Youth Sexual and Reproductive Health Forum

10 October 2018 | Novotel Brisbane

Hosted by the Sexual Health Ministerial Advisory Committee

Queensland Government

Sexual Health Ministerial Advisory Committee

Inaugural Stakeholder Engagement Forum

The inaugural Sexual Health Ministerial Advisory Committee Stakeholder Engagement Forum was held in Brisbane on 10 October 2018, with a focus on youth sexual and reproductive health.

The Youth Sexual and Reproductive Health Forum (Youth Forum) provided a safe, welcoming and inclusive environment for young people, youth workers, sexual health practitioners, educators and policy-makers to voice their opinions on the current youth sexual and reproductive health landscape in Queensland, with the view to identifying barriers, opportunities and priorities in education and service provision, with a particular focus on 12–18 years.

The valuable information and opinions articulated at the Youth Forum will assist the Sexual Health Ministerial Advisory Committee to formulate expert advice and recommendations for action for presentation to the Minister for Health and Minister for Ambulance Services.

The Committee and the Communicable Diseases Branch extends its gratitude to the delegates, particularly the youth delegates, who gave so freely of their time and expertise to contribute to the discussion and the success of the 2018 Youth Sexual and Reproductive Health Forum.

Background

The announcement of an expert Sexual Health Ministerial Advisory Committee (Committee) was made by the Minister for Health and Ambulance Services in December 2016, following the launch of the *Queensland Sexual Health Strategy 2016–2021* (Strategy) earlier in the same month. Reflecting the innovative whole-of-government Strategy, eleven members representing diverse sector expertise and populations were appointed to the Committee to guide the implementation of the Strategy over its lifespan and provide advice to the Minister on matters that inform achieving optimal sexual and reproductive health for Queenslanders.

The Committee meets quarterly to discuss priorities and progress identified actions, and following its official establishment in 2017, the Committee held meetings in June 2017, September 2017, May 2018 and August 2018. Each meeting was themed, and presentations were received from the experts on the Committee representing the area of focus.

At the September 2017 Committee meeting, Department of Education Acting Assistant Director-General - State Schools Operations, Hayley Stevenson, delivered a presentation to the Committee on the contemporary position of Relationships and Sexuality Education (RSE) within Queensland state schools.

The Committee learned that schools are required to implement the Australian Curriculum Version 8 by the end of 2020, and are required to provide health and wellbeing education, either through the pastoral care program or via the curriculum. Version 8, released in 2017, allows greater flexibility in decision-making about how the Australian Curriculum is implemented in each individual school and provides schools with material to support implementation (Curriculum into the Classroom - C2C) that they are encouraged to adapt to suit the context in which they are being delivered.

Explanation was provided around the recommendation that the Australian Curriculum for Prep to Year 10 is implemented via 'learning areas' in primary schools, and that the learning areas of Science, Technologies and Health and Physical Education (HPE) cover topics that relate to RSE. These topics include sexual and reproductive health, relationships, growth and development, identity, inter- and intra- personal skills and decision-making. Within HPE, 'relationships and sexuality' is one of the twelve focus areas, and three of the C2C units make specific reference to this focus area – Year 5 Health Unit 4 – Growing Up; Year 7 Unit 1 – Approaching Adolescence; and Year 9 Unit 1 – Respectful Relationships. In addition to these curriculum resources, the Department of Education and Training provide staff with access to other resources through partnerships or agreements with external providers, such as .

At the May 2018 Committee meeting, Associate Professor Rebecca Kimble - Senior Staff Specialist, Obstetrics and Gynaecology, Department of Health, delivered a presentation entitled 'Addressing the Sexual and Reproductive Health Needs of Young People'. This presentation featured information about the impact of untreated sexually transmissible infections (STIs) on the reproductive health of young people, information on the 13 HEALTH webtest pilot project (www.health.qld.gov.au/13health/webtest), a summary of the School-Based Youth Health Nurse (SBYHN) program funded under the *Queensland Sexual Health Strategy 2016-2021*, and information about termination of pregnancy and syphilis in pregnancy in Queensland.

Additionally, the Committee was advised of an upcoming media campaign being developed by the Queensland Health Strategic Communications Branch (SCB), which was being created to assist with improving the sexual health attitudes, awareness and behaviours of young Queenslanders aged 1529 years. The campaign was to be informed by the results of formative research conducted in 2017 (which was consistent with earlier national surveys), indicating high and rising STI rates, particularly among young adults, coupled with decreasing

knowledge of correct safe sex practices. The research indicated that young Queenslanders display significant knowledge gaps in relation to sexual health and STIs, which impacts their choices and behaviour, and suggested opportunity for improvement, particularly regarding healthcare education and communication. Since the research highlighted that the primary source of information for most young people aged 16-29 years is the internet, the development of a website (www.qld.gov.au/stoptherise went live in September 2018) was identified as a critical element of the media campaign.

The presentation and formative research sparked discussion amongst the Committee, and agreement was reached that this section of the sexual and reproductive health sector needed further exploration, as there were indications that there may be opportunities for the Committee to facilitate improvement in the sexual and reproductive health outcomes for young Queenslanders. This culminated in the decision to dedicate the inaugural Committee stakeholder engagement forum to exploring the sexual and reproductive health landscape as currently experienced by young Queenslanders, by inviting them to participate in a day of facilitated discussion and the identification of the most pressing priorities, with the view to the formation of a focused plan for action.

Purpose and Approach

In May 2018, the Committee recognised that there were significant opportunities to explore improvements for the sexual and reproductive health of young people. The Committee decided that there was a need to consult with young people and the various sectors and stakeholders involved and the annual stakeholder engagement forum would be an appropriate and valuable platform to facilitate the exploration and discussion of current and specific issues to inform a focussed plan of action that aligns with the success factors of the Strategy.

The Committee sought to identify the sexual and reproductive health needs of young people, particularly those aged 12–18 years, and to explore the current perception of how well these needs were being met, within the identified key themes of *Education and Prevention* and *Service Access and Integration*.

Forum planning was undertaken by a time-limited Youth Forum Sub-Committee comprising the SHMAC Chair and four SHMAC members. Planning was also informed by an online survey undertaken through the Office for Youth's Queensland Youth eHub (Youth eHub). The Youth eHub provides a platform for the government to seek the views of young people in Queensland on various issues and topics.

A sexual and reproductive health Youth eHub survey sought views from young people aged 16-25 years of age, and was open for the period 17 September to 5 October 2018. De-identified information and quotes gathered through the survey were on display at the Forum.

Recognising the importance of consumer representation in the discussions, whilst having regard for legal capacity, a diverse five-member panel of young people aged 18-26 years was convened to engage in a wide-ranging discussion about the experiences that might be encountered by young Queenslanders when trying have their sexual health needs met.

The discussion was facilitated by Emeritus Professor Cindy Shannon, and resulted in enthusiastic engagement with the audience, particularly from the numerous young people present.

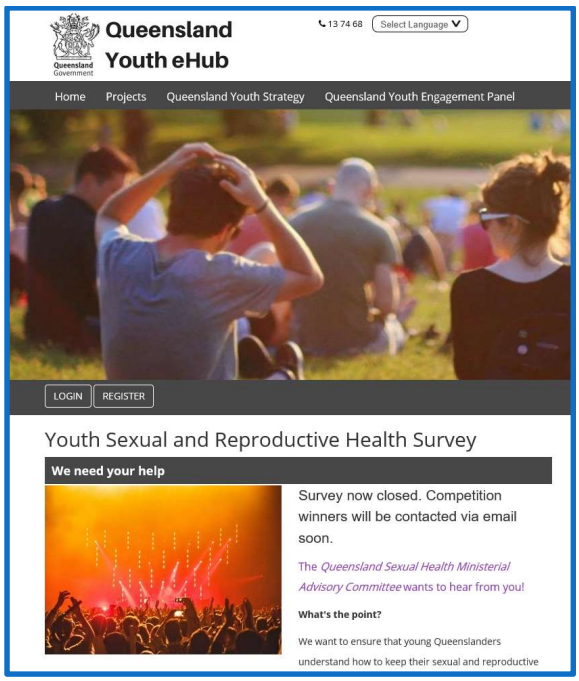
Two sets of facilitated small group sessions were then held to capture and further explore the themes, issues and ideas generated by the youth panel discussion.

A graphic recorder was used to capture and summarise issues raised during the Forum in a way that would appeal to young people. The resultant images can be seen in Appendix 3.

Due to the sensitive nature of discussions during the Forum, and the potential for there to be a small number of participants between 16 and 18 years of age, a detailed consent process

was used for Forum participants. This process recognised the concept of 'mature minors' aged under 18 years, who could self-assess their capacity to consent to participate in the Forum. In addition, a private, sensory space was made available for young people to use when required at the venue, and additional support was available as needed from youth sector organisation representatives in attendance on the day.

Gift cards were used to acknowledge the contribution of young people participating in the Forum and as incentives to participate in the Queensland Youth eHub online survey.



Youth Panel Discussion

The Youth Panel was comprised of five young Queenslanders who were identified to the Committee based on previous lived and youth advocacy experience. Having regard for the inherent sensitivities and risks associated with engaging children and young people from the identified age cohort in a public discussion on matters of sexual and reproductive health, young adult participants were selected to provide perspectives based on their own lived experiences that would represent diversity in gender, sexuality, culture, age and geographical location.

Our Youth Panel participants provided the following information about themselves and their interest in participating in the forum:

Tom, age 19

Tom is a Queensland Family and Child Commission (QFCC) Youth Champion, he is studying politics, and he works for a domestic violence prevention program, R4Respect. In this role, he creates social media content for young people containing messages about warning signs, controlling attitudes and how to form non-violent, respectful relationships. Tom promotes recognition and understanding of the incredibly complex and difficult lives young people lead. His perspectives are informed by the interactions he has with young people online and with his peers.

Tom's interests include politics, public policy, men working to create healthy relationships, domestic violence prevention, creating a culture of consent and respect, LGBTQIA+ representation and advocacy, and using social media as a tool for positive social change.

Makayla, age 19

Makayla lives in regional Queensland and has been a member of the PCYC Charters Towers Youth Management Team for 4 years. Her role includes running events for the town, attending networking meetings within the community and connecting with services that share the same goals- helping to develop and build on the potential of the town's youth.

Through Makayla's experience in this role, she has had the opportunity to help develop the youth in her community into the best leaders and people they can be, and describes her favourite part of this role as watching team members achieve, learn and grow. She enjoys engaging with the community and making as many links to services and community members as she can, and she wishes to build from this experience into a career in youth work.

Elloise, age 26

Elloise is a QFCC Youth Champion, and she is currently enrolled in a Bachelor of Social Science. She has previously studied nursing, and is a mother of two daughters. She became a mother at a young age, and experienced the child protection system and living in out-of-home care. She is an experienced CREATE young consultant and is now employed at CREATE Foundation as a community facilitator and an active member of G-Force (a working party chaired by CREATE Foundation, comprised of government and non-government organisations, that assists young people transitioning out of child protective care). Elloise has shared her insights at various events, conferences and in the media advocating for children and young people living in care. Elloise uses both personal

experience and professional knowledge to bring unique perspectives and positive change to current issues affecting Queensland's young people.

Elloise's interests include empowering children and young people to have their voices heard, breaking the cycle of structural barriers which affect children and young people in later life, supporting the needs of young families and advocating for children and young people living in out-of-home care.

Taz, age 20

Taz is a QFCC Youth Champion, and a Kalkadoon and Bwgcolman Brotherboy. He is passionate about his culture and wants to educate and encourage the current generation and generations to come, in all walks of life. Taz has lived experience in out-of-home care. Since the age of two, Taz struggled with gender dysphoria and has become an advocate, educator and mentor for young people who share the same story. Through the medium of social media and videos, he shares his story about his personal struggle with mental health and self-harming behaviours. In 2015 Taz filmed a documentary with the SBS about being a Brotherboy - the first of its kind for the Brotherboy community – and has featured in other short films. Taz has worked with headspace and currently works with Diverse Voices.

