Policy Document

Transgender Health and Access to Care (2025)

Executive Summary

*'There needs to be a more vocal acknowledgment of not only acceptance of transgender people in health care, but condemnation of policies/beliefs that target this minority.'**

Transgender and gender diverse people must have access to accessible high-quality healthcare. This policy supports and guides AMSA in its advocacy for this right. Healthcare covered by this policy includes medical, surgical, mental health, family planning and reproductive care, as well as screening programs. High-quality healthcare considers and is responsive to the unique needs and circumstances of each person, and the communities each person identifies with. This is the standard that all people deserve. Trans and gender diverse people must not be forced to settle for less.

This policy respectfully uses TGD hereafter to refer to transgender and gender diverse people and communities.

High-quality healthcare for TGD people must be gender-affirming, delivered by healthcare professionals who are confident and competent in their knowledge and ability to serve the TGD community, and delivered by healthcare systems dedicated to redressing inequity in access. This necessitates improving education and training for both medical and allied health professionals, to enable provision of holistic, safe and appropriate multidisciplinary care to TGD people. This policy also addresses the experiences of TGD people during secondary education, highlighting the impact these experiences can have on the social determinants of health, and advocating for solutions that will foster respect and self-expression.

The policy background explores challenges in TGD health and access to care, considering gender-affirming care, stigmatisation, financial cost, medical systems, screening programs, family planning and reproductive health, and rural healthcare and its accessibility. It frames solutions around models of care, clinical practice, and addresses issues unique to rural settings. Solutions are further developed as policy points.

In recent years, public discourse regarding healthcare for TGD people has increasingly platformed views that undermine better healthcare outcomes and

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healthcare access. Politicians and politically motivated media personalities in Australia (and elsewhere) have attacked healthcare through transgender people for perceived political gain. AMSA stands for gender-affirming care for all TGD people and has consistently refuted these attacks. It is likely that AMSA will need to consistently reaffirm our stance against these regressive trends, and respond to policy developments like the forthcoming National Health and Medical Research Council "National clinical practice guidelines for the care of TGD people under 18 with gender dysphoria", as we continue to advocate for the best possible health outcomes and access to care for TGD people.

**Quote from medical student feedback*

Policy Points

AMSA Calls upon:

1. The Commonwealth Government of Australia to:

a. Establish health strategies and guidelines to cater for the specific needs to TGD people, in addition to those outlined for LGBTQIASB+ health;
b. Include gender-affirming healthcare under Medicare and the PBS to improve access to care by:
    i. creating Medicare items specific to specialist gender-affirming services including, but not limited to:
        1. gender-affirming hormone therapy;
        2. puberty-blockers;
        3. surgical procedures; and
        4. post-surgical care;
    ii. improving access to testosterone prescriptions for transgender men and gender-diverse people presumed female at birth; and
    iii. extending eligibility to include young people under 18 years of age, ensuring timely access to transition-related care and treatment.
c. Increase transparency and coordinate equal access to healthcare, education and support services to TGD people in rural and regional areas;
d. Collect population data on numbers, demographic features and health statuses of TGD people in Australia through avenues such as the Census; and
e. Prioritise increased research and reliable data collection into TGD People, with leadership and funding support from the National Health and Medical Research Council (NHMRC), ensuring 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. people experiencing homelessness; and
    v. people of culturally and linguistically diverse backgrounds.

2. Australian State and Territory Governments to:

a. Establish health strategies and guidelines to cater for the specific needs to TGD people, in addition to those outlined for LGBTQISB+ health;
b. Work proactively with healthcare professionals to develop inclusive TGD health programs reflecting the TGD lived reality including, but not limited to:
    i. adopting affirming and inclusive language in public health campaigns, free from cis- and hetero-normative assumptions;
    ii. educational campaigns for TGD populations, including health screening and family planning;

iii. increasing support for community-run peer support programs, such as providing resources to streamline access to gender-affirming care or establishing online networks;
iv. facilitating increased research and reliable data collection into TGD people in areas like family planning and puberty blockers; and
v. engaging multidisciplinary care with clear pathways to refer patients and for patients to access psychology, endocrinology, and surgical services.

c. Prioritise the expansion of funded services, including family planning and screening programs, that cater to the specific needs to TGD people in consultation with organisations that represent TGD people 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. people experiencing homelessness; and
    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. Guarantee safe and supportive environments for all students to feel represented and advocate for themselves by:
    i. expanding sexual health education to include comprehensive sexuality education that is standardised nationwide with clear mandatory reporting requirements;
    ii. educating all students on respectful pronoun use and gender diversity;
    iii. incorporating gender-inclusive facilities, such as all-gender toilets; and
    iv. creating inclusive administrative systems which allow students and staff to formally change name and gender markers.
c. Work directly and collaboratively 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; and
d. Provide clear guidelines on the provision of inclusive preferred names and pronouns in school records.

