

## HIV Prevention Needs of Trans and Gender Diverse People in Australia

By J. R. Latham

Trans and gender diverse people were, rightly, named as a priority population in the *Eighth National HIV Strategy 2018-2022* [1]. This strategy has the aim of ‘virtually eliminating’ HIV transmission in Australia during ‘the life of the strategy’. Understanding the specific sexual health needs of trans and gender diverse people, as well as experiences in seeking healthcare services, is a critical issue to be addressed if Australia is to meet this ambitious goal. For too long, trans and gender diverse people’s sexual health needs have been obscured by a medical model of disease that pathologises the experience of being trans and/or gender diverse itself (as the psychiatric disorder ‘Gender Dysphoria’) with dire consequences for understanding the sexual experiences and healthcare needs of trans and gender diverse people. While momentum is building to de-pathologise trans and gender diverse experiences and desires, with many medical associations including the World Health Organization suggesting this is appropriate, significant issues remain for trans and gender diverse people’s healthcare access as a direct result of these practices.

In this essay, I outline issues relating to gathering data with trans and gender diverse populations and suggest that shifting our focus towards how health services are delivered offers a way to circumvent these problems. I argue that a historical relation to how trans and

gender diverse people’s sexualities have been misunderstood by medicine has led to a host of difficulties in providing appropriate sexual healthcare to trans and gender diverse people, resulting in increased trepidation between clinicians and patients that directly impacts HIV prevention strategies. I explore how access and trust have been impeded, and what we can all do to improve environments of care conducive to effective sexual healthcare for all of us.

### Background

For some time it has been acknowledged that there is little epidemiological data as they relate specifically to trans and gender diverse people and HIV prevalence [2]. For a variety of reasons that tend to relate to social marginalisation, trans and gender diverse people may well be over-represented in other priority populations, such as people in custodial settings and people who inject drugs. Australian research is severely limited, often referencing international data that may not be relevant to local contexts, especially as many studies report on small or specific samples [3]. Health data systems, and clinical research, often fail to capture gender details in accurate ways for trans and gender diverse people, thus making our participation potentially invisible. Categories such as ‘men’ or ‘male’ may include (explicitly or unwittingly) trans

men, trans women, nonbinary and gender diverse people, or exclude one or more of these categories. The invisibility of trans and gender diverse people within research and clinical data sets makes studying practices and prevalence within these populations difficult. The constantly shifting terrain regarding preferred language also makes research in this area complex. It is also the case that most of the international research on trans and gender diverse people in relation to HIV pertains to trans women, often sex workers, and tends to see the needs of trans women, trans feminine and gender diverse people assigned male at birth as a high-risk population by default. It is common, though inaccurate and unhelpful, to consider trans women and gender diverse people assigned male at birth who have sex with men as synonymous with men who have sex with men [4]. These kinds of misunderstandings miss crucial opportunities to understand the different experiences and health needs of trans and gender diverse people [5]. Trans men, trans masculine and gender diverse people assigned female at birth are often excluded from such research altogether. These gaps in knowledge then fuel reluctance from healthcare providers to support trans and gender diverse people who come to them for help. Clinicians and other support workers may well feel like they do not

have the specialised knowledge to offer appropriate care. While it is undoubtedly the case that more targeted research would be beneficial, we need to take care around increasing surveillance of a stigmatised population that has a long history of objectification in medicine.

Given these significant issues in epidemiological data gathering, it is useful to shift our focus towards thinking more broadly about how to improve healthcare experiences in ways that will benefit trans and gender diverse people, and thus improve HIV prevention, testing and care. Aspects of HIV management already known to improve outcomes, such as timely patient follow up and support for treatment adherence, rely on a host of actors providing a supportive environment of care. Identifying and addressing the complex reasons for trans and gender diverse people's reluctance and hesitancy in accessing healthcare and support, and finding ways to proactively counter those issues, offers us a way to provide better health services for all. The HIV sector is particularly well positioned to do this since good sexual healthcare and disease prevention is founded upon practising nonjudgmental, individualised care. The stigma attached to trans and gender diverse people, and trans and gender diverse people's sexualities in particular, can eclipse this fact. As I will outline below, there are ways that the medicalisation and pathologisation of trans and gender diverse people's identities and expressions of gender and sexuality have impeded this practice. However, clinicians have the opportunity to build the trust necessary to provide trans and gender diverse people the sexual healthcare we need by prioritising the minutiae of everyday practices, such as establishing and maintaining a good rapport, and overcoming a lack of information with compassion and kindness.

