital surgical interventions, non-genital surgical interventions and/or psychological support [26]. Other barriers include discrimination, socioeconomic barriers, financial barriers, and a lack of cultural competence by providers [18, 27]. These barriers must be recognised and addressed to improve the quality of healthcare provided to the TGD community to a level that is commensurate with the general population.

<u>Access to Gender Affirming Care</u>

The most recent 'Writing Themselves In' survey - a national survey of the health and wellbeing of LGBTQIA+ individuals reported that only 17.1% of TGD youth felt supported to affirm their gender via access to puberty blockers [4]. Timely access to TGD healthcare has been associated with better psychological outcomes [28, 29, 30]. However, with ballooning wait-times in accessing these services through public gender clinics, and challenges in finding doctors who are able and willing to provide gender-affirming care creates unnecessary distress. To improve access, the informed consent model of care was first created in 2017 by the Equinox Gender Diverse Health Centre in Melbourne [31]. These guidelines were endorsed by the Australian

Professional Association for Transgender Health and Gender Clinic, whereby the General Practitioner is the primary care provider responsible for the provision of gender-affirming hormone therapy (GAHT). This model places an emphasis on individualised, patient-centred care and self-determination. While mental health professionals remain a key source of support, this model has been shown to have beneficial psychological outcomes and higher patient satisfaction [32]. The informed consent model has largely replaced the 'Approval Letter' method which requires a written endorsement from a mental health professional prior to starting hormones. Whilst the latter remains a viable pathway to access gender affirming care for many, it creates unnecessary obstacles in accessing GAHT and can lead to adverse psychological outcomes for patients, including an increased risk of post-traumatic stress disorder [32]. Therefore, increasing uptake of an informed consent model amongst General Practitioners could be a practical solution to alleviate increasing demand and pressure on public gender clinics.

Stigmatisation

TGD individuals will likely have lengthy contact with healthcare providers, particularly when commencing gender-affirming care. Stigma and acts of discrimination can also be perpetrated by health service providers and lead to patients becoming hesitant in accessing appropriate and timely medical services [27]. Even the provision of GAHT still contains elements that perpetuate the pathologisation of TGD people. Generally when a person is prescribed hormones, the treating physician will use a diagnosis such as androgen deficiency or estrogen deficiency as there are no Medicare codes specific to trans individuals [33].

The impact of stigma and misgendering on one's mental and physical health can be profound and long lasting. Institutional change is required to improve health equity for TGD individuals nation-wide. Practitioners providing care to TGD people, especially those publicly advocating for improvements in the care provided to TGD children and adolescents, are also vulnerable to harassment from media outlets and subsequent societal stigma [34]. The provision of inclusive care for TGD individuals is not solely reserved for those with an interest in TGD, sexual, and/or reproductive health, but should be the responsibility of every healthcare provider, free from persecution or marginalisation.

Access to Specialist Care

In the provision of individualistic care for those seeking gender affirmation, specialist consultations are sometimes required to address the complex needs of certain patients and patient groups .This includes, but is not limited to paediatric and adult endocrinologists, sexual health physicians, gynaecologists, urologists, speech therapists, general surgeons, plastic surgeons and specialists in post-surgical care. However, due to high demand and a lack of availability many patients experience lengthy wait-times, which impairs their access to healthcare [35]. In 2003, the Royal Children's Hospital of Melbourne established the first Multidisciplinary Gender Service to simplify the process of accessing these services and the number of patients referred annually has since grown exponentially [36]. Australian Governments have recognised the success of this program and have since supported the creation of other multidisciplinary services; however, patients can wait over a year to be seen [18]. Expanded funding of public gender services could help address the complex needs of certain patient groups as an adjunct to the informed consent model in accessing gender-affirming care.

Financial Barrier

Financial cost is also a prohibitive factor in accessing gender affirming care [18]. Most hormonal therapies are readily accessible under the Pharmaceutical Benefits Scheme. However, in 2015 the Pharmaceutical Benefits Advisory Committee (PBAC)

introduced new requirements for accessing testosterone formulations, determining that either the treating GP or the patient must have first consulted with an endocrinologist, urologist, paediatrician or sexual health physician before testosterone can be prescribed [35]. This can increase the financial and psychological burden on those patients who are required to pay for and attend these additional specialist consultations [22]. Furthermore, for individuals living in regions where fewer gender services are available, access to low-cost options may be limited. The alternative is having a GP write a private script for unsubsidised hormonal therapy which significantly increases the cost per script. Haire et al. found that the cost of attending health services (including travel and other copayments) forced individuals to choose services on the basis of bulk billing and convenience of location instead of "seeking out trans-friendly recommended providers"[24]. The economic burden that accompanies GAHT can then impact accessing other health services.