4. Australian Universities and Medical Schools to:

a. Embed inclusive TGD health education, guided by the AMSA LGBTQIASB+ Curriculum Guide, within all medical programs, acknowledging both health and non-health challenges faced by this community. This must include:
    i. training educators in culturally safe practice and TGD-specific content while facilitating safe classroom environments for TGD students;

ii. teaching programs which address the clinical and non-clinical aspects of gender affirming care;
iii. incorporating TGD representation within teaching and examination, including materials authored by TGD people, lived-experience workshops, communication skills training and objective structured clinical examinations (OSCEs);
iv. ensuring consistency across medical schools in the depth and quality of TGD teaching; and
v. formal assessment of student competency in TGD health, including communication skills and clinical knowledge.

b. Commit to creating 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 each persons' pronouns and preferred names;
iv. providing all gender toilets; and
v. establishing clear grievance and escalation processes for students who experience discrimination or exclusion on the basis of gender diversity.

c. Ensure administrative support processes are inclusive, safe and produced in consultation with LGBTQIASB+ communities, 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; and
iv. include pronouns on university student and staff name badges.

5. Medical, Nursing, and Allied Health Professionals and Students to:

a. Demonstrate respect, sensitivity, and open-mindedness when acknowledging diverse gender identities and understand the unique healthcare challenges faced by TGD people;

b. Provide safe spaces for TGD patients to express their health concerns by:
i. addressing personal and workplace stigma through education, reflection and policies that challenge bias and stereotypes;
ii. increasing visibility of TGD care within healthcare settings such as through displays which promote inclusion and awareness;
iii. challenging attitudes and behaviours rooted in bias and stigma that are harmful to TGD people;
iv. tailoring services and resources to the specific and complex needs of TGD people, including the use of inclusive language, raising awareness for screening tests and family planning; and
v. respecting the autonomy of TGD people in decisions regarding fertility preservation.

c. Advocate for greater systemic change within administrative and referral systems which are inclusive of, and acknowledge, the broad spectrum of gender identities which allow patients' to express preferences regarding:
    i. preferred name;
    ii. gender; and
    iii. pronouns.
d. Facilitate events, organisations and student societies that are inclusive, judgement-free and safe for TGD people, including the introduction and normalisation of pronouns, inclusive language and prioritising use of inclusive venues.

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 including:
    i. gender-affirming care via the informed consent model;
    ii. mental health support;
    iii. sexual health services;
    iv. young people and their families; and
    v. people considering de-transition.
c. Expand all specialist training pathways to incorporate modules to cater to the specific needs of TGD people, for example:
    i. communication skills; and
    ii. gender-affirming surgeries.
d. Develop clear, enforceable guidelines to cater to the specific healthcare needs of TGD including, but not limited to, contraceptives and screening for TGD people; and
e. Endorse AMC accreditation guidelines requiring medical schools to include compulsory assessment of student competency in TGD health.

Background

MENTAL AND PHYSICAL HEALTH

The mental and physical health of TGD people is inextricably linked to societal stigma and discrimination driven by a cis-normative culture. As such, transphobia remains heavily prominent, with nearly two-thirds of TGD people in Australia reporting abuse or social exclusion within a 12-month period (1). TGD people in Australia face significantly higher rates of mental health challenges, whereby approximately 43% had attempted suicide in the past; a stark contrast compared to the general population's rates (3.3%) (2). Depression and anxiety disorders are significant concerns, with a 2024 study reporting approximately 40.9% of TGD people experiencing depression in the past year and 29.1% experienced anxiety (3). Additionally, approximately one-quarter of TGD people have engaged in substance use in the past month, attributable to the stigma (2). These figures highlight the pressing need for healthcare systems to provide inclusive and accessible care to address the unique psychological and emotional needs of this community (4). A higher prevalence of negative social determinants for health, such as homelessness and unemployment, coupled with experience of abuse can induce a greater risk of being trapped in a cycle of poverty (4). Though specific population data for Australia is unavailable, globally, TGD people share a higher burden of disease, with increased rates of comorbidities (5).