Taz's interests include transgender and suicide issues in Australia, especially in Aboriginal and Torres Strait Islander and LGBTIQ+ communities.

Beenush, age 22

Beenush was born in Cairns to Pakistani Muslim parents, and was only able to move out of the family home when she married, at age 17. Growing up, she visited Pakistan every 2 years with her family, and lived there (attending school) for a year and a half at around age 10. Beenush completed a Bachelor of Law (Hons) at QUT in 2017, and following graduation she worked as a Domestic Violence Specialist worker. Her current role as Domestic Violence Primary Prevention Program Coordinator at R4Respect reflects her passion for work in domestic violence prevention.

Beenush is also passionate about the need to educate and empower Culturally and Linguistically Diverse (CALD) adolescents about their own health needs, and draws on her own cultural background to reflect on issues that young Queensland CALD people might experience.

Having introduced the Youth Panel to the audience, Emeritus Professor Cindy Shannon asked each panel member what had encouraged them to volunteer their time to participate in the day's events. Whilst each panel member responded with various individual views, common to each response was the fervent determination to see the needs of the young person, from the perspective of the young person, captured and utilised to improve the systems in which sexual and reproductive health information and services are delivered in Queensland.

By posing a series of free-ranging and specific questions, and offering each panel member the opportunity to contribute their thoughts and opinions on each through the lens of their own knowledge and/or experience, Professor Shannon guided the participants and the audience through a discussion that covered, and perhaps uncovered, many important issues. For this report these issues have been summarised and collated under the headings below, however it should be noted that often issues are complex and could be classified in a variety of ways, reflecting the multi-faceted nature of sexual and reproductive health.

Empowerment and Agency

The view was expressed by panel members that they consider it to be a myth that young people aren't competent to make choices for themselves. They feel that their choices and relationships are often diminished or dismissed by adults, and this can be exacerbated when there are factors such as disability, gender diversity or culture involved. It was noted that there are many mature minors who, due to life circumstances, have been forced to develop agency (the ability to think and act for themselves) from a young age and so they seek respect and support for self-determination for mature minors. Some of these choices may

involve sex and sexuality, and it was suggested that in many cases it would be more beneficial to provide support to mature minors who have chosen to engage in same or similar-aged non-coercive sexual relationships via strategies which recognise how trauma might impact a person's behaviour or decision making (trauma-informed) and that focus on reducing the negative effects of behaviours (harm minimisation), rather than punitive (punishment-focused) responses. The panel were all in agreement that providing comprehensive education on all matters relating to sexual and reproductive health was critical in the development of a young person's health agency, including affirmative modelling of consent, appropriate online and text communications and peer education. It was specifically highlighted that young males should be actively encouraged and engaged to increase their ownership and awareness of their sexual and reproductive health needs, as it was felt that this group were the least engaged.

Education and Prevention

The panel were unanimous in their view that they did not receive enough information through RSE at school. They described receiving one day of RSE lessons in grade 10, and noted that if students were absent, or disengaged from traditional schooling, then they effectively missed out altogether. Panel members described the RSE they received in the school setting as narrow, inadequate and too late. Further, the information they received was heteronormative - information delivered from the perspective that male-female relationships are the 'norm' – and delivered by HPE teachers who might not be appropriately trained or comfortable to deliver the content effectively. The view was expressed that the information received didn't prepare young people for the practicalities or consequences of reproductive and sexual issues in a meaningful way. Some panel members indicated experiences with educators who had displayed queer-phobic behaviour or implied shame around issues like puberty, which caused fear and mistrust, such that some described disengaging from the process. Myths were discussed, along with difficulties knowing how and where to access to appropriate resources, and the panel considered that in the absence of trusted and consistent information, these myths would continue to persist. Panellists articulated a need for earlier, age-appropriate education delivered on a consistent basis, where everyone receives the same comprehensive information, in a manner that normalises sexual health and sexuality positively, and considers differences including disabilities, culture and gender identity.

Environment and Shared Responsibility

Societal attitudes toward sex and sexuality featured heavily in the panel conversation. Panellists reflected that a lack of early education and normalisation with respect to bodies, relationships and different models of gender identity and sexuality creates fear and perpetuates sexism, stigma and discrimination. Panel members considered that because of these societal constructs (beliefs and systems held and accepted by a community), unequal and often negative or hostile judgements are applied to certain groups within the population, based on differences in gender, physical and intellectual abilities, gender identity, sexual orientation, and/or culture. One panel member shared her experience of pregnancy, recalling that her joy at becoming a mum was not shared due to the stigma attached to her status as a young woman in the care of child protective services. It was also noted that significant stigma and discrimination is associated with those young people engaging in sex work, and significant hardship can be experienced by those in small geographical and/or cultural communities, where racism, sexism, system prejudice and shame all act as barriers to connecting with information and services.

Panellists remarked that often the onus of sexual health and reproductive health, and especially contraception, is placed on females, and that male versus female stigma looks quite different, such that derogatory comments might be levelled toward the female partner of a male seeking a sexual health check, rather than toward the male himself. The panel acknowledged that in all parts of society, judgement and fear of shaming stifles the ability to seek information and assistance, and suggested that the role of peer-educators in health promotion and support provision might be crucial in improving this situation. Specific mention of this was made with reference to improving access to services by Aboriginal and Torres Strait Islander people, where understanding the cultural needs *first and foremost* and using them as the foundation of any action taken is considered critical for success.

Access and Confidentiality

The panel conversation highlighted for all present that optimising sexual and reproductive health is not just a health system issue or response – issues impacting on sexual and reproductive health can be multi-factorial and have origins in other settings, and understanding each is critical to the success of any holistic, integrated systemic response. Panel members suggested that co-ordinated multi-agency responses, and applying trauma-informed practices, were necessary to improve system responses. Further, they proposed that the creation of friendly and safe spaces housing co-located adolescent services would

ensure more engagement and result in better outcomes for young people. In regional areas, where a lack of sexual health services and a lack of choice of providers was reported, the panel suggested the need for a mechanism for community outreach, such as a mobile clinic visiting the community regularly. It was noted that this model of care could be adapted to address other barriers to access, such as providing options for those who are disengaged from school or living out of home. The panel discussion touched on other issues impacting on an individual's ability to access services, such as problems with privacy and confidentiality due to close connections in small or culturally-sensitive communities, erroneous assumptions, lack of training, understanding or appropriate discretion by some primary health carers, and financial and transport constraints. Panel members suggested that it was important to create and leverage existing opportunities in health care to offer sexual and reproductive health care, noting that a good example of this might be to expand the mandatory Aboriginal and Torres Strait Islander health checks to include sexual and reproductive health matters.

Small Group Sessions Summary

Two sets of small group sessions were run, with discussions in each session guided by a youth and a sector co-facilitator.

Small Group Sessions Set 1; Blended Sector Settings

The first set comprised four small group sessions, with one session devoted to those participants who had registered as youth delegates, and the remaining three sessions of sector representatives and service providers who had been mixed together by being randomly assigned to groups/rooms. The groups were instructed to break down the key messages identified in the wrap-up of the youth panel discussion, and to identify any other barriers to access that may not have been raised.

Small Group Session 1

This group of approximately 18 delegates chose to explore the view expressed during the panel discussion that young people don't receive enough education about their bodies, and sought to identify and detail the reasons why, and how this might be addressed.

Following an initial discussion, the group consensus was that they agreed with the view expressed by the panel. They reflected that everybody is different, and everybody's expression of sexuality is different, and that it is common for young people of the same age to be at different stages of development. It was acknowledged that often parents do not possess contemporary or comprehensive knowledge; there can be cultural and other barriers to open discussions, and that education in the school setting tends to focus on the physical changes of puberty, how to put on a condom and STIs, but not on what to expect regarding how puberty or intimacy/sex feels and how to negotiate relationships, empowerment and agency. Often, the fear of embarrassment or shame means that a young person with questions will turn to a friend or social media for answers, and these sources may not always be reliable. In some cases, pornography is viewed by young people to gain some insight into the practicalities of sex, and it was highlighted that since this medium is not designed for that purpose, the inherent messaging is inappropriate and can result in harmful behaviours. The group reflected that there is a lack of standardised terms for the broad

spectrum of diversity in sexuality, and that common language and a safe and supportive environment was required to allow young people to feel comfortable and know that it is 'normal/acceptable' to explore these topics.

In light of these discussions, this group agreed that more comprehensive age-appropriate education was required for children and young people that is broader than advocating abstinence and avoiding pregnancy and STIs. They suggested that holistic information about the physical and emotional impacts of sex, shared responsibilities, legislative facts and legal consequences involved in sexual relationships and further guidance on healthy, respectful relationships, based on the concepts of mutuality (the sharing of feelings, actions or a relationship between two or more people) and consent, should be included. This information should be delivered in consistent, age-appropriate stages from a young age, and should be backed by contemporary, inclusive, accessible and accurate/trusted resources. Correct terms and slang should be appropriately referenced, and consideration should be given to reaching mainstream and marginalised young people inclusively, and teaching young people how to critique information and decisions.

Small Group Session 2

This group of approximately 25 participants split themselves into two groups to discuss issues raised in the youth panel discussion.

Sub-group one focussed on education in schools, and observed that there seems to be inconsistency in the RSE provided across Queensland. This was attributed in part to the flexibility afforded to each school in implementing the content of the Australian Curriculum, and that enhanced content and consistency in implementation would require supportive school principals to act together as change champions. This view was balanced with the observation that there is too much emphasis on schools as the sole source of education, with associated pressure on principals and teachers, and questioned whether effort might need to be directed toward effecting a societal shift that supports educators and encourages parents to be more involved in RSE delivery and discussions with their own children. There was discussion about the broad nature of sexual health, and its foundations in relationships and societal attitudes. It was acknowledged that societal attitudes shift over time, and that as this happens, associated sexual and reproductive health and education needs change. The observation was made that it now encompasses much more than just contraception and

STIs, and that since the school setting is a microcosm of society, RSE information and resources delivered within the curriculum should reflect the current needs of all the diverse groups within the population. Since health and wellbeing impacts learning, the delivery of this information in the curriculum should be mandated. It was acknowledged, however, that there are competing priorities within the curriculum – there is so much that educators are expected to teach – so this group queried how this issue might be managed in a way that provides effective resourcing and support to teachers and principals. Increased engagement and integration of school-based youth health nurses (SBYHN) was suggested, and since sexual health has origins in relationships and interpersonal skills, the group questioned whether the current arrangement of RSE delivery by HPE teachers in Y10 – 12 was appropriate.

Young people attending on the day indicated that the HPE RSE messages that they received promoted abstinence only, with no coverage of contraception or how to negotiate issues including first time sex and consent, which they felt left them with no option but to seek some insight through accessing pornography. They reported that access to information about these issues was magnified for young people disengaged from school or for those who didn't have supportive parents, and reflected that if one is not sufficiently informed to be able to identify risks, one is not able to make appropriate choices or seek help. This group stressed the importance of education, specifically peer-education, in helping to minimise stigma and discrimination, reflecting that 80 per cent of queer violence happens in school settings.

Sub-group two reflected that RSE delivered in high school in HPE lessons was too late and focussed on the biological mechanism of sex, rather than providing guidance on respectful and trusting relationships. It was felt that a lack of understanding and education on the latter provides the origin for issues such as stigma and violence. Attention was drawn to Norwegian/Scandinavian models of RSE, where sexual health and sexuality is normalised within society from a very young age, with age-appropriate, diversity inclusive and sex-positive messages featuring love, trust and respect embedded in the nationally-consistent teachings. This subgroup agreed that a nationally-consistent sexual health curriculum is required in Australia, that provides multiple access points and allows for connectivity and cohesiveness whilst maintaining privacy and confidentiality.