HIV continues to exist throughout communities in Australia. As readers of *HIV Australia* would be well aware, understanding safer sex practices, different barrier methods, how to use PrEP (Pre-Exposure Prophylaxis) and PEP (Post Exposure Prophylaxis), and the risks associated with individual sexual

practices and desires are key to HIV prevention. Pivotal to addressing the specific sexual healthcare needs of trans and gender diverse people requires understanding how experiences of discrimination produce hesitancy and reluctance in using services, as well as recognising the ways that pathologisation has impeded trust, particularly in relation to sexuality.

## My Research Profile

I have been researching trans and gender diverse people's experiences of medicine for over ten years. This has included interviewing trans and gender diverse people, conducting focus groups with queer, trans and gender diverse people with disability, and analysing medical, autobiographical and cultural texts about trans and gender diverse people and healthcare. I have spent years advocating for the needs of trans and gender diverse people to the Victorian government, as well as with individual health practitioners and aged care services. I have taught courses on trans inclusive care to healthcare providers, and lectured in queer and trans theory to undergraduate and postgraduate students. I have a PhD in public health and cultural studies, and wrote a thesis about practices of transgender medicine. My expertise is skewed towards trans men and gender diverse people assigned female at birth, an under-researched population in both transgender medicine and HIV [6]. I outline these experiences because I am not simply a trans person who has opinions about how trans healthcare should be provided. I have academic, policy and advocacy expertise, and this is authority that matters. I also have the experience of this expertise being undermined and of being misunderstood as a 'disgruntled patient'. I am committed to the improvement of trans lives, and believe passionately that our rights, particularly access to healthcare, are key to our ability to live and flourish in the world. Understanding the ways our access to, and experiences of, healthcare provision is compromised is critical to this endeavour, as it is to the effort to eliminate HIV transmission.

For this essay, I spoke with trans and gender diverse people who are doctors working in Victoria, including in HIV

prevention and management. Two agreed to be interviewed on the record, one anonymously (Informant 1), and the other, Dr Nate Reid. Dr Reid is a general practitioner working in primary healthcare at three clinics in Melbourne. He specialises in trans healthcare, HIV, mental health, sexual health, and drug and alcohol care, and primarily sees trans and gender diverse patients, which he has done for the past six years. Our anonymous informant is a junior doctor who has worked at a number of regional and urban hospitals. Neither could recall receiving any information on trans and gender diverse healthcare throughout their formal medical education. Dr Reid has worked in HIV management, and participates in educating other clinicians about HIV and trans healthcare. Informant 1 has worked with trans, gender diverse and HIV positive patients and been involved in the diagnosis and early treatment education of people living with HIV. Both expressed concern about the experiences of trans and gender diverse patients in a wide variety of healthcare settings. They each emphasised that efforts at improving HIV prevention measures relied on improving medical care for trans and gender diverse people more broadly.

We all deserve the respect and human dignity of healthcare. However, the history, and many current practices, of transgender medicine make this quite difficult for trans and gender diverse people in some specific ways. Yet there are some simple actions that healthcare providers can take to resist perpetuating the kinds of prejudices that exclude trans and gender diverse people from services we need. It is my hope that understanding these experiences will help people working across the HIV sector to comprehend some of the hurdles to access and support trans and gender diverse people experience, so that all services can act in ways that ensure appropriate healthcare is available to everybody. This is fundamental to a strategy of universal HIV prevention.

## An Adversarial Relation to Medical Care

Healthcare for trans and gender diverse people is punctuated by a distinct

relation to medicine, and this has profound effects for HIV prevention strategies. In large part this relates to the history of access to transgender medicine, which continues to position trans and gender diverse people in an adversarial relation to medical practitioners. Transgender medicine involves particular medical interventions (hormones, surgeries) that aim at re-positioning anatomy in relation to cultural norms of male and female bodies. Many trans and gender diverse people want or need such interventions for a host of reasons, yet must articulate their desires within a particularly narrow narrative of suffering and adherence to gender stereotypes in order to access them. This need to tell a particular story about one's life, along with the anxiety that failing to do so will result in such bodily alterations being made more difficult or impossible, produces medical practitioners as gatekeepers. Literary scholar Jay Prosser, who researched 'transsexual autobiographies' (as they were known at the time), aptly describes this problem. As he outlines, 'The patient's position is to confess, the professional's – half priest holding the key to the patient's salvation, half detective decoding this clinical narrative – to listen, to take note – and precisely to police the subject's access to technology... a shocking equation when we remember this is supposed to be a healthcare/patient relation' [7]. Medical practitioners and patients continue to be constituted in this way. This is because trans and gender diverse identities and expressions have been pathologised as psychiatric disorders ever since homosexuality was removed from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* – the handbook of what is categorised as a psychological illness, condition or disorder. While not all trans and gender diverse people desire or seek medical interventions, awareness of how this regulation works permeates trans and gender diverse communities and may well act in the decision-making processes for people who do not seek out hormones or surgeries.