Hormone therapy is a critical aspect of transgender healthcare; however, it requires careful monitoring and management by doctors to mitigate potential long-term health risks. For example, hormone use without medical input increases the risk of cardiovascular complications such as VTE (6) and may also impact bone health by increasing the risk of osteoporosis (7). Furthermore, a 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). Access to gender-affirming care decreases the risk of depression and anxiety, preventing self-harm, suicidal ideation and attempts (8). Over 59% of TGD people report difficulty in accessing hormonal treatment, with some not being able to find a doctor to prescribe (9). These challenges underscore the importance of a healthcare system that is informed, inclusive, and responsive to ultimately ensure comprehensive care that addresses both physical and hormonal health.

CHALLENGES

In Australia, TGD people continue to face numerous challenges in accessing safe health care. These include limited access to providers knowledgeable in gender-affirming care (4,10), such as hormonal treatments, genital and non-genital surgical interventions, and psychological support (11). Additional challenges include discrimination, financial and socioeconomic constraints, and a lack of cultural competence among providers (12,13). Overcoming these challenges is essential to ensure that the quality of health care available to the TGD community is commensurate with that of the general population.

Gender-Affirming Care.

Gender-affirming care is care that supports a person's gender identity (14). The most recent national survey of the health and wellbeing of LGBTQIA+ people, 'Writing Themselves In', reported that only 17.1% of TGD youth felt supported to affirm their gender via access to puberty blockers (4). In Australia (at time of writing excluding Queensland), TGD youth under 18 may commence puberty blockers with informed consent from themselves and a guardian or in cases of disagreement, the Family Court. Their doctor must fulfil key requirements: a diagnosis of Gender Dysphoria in Adolescence by a qualified mental health clinician, a medical assessment including fertility preservation, and the attainment of at least Tanner stage 2 pubertal status (15). Insufficient parental support and concerns about parental discovery are key challenges that leave some youth unable to access hormone therapy (16,17). These are compounded by a lack of practitioners with competency in gender-affirming care, delaying the initiation of treatment.

Legal access to gender-affirming care for young TGD people continues to be a challenge. In January 2025, Queensland paused the provision of puberty blockers and hormone therapies for new patients under the age of 18 (18). A lack of access to puberty blockers leads to significant, well-documented negative outcomes, including higher rates of depression, suicidal ideation, and self-harm among TGD youth, due to pubertal changes that exacerbate gender dysphoria (8,19). Young people on puberty blockers have very high rates of satisfaction and continuity of care, and low rates of regret after commencing therapy (20,21). While clinicians are supported by a well-established gender-affirming model of care, there is no established clinical framework for when people request to de-transition (22). Reasons for de-transition are complex and often involve external factors, resulting in a need for clinicians to better understand how they can best provide support and care when these requests are made (22,23).

Stigmatisation.

Stigma and acts of discrimination by health providers can discourage TGD patients from accessing appropriate and timely medical services (12). The impact of stigma on one's mental and physical health can be profound and long lasting, promoting substance abuse, eating disorders, ineffective coping, lower self-esteem and suicidality, as well as reduced healthcare utilisation and delayed treatment (24,25). Practitioners who publicly advocate for improvements in care provided to TGD children and adolescents are also vulnerable to harassment from media outlets and societal stigma (26).

Transphobic attitudes from medical practitioners and administrative staff can manifest as misgendering, deadnaming and excessive and invasive questioning (27–29). 53% of young TGD people 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 (13). These negative experiences can
severely impact health-seeking behaviours and TGD health outcomes (13). 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 (13).

Financial Cost.

Financial cost is also a prohibitive factor in accessing gender affirming care (13). Most hormonal therapies are readily accessible under the Pharmaceutical Benefits Scheme, but a consultation with an endocrinologist, urologist, paediatrician or sexual health physician by the patient or treating GP is required before testosterone can be prescribed (30). This can increase the financial and psychological burden on patients who are required to pay for and attend these additional specialist consultations (27). The cost of attending health services (including travel and other co-payments) can force TGD people to choose services on the basis of bulk billing and convenience of location instead of "seeking out trans-friendly recommended providers".