Small Group Session 3

This group of approximately 25 contributors discussed the importance of sexual and reproductive health education in home and school settings, and the importance of normalising discussions using consistent and age-appropriate messaging, from a young age. As with small group session 2, this group cited European models of RSE, where sexual health education is provided early and consistently, and commented that the evidence suggests that this is responsible for the observed higher age of sexual debut and lower teen pregnancy rates in these countries.

The issue of young people accessing pornography was discussed, and there were differing opinions on the place/role of pornography in society. It was suggested that for some marginalised populations, certain pornography is the only accessible representation of their sexual preferences available to them, and for them, this represents empowerment. There was also agreement that there can be harmful and inappropriate messaging embedded in pornography, and that perhaps there was a need to make affirmative materials available.

As in other groups, the critical role of parent-led education was highlighted, and outreach, diversity and the incorporation of lived experience all featured in discussions. The use of digital technology and platforms to supplement school-based education for young people was recommended, and it was highlighted that there is a gap in access for young people in rural or cultural situations (due to issues with privacy and confidentiality) who require sexual and/or or reproductive health services, such as contraception. The need for appropriate and ongoing training in adolescent development, including sexual and reproductive health needs, for any service provider working with young people was emphasised, and it was suggested that it might be beneficial to link educators, mentors, youth workers etc with other health and community specialists, so that they may call on extra assistance and seamless referral pathways are established as required. The point was made that most people tend to access mainstream services (primary health care) first, so these services should be fortified and expanded where possible.

Small Group Session 4 – Youth Group

The youth group was comprised of approximately 20 young people, and they chose to focus exclusively on the importance of education. Discussions revolved around the sexual and

reproductive health needs of priority populations, including providing education to combat stigma and shame in rural and remote communities, providing outreach to educate and assist those who are disengaged, disinterested or unable to access sexual health information, and ensuring that all forms of diversity are included and catered for. The group were strong in their opinion that peer-education is a very effective tool, and expressed that it is important to young people that the information delivered encompasses language, experiences and people that they can directly relate to.

They were very clear about wanting access to more information across a range of subjects, including healthy relationships, domestic violence/sexual assault and how and where to access health services. They also advocated for no separation of genders during the delivery of RSE, arguing that it is important for everyone to have the capacity to understand the diversity of individual experiences. It was felt that the ability to empathise with each other, based on shared knowledge, might help minimise issues relating to stigma and discrimination. There was considerable discussion again about the importance of affirmative messaging in health promotion, and for the messages to support self-determination by providing all appropriate information and associated consequences to facilitate informed choices, rather than simply advocating avoidance or abstinence. The Condoman and Lubelicious campaign, developed by Aboriginal and Torres Strait Islander people for Aboriginal and Torres Strait Islander people, was mentioned as a successful example

The group reiterated the importance of quality education and suggested a hub/access point/marketplace for sharing information and ideas, and advocated for easier and more consistent access to information and services relating to contraception.

Clarity around mandatory reporting legislation was discussed at length, as young people felt that at times there was inconsistency in the interpretation and application of this legislation between service providers. They advocated for clear instruction at the commencement of any relevant interaction with any service providers about what the obligations of each party were in respect of this, and queried how it might be possible to achieve a system response that, in certain circumstances, had the ability to provide ‘protection without punishment’.

Summary of Small Group Sessions Set One

- → Importance of education, not just in the school setting
- → Education required for parents and carers, so that they can support the education and agency of their children
- → Consistent but diverse language – standardised where possible, but includes slang used by target populations
- → Inclusive delivery of affirmative and empowering education (shift from 'avoid' to 'information and natural consequences'), with no gender-based separation
- → Timing of education provision is critical – should be early, on-going and age-appropriate
- → Normalisation of sexual health - should be framed as just another component of an individual's overall health and wellbeing
- → Consider specialist partnerships and seamless referral pathways with schools, health services, youth/community services
- → Comprehensive information on legislation around mandatory reporting and confidentiality, service providers should declare their obligations clearly and 'up front'
- → School-based educators are front-line staff – they should be upskilled and trained to deliver the necessary information in the absence of influence from their personal values
- → Consult young people about what they need, and include them as partners in the design and delivery of system responses
- → Move toward technology-based information – desire for comprehensive, respected, inclusive, sex-positive website. Apps are also useful for some things, but website preferred for information gathering and point of reference
- → Utilise peer-education and develop outreach models, consider leveraging hubs like Centrelink to provide additional services to young people
- → Utilise alternative models for intervention where appropriate – young people may not seek assistance out of fear of criminalisation
- → Consider a public education campaign on youth-focussed sexual health and sexuality

Small Group Sessions Set 2; Settings-Based

The second set of four small group sessions again retained the youth-only group, however the sector representatives/service providers were redirected into groups based on the service provision setting that the delegate indicated upon registration. Some of the young people chose to forego the youth-only session so that they could participate in another settings-based session of their choice.

The groups were asked to reflect on the take-home messages from the first set of small group sessions, and to identify how associated improvements might be achieved in their setting. The group were encouraged to consider that this could involve scaling-up currently existing models or the creation of innovative new service models.

Small Group Session 5 – Education Settings

Within the education setting group, which was comprised of approximately 20 people, discussions were held about stigma and discrimination faced by certain groups within the school environment, noting that young parents, young people engaging in sexual activity under the age of consent and LGBTIQ youth face the most difficulties. It was highlighted that taking an inclusive approach to addressing these issues, rather than in isolation, was considered the most effective approach. As with other sessions, a single comprehensive sex-affirmative website featuring a live chat option was raised as the best mechanism to educate parents/carers, young people and the wider community. The role of appropriately trained youth ambassadors was endorsed, with Mansfield State High School raised as an existing example[1]. Again, the need to clarify mandatory reporting requirements and provide increased training and links for service providers featured in discussions.

This group reflected on society in general and queried whether values had remained or become increasingly conservative, such that educators are fearful of having sexual and reproductive health conversations due to the potential for negative parental or media

[1] Mansfield State High School is a public independent co-educational secondary school in Brisbane's southern suburbs. Each year a student council is formed to lead the student body. The student council is comprised of two captain positions, two vice-captain positions and two prefect positions per year level group. The prefects meet with their year level student body, and raise issues as required with the student council. The school captains will report on year-level issues to the School Principal, who may report back to the student council as required.

feedback. It was acknowledged that the community needed to move toward a more sex-positive culture, and that school principals needed to be encouraged to support the embedding of RSE within a range of subjects, as an opt-out, rather than opt-in, program.

This group suggested the involvement of police assistance in parental engagement, by providing education targeted at parental groups illustrating what the possible consequences are of young people not receiving comprehensive RSE.

Small Group Session 6 – Health Settings

Approximately 28 people were present in the health settings group, and they chose to work on the points raised in the first set of small group sessions under four main themes:

Peer education

The importance of youth involvement in youth issues was clearly articulated here, and the development of youth champions and peer educators/navigators was promoted as a crucial way of engaging with young people in a way that feels comfortable for them. This model gives young people access to connect with contemporaries who look like them, talk like them and can share with them the benefit of knowledge and lived experience in a way that adult service providers may not be able to replicate.

Things to be considered with implementing such a model includes appropriately funding services and positions, rigorous and ongoing formal training with assessment (including, but not limited to, training in trauma, relationships, health matters, respect and consent), providing peer educators with access to information about available services and appropriate referral pathways, strengthening networks with youth community services, providing diversity in representation (transgender, LGBTIQ, Aboriginal and Torres Strait Islander, substance abuse issues, mental health challenges, foster home/care experiences, young parents etc), and ensuring that everyone is given access to safe spaces in which to consult with their young peers. It was proposed that the peer educators would have a presence on the proposed website (discussed further in this section) and other social media sites visited by young people, such as Instagram, and that they would have access to the resources associated with the website.

Empowerment

This section focussed on how to improve access to and experiences within health services, how to empower those who work with and support young people, and how to best support a young individual's self-determination with respect to their health needs.

The phrase 'knowledge is power' was used to reflect the fact that access to information is so important in developing an individual's ability to take responsibility for, and make well-informed decisions about, their own health needs. The group reflected that it is important that individuals are taught concepts as simple as 'it's ok to have sex', and that 'talking about sexual health is as normal as talking about any other aspect of your health', which then provides the basis for them to be able to feel confident to proactively seek help and support.

Accessing GP services was also discussed here, and the group made the point that any patient seeking assistance should be treated with respect and without judgement. The group suggested that increased sexual and reproductive health care education for GPs and associated practitioners is required, and that symbols such as red umbrellas or rainbow flags could be displayed to indicate safe, inclusive and welcoming environments. This could be further enhanced by advertising the biographies and pictures of staff, with their areas of specialty highlighted, and ensuring that there is diversity and representation within healthcare provision wherever possible. A specific list or network of registered sexual health practitioners in each area was considered desirable, as was the opportunity to have and make choices in selecting healthcare providers. For those individuals who have potentially more specialised health requirements, such as transgender people, consulting an informed and compassionate communicator who can welcome them with appropriate pronouns and consult and treat, or refer appropriately, was considered crucial to optimal health and wellbeing outcomes.

Other issues raised as impacting empowerment included making appropriate provisions for service access in rural areas or for after-hours care, such as outreach and online services, co-locating services ("one-stop shop"), including youth co-design and young people in resource and service provision (lived experience and peer navigators), and the reinforcement of body autonomy ('my body my choice').

Stigma/discrimination

Stigma and discrimination were cited as the integral reasons why young people don't seek sexual and reproductive health information, checks and/or tests. Education and awareness were promoted as crucial to minimising stigma and discrimination, ensuring that younger

people received equitable age-appropriate access to sexual and reproductive health education. Associated with this was the normalisation of sexual and reproductive health issues, through using appropriate and shared language, minimising judgement, encouraging flexibility and acceptance, and encouraging people to 'call-out' discriminatory attitudes and behaviours.

The creation of support networks and youth champions to explore societal values, create opportunities to discuss sexual and reproductive health issues, bust myths, promote body positivity and inspire others to be curious and respectful of differences, rather than fearful, was again suggested.

Mandating sexual and reproductive health checks, and creating opportunity within scheduled appointments (e.g. checking on sexual health issues whilst consulting on reproductive health issues) was also suggested as a method for normalising this area of healthcare, thus serving to reduce the stigma associated with it. It was further suggested that creating and maintaining oversight of a register of professional service providers who declare personal objections to providing certain health services (e.g. termination services) might be of value.

The creation of a youth-friendly mobile service ("youth bus") was suggested as a vehicle to create access to private and confidential sexual and reproductive healthcare services for young people living in rural/isolated areas. Public awareness campaigns, utilising health promotion advertisements on dating websites, and advertisements on social media were also suggested as critical elements in reducing stigma and discrimination.

Focused website

The development of a centrally-maintained, evidence-based and reputable website was again raised and explored in detail. As in other groups, this group advocated a youth co-designed, fun, interesting, interactive, user-friendly single portal, which houses separate pages for priority populations, users, and service providers. The group felt it should feature links to social media, the sites of other sector stakeholders (including clinics, legal services, community services, interstate agencies), and allow on-line communication with registered professionals and peers.

An app, with appropriate privacy and confidentiality barriers, should be associated with the website, and should allow access to education, appointments, results, referrals and contact tracing information. Ease of access was highlighted, suggesting that language should be inclusive, simple and humorous (not too serious), any text should be well-sized, a text-to-voice option should be embedded, and a variety of modalities should be used to deliver

information. As an example of this, it was suggested that short videos, using simple language with diverse, real people (not actors, and not hiding features such as pimples, body hair or cellulite), should be used to provide information and practical instruction on issues including kissing, masturbation, first-time sex, contraception and reproductive issues such as use of tampons.