### Problems with Diagnosing Gender

With each edition of the *DSM*, the diagnosis attached to trans and gender diverse identities and expressions is

contested and revised. Currently known as 'Gender Dysphoria', access to transgender medical interventions (known by many names including sex or gender confirmation, affirmation or reassignment; cross sex hormone use, treatment or therapy; gender transition; sex change) is overwhelmingly available only subsequent to diagnosis. This process of diagnosis means that trans and gender diverse people must convince a number of medical professionals that they are suffering a diagnosable mental disorder for which they deserve treatment. The process of diagnosis positions practitioners and patients as antagonists, with patients needing to narrate their life experiences through archaic stereotypes about gendered expressions and behaviours that may not represent their experience [8]. The criteria for diagnosis also demands 'clinically significant distress or impairment' thus disallowing the myriad trans and gender diverse people who experience their desires as celebratory acts of self-determination and empowerment. I do want to caution here about interpreting this commentary as a condemnation of clinical services, or that trans and gender diverse people are inherently victimised by health services. Instead, my point is to emphasise that clinical care has been entangled historically in relation with social prejudices, and that good care requires acknowledging and resisting that practice.

Many trans and gender diverse people and advocates, justifiably, express concern that de-pathologisation (removing the mental disorder diagnosis from the *DSM*) will jeopardise access to surgical and hormonal interventions from medical practitioners. There is a fear that without the diagnosis, clinicians will stop providing medical services to trans and gender people who want or need them. As I have argued elsewhere, defending the diagnosis is not the only, or best, way to protect (and expand) access to medical interventions for trans and gender diverse people [9]. Rather, continuing to defend or justify the pathological classification of trans and gender diverse people as inherently mentally unwell acts to exclude, rather than include, us in a host of social, political, economic

and health domains. It also serves to further stigmatise, rather than de-stigmatise, trans and gender diverse people [10].

### Is Being Trans a Disorder?

Increasingly it has become commonplace in clinical research, best practice guidelines and advice to clinicians to assert that 'being [trans and/or gender diverse] is not a mental health disorder' [11]. However this assertion circumvents the reality that there remains a psychiatric diagnosis attached to transgender medicine (most commonly, 'Gender Dysphoria'), and desires for such interventions, which trans and gender diverse people must continue to navigate. 'Informed consent' models of treatment try to avoid this problem, but are available only to those not seeking surgery, and are exceptional rather than standard practice [12]. In this way, proclaiming that 'being trans and gender diverse is not a mental health disorder' does a disservice to the complex experience of accessing medical interventions, particularly surgeries, for which people continue to need a psychiatric diagnosis. It further ignores a fundamental issue in the provision of healthcare to trans and gender diverse people, which is that in order to access medical interventions in processes that require the psychiatric diagnosis, trans and gender diverse people are positioned in an adversarial relation to medical care that has far-reaching effects throughout their lives. Gender identities that challenge the very idea of a fixed and stable experience of gender, as nonbinary and many others do, do not facilitate access to medical interventions in processes that continue to practice healthcare as though being trans *is* a mental health disorder, such as via requiring psychiatric assessment of a diagnosis that pathologises those desires.

Research suggests that trans and gender diverse people who want medical interventions do better with access to them, and that withholding that access (including via unreasonable wait times, monopolised services that are financially burdensome and delays in treatment) is more likely to produce negative outcomes. For example, mental health research in Australia reported that trans

and gender diverse people who had access to hormones had significantly lower prevalence of depressive symptoms than those who wished to access hormones, but were unable to do so [13]. It is critical to understand that the pathologisation (and related medical practices) of trans and gender diverse identities and expressions has far-reaching consequences in the provision of care, perhaps HIV prevention-related care in particular. In large part, this is because the ongoing effects of this pathologisation are key determinants in trans and gender diverse people's hesitancy and reluctance to access healthcare throughout their lives.

## The Sexual Health Needs of Trans and Gender Diverse People

Only recently have the sexual health needs and sexual practices of trans and gender diverse people begun to be given the clinical and social research attention they deserve. In large part this relates to a medical misunderstanding regarding the sexual lives of trans and gender diverse people, which is also connected to the diagnostic practices of transgender medicine. It has long been thought, wrongly, that trans and gender diverse people overwhelmingly avoid sexual relationships [14]. While this is undoubtedly the case for some people, assuming that trans and gender diverse people will be so filled with self-loathing regarding their gender that they will not sexually interact with other people was, until recently, considered an *inherent* aspect of transgender identity. Trans and gender diverse people who expressed that they had sexual desires were routinely denied medical interventions on the basis that their sexuality itself was evidence that they were not suffering the kind of clinically significant distress transgender medical interventions could remedy. Put simply, sexual interest precluded access to hormones and surgery. This is critical to understand for the purpose of improving practices and experiences of healthcare for trans and gender diverse people, as an emphasis on suffering and an absence of sexuality defined the clinical diagnosis itself (and may well continue to do so). One of the ongoing

effects of this diagnostic practice has been the occlusion of the specific complexities of many trans and gender diverse people's sexual lives, especially those people who do engage in varied forms of sexual pleasures. This has led to a lacuna in understanding trans and gender diverse people's sexualities, with concomitant impacts for sexual health.