Some patients may seek gender-affirming surgery (GAS), leading to exorbitant out-of-pocket-costs as most are not covered under Medicare and provided by the private system. Chest surgery can cost up to $10,000, vaginoplasty can cost between $25,000-$30,000 (13), and phalloplasties can cost between $50,000 to $80,000 (31). 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 due to a lack of language, family and community support (32).

Medical Systems.

The degree to which clinicians and healthcare systems foster inclusive practices towards TGD people significantly influences both the accessibility and quality of care. 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 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 people (33). In primary care systems, TGD people frequently experience gatekeeping, which prioritises the clinician's own subjective eligibility criteria to determine if a patient is ready to engage in the medical transition (34). Oftentimes, clinician attitudes and systemic biases are strongly rooted in stigma and prejudice, and can result in clinical decisions that cause the TGD patient to feel invalidated (35). For example, they may require a psychiatric assessment to prove they are 'transgender enough' (35). This 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 compared to cisgender patients who can seek treatments without a psychological assessment (36). Additionally, access to GAS is a key challenge in Australia, with few surgeons capable of providing GAS (2).

Furthermore, most electronic medical record systems (eMRs) and medical forms only record sex presumed at birth and legal names (28,37). The inability to provide gender identity and preferred names constitutes a form of structural violence (28), by creating a hostile and distressing environment for patients (37). Misgendering and/or deadnaming has been reported in more than a fifth of emergency department discharge letters (29). These issues in the medical system present several opportunities to improve.

Rural and Regional Healthcare.

Rurality compounds the challenges of accessing streamlined gender-affirming healthcare (13). The exact impact of rurality on TGD health outcomes, however, is difficult to gauge as there is limited research on the topic (38). In a 2023 qualitative study in rural Australia, access to respectful and holistic care was insufficient beyond sexual health centres, especially in allied health services (38).These areas experience a lack of trained healthcare practitioners for TGD patients which can lead to 'inappropriate curiosity', detracting from the quality of care (39). However, access to healthcare services is variable in different regions, with some being readily available within weeks (38).

Transphobia can lead to threats of violence, but this can be due to the lack of education and exposure to LGBTQIASB+ communities in rural/regional areas. Contrastingly, people in the study felt safe because people 'mind their own business' in rural communities (38). However, isolation and loneliness were common experiences, especially in those under 25 (38). Connection to transgender community and networks are difficult to maintain because of geographical distances. Transgender people in the workforce can be subject to a perpetuating cycle of discrimination and stigma through hiring bias, harassment, and restricted advancement opportunities (40). This can undermine mental health, economic stability and willingness to seek care (38).

Screening.

It is a significant challenge for TGD people to access screening services. Reasons why TGD people choose to not undergo screening services include the belief that it isn't necessary or that it may be embarrassing or frightening, and concerns about homophobia, transphobia or being misgendered (41). 22.6% of LGBTQ+ people eligible for breast screening aged 50 to 74 never had a mammogram, which is more than double the proportion of non-LGBTQ+ people who never had a mammogram (42). Many people still perform self-checks of their breast or chest tissue, indicating that although they are concerned about breast cancer, they remain reluctant to participate in national screening programs (43). Interestingly, access to care or sociodemographic factors were not the main reasons for prostate cancer screening differences between transgender women and cisgender men; instead, transgender women were more strongly influenced by recommendations from a clinician (44).

In terms of cervical cancer screening, the National Cervical Screening Program clearly

states that all people with a cervix are eligible for a Cervical Screening Test (CST) (45). However, there still remains a significant proportion of TGD people who are not regularly screened. It is estimated that only 58% of LGBTQ+ Australians eligible for cervical screening had done a CST in the previous two years (46). The screening test poses a unique challenge because of the highly gendered and intimate nature of the procedure itself (46). In a 2022 study, up to 44.6% of participants had never been recommended a CST by a health professional (47).

Family Planning and Reproductive Health.