Finally, it was proposed that the resulting website should be supported with an extensive public awareness campaign, designed to promote the importance of youth sexual and reproductive health and incentivise people to access the resource.

Small Group Session 7 – Community and Family Settings

The community and family settings group, consisting of approximately 25 contributors, were looking to explore how parents/carers and families could be better supported to understand and communicate about sexual and reproductive health issues, and how this would better position them to provide more effective education and support to their children.

The group reflected that parents may not always feel empowered to know what is developmentally appropriate with respect to sexual and reproductive health matters as children transition to adolescence, and may feel less supported in these latter stages to have conversations with their teens about consent, safety, relationships, benefits to delaying sexual debut and the concept of sex as a pleasurable and healthy activity.

Further, consternation about legal repercussions surrounding minors who have chosen to have non-coercive and consensual intercourse under the legal age of consent may complicate parental responses and possibly hinder or prevent the adolescent receiving appropriate support and assistance.

Within the community setting it was felt that peer navigators in sexual health services would be beneficial, providing that they successfully completed training to an appropriate quality standard prior to being deployed, and maintaining that standard during employment. All agreed that it is crucial to incorporate youth participation and co-design in the development of any resources or services, and that a web-based resource would provide benefit in both settings.

In line with recommendations from other groups, the desirable components of a website were discussed in detail and included:

- Pages for different audiences (including parents/carers, young people, educators, priority populations etc) housing regularly updated relevant information and tips
- Language and imagery that is familiar, relevant and appropriate
- Variety of educational materials embedded – images, videos, FAQs – videos used to demonstrate unfamiliar practices, places or procedures (e.g. first visit to sexual health clinic)
- Live chat option
- Advocate government-funded website but concern that government ownership might restrict content or 'look and feel' of the website.

Small Group Session 8 – Youth Group

The youth group of approximately 15 participants discussed the resources currently in existence that they were aware of, such as the Traffic Lights program. It was suggested that whilst this program provided an excellent framework for sexual health information, certain elements of it needed to be updated to reflect information provision in an affirmative way, such as removing 'engaging in transactional sex' from the 'red-light category' (it was felt that this was shaming, rather than informative).

They stressed the importance of having young people engaged in the development of information, resources and services, and coined the phrase 'nothing about us without us' to highlight this, noting that a top-down approach is often not the most successful strategy when attempting to engage people.

The group discussed the need for wide societal change, so that conversations about sexual and reproductive health would become a normal part of life, and promoted an ethos of 'embrace rather than impose', so that differences in areas such as culture, race, gender and sexuality would be less of a source of tension and harm. They felt that body parts are just 'pieces of flesh', and should not serve as the basis for differentiating or discriminating against people.

The group promoted early education as a crucial element in effecting societal change, suggesting that it should commence formally at around the age of five and continue over the lifespan of the person. They suggested that ensuring that everyone receives the same

inclusive information would assist in the reduction of stigma and would ensure that all needs are met, and they advocated combating ignorance by ‘creating opportunities to learn’.

The group discussed ways in which parents could be encouraged to engage in proactively providing access to sexual and reproductive health checks for their children. It was suggested that the addition of these checks to other mandated child health checks (such as alongside the immunisation schedule), and creating further age-appropriate opportunities (‘the child health passport’), would be an efficient and successful way to achieve this.

As with other groups, this group of young people also discussed the value of peer-educators, youth champions, clarity around mandatory reporting and a centrally and continuously maintained website with associated promotion campaign.

Summary of Key Issues

After the Youth Panel and the two sets of small group sessions, eleven priorities were identified by the groups as follows:

1. Overcoming Access Barriers

The group highlighted that there may be service access barriers for this age group, which range from a lack of services, an inability to independently access Medicare until 15 years of age, a lack of transport or funds, to a lack of information/education and personal lack of confidence. Further specific barriers may be faced by priority populations within this age group.

The group highlighted the need to clearly identify barriers where they exist, and recommended the involvement of young people and service providers in the design of innovative, multi-mode and multi-agency service delivery solutions to these barriers.

2. Ongoing Professional Development, Education and Training for All Service Providers

The group highlighted the importance of ensuring that any person providing services for young people should be equipped with the knowledge and skills required to sensitively, compassionately and proficiently respond to the diverse range of needs that might present within the relevant age group. This could include having a comprehensive knowledge of available services to be able to refer young people on to as required, or using inclusive language.

The group recommends initial sexual health-related education and proficiency assessment for service providers, with regular updates and training.

3. Peer Education

The group acknowledged that young people often look to each other for information, advice and role modelling, and that a lack of appropriate education amongst young people might perpetuate the spread of misinformation, myths and stigma.

The group recommends training, developing and appropriately remunerating a diverse peer-educator workforce to serve as youth health promotion and support officers. It was acknowledged that peer-educator competency should be assessed on an on-going basis, as

with other service providers, to ensure the quality and integrity of the peer education service provided.

4. Parent and Carer Education

The group acknowledged that parents and carers are the first educators of their children, and that for many, staying up-to-date with accurate information about sexual and reproductive health matters, and knowing how and when to broach these matters with their children or those in their care, can be difficult. The group further reflected that a lack of education and confidence amongst parents may impact decisions made around supporting RSE delivery in school settings.

The group recommends facilitating the provision of sexual and reproductive health education and/or resources to parents and carers, and notes that accessibility by this group would be optimised by utilising technology.

5. Website Resource

The group emphasised the fact that there is no single authoritative comprehensive web-based sexual and reproductive health resource for young Queenslanders and those who support them. The group acknowledges that there are many different websites available covering many different aspects of these topics, but it is time-consuming to search for, and verify the authenticity of, each. Further, this means that information access is likely to be inconsistent between young people and those who support them.

The group recommends the development of a universal/central website, that provides a ‘one-stop-shop’ of relationships, sexuality and sexual and reproductive health information and resources. The website should feature different ‘portals’ for the different target groups (which should include young people, parents/carers, teachers, sector professionals and priority populations), and the language, content and imagery should be pitched to the level of the target audience. The group suggests co-design with young people to avoid the feel of ‘top down’ communication, and it should incorporate humour, videos and demonstrations, myth busting, diverse and real people, live chat options with professionals, lived-experiences, and incentives to encourage participation, such as quizzes and competitions.

The group recommended that while the Queensland Government should support and fund such a website, it should be hosted by an external agency that is less constrained in terms of the ‘look and feel’ of the website so that it will appeal to young people.

6. Overcoming Stigma and Discrimination

The group recognised that stigma and discrimination is behaviour that often results from a lack of understanding and deeply entrenched stereotypes, and that stigma and discrimination relating to sexual health matters is complex and pervasive within the greater community. Positive education and awareness is crucial to overcoming stigma and discrimination. Activities designed to bust myths, normalise sexual and reproductive health issues, positively influence language, attitudes and behaviours, encourage inclusion, and provide support for those who need it should be created and actively promoted.

The group recommended that sustained and multi-faceted efforts such as these will be required.

7. Youth Empowerment

The group highlighted the importance of supporting young people to make, or be involved in making, decisions relating to their health and well-being. It was noted that providing them with information and education is critical to enable them to develop sound decision-making abilities and a positive understanding of their bodies and their health needs.

The group recommends involving young people in the design and implementation of any services aimed at this demographic.

8. Role of Pornography

The group acknowledged that pornography seems to be a significant channel for sex education, particularly for young men. This was acknowledged as a serious risk, since it is so easily accessible and many pornographic films feature exploitation and sexual violence, providing a narrow and unrealistic view of sex and relationships for young people.

Whilst there was debate about the place of pornography in society, some members of the group suggested that pornography could be used in a more empowering way by depicting respectful and diverse sexual relationships.

9. Legislative Frameworks

The group recognised that there may be different perceptions and interpretations within the sector of applicable legislation including mandatory reporting, particularly at areas of intersection between different service providers. The group acknowledged that young people express feeling scared and anxious about seeking information and assistance with respect

to their sexual and reproductive health needs, as they don't necessarily fully understand the implications of mandatory reporting and fear a punitive response if information is disclosed.

The group recommends the review of mandatory reporting legislation to ensure consistent application, with the incorporation of supportive and protective, rather than punitive, measures where appropriate. The group recommends that a simple-language interpretation of mandatory reporting legislation, and any differences in application between various practitioners, should be made publicly available.

10. Youth Health Strategy

The group indicated that the development of a specific youth health strategy was desirable. This strategy should facilitate multi-agency collaboration, it should be appropriately funded and it should encompass and optimise already existing community services.

11. Inclusive and Earlier Education

The group highlighted that education is crucial to a person's ability to optimally manage their health and wellbeing, and noted that young people report needing much more information much earlier than they have been provided through RSE in the school setting. The group acknowledged that schools are not solely responsible for the delivery of this education, and that challenges including a crowded curriculum and a lack of parental engagement and community support may need to be overcome.

The group recommends the provision of age-appropriate and on-going sexuality education from an early age, so that by the time young people reach the age of needing to consider matters of sexual and reproductive health, seeking information and services is considered 'normal' and is something that they can navigate sensibly and confidently.

Issues to Action

In the last session of the afternoon, all delegates reconvened to discuss the key issues that were identified. A process was undertaken to allow each participant to cast their votes on which issues should be prioritised for action, and four of the eleven issues were highlighted through this ballot:

→ Inclusive and Earlier Education

The early provision of sexual and reproductive health education, in a structured, consistent, inclusive and age-appropriate manner, through the school curriculum and via other resources, emerged as the clear preference.

→ Overcoming Stigma and Discrimination

→ Ongoing Professional Development, Education and Training for All Service Providers

→ Youth Empowerment

Overcoming stigma and discrimination through sustained activities designed to promote sex positivity, disempower myths and entrenched stereotypes, and support inclusivity, scored second in the ballot. This was very closely followed by the wish to see increased and consistent professional development activities designed to provide support and education for any professional working in the youth space, and the desire to see increased recognition and support for young people to be integrally involved in making decisions that impact their lives.

The Committee acknowledges the importance of these issues, and agrees that there are benefits in taking all of the top four issues forward. Recognising the importance of youth empowerment and co-design, the Committee has discussed the possibility of empanelling a youth working group of approximately 6 – 8 mature minors and young adults with diverse experience to provide advice and assist the Committee to progress this body of work. The Committee will prepare and provide recommendations to the Office of the Minister for Health and Minister for Ambulance Services on this basis.

Appendix 1 – Delegates

The Youth Forum was attended by approximately 100 delegates from regional and metropolitan areas of Queensland, with approximately one third of delegates identifying as young people (aged 1629 years).

Representatives from various Queensland government departments, including Queensland Family and Child Commission, Queensland Police Service, Department of Education, Department of Child Safety, Youth and Women and the Department of Health were in attendance on the day, along with excellent representation from non-government organisations working in the youth sexual and reproductive health space, including Open Doors, Brisbane Youth Service, Headspace, Daniel Morcombe Foundation, Respect Inc and R4Respect, to name but a few.