### Unhelpful Assumptions

Heterosexist assumptions surrounding trans and gender diverse people's sexual desires and practices pervade medical literature. Like all other categories of people, trans and gender diverse people have a wide variety of sexual interests and orientations. However, trans and gender diverse people have been misunderstood as intrinsically asexual prior to achieving a 'congruent gender embodiment'; meaning undergoing all of the medical interventions available, particularly genital reconstruction. That this is inaccurate is only beginning to be realised in the field of medicine. As research from Belgium reports, 'we have the clinical impression that often a hyposexual status is *assumed*. This is in contrast with our retrospective findings, indicating that the majority is sexually active before and after starting cross-sex hormone therapy' (emphasis added) [15]. 'Post-transition' heterosexuality was also assumed, especially for trans men and gender diverse people assigned female at birth who were, until recently, misunderstood as almost universally attracted only to cis (nontrans) women. This resulted in an attendant conflation of the risk profiles of trans men and gender diverse people assigned female at birth with that of cis lesbian women, often left out of HIV prevention strategies completely [16]. It has also meant that those trans men and gender diverse people assigned female at birth who are sexually interested in men have rarely been incorporated into HIV prevention strategies [17], and who may be particularly vulnerable to transmission risks, differently from people who are not trans or gender diverse sexually engaging with men. In one of the only studies specifically designed by and for trans and gender diverse people in Australia, 89.7% of over 1500 participants reported 'some kind of sexual experience' and 60.9% defined

their sexual orientation in a way that suggested varied genders in their relationships (e.g., queer, pansexual, bisexual) [18]. This indicates how erroneous it is to assume that trans and gender diverse people will be heterosexually oriented or not engage in sexual interactions.

While these assumptions are finally being corrected, these historical errors produce at least two significant issues: that trans and gender diverse people remain cautious regarding discussing their sexual lives with health professionals, and that there is a lack of research and accurate information relating to the sexual health needs of trans and gender diverse people. Dr Reid referenced this problem, as he described: "it instantly creates people being a little bit guarded when they're accessing more broad healthcare. Because if you've heard that the psychiatrist doesn't like it if you're a transfemme person who is interested in women, then you're not going to necessarily disclose that. And then you're potentially not going to necessarily disclose that to your doctor. And then you might be having sex that could result in pregnancy [or HIV transmission] and you're not necessarily getting that information."

### Health Promotion

Including trans and gender diverse people in education and health promotion campaigns about HIV prevention is a useful first step, as visibility and representation are critical to countering the assumption that trans and gender diverse people are not sexually active [19]. Undoubtedly this opens up possibilities for engaging more trans and gender diverse people in HIV prevention, as well as informs other people that we are sexually active in their communities. It also points out this fact to clinicians and others working in the HIV sector. These depictions, however, can also inadvertently work to alienate those trans and gender diverse people who do not identify with the sexual lives of those depicted. Relatedly, Informant 1 made the point that PrEP and PEP were often advertised only at specific clinics, for which many populations, including certain trans and gender diverse people, do not feel

comfortable or able to use. As they put it, “other populations who are not the usual cis-gay men, they have trouble accessing HIV resources. There are large immigrant populations that don’t feel comfortable using those resources, because they’re targeted at gay men. I think all the PEP and PrEP places, they’re very loudly gay friendly, which is obviously great, but also not great for other populations. So I imagine if you’re not the target group, then maybe that makes it a little bit more difficult, saying, ‘Hey, I need this too.’” It is important to note that any doctor can write a prescription for PrEP, which can be dispensed by any pharmacy. PrEP is currently listed as a Schedule 85 (s85) drug, and can be accessed through the Pharmaceutical Benefits Scheme (PBS, ‘Restricted Benefit’) [20].