Some patients may seek surgery as part of affirming their gender and often through the private health system, where out of pocket costs can be exorbitant. Chest surgery can cost up to $10,000, vaginoplasty can cost between $25,000-$30,000 [18], and phalloplasties can cost between $50,000 to $80,000 [36]. To assist with these financial burdens, an individual may be granted an early release of their superannuation on compassionate grounds. However, even then, some gender affirming surgeries are not readily accessible in Australia. As a result of these financial barriers, it is common for TGD people to undergo surgery overseas, which can lead to issues in accessing safe and effective post-surgical care [36, 37]. For many TGD people, altering their body can be integral to their care if they are experiencing distress or incongruence between their gender identity and their body. Urgent action is required to ensure TGD can access the care necessary for them to affirm their gender through the public health system.

Medical systems

Whether or not clinicians and medical systems demonstrate inclusivity towards the TGD community is a factor that can profoundly impact a TGD patient's ability and/or desire to access and receive appropriate healthcare. It is therefore important to understand which behaviours and aspects of the medical system are appropriate, and inappropriate, in delivering holistic and accessible care to TGD individuals.

TGD individuals frequently experience gatekeeping when seeking gender-affirming care; that is, to experience many unnecessary and unfair hurdles that may delay, deter or bar an individual from accessing a service [38]. Oftentimes, these attitudes and systems are strongly rooted in stigma and prejudice, and can result in clinical decisions that make the TGD patient feel invalidated [38]. For example, they may require a psychiatric or endocrinological assessment to prove they are 'transgender enough', or be denied gender-affirming care because they do not fit the clinician's expectations for a transgender individual [38]. The latter especially evidences how medical systems can fail to acknowledge the diversity of the TGD experience, and sustain an unjustified double standard of healthcare provision towards TGD patients [39]. It is hence clear how medical systems and clinicians can impinge on TGD individuals' ability to access timely and safe healthcare [38].

This lack of accessibility may be further compounded by transphobic attitudes from practitioners and administrative staff which can manifest as misgendering, deadnaming and excessive and invasive questioning [22, 38, 40]. 53% of young TGD individuals indicate negative past experiences with clinicians for reasons such as inappropriate language use, feeling invalidated or not being listened to, and being deliberately and consistently misgendered [18]. These negative experiences can severely impact health-seeking behaviours and TGD health outcomes [18, 38]. Further disaggregation of this data shows 11% chose not to complain due to fearing denial of

gender-affirming care, 22% avoided healthcare for a period of time and 11% chose not to see clinicians at all [18].

Furthermore, most electronic medical record systems and medical forms, such as pathology and referral forms, only record sex and legal names [40,41]. The inability to provide gender identity and preferred names constitutes a form of structural violence [40], by creating a hostile and distressing environment for patients [41]. Inaccurate pronouns and names on medical records can further license transphobic behaviour in healthcare settings, such as the aforementioned deadnaming and misgendering, and exclude TGD individuals from accessing pertinent and acceptable healthcare. Unfortunately, most systems are not built to accommodate this information, and thus compromise health outcomes for TGD individuals.

Conversely, TGD patients reported greater satisfaction and increased engagement with healthcare services that provided sensitive and holistic care [22, 41]. Such services created welcoming spaces through respectful, patient-centred healthcare and displays of support and education on LGBTQIA+ health [22]. Moreover, institutions that provided additional support for mental wellbeing and the navigation of gender further enhanced the continued uptake of health services by TGD patients [41]. Improvements in the healthcare system to combat stereotyping, prevent language and systems which perpetuate transphobic attitudes and create safe spaces for gender is therefore paramount to improving TGD experiences and health outcomes.