Sexual Health Ministerial Advisory Committee Members	
Emeritus Professor Cindy Shannon	Chair, Sexual Health Ministerial Advisory Committee Chair, Youth Sexual and Reproductive Health Forum
Dr Anthony Allworth	Medical Director, Infectious Diseases, Metro North HHS
Dr Graham Nielsen	Sexual Health Physician, Biala Sexual Health Service, Metro North HHS
Mr Phillip Carswell OAM	Community member, specifically advocating the perspectives of Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning + (LGBTIQ+) communities
Ms Hayley Stevenson	Acting Assistant Director General, State Schools – Operations. Department of Education

Mr Ignacio Correa-Velez	Associate Professor, Faculty of Public Health, Queensland University of Technology
Dr Stephen Stathis	Medical Director, Child and Youth Mental Health Service, Children's Health Queensland
Ms Candi Forrest	Sex worker advocate
Youth Panel Participants	
Elloise Waite	QFCC Youth Advisory Council
Taz Clay	QFCC Youth Advisory Council
Tom R	QFCC Youth Advisory Council, R4Respect
Mikayla Foster	PCYC Charters Towers
Beenush Khokhar	R4Respect
Youth Breakout Session Facilitators	
Andrea Mills	Peer Educator, Cairns and Hinterland Hospital and Health Service
Karly Smith	PCYC Charters Towers
Kayla Rose	Respect Inc
Jayden Parsons	PCYC
Taz Clay	QFCC Youth Advisory Council

Tom R	QFCC Youth Advisory Council, R4Respect
Eloise Higgins	Central Queensland Youth Connect
Ryan Sheldrake	R4Respect
Sector Breakout Session Facilitators	
Chris Pickard	Open Doors Youth Service
Phil Smith	Brisbane Youth Service
Susan Fotheringham	Nurse
Michelle Clekovic	School-based Youth Health Nurse
Ainsley Duncan	Behaviour Specialist, Department of Education
Jodie Fisher	Gender Clinic
Nick Pouchkareff	School-based Youth Health Nurse
Belinda Tessieri	headspace Southport
Youth Participants	
Jade Mirabito	headspace Southport

Savannah Whieldon	headspace Southport
Ariella Sinclair	headspace Southport
Perla Perdilla	Student, University of Queensland
Renon Shafer	Youth Focus Peer Educator, Respect Inc
Ivy Belle	Vice Chair, Youth Representative, Respect Inc
Rachael Pascua	R4Respect Youth Worker, YFS
Ray Holding	Brisbane Youth Service
Emilia Baudelaire	Brisbane Youth Service
Katara Laracy	Open Doors Youth Service
Darren Ong	Open Doors Youth Service
William Lovejoy	Open Doors Youth Service
Tristan Williams	Open Doors Youth Service
Kei Cobb	Open Doors Youth Service
Isabella Williamson	Open Doors Youth Service

Jordan Young	Central Queensland Youth Connect
Ingram Gordon	
Nadia Saeed	Youth Ambassador, R4Respect
Kassity Knox	YMCA
Department of Health Representatives	
Dr Alun Richards	Medical Director, BBV/STI Unit, Communicable Diseases Branch
Alison Thompson	Manager, BBV/STI Unit, Communicable Diseases Branch
Amanda Reeves	Manager, Sexual Health Strategy, Communicable Diseases Branch
Melissa Warner	A/Principal Public Health Officer, BBV/STI Unit, Communicable Diseases Branch
Julie Harvey	Principal Public Health Officer, BBV/STI Unit, Communicable Diseases Branch
Abby Fryer	HIV Public Health Nurse, HIV Public Health team, Communicable Diseases Branch
Kylee Parsons	CNC, Young People's Health Check, Townsville Hospital and Health Service
Belinda Connelly	Clinical Nurse Sexual Health, Princess Alexandra Hospital

Nicole Cool	Senior Officer, Central Queensland, Wide Bay and Sunshine Coast PHN
Sharon McDonald	Principal Policy Officer, Strategic Policy and Legislation Branch
Rachel Vowles	Manager, Strategic Policy and Legislation Branch
Caroline Thng	Senior Medical Officer, Gold Coast Sexual Health Clinic
Kathy Brown	Senior Director, Aboriginal and Torres Strait Islander Health Branch
Kristel Modderman	Senior Project Officer, Aboriginal and Torres Strait Islander Health Branch
Paul Durante	Director, Aboriginal and Torres Strait Islander Health Branch
Joseph Debattista	Sexual Health and HIV Coordinator, Metro North Public Health Unit
Lisa Hutchinson	Nurse Manager, State-Wide SBYHN, Children's Health Queensland
Michelle Clekovic	SBYHN, Children's Health Queensland
Jodie Fisher	Clinical Nurse, Queensland Children's Hospital Gender Clinic
Erin Sharwood	Clinical Ethics Fellow, Children's Health Queensland
Courtney Lougoon	Clinical Nurse, Gold Coast Sexual Health Clinic

Julian Langton-Lockton	Sexual Health Physician, Biala Sexual Health Clinic
Jacqualine McLellan	Clinical Nurse, Biala Sexual Health Clinic
Narelle O'Connor	SBYHN, Children's Health Queensland
Cheryl Hewlett	SBYHN, Children's Health Queensland
Lucille Chalmers	General Manager, Brisbane South PHN
Aurora Bermudez Ortega	Health Integration Manager, Brisbane South PHN
Dominique Collett	Project Officer, Royal Brisbane and Women's Hospital
Sara Vale	Program Director Sexual Health, Tropical Public Health Services Cairns
Carla Gorton	Sexual Health Coordinator, Cairns Sexual Health Service
Laura Easterbrook	CNC, Child Protection, Sunshine Coast HHS
Heather McGregor	A/Team Leader, Strategic Communications Branch
Jennifer Cassidy	A/Marketing Manager, Strategic Communications Branch

Vicki Moore	A/ND Youth Health, Children Health Queensland
Mekala Srirajalingam	Sexual Health Physician, Ipswich Sexual Health and BBV Service
Clare Mason	Social Worker, Dovetail
Morgan Dempsey	Health Worker Coordinator, Cairns North Community Health
Nicholas Fawcett	Program Manager, Mental Health Alcohol and Other Drugs, Central Queensland, Wide Bay and Sunshine Coast PHN
Sector Representatives	
Phillip Sariago	Project Coordinator,
Peter Black	President Queensland AIDS Council
Sue Breckenridge	Placement Student, Central Queensland, Wide Bay and Sunshine Coast PHN
Jennifer McIntosh	QUT Health
Melinda Hassall	Clinical Nurse Lead, ASHM
Katelin Haynes	Queensland Program Manager, ASHM
Helen Casey	A/Manager, Department of Education
Kim Bennett	Nurse Manager, Department of Education

Andrea Lauchs	Executive Director, Department of Child Safety, Youth and Women
Georgia Grayson	Projects Officer, Daniel Morcombe Foundation
Holly Brennan OAM	CEO, Daniel Morcombe Foundation
Judith Dean	Post-Doctoral Research Fellow, School of Public Health University of Queensland
Nicole Allen-Ankins	Manager, Office for Youth, Department of Child Safety, Youth and Women
Susan Wilson	Principal Policy Officer, Department of Education
Shaye Austin	Open Doors Youth Service
Deborah Clegg	Project Officer, Department of Education
Rebecca Johnson	IndigiLez Women's Leadership and Support Group
Rebecca Reynolds	Executive Director, QuAC
Siyavash Doostkhah	Director, Youth Affairs Network of Queensland
Alex David	Director, Intersex Human Rights Australia
Vicki Ogilvie	Regional Youth Support, Department of Education

Liz Walker	Managing Director, Youth Wellbeing Project
Pamela Doherty	Education and Training Coordinator, Children by Choice
Angela Wunsch	Manager Child and Family,
Ben Wharton	Workshop Coordinator, Traction
Zhihong Gu	Program Manager, ECCQ
Robert McCall	Inspector, Queensland Police Service
Nicole Powell	Sergeant, Queensland Police Service
Sandy Murdoch	Founder, Traction
Claire Moran	Manager- Tertiary Education,
Rachael Donovan	Queensland Family and Child Commission
Shelley Argent	PFLAG
Megan Appleton	General Practitioner
Penni Davidson	P and Cs Queensland
Monique Belousoff	General Manager Stakeholder Engagement,

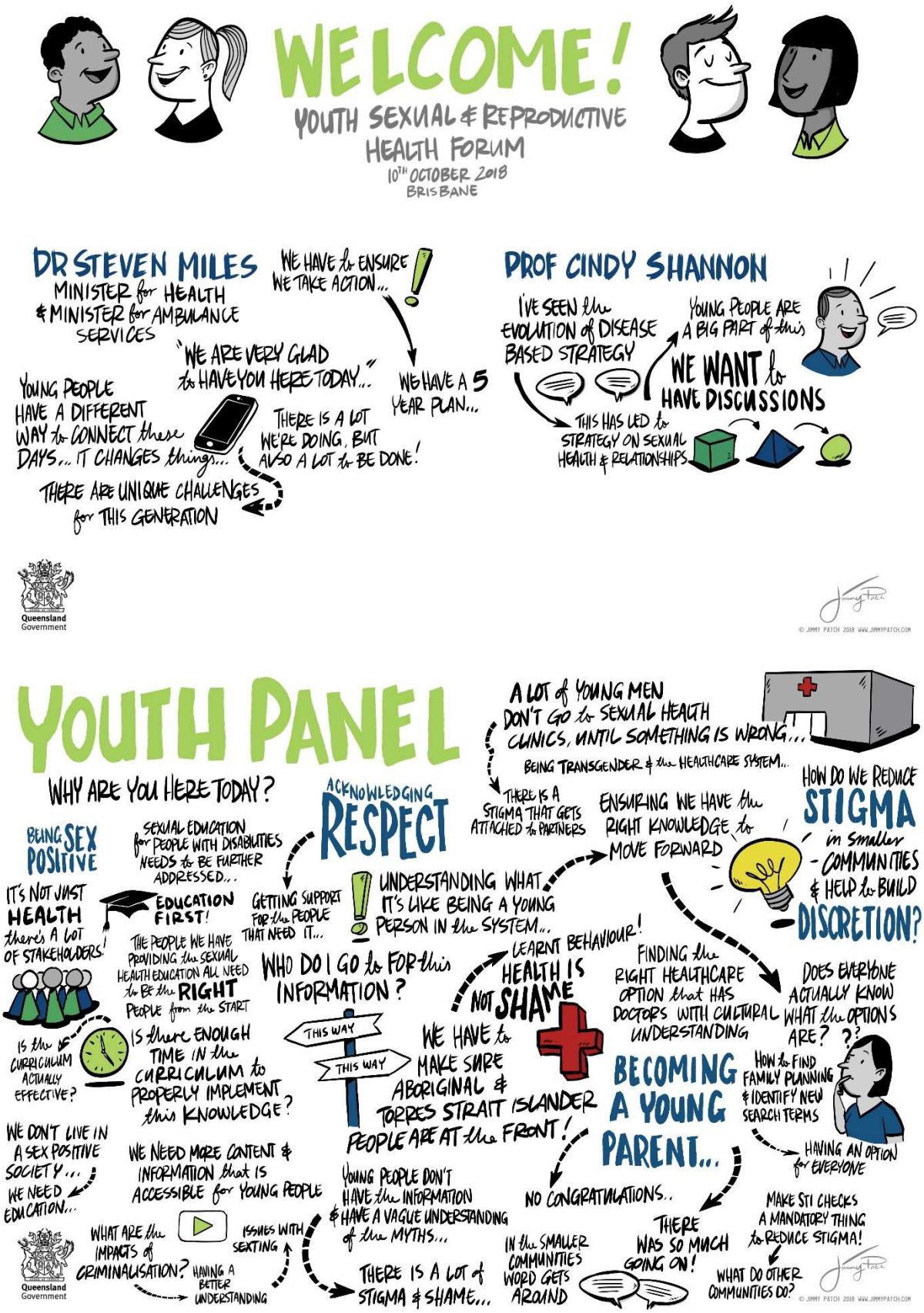
Allyson Mutch	Senior Lecturer, School of Public Health, UQ
Sharon Stokell	Business Manager – Clinical Services and Operations, True Relationships and Reproductive Health
Lisa Fitzgerald	Lecturer, School of Public Health, UQ