### Testing Problems

Gender-normative assumptions about the kinds of sexual practices trans and gender diverse people participate in can distort the complexities of our sexual lives in ways that specifically harm HIV prevention strategies. Trans men and gender diverse people assigned female at birth may engage in receptive genital sex, and trans women and gender diverse people assigned male at birth may practice insertive genital sex: two of the potentially highest transmission risk practices. Assuming this is not the case can lead to insufficient discussions or testing in relation to sexual health measures. For example, PrEP protection protocols differ depending on the kinds of sexual practices involved. When these are conflated with gender categories in clinical engagements, research or health promotion campaigns, the experiences and needs of trans and gender diverse people can be missed completely. For too long, sexual health strategies have been based on identity categories (and assumptions about what those identities entail), rather than practices (what people actually do) [21]. Both Informant 1 and Dr Reid discussed issues relating to STI testing, where clinicians had (wrongly) assumed a patient was not trans, and thereby not order relevant testing, such as pregnancy testing. Australian research into sexual health reported non-binary participants assigned female at birth had the most prominent gap in being tested for STIs

but not HIV [18]. This is important as these may be people at a higher risk of HIV transmission, especially if they are having sex with men. This emphasises how crucial it is to develop the kinds of environments and relationships that allow for, and encourage, trans and gender diverse people to be able to speak frankly about our sexual lives.

### Trans Specific Physiology

Physiological changes specific to hormone use or genital surgeries could also increase risk of disease transmission. There is some evidence for the efficacy of PrEP for trans women and gender diverse people assigned male at birth, although research is severely limited and has tended to focus exclusively on anal sex risks. In analysis of trans women and Truvada published from the iPrEx study, those who reported condomless anal sex tended to use PrEP less consistently, differently from men in the study who had better adherence, especially those who engaged in higher risk practices [22]. People who have undergone vaginoplasties are likely to experience a different level of risk of transmission via the vaginal wall, which will also depend on the kind of surgery and tissue used, for which there are varied possibilities and limited research.

Dr Reid described how there can also be physiological factors that increase transmission risk for people who take testosterone, “I think that there’s also the group of people that have [increased risk] just due to physiology, who’ve been on testosterone for a long time. So [they’re] at a higher risk, just because of mucosal rupture is more likely and things like that. And also within that, not necessarily wanting to discuss that with their health providers.” These are factors that increase the risk of abrasion during sex, increasing the possibility of disease transmission. These social and biological factors highlight the need for clinical and longitudinal research specific to the needs of trans and gender diverse people.

### Heightened Vulnerability

Systemic and institutional discrimination and prejudice trans and gender diverse people experience, including by medical services, increases reliance on

alternative sources of information, which may be erroneous. Both Informant 1 and Dr Reid expressed concern about knowledge gaps surrounding PEP and PrEP they had experienced with trans and gender diverse patients, especially those engaging in higher risk sexual practices. Both discussed being aware that trans and gender diverse people often learned from each other via informal peer networks that could circulate inaccurate or misleading information, such as that using testosterone prevented pregnancy. In previous research I conducted with trans women aged over 65, one participant reported that she had been told she could not acquire HIV due to having undergone genital reconstruction surgeries, and that this (dangerously inaccurate) idea circulated throughout her friends and other trans women she knew [23]. Informant 1 talked about how trans men, masculine and gender diverse people who have sex with men could be misinformed about sexual health measures due to relying on information created for cis (nontrans) gay and bisexual men. In particular, trans and gender diverse people sexually active in communities of other queer men might rely on PEP, as a result of engaging with health promotion campaigns that promote PEP to MSM. Research relating to PrEP efficacy reports that the different ecologies of the rectum and vagina produce different levels of protection, suggesting that different dosing or drug combinations may be necessary for people engaging in receptive vaginal sex [24]. Due to a lack of research, we do not know whether the effects of testosterone use (e.g., potentially thinning tissue) make PrEP less effective. Daily PrEP is recommended for trans men and gender diverse people engaging in receptive sex with men [25].

Trans and gender diverse people may also experience heightened vulnerability within relationships, which increases HIV transmission risk. Sexual interactions can be gendered expressions of agency and trans and gender diverse people may use sex as a way of validating their gender identity [26]. Dr Reid described how “[there is] a group of people who particularly when first coming out, that the idea of having sex with cis men is a

way of affirming their gender and saying like, 'I'm a gay man.' And within that being in a really vulnerable place, and more likely to be influenced by the people that they're having sex with about having less safe sex or having that kind of a little bit of a power imbalance within that. And just being slightly more vulnerable." Australian research into the sexual experiences of trans and gender diverse people suggests an increased likelihood of engaging in condomless sex with men, and that inconsistent condom use may be common [18]. Within that survey, experiences of sexual violence and coercion were four times higher among respondents than the general population in Australia: sexual violence or coercion was reported by 66.1% of non-binary participants assigned female at birth, 54.2% of trans men, 44.5% of non-binary people assigned male at birth, and 36.1% of trans women. Dr Reid also recounted how gay trans men and masculine patients he had spoken with about their sexual lives described being expected to participate in condomless sex if it was known that they were using PrEP. It is important to recognise that experiences of sexual vulnerability and exploitation may well be highly prevalent among trans and gender diverse people, and that there is a public health value to sexual empowerment.