Rural and Regional Healthcare

Rurality compounds the challenges of accessing streamlined gender-affirming healthcare, [18, 19]. The exact impact of rurality on TGD health outcomes, however, is difficult to gauge as there is limited research on the topic. Moreover, what little research has been conducted on Australian TGD health is heavily concentrated in metropolitan inner city regions. For example, a cross-sectional study investigating the health status and needs of transgender Australians reported 83% of respondents resided within inner city regions, RA1 with accordance to the Australian Standard Geographical Classification-Remoteness Area coding [42]. Unfortunately, data aggregated in mostly metropolitan regions is non-generalisable, therefore highlighting the need for more rural- and regional-specific research in order to better evaluate their outcomes for TGD health and education

Most of the major TGD-specific support services and healthcare networks are metropolitan-based, hence posing accessibility issues for TGD individuals living in rural and regional Australia [19]. With increasing rurality there are fewer low-cost options and more complex pathways to accessing gender-affirming care, which is expounded by the distance between services and a lack of doctors willing to facilitate such care [42]. Despite this, many TGD individuals prefer consulting with local services or online support systems due to the financial burden of commuting to the city [18,22,41]. This trend is reflected by a report from Melbourne's Royal Children's Hospital, which found that despite a forty-fold increase in referrals to gender-identity services over 2003-2013, only a quarter of those were for patients from regional and rural Victoria [23].

TGD health discrepancies in rural settings are further exacerbated by social stigma [41, 43]. A United States based survey found rural TGD individuals reported significantly lower self-esteem, increased incidences of depression and anxiety and were more likely to engage in riskier behaviours, such as substance use, heavy alcohol drinking on a regular basis, binge drinking, marijuana drug use and unprotected sex [43]. This data demonstrates that TGD patients within rural settings are at higher risk of worsened health outcomes, which may be due to health literacy,

attitudes towards TGD populations and stigma, compared to metropolitan equivalents.

In rural and regional Australia, there is insufficient access to healthcare practitioners who are willing and competent in caring for TGD patients, hence compromising their health and safety by limiting access to vital health services and TGD-friendly spaces.

Screening

There is a significant barrier for TGD to access screening services. According to a survey done by Australian Research Centre in Sex, Health, and Society, only 11.2% of participants have done a mammogram for breast cancer screening and only 2.1% have had a prostate check via rectum [13]. However, 54% participants have performed a self-check on breast or chest tissue, indicating although many people are concerned about breast cancer, they are still reluctant to participate in national screening programs [13].

In terms of cervical cancer screening, the National Cervical Screening Program clearly states that all individuals with a cervix are eligible for a cervical screening test [44]. However, there still remains a significant proportion of TGD individuals who are not regularly screened. Only 18.7% of eligible TGD individuals are regularly screened according to the guidelines and 54.3% of eligible TGD individuals have never had cervical screening [45]. Reasons given by TGD individuals as to why they chose to not have cervical screening include "I don't think I need one (28%)", "it's embarrassing and frightening (52%)", "I'm worried about homophobia or transphobia (20%)", and "I am concerned that I will be misgendered (16%)" [46]. Hence, it is clear that solely depending on the government recommendation to increase awareness and participation is insufficient in building an inclusive screening program for TGD individuals. Insensitive attitudes from medical professionals also present a barrier to accessing healthcare. Therefore both stakeholders, the government and medical professionals, hold vital roles in raising awareness within TGD community about the importance of screening tests and their entitlement to cervical screening.

Family Planning and Reproductive Health

Many gender affirming therapies, both hormonal and surgical, cause partially reversible or permanent damage,but despite being significantly linked to the patient's quality of life, the consequences of gender affirming therapies for fertility are often not thoroughly discussed with patients [47,48]. Feminising hormone therapy interrupts spermatogenesis and masculinising hormone therapy stops ovulation, either reversibly or irreversibly depending on regime and duration, and predictably the surgical removal of reproductive organs via a hysterectomy or orchiectomy causes complete, irreversible infertility. More recently the World Professional Association for Transgender Health (WPATH) placed an emphasis on reproductive rights, including the ability to have biological children if one wishes to after transition [48]. In the WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (SOC), it is recommended that "fertility preservation should be offered to anyone considering undertaking medical treatment which may have a permanent impact on their fertility" [48]. However, the 2018 Australian TGD Sexual Health Survey found that less than half of the participants, many of whom have already undergone some kind of gender affirming therapy, had been given information on reproductive health and fertility preservation options [49]. The lack of counselling around fertility preservation deprives many TGD individuals of their reproductive rights.

Common ways to preserve fertility include sperm, oocyte, and embryo cryopreservation [50]. However, as gamete cryopreservation costs $300-$500 per year and IVF costs $15,000-20,000 per attempt, the financial burden of undertaking these

procedures often precludes TGD individuals from preserving their fertility before undergoing gender affirming therapies [48]. While fertility preservation may be important for some individuals, medical professionals should always respect the autonomy of TGD individuals in regards to their decisions of preserving or not preserving fertility.