Appendix 2 – Forum Program

SHMAC Annual Stakeholder Engagement Forum 2018 Youth Sexual and Reproductive Health	
08:00 – 08:50	Registration
08:50 – 09:10	Welcome to Country
09:10 – 09:20	Official Opening
09:20 – 09:35	Welcome Address
09:35 – 10:30	Youth Panel
Morning Tea	
11:00 – 12:00	Small Group Sessions – Set One
	1. Session 1
	2. Session 2
	3. Session 3
	4. Session 4 – Youth Delegates
12:00 – 12:30	Small Group Sessions Set One Wrap-Up

Lunch	
13:30 – 14:30	Small Group Sessions – Set Two
	5. Session 5 – Education Setting
	6. Session 6 – Health Setting
	7. Session 7 – Education Setting
	8. Session 8 – Youth Delegates
14:30 – 15:00	Small group Sessions Set Two Wrap-Up
Afternoon Tea	
15:30 – 16:30	Forum Wrap-Up and Identification of Priorities for Action

Appendix 3 – Graphic Imagery




SESSION 1
WE NEED MORE THAN 1 CONVERSATION
PARENTS AREN'T ALWAYS EMPOWERED TO HELP..
THERE'S NOT ENOUGH TIME ALLOCATED...
WE DON'T SPEAK ABOUT THIS ENOUGH!
YOUNG PEOPLE DON'T KNOW ENOUGH ABOUT their BODIES & HOW they WORK...
WHY NOT?
DO WE DISCUSS this AT HOME?
CULTURAL ACCEPTANCE & HOW this CAN CREATE A LACK OF UNDERSTANDING
HAVING ACCESS to ACCURATE INFORMATION
FALSE
OR
TRUE
THERE IS SEVERE LANGUAGE ATTACHED to SEXUALITY & GENITALIA
#@!#
NEED for STANDARISED TERMS for the BROAD SPECTRUM of SEXUALITY
BODIES ARE HYPERSEXUALISED IN the MEDIA!
BODIES ARE DIFFERENT & YOUNG PEOPLE NEED to UNDERSTAND THIS
HOW DO WE CREATE AN OPEN DISCUSSION ABOUT THIS & ENCOURAGE UNDERSTANDING?
WE NEED BROADER SEX-POSITIVE EDUCATION THAT INCLUDES the PRACTICALITIES
PORNOGRAPHY IS NOT REALITY...
RACIAL & CULTURAL BARRIERS EXIST THAT CAN INHIBIT THE ABILITY TO DISCUSS BODIES & SEXUALITY
Queensland Government
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SESSION 2
HAVING A "ONE-STOP-SHOP" WEBSITE WITH ALL OF the RIGHT INFO
SEX ED IS CURRENTLY BEING DELIVERED, BUT IT'S INCONSISTENT
HAVING A 2 WAY DISCUSSION
ACCESSING SEXUAL HEALTH INFORMATION ON LINE...
80% OF HOMOPHOBIC VIOLENCE IS AT SCHOOL
WE HAVE A NEED for MANDATED COMPREHENSIVE INCLUSIVE SEXUAL EDUCATION
IT'S BEING LEFT to THE DISCRETION OF the PRINCIPALS, AS TO WHAT & HOW MUCH IS DELIVERED
YR 10-12 IS TOO LATE..
PEER to PEER INFORMATION
THIS EDUCATION NEEDS to BE DELIVERED BY PEOPLE WHO KNOW & UNDERSTAND!
HOW DO WE OPEN UP this CONVERSATION to BE A MORE INCLUSIVE EDUCATION for ALL YOUNG PEOPLE
UNDERSTANDING SEX AS MORE THAN REPRODUCTION
PRINCIPALS & EDUCATORS NEED SUPPORT FROM PARENTS & THE COMMUNITY
WHAT IS MOST USEFUL & WHAT IS the RIGHT INFORMATION?
IT'S REALLY ABOUT ACCESS
RESPECTFUL RELATIONSHIPS
AT THE RIGHT TIME for EVERYONE
IT'S NOT JUST ABOUT SCHOOLS
TO BE CONFIDENT & EFFECTIVE
SEXUALITY EDUCATION
IS PART OF A BROADER EDUCATION ON HOW TO TREAT PEOPLE WITH RESPECT
THE IMPORTANCE OF CONSISTENT RESOURCES: NATIONALLY, REPUTABLE, ACCURATE, INCLUSIVE & AGE APPROPRIATE
SEX ED
THE SCHOOL SETTING IS JUST A MICROCOSM OF the GREATER COMMUNITY
Queensland Government
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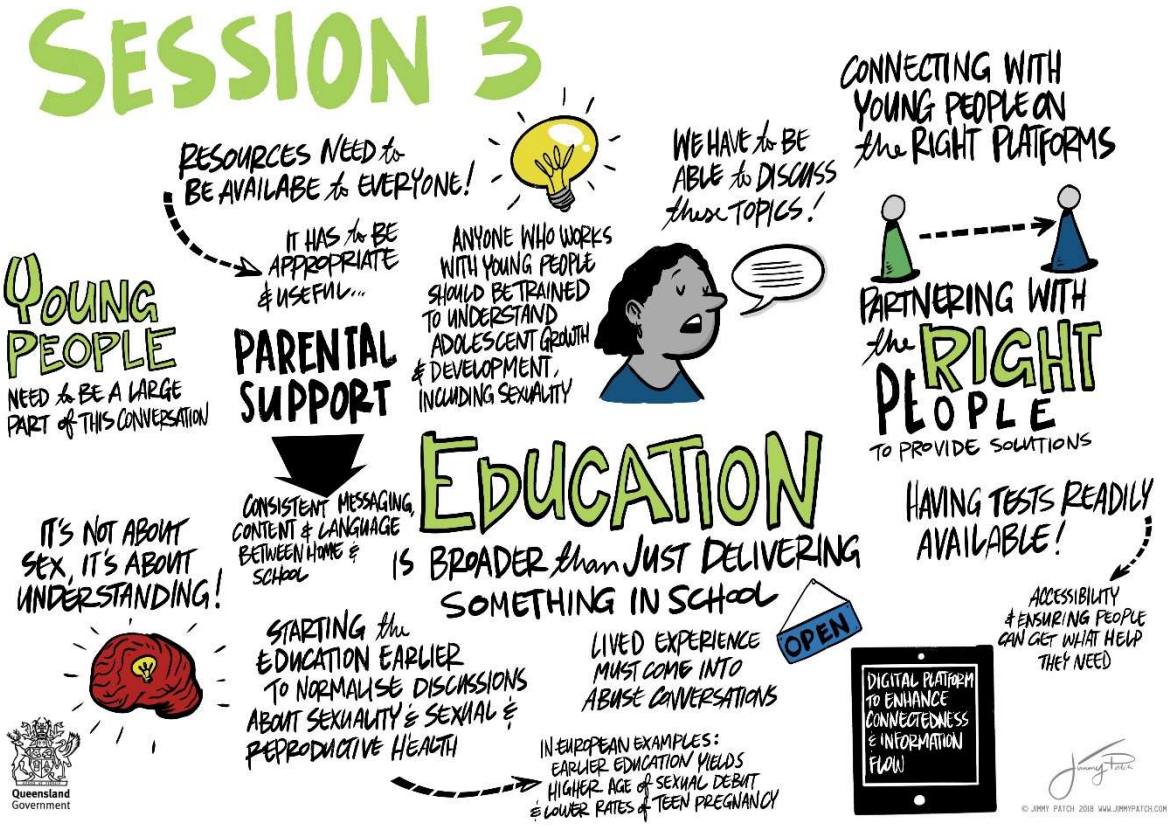
SESSION 3
RESOURCES NEED to BE AVAILABE to EVERYONE!
IT HAS to BE APPROPRIATE & USEFUL...
WE HAVE to BE ABLE to DISCUSS these TOPICS!
CONNECTING WITH YOUNG PEOPLE on the RIGHT PLATFORMS
YOUNG PEOPLE
NEED to BE A LARGE PART of THIS CONVERSATION
PARENTAL SUPPORT
ANYONE WHO WORKS WITH YOUNG PEOPLE SHOULD BE TRAINED TO UNDERSTAND ADOLESCENT GROWTH & DEVELOPMENT, INCLUDING SEXUALITY
PARTNERING WITH the RIGHT PEOPLE
TO PROVIDE SOLUTIONS
CONSISTENT MESSAGING, CONTENT & LANGUAGE BETWEEN HOME & SCHOOL
EDUCATION
IS BROADER than JUST DELIVERING SOMETHING IN SCHOOL
HAVING TESTS READILY AVAILABLE!
ACCESSIBILITY & ENSURING PEOPLE CAN GET WHAT HELP THEY NEED
IT'S NOT ABOUT SEX, IT'S ABOUT UNDERSTANDING!
STARTING the EDUCATION EARLIER TO NORMALISE DISCUSSIONS ABOUT SEXUALITY & SEXUAL & REPRODUCTIVE HEALTH
LIVED EXPERIENCE MUST COME INTO ABUSE CONVERSATIONS
OPEN
DIGITAL PLATFORM TO ENHANCE CONNECTEDNESS & INFORMATION FLOW
IN EUROPEAN EXAMPLES: EARLIER EDUCATION YIELDS HIGHER AGE of SEXUAL DEBUT & LOWER RATES of TEEN PREGNANCY
Queensland Government
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SESSION 4
VOTE #1
BEING INFORMED
A CONVERSATION WITH SOMEONE WHO CAN MAKE YOU FEEL HEARD CONFIDENTIALLY
INCORPORATE SEXUAL & REPRODUCTIVE HEALTH CHECKS INTO DEVELOPMENTALLY AGE APPROPRIATE REGULAR HEALTH CHECKS, CONCEPT OF CHILD HEALTH PASSPORTS
HAVING SOMEONE to GO to IN SCHOOL THAT the STUDENTS NOMINATE!
POSITIVE HEALTH PROMOTION IS IMPORTANT
BEING ABLE to DISCUSS these THINGS IN DETAIL
PARENTS ARE AFRAID of WHAT'S BEING TAUGHT!
WHAT IS MY CHILD BEING TAUGHT?
CLARITY AROUND MANDATORY REPORTING