## Hesitancy in Healthcare

In a previous research project I conducted with trans and gender diverse people in Australia aged over 49, all participants reported that negative experiences of seeking transgender medical interventions precipitated reluctance to seek subsequent healthcare and social support services throughout their lives [27]. This shows how positioning trans and gender diverse people as needing to prove their desire for medical interventions through the prism of a psychiatric diagnosis has far-reaching and long-term effects for the provision of healthcare. Qualitative research from the UK into older trans and gender diverse people's experiences of accessing healthcare suggests that being put in the position of educating service providers also increases the difficulty and reluctance in accessing services, which is a pervasive experience

of trans and gender diverse people of varied ages [28]. In an Australian study on trans and gender diverse young people, 30% of respondents reported that previous negative experiences with healthcare professionals prevented them from seeking mental healthcare [29]. When I spoke with doctors for the purpose of this essay, they echoed this sentiment: that hesitancy and reluctance were foundational problems in providing care to trans and gender diverse patients, and that experiences of discrimination in healthcare is a systemic issue.

## Experiences of Discrimination

Relatedly, a friend of mine recently recounted trying to engage the professional support of a psychologist who advertised expertise with trans and gender diverse clients. The psychologist misgendered them and went on to justify that mistake. My friend disengaged from the service and gave up seeking help. This anecdote illustrates how 'denial of service' can be subtler than open hostility or explicit refusal to treat trans and gender diverse people.

Pronouns are powerful descriptors of identity. All people experience gender as fundamental to how they live their lives and relate to others and deserve to have this sense of themselves respected by other people, especially health professionals. The language surrounding gender diversity is constantly shifting, and while this might seem complex or even convoluted to people not connected to trans and gender diverse people, these nuances are important to understand not only because they are valid expressions of gender and identity, but because relationships to prejudice can be informed by precisely this logic. That is, that a gender identity or sexual expression might be confusing to care providers can be the reason trans and gender diverse people are reluctant to access healthcare.

Informant 1 gave gruelling examples of trans and gender diverse people being routinely misgendered. Even when gender markers, pronouns and names were clearly written on files, these were often misunderstood by hospital staff as a mistake, which impeded healthcare,

sometimes in practical terms, as they outlined: "with patients in clinics, if they got called by the wrong name they just wouldn't come up, so then they didn't get their appointment." Problems were described in linking medical files when patients had changed their names and/or gender marker, even as they retained an identical Medicare number. Similarly, trans and gender diverse people will often encounter administrative or software systems that functionally exclude us, e.g., trans men who are recorded as male may not be routinely reminded of preventative cervical or breast screening they may need. These administrative issues are often put upon trans and gender diverse people to try to manage, rather than recognising the need for bureaucratic systems to accommodate these changes. The result is that access to these kinds of preventive health measures is made more complicated, if not impossible, for trans and gender diverse people.

## Insufficient Confidence

There is a related hesitancy in accessing preventative measures such as PrEP, as research and information that pertains specifically to trans and gender diverse people remains severely limited [30]. There are few studies into the long-term effects of using hormones, and trans and gender diverse people may be sceptical about the risks relating to multiple drug interactions. Dr Reid talked about how this lack of information impacts trans and gender diverse people's consideration of sexual health measures: "There's probably more hesitancy in the trans population, in my trans patients than the cis gay guys. And the most common hesitancy is less around the actual PrEP itself, but it's more around people being concerned about adding an extra thing to their body. They're potentially already taking hormones and then PrEP, we've got safety data on PrEP but there's still potential long-term impacts on bone health and things like that. And people are like, 'Well, I'm already on hormones which could potentially be affecting this.' And so I think that often the hesitancy is more around that than actual PrEP itself." Here we can see how a lack of clinical data translates directly into hesitancy in accessing HIV prevention measures. This tends to lead to practising by trial and

error, which can lend itself to decreased confidence for trans and gender diverse people, especially if they experience adverse effects. Eliminating HIV transmission will only become possible when trans and gender diverse people have the confidence of clinical research that is tailored to our specific needs, situations and experiences.