Specific guidelines around contraceptive counseling for TGD individuals have not yet been established due to a lack of research [51]. However, many patients are unaware that testosterone and oestrogen therapy do not act as contraceptives, since breakthrough ovulation can still occur and spermatogenesis may not completely cease. One study found that 24% of transgender male participants became pregnant after gender affirming therapies [52]. Not only is pregnancy itself an emotionally draining process, unintended pregnancies can pose great challenges to TGD individuals' social situation and gender identity. Hence developing specific guidelines for contraceptive counseling is an important factor in respecting the reproductive rights and autonomy of TGD individuals.

Education of Healthcare Professionals

It is clear from previous discussion that healthcare professionals and their ability to provide appropriate TGD-specific care are crucial factors in improving TGD health outcomes. Therefore, as demand for such services grows, so does the need for better education of healthcare professionals and students on the topic [53].

Australian medical schools currently provide limited teaching on TGD healthcare. Only 33% of schools have modules dedicated to sexuality in their curriculum, while most others only briefly and superficially touch upon the topic [54]. Even then, teaching on TGD healthcare tends to be grouped under a generalised coverage of LGBTQIA+ healthcare, which results in only a superficial understanding of the TGD community's specific needs [54]. Moreover, there is also a lack of education on TGD healthcare in post-medical school training, including for specialties like endocrinology which are more relevant to providing gender-affirming care. 60% of endocrinologists reported having no training in transgender medicine during their specialty training and 75% of endocrinologists did not feel confident in commencing hormone therapy in transgender patients [55].

The challenges of providing gender-affirming care are further compounded by a lack of clear guidelines surrounding the issue [53]. As a result, TGD patients report having to educate their healthcare providers on the provision of safe and appropriate healthcare, leaving undue burden on this vulnerable population group [27, 56]. This role reversal has the potential to jeopardise the trust between TGD patients and health professionals, further barring future positive interactions with health professionals. Improvement in education of healthcare workers would not only reduce discrimination but also address the issue of reduced accessibility and availability of gender-affirming health services [53].

As holistic, multidisciplinary care becomes increasingly favoured in today's medical scene, it is just as important to educate allied health professionals as it is to train medical staff on providing safe and appropriate healthcare. However, current allied healthcare students across various fields of physiotherapy, pharmacy, and psychology reported little to no formal training in TGD care [54].

Educating medical and allied health professionals on TGD-specific healthcare would greatly improve TGD health outcomes [27]. Ensuring that all health professionals are capable of providing competent care to TGD patients would expand the range of options clients have so that they may more easily find a medical professional who can best fulfil their needs [27]. This universal competency amongst health professionals in caring for TGD patients would also help normalise and validate TGD identities in

healthcare. Therefore, education of medical and allied health professionals is an essential part in reducing discrimination of TGD patients, improving access to healthcare and bolstering the overall wellbeing of the TGD community [27].

Secondary education

The discrimination that young TGD people experience in school can be linked to difficulties in accessing further education and employment later in life, as well as being a major driver for poorer health outcomes.

Currently, there is a lack of relevant and inclusive teaching about gender diversity in secondary sex education. Consequently, strategies used to support same-sex attracted youth tend to be extrapolated to the TGD student community, whose unique needs are overlooked as a result [57]. Two-thirds of student participants in an Australia-wide study from both government and non-government schools reported sexuality and puberty education being 'mostly inappropriate' with one student reporting "no mention of trans or intersex" and "mostly intolerant teachers" [57]. Other reports of negative experiences in secondary education include being "made to use a disabled toilet instead of male toilets", being unable to formally change to their gender on school records (only 10% of whom were able to do so, whereas another 41% had wanted to), and strongly gendered uniforms [57]. Broad revision to secondary school curriculum that prioritises diversity in the student body is intrinsic to improving TGD experiences and awareness towards TGD health.

Further, supportive teachers and peers are key protective factors for TGD students [57, 58]. Survey participants who reported no teacher support were over four times more likely to leave school (23% as compared to 5% who had safer, more inclusive school environments) [57]. Conversely, students who lacked supportive classmates were more likely to experience various forms of harassment in school, including cyberbullying and social exclusion [57]. Training school staff and students on providing a safer environment such as through teaching appropriate language and pronoun use, adopting supportive and inclusive behaviours towards TGD students, and negotiating for inclusive administrative systems, facilities and uniforms, markedly improve TGD experiences in secondary schooling by acknowledging diversity within social communities and providing localised and accessible peer and school-based support to TGD students [57]. Improving positive experiences in secondary schooling through more inclusive and peer-supported environments will consequently assist in educational attainment and better physical and mental health outcomes for TGDB students.

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Policy Details

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