INCLUDING TRANS PEOPLE INTO the SEXUAL HEALTH EDUCATION CURRICULUM
NO SEPARATING GENDERS
OUTREACH IS IMPORTANT FOR HARD TO REACH POPULATIONS
HAVING AN EDUCATION for PARENTS
CONFIDENTIALITY STIGMA & SHAME ARE IMPORTANT ISSUES FOR RURAL POPULATIONS
HAVING MORE EMPOWERING CONVERSATIONS that ARE MEANINGFUL
PROFESSIONAL DEVELOPMENT for EDUCATION STAFF
MAKING things SAFER for EVERYONE
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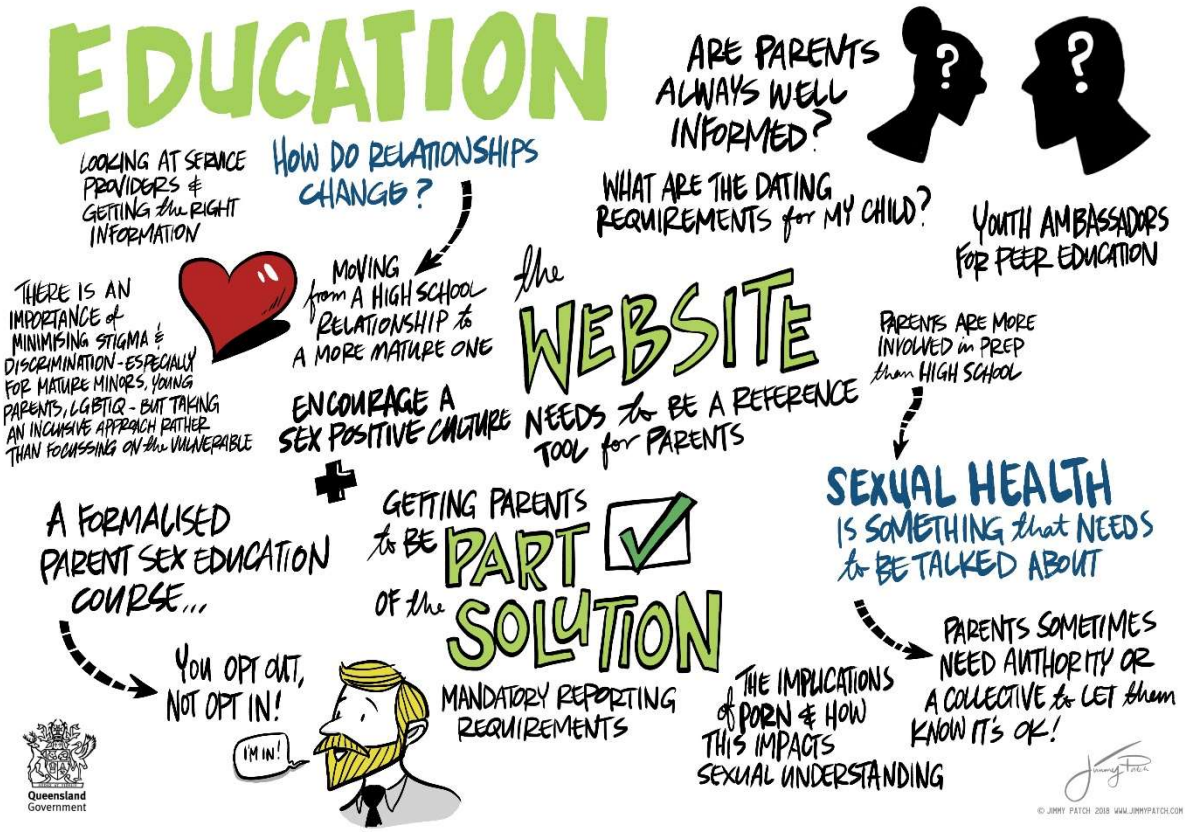
EDUCATION
ARE PARENTS ALWAYS WELL INFORMED?
LOOKING AT SERVICE PROVIDERS & GETTING the RIGHT INFORMATION
HOW DO RELATIONSHIPS CHANGE?
WHAT ARE THE DATING REQUIREMENTS for MY CHILD?
YOUTH AMBASSADORS FOR PEER EDUCATION
THERE IS AN IMPORTANCE of MINIMISING STIGMA & DISCRIMINATION - ESPECIALLY FOR MATURE MINORS, YOUNG PARENTS, LGBTIQ - BUT TAKING AN INCLUSIVE APPROACH RATHER THAN FOCUSSING ON the VULNERABLE
MOVING from A HIGH SCHOOL RELATIONSHIP to A MORE MATURE ONE
the WEBSITE
PARENTS ARE MORE INVOLVED in PREP than HIGH SCHOOL
ENCOURAGE A SEX POSITIVE CULTURE
NEEDS to BE A REFERENCE TOOL for PARENTS
A FORMALISED PARENT SEX EDUCATION COURSE...
GETTING PARENTS to BE PART OF the SOLUTION
SEXUAL HEALTH IS SOMETHING that NEEDS to BE TALKED ABOUT
YOU OPT OUT, NOT OPT IN!
I'M IN!
MANDATORY REPORTING REQUIREMENTS
THE IMPLICATIONS of PORN & HOW THIS IMPACTS SEXUAL UNDERSTANDING
PARENTS SOMETIMES NEED AUTHORITY OR A COLLECTIVE to LET them KNOW IT'S OK!
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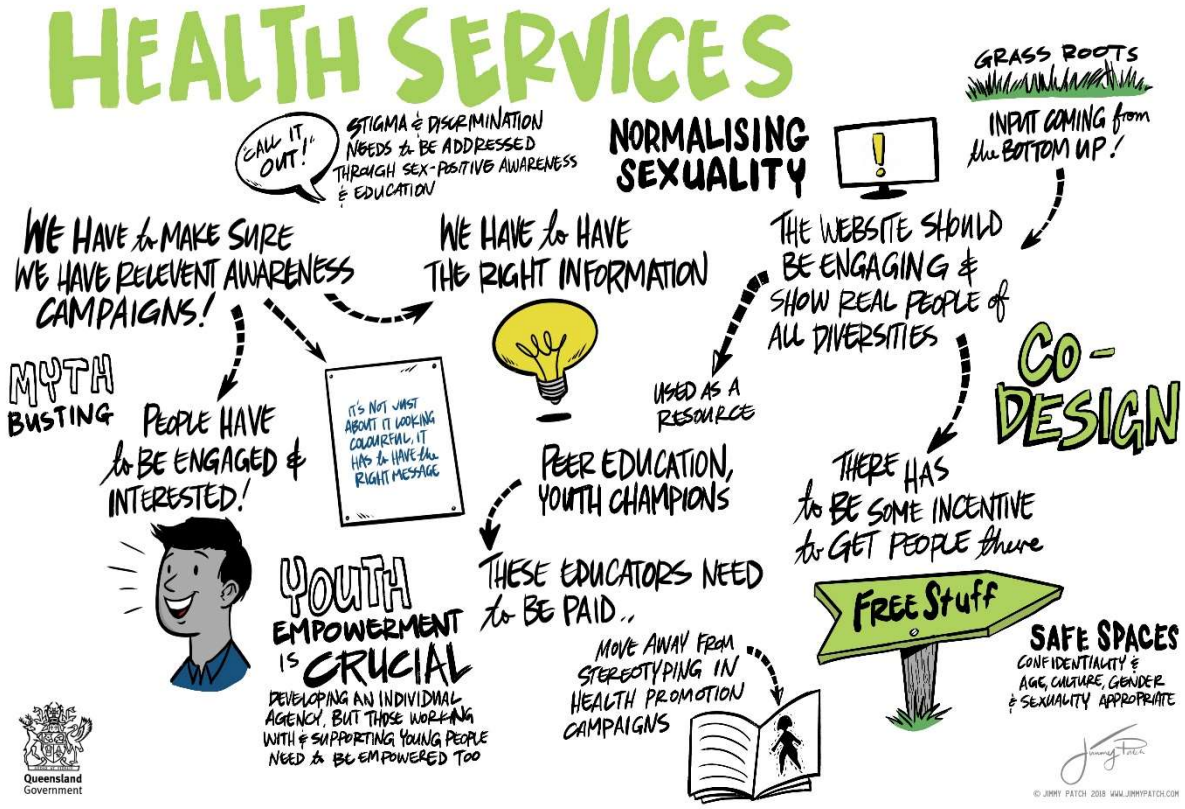
HEALTH SERVICES
GRASS ROOTS
INPUT COMING from the BOTTOM UP!
CALL IT OUT!
STIGMA & DISCRIMINATION NEEDS to BE ADDRESSED THROUGH SEX-POSITIVE AWARENESS & EDUCATION
NORMALISING SEXUALITY
WE HAVE to MAKE SURE WE HAVE RELEVENT AWARENESS CAMPAIGNS!
WE HAVE to HAVE THE RIGHT INFORMATION
THE WEBSITE SHOULD BE ENGAGING & SHOW REAL PEOPLE of ALL DIVERSITIES
CO-DESIGN
MYTH BUSTING
PEOPLE HAVE to BE ENGAGED & INTERESTED!
IT'S NOT JUST ABOUT IT LOOKING COLOURFUL, IT HAS to HAVE the RIGHT MESSAGE
USED AS A RESOURCE
PEER EDUCATION, YOUTH CHAMPIONS
THERE HAS to BE SOME INCENTIVE to GET PEOPLE there
FREE Stuff
YOUTH EMPOWERMENT IS CRUCIAL
DEVELOPING AN INDIVIDUAL AGENCY, BUT THOSE WORKING WITH & SUPPORTING YOUNG PEOPLE NEED to BE EMPOWERED TOO
THESE EDUCATORS NEED to BE PAID..
MOVE AWAY FROM STEREOTYPING IN HEALTH PROMOTION CAMPAIGNS
SAFE SPACES
CONFIDENTIALITY & AGE, CULTURE, GENDER & SEXUALITY APPROPRIATE
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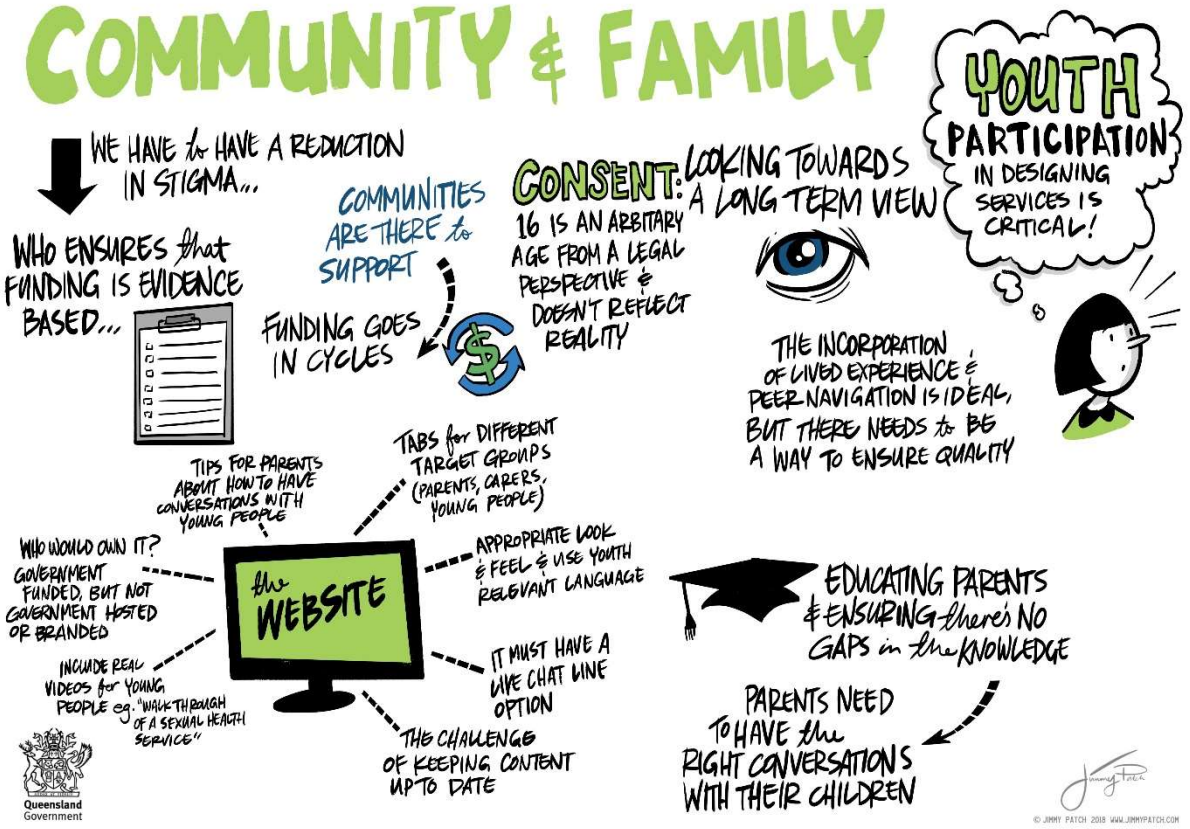
COMMUNITY & FAMILY
WE HAVE to HAVE A REDUCTION IN STIGMA...
WHO ENSURES that FUNDING IS EVIDENCE BASED...
COMMUNITIES ARE THERE to SUPPORT
FUNDING GOES IN CYCLES
CONSENT: LOOKING TOWARDS A LONG TERM VIEW
16 IS AN ARBITARY AGE FROM A LEGAL PERSPECTIVE & DOESN'T REFLECT REALITY
YOUTH PARTICIPATION IN DESIGNING SERVICES IS CRITICAL!
THE INCORPORATION OF LIVED EXPERIENCE & PEER NAVIGATION IS IDEAL, BUT THERE NEEDS to BE A WAY TO ENSURE QUALITY
TIPS FOR PARENTS ABOUT HOW TO HAVE CONVERSATIONS WITH YOUNG PEOPLE
TABS for DIFFERENT TARGET GROUPS (PARENTS, CARERS, YOUNG PEOPLE)
WHO WOULD OWN IT? GOVERNMENT FUNDED, BUT NOT GOVERNMENT HOSTED OR BRANDED
the WEBSITE
APPROPRIATE LOOK & FEEL & USE YOUTH RELEVANT LANGUAGE
INCLUDE REAL VIDEOS for YOUNG PEOPLE eg. "WALK THROUGH OF A SEXUAL HEALTH SERVICE"
IT MUST HAVE A LIVE CHAT LINE OPTION
THE CHALLENGE OF KEEPING CONTENT UP TO DATE
EDUCATING PARENTS & ENSURING there's NO GAPS in the KNOWLEDGE
PARENTS NEED TO HAVE the RIGHT CONVERSATIONS WITH THEIR CHILDREN
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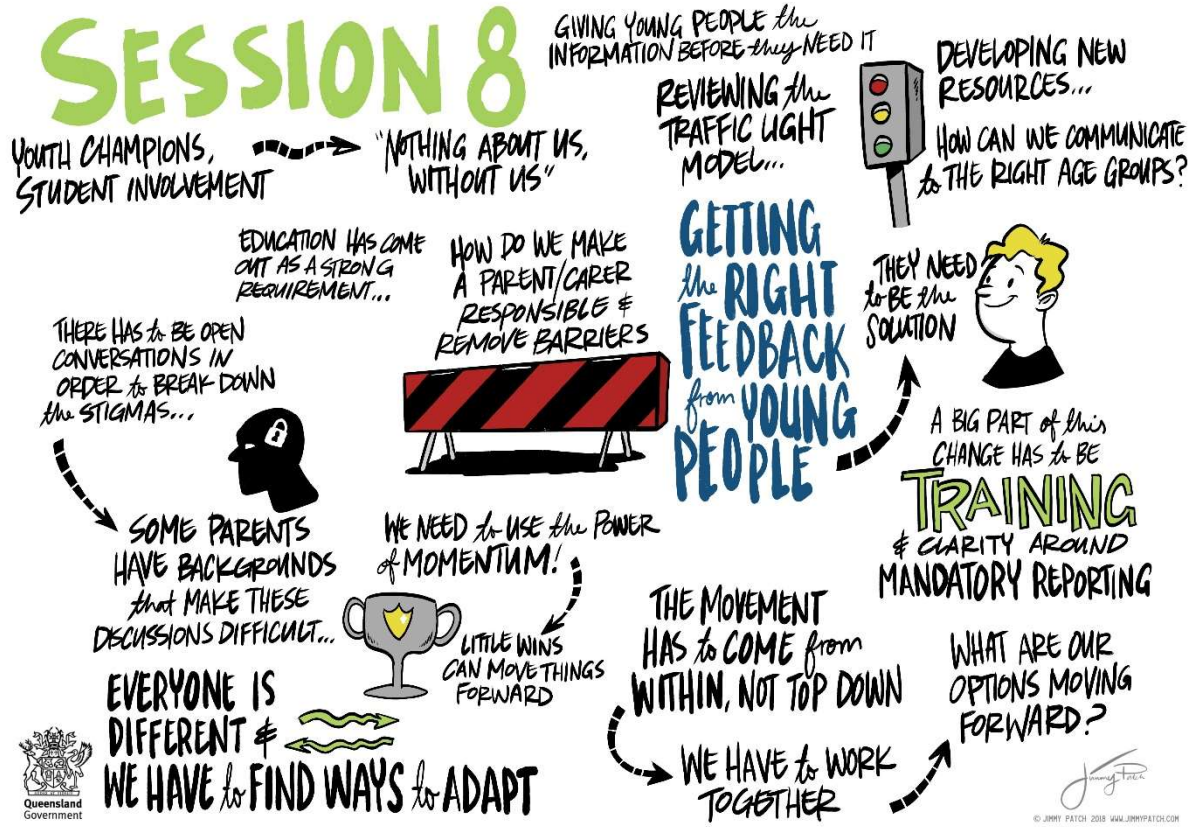
SESSION 8
GIVING YOUNG PEOPLE the INFORMATION BEFORE they NEED IT
YOUTH CHAMPIONS, STUDENT INVOLVEMENT
"NOTHING ABOUT US, WITHOUT US"
REVIEWING the TRAFFIC LIGHT MODEL...
DEVELOPING NEW RESOURCES...
HOW CAN WE COMMUNICATE to THE RIGHT AGE GROUPS?
EDUCATION HAS COME OUT AS A STRONG REQUIREMENT...
HOW DO WE MAKE A PARENT/CARER RESPONSIBLE & REMOVE BARRIERS
GETTING the RIGHT FEEDBACK from YOUNG PEOPLE
THEY NEED to BE the SOLUTION
THERE HAS to BE OPEN CONVERSATIONS IN ORDER to BREAK DOWN the STIGMAS...
A BIG PART of this CHANGE HAS to BE TRAINING & CLARITY AROUND MANDATORY REPORTING
SOME PARENTS HAVE BACKGROUNDS that MAKE THESE DISCUSSIONS DIFFICULT...
WE NEED to USE the POWER of MOMENTUM!
LITTLE WINS CAN MOVE THINGS FORWARD
THE MOVEMENT HAS to COME from WITHIN, NOT TOP DOWN
WHAT ARE OUR OPTIONS MOVING FORWARD?
EVERYONE IS DIFFERENT & WE HAVE to FIND WAYS to ADAPT
WE HAVE to WORK TOGETHER
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Appendix 4 – Glossary