## Accessibility and Availability

The most crucial aspect to accessing healthcare is its availability. Problems relating to availability are geographic, economic and political. The cost of healthcare is a fundamental factor in its availability, with trans and gender diverse people often shouldering the costs of medical services individually, meaning that services – and consequential research on people using such services – are skewed towards people who can afford to pay for them [31]. While there are services that do not charge out of pocket expenses to trans and gender diverse people for direct consultations, these are rare, and medications, surgeries and other specialist care continue to be exorbitantly expensive with many excluded from public systems of healthcare (e.g., the Pharmaceutical Benefits Scheme or public hospital services). As readers of *HIV Australia* are no doubt aware, we are all better off if everyone has access to the healthcare they need. Recognising that trans and gender diverse people are routinely and systematically discriminated against in provision of healthcare, then taking an active role in ensuring appropriate care is available and accessible is therefore paramount. This is an issue not only for clinicians, but emphasises the important roles of policymakers, advocates, health promotion and education across the HIV sector in increasing access for trans and gender diverse people.

For some time, the need to mainstream trans healthcare has been at the forefront of reviews and advocacy, and the sector has seen an increase in awareness and cultural sensitivity type training [32]. These are useful steps but require some cautious optimism as these programs can be unhelpfully prescriptive and/or perpetuate

universalising assumptions about the experiences and needs of trans and gender diverse people that can be problematic. One that I attended, as an example, reported that trans men do not have genital reconstructive surgeries, which is simply false. There is a need to coordinate these programs to ensure they are accurate and evidence-based, as well as designed and provided by people with appropriate expertise. This practice also risks becoming a tick-box activity with few systematic impacts. It can be common in these programs to caution against asking trans and gender diverse people about their histories or bodies. This is understandable, as we can be subject to intrusive questioning based in curiosity rather than clinical need. Dr Reid referenced this problem, as he described: “I know that there’s definitely doctors who just don’t want to offend people. They don’t want to ask the wrong thing and I do think that’s a barrier.” It is completely understandable that clinicians, and the host of other people working across the HIV sector, hold this fear. Responding to that fear with avoidance, however, reinforces to trans and gender diverse people that healthcare settings are unsafe, which compounds ongoing problems of trust and access. Similarly, putting the onus on trans and gender diverse people to make doctors feel comfortable is an inversion of clinical care. Rather, it is up to service providers to create environments conducive to supporting trans and gender diverse people.

Dr Reid suggested there are ways to manage this potential anxiety that are common practices in medicine more generally. As he put it, “if you don’t know, don’t suddenly shut down and go, ‘Oh, well, I don’t know anything about this.’ Say something like, ‘Okay, so how do you want me to support you? Or what can I do to help you?’ And if that person doesn’t know, do what you would do if someone came in with a weird rash that you didn’t know and find somebody who knows and ask them the question. So both respecting that the patient’s not going to have all the answers, but might actually know what they need. And if they don’t, don’t expect them to come up with the answers as well. I think that’s

fundamental to what you should normally be doing as a doctor.”

## Specialist Services

Trans and gender diverse people may well have multiple experiences of rejection from healthcare services via the justification that a service or individual practitioner does not specialise in transgender medicine [33]. While specialised clinics are useful in the short term, their existence can act to diffuse responsibility from all services to be informed of the needs of trans and gender diverse populations and to provide appropriate care. The value of specialist services is in their opportunity to learn and teach all services how to best serve marginalised people and communities, rather than be an end in themselves. Equinox in inner Melbourne, as an example, provides primary care to trans and gender diverse people, and engages in evaluation and reporting on its practice. It does so as a commitment to the improvement of care of its own patients, and as a teaching tool for other services in providing supportive care to trans and gender diverse people [34]. These specialist services, however, are limited in their capacity (demand far outweighs supply) [35]. They also tend to be located in areas that have far greater access to other services than those in regional, remote and rural locations, and other states and territories in Australia.

Understanding the health needs of trans and gender diverse people as inherently specialist or specialised is an impediment to healthcare. We are human beings with all the same kinds of health needs as everybody else, yet often experience seeking routine medical care to be riddled with prejudices. Even if one lives in inner Melbourne and uses Equinox as a primary care facility, we are not insulated from the wider healthcare system within which we are routinely discriminated against. Aged care services, emergency services, injuries or illnesses requiring hospital admission, rehabilitation services, psychiatric facilities and a host of other routinised healthcare all need to be tailored and sensitive to the needs of trans and gender diverse patients. As Dr Reid expressed, “there’s a real need for the

normalisation of being able to take proper sexual histories, and definitely about being nonjudgmental, and asking broadly in relation to sexual health test questions...there's that barrier with not necessarily being comfortable asking people with trans bodies about what their sexual practices are." All healthcare professionals, and people working across the HIV sector, need to take an active role in ensuring that they are capable of engaging with trans and gender diverse people with respect. There are some relatively simple ways to do this, such as being attentive to privacy and creating a welcoming environment, I have described in previous research [36].