Many gender affirming therapies, both hormonal and surgical, cause partially reversible or permanent change and the consequences of gender affirming therapies for fertility are often not thoroughly discussed with patients (48,49). Feminising hormone therapy
interrupts spermatogenesis and masculinising hormone therapy stops ovulation, depending on regime and duration (50). Further, the surgical removal of reproductive organs via a hysterectomy or orchiectomy causes complete, irreversible infertility. In the World Professional Association for Transgender Health (WPATH) 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 (51).The lack of counselling around fertility preservation deprives many TGD people of their reproductive rights.

Common ways to preserve fertility include sperm, oocyte, and embryo cryopreservation (52). 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 people from preserving their fertility before undergoing gender affirming therapies (48). Furthermore, specific guidelines around contraceptive counseling for TGD people have not yet been established due to a lack of research, leaving many people unaware of appropriate contraceptive practices (53).

Research.

While the evidence for inequity is overwhelming, the extent of this in Australia cannot be clearly drawn due to the lack of population data, making it hard to compare outcomes between the TGD and general population (54). Such population data could be obtained from the Australian Bureau of Statistics' Census, however, the most recent Census omitted any mention of gender identity (55). Additionally, much research aggregates findings from LGBTQIASB+ communities without disaggregating findings specific to TGD people. Research must account for the diversity within the TGD community, as the unique challenges faced by Aboriginal and Torres Strait Islander (56), rural and regional (13), refugee (57), homeless, low

income, migrant and disabled (58) TGD populations are currently underappreciated (27).

SOLUTIONS

TGD patients report greater satisfaction and increased engagement with healthcare services that provide sensitive and holistic care (27,37). Such services create welcoming spaces through respectful, patient-centred healthcare and displays of support and education on LGBTQIASB+ health (27). 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 (37). Multidisciplinary gender services for children can simplify access to specialist care, and such services have expanded across many children's hospitals in Australia (59). eMRs should be revised to enable easier updates to a patient's name and gender, and to incorporate options that more accurately reflect TGD identities (29). Thus, improvements in the healthcare system to combat stereotyping and transphobic language and systems can create safe spaces for TGD people, and are therefore paramount to improving health outcomes.

Care Models and Frameworks.

The Australian Professional Association for Trans Health (AusPATH) Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy is a guideline for healthcare professionals, that supports the informed consent model of care framework, prioritising the individual's autonomy and self determination [see More Information] (60). While mental health professionals remain a key source of support, this model has been shown to have beneficial psychological outcomes and higher patient satisfaction (61).

According to Tudor-Hart's notion of the inverse care law, services most needed by identified population groups are often difficult to access (62). Approachability and acceptability are key factors of transgender healthcare with timely access to TGD healthcare being associated with better psychological outcomes (11,63,64). However, availability does not equate to healthcare utilisation (62). Thus, informed consent, peer navigation, and the availability of relevant services can ensure the delivery of appropriate transgender healthcare.

Clinical Practice.

It should be a top government priority to fund better training in trans health issues for doctors (2). Clinicians should recognise that TGD people are more likely to present with acute conditions especially related to mental health, and have increased rates of leaving before completing treatment (29). The use of affirming language helps to minimise misgendering and deadnaming in discharge documentation (29). Both the sex at birth and current gender identity should be included in patient histories (29). Clinicians should be confident in recommending and informing patients about contraception and screening tests such as the CST, including the preferred term for genital area, previous experience and preference for self-collection or speculum (46,65). More reproductive counselling training should be provided to

primary care providers so that patients are better informed about fertility options prior to gender-affirming hormone therapy. Moreover, more surgical education of GAS would help meet shortages (2). On top of this, accessible point-of-care and trans-community led online health resources can support professional development and education (2).

Rural and Remote Areas.

In rural areas, there is a need for greater support services and improved access to allied health, alongside better availability of mental health services staffed by professionals trained in TGD health care. Other solutions include online social support networks, community-led strategies targeting unemployment and education about LGBTQIASB+ communities in rural/remote areas to reinforce safety and acceptance (38).

EDUCATION

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 (66). Australian medical schools currently provide limited teaching on TGD healthcare. 89% of clinical year students reported no specific teaching on LGBTQIASB+ healthcare, and when it was included, it comprised less than 16% of the time (35). Even when included, teaching on TGD healthcare is largely either generalised under LGBTQIASB+ healthcare or confined simply to a conversation on pronouns. Gender diversity is a normal variation of human physiology and must be represented in curricula accordingly (67).

This together with the gross lack of TGD healthcare instruction post-medical school, including for specialties like endocrinology that are key providers in gender-affirming care, is worrying (68). The mere 19% of Australian endocrinologists that feel confident providing care to TGD patients pales to the 45% of TGD people that see an endocrinologist as part of their care journey. 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 (66). This would unburden TGD patients having to educate their healthcare providers on the provision of safe and appropriate healthcare.

Current allied healthcare students across various fields of physiotherapy, pharmacy, and psychology reported little to no formal training in TGD care (68). Educating medical and allied health professionals on TGD-specific healthcare significantly improves TGD health outcomes (12). 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 (12). 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 (12).

Secondary Education.

TGD youth face discrimination, stigma and social rejection in school that lead to higher rates of dropping out and poorer academic achievement (69,70). These disadvantages in early life can perpetuate and contribute to poorer social determinants of health compared with their cisgender peers. The tendency for strict gendered segregation (gendered facilities, uniforms, boys/girls activities) in schools creates discrimination and a lack of belonging for TGD students and limits the ability for students to explore different expressions of gender (69).

Providing robust support for TGD youth can lead to better schooling outcomes paving the way for TGD adults who have the support and structures to better handle health concerns.

Protective factors for TGD students include interpersonal support from teachers and fellow students; higher personal resilience; and safer school environments (71). Students with a lack of support from their teachers are four times more likely to leave school. Teachers' support may include using the student's correct name and pronouns (72). The resilience and activism of TGD students is helpful in creating community and safety where it did not exist, but treating TGD as only victims is harmful and a shift to a strengths-based focus, celebrating their contributions to their communities is needed (72). Safer school environments for TGD youth can be created through an inclusive curriculum that normalises TGD experiences; student run organisations that encourage free expression and socialisation with other TGD peers; and inclusive school facilities (e.g. gender neutral bathrooms) (71).

For More Information

GENDER DYSPHORIA

Gender dysphoria remains a medical diagnosis in the DSM-V. 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.

Callander D, Wiggins J, Rosenberg S, Cornelisse, VJ, Duck-Chong E, Holt M, Pony M, Vlahakis E,, MacGibbon J, Cook T. **The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings.** The Kirby Institute, UNSW Sydney; 2019. Accessed August 18, 2025. https://www.kirby.unsw.edu.au/sites/default/files/documents/ATGD-Sexual-Health-Survey-Report_2018.pdf

TYPES OF AFFIRMATION

Gender affirmation may be social, legal, medical or surgical, and different TGD people will have different preferences for the forms of affirmation they desire. 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.

ACON. **What is gender affirmation?** Transhub. 2021. Accessed August 19, 2025. https://www.transhub.org.au/101/gender-affirmation

INFORMED CONSENT MODEL

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. The Trans and Gender-Diverse People in Community Health (TGDiCH) program follows this informed consent framework to increase access to gender-affirming hormone treatment. This was done outside acute care settings in primary care using a peer navigator (PN) model. The PN model involves people with lived experience who support other peoples' wellness, focusing on their strengths, understanding their health priorities and giving current, relevant information about services.

Clune S, Collier J, Lewis V. **Health equity for trans and gender-diverse Australians: addressing the inverse care law through the provision of gender-affirming health care in the primary healthcare setting.** Aust J Prim Health. 2023;29(2):186-193. https://doi.org/10.1071/PY22149

AUSPATH: AUSTRALIAN INFORMED CONSENT STANDARDS OF CARE FOR GENDER AFFIRMING HORMONE THERAPY (2022)

'These new national Standards of Care are intended to assist and enable clinicians across Australia to better meet the medical gender affirmation needs of their trans women, trans men and non-binary patients. They unapologetically centre the trans person seeking hormonal intervention and empower the clinician to facilitate this access.'

AusPATH. **Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy.** Australian Professional Association for Trans Health; 2024. Accessed August 16, 2025. https://auspath.org.au/wp-content/uploads/2022/05/AusPATH_Informed-Consent-Guidelines_DIGITAL.pdf

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Policy Details:

Name: Transgender Health and Access to Care (2025)

Category: F - Public Health Australia

History: Reviewed, Council 3, 2025

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