## Conclusion: Providing Nonjudgmental, Individualised Care

Being trans and/or gender diverse continues to be pathologised in Australia and elsewhere around the world. This has far-reaching consequences for the healthcare of trans and gender diverse people, as well as public health goals such as the elimination of HIV transmission. As long as 'Gender Dysphoria' continues to be classified as a psycho-pathology, a host of inaccurate assumptions about trans and gender diverse people's mental competency, and health needs, will continue to interfere in the provision of care. It also makes possible a particular loophole in medical ethics whereby clinicians can refuse to treat trans and gender diverse people on the basis that it is not their 'speciality'. It is a good thing that there are specialist primary care clinics for trans and gender diverse people, such as Equinox or Preston Trans and Gender Diverse Clinic in inner Melbourne. However, these should not circumvent the need for *all* sexual health practitioners, and indeed all primary and tertiary care physicians and those working across the HIV sector, to be informed on the sexual health needs and best practice in providing appropriate care to trans and gender diverse patients. While research is severely limited, there has been a failure to take up the recommendations made by reviews, evaluations, scientific and social research that does exist.

Significant (usually unpaid) work by trans and gender diverse activists in advocacy, health promotion and contributing to research projects deserves to be taken seriously. Problems arising from the circulation of inaccurate information could be remedied if peer support and advocacy groups were funded and engaged with appropriate health professionals who could ensure advice offered is evidence-based and up-to-date with emerging research.

It is important to keep in mind that 'trans and gender diverse people' are not a homogenous group: not in terms of risk categories, not in terms sexual experiences or desires, and not in terms of understanding and access to sexual health measures. Even the label 'trans communities' is somewhat of a misnomer, as it suggests we are our own community when it is more useful to understand trans and gender diverse people as existing in all communities. Indeed, probably the only thing one might be able to universalise about the experiences of trans and gender diverse people is that accessing appropriate, supportive, understanding healthcare is challenging. Even individual supportive doctors are surrounded by other actors (other clinicians, reception staff, administrative systems, other service-users) that can negatively impact the experience.

Understanding that previous interactions with healthcare professionals may well have been problematic, as well as the history of how transgender medicine itself has pathologised the desires of trans and gender diverse people, especially in relation to sexuality, are crucial in contextualising how trans and gender diverse people experience health services in general and engagements with sexual health measures in particular. We are routinely denied care, refused services, expected to act as teaching tools, subject to invasive questions that have no clinical relevance, or confronted with open hostility. These experiences of discrimination and mistreatment, including in practices of transgender medicine itself, create an environment of fear and mistrust for trans and gender diverse people that produces reluctance and hesitancy in accessing healthcare. One of the

consequences to the gatekeeping model of transgender medicine is an experience by trans and gender diverse people as being disempowered, which has social and public health consequences: it affects people's ability to engage in safer sex practices and it affects our ability to access and request kinds of medical and preventative healthcare we need. Re-considering how we think about disease transmission and prevention we might hope has been one of the beneficial consequences of living through a global pandemic. In addition to appreciating how our individual practices can promote a public good, it has also been brought into stark relief how systemic inequities produce different experiences of health and illness. The *Eighth National HIV Strategy* recommends that priority populations be 'provided with tailored education, including correct and consistent condom use, safe sex practices, community mobilisation, peer education and outreach, health promotion, capacity development, harm reduction approaches, needle and syringe programs, increased testing (including making it easier for people to ask for and be offered testing), and promotion of early HIV treatment' (p. 25). Besides the parenthesis here, these suggestions seem to put the burden of reducing HIV transmission on these priority populations, rather than on the sector or society more broadly. A risk here is that none of these aims are particularly relevant or possible without the key insight here: '*making it easier for people to ask for and be offered testing*' and '*have access to the means of prevention*' (p. 24; emphasis added).

As readers of *HIV Australia* would be cognisant, patients – people – do better when supported. All clinicians have the capacity to support trans and gender diverse people, and indeed the ethical imperative to do so. Trans and gender diverse people live across Australia in all kinds of communities, and many in all likelihood access a host of services without it being known that they are trans and/or gender diverse. The onus must be on services to create environments of care that make it safe for trans and gender diverse people to talk about our experiences of gender and sexuality, to be able to be accurate



about our embodied history and to be respected in our identities and relationships. This can be tricky terrain in a field that has its history steeped in sexist and homophobic assumptions and practices, yet every day health professionals have the opportunity to do things differently. This means starting from a position of openness and generosity, recognising the importance of simple gestures that are polite and respectful, resisting assumptions about people's experience or identity (especially as it relates to gender and sexual practices), and responding with kindness to disclosures of intimate details. These are practices of compassionate care that are vital to improving the sexual healthcare for all people in Australia, which is what is necessary if we are to continue on the path to eliminating HIV transmission. We need people working across multiple sites and roles to take up these challenges. I hope you will be one of them.

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