Definitions

Agency is the capacity of individuals to make their own free choices and act independently.

Trauma-informed care provides a framework for understanding how trauma affects people's lives, particularly with respect to behaviour and decision-making, and incorporating this knowledge into service delivery.

Harm minimisation or **harm reduction** are terms that represent public health policies designed to focus on reducing the negative effects associated with a variety of human behaviours.

Lived experience is defined as personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people. It may also refer to knowledge of people gained from direct face-to-face interaction rather than through a technological medium.

Source: Oxford Reference http://www.oxfordreference.com/view/10.1093/acref/9780199568758.001.0001/acref-9780199568758-e-1552)

Punitive: (adjective) Inflicting or intended as punishment.

Source: Oxford Dictionary https://en.oxforddictionaries.com/definition/punitive

Mutuality: (noun) The sharing of a feeling, action or relationship between two or more parties.

Source: Oxford Dictionary https://en.oxforddictionaries.com/definition/mutuality

Consent: (noun) Permission for something to happen or agreement to do something.

Source: Oxford Dictionary https://en.oxforddictionaries.com/definition/consent

Affirmative Consent or Enthusiastic Yes: Active, affirmative, conscious and voluntary consent to engage in sexual activity.

Australian Age of Consent Laws

Societal/social constructs: (noun) an idea that has been created and accepted by people in a society

Source: Merriam-Webster https://www.merriam-webster.com/dictionary/social%20construct

Condoman and Lubelicious : Characters created by Aboriginal and Torres Strait Islander people as part of a culturally-based sexual health promotion campaign.

Bodies, gender and gender identities

Sex: a person's sex is made up of anatomical, chromosomal and hormonal characteristics. Sex is classified as either male or female at birth based on a person's external anatomical features. However, sex is not always straight forward as some people may be born with an intersex variation, and anatomical and hormonal characteristics can change over a lifespan.

Intersex: an umbrella term that refers to individuals who have anatomical, chromosomal and hormonal characteristics that differ from medical and conventional understandings of male and female bodies. Intersex people may be "neither wholly female nor wholly male; a combination of female and male; or neither female nor male" (*Sex Discrimination Amendment Act (Sexual Orientation, Gender Identity and Intersex Status) 2013* (Cth)).

Intersex people may identify as either men, women or non-binary (see below).

Gender: Gender refers to the socially constructed and hierarchical categories assigned to us on the basis of our apparent sex at birth. While other genders are recognised in some cultures, in Western society, people are expected to conform to one of two gender roles matching their apparent sex; for example, male = man/masculine and female = woman/feminine.

Gender norms define how we should dress, act/behave, and the appropriate roles and positions of privilege we have in society, for example the power relationships between men and women. Failing to adhere to the norms associated with one's gender can result in ridicule, intimidation and even violence (Aizura, Walsh, Pike, Ward, & Jak 2010).

Many people do not fit into these narrowly defined and rigid gender norms. Some women may feel masculine, some men may feel more feminine and some people may not feel either, or may reject gender altogether (see below).

Gender identity: refers to an inner sense of oneself as man, woman, masculine, feminine, neither, both, or moving around freely between or outside of the gender binary.

Gender binary: the spectrum-based classification of gender into the two categories of either man or woman based on biological sex, as described above.

Transgender/Trans/ Gender diverse: umbrella terms to refer to people whose assigned sex at birth does not match their internal gender identity, regardless of whether their gender is outside the gender binary or within it. Transgender/trans or gender diverse people may identify as non-binary, that is: they may not identify exclusively as either gender; they may identify as both genders, they may identify as neither gender; they may move around freely in between the gender binary; or may reject the idea of gender altogether.

Transgender/trans or gender diverse people may choose to live their lives with or without modifying their body, dress or legal status, and with or without medical treatment and surgery. Transgender/trans or gender diverse people may use a variety of terms to describe themselves including but not limited to: man, woman, transwoman, transman, transguy, trans masculine, trans feminine, tranz, gender-diverse, gender-queer, gender-non-conforming, non-binary, poly gendered, pan gendered and many more (see Aizura, Walsh, Pike, Ward, & Jak 2010).

Transgender/trans or gender diverse people have the same range of sexual orientations as the rest of the population. Transgender/trans or gender diverse people's sexuality is referred to in reference to their gender identity, rather than their sex. For example, a woman may identify as lesbian whether she was assigned female at birth or male.

Transgender /trans or gender diverse people may also use a variety of different pronouns including he, she, they, ze, hir. Using the incorrect pronouns to refer to or describe trans people is disrespectful and can be harmful (see misgendering below).

Cisgender/cis: term used to describe people whose gender corresponds to the sex they were assigned at birth.

Gender questioning: not necessarily an identity but sometimes used in reference to a person who is unsure which gender, if any, they identify with.

Sistergirl/Brotherboy : terms used for transgender people within some Aboriginal or Torres Strait Islander communities. Sistergirls and Brotherboys have distinct cultural identities and roles. Sistergirls are Indigenous women who were classified male at birth but live their lives as women, including taking on traditional cultural female practices (Sisters and Brothers NT, 2015a). Brotherboys are Indigenous transgender people, whose bodies were considered female at birth but "choose to live their lives as male, regardless of which stage/path medically they choose" (Sisters and Brothers NT, 2015b).

Sexual orientations

Sexual orientation refers to an individual's sexual and romantic attraction to another person. This can include, but is not limited to, heterosexual, lesbian, gay, bisexual or asexual. It is important to note, however, that these are just a handful of sexual identifications - the reality is that there are an infinite number of ways in which someone might define their sexuality. Further, people can identify with a sexuality or sexual orientation regardless of their sexual or romantic experiences. Some people may identify as sexually fluid; that is, their sexuality is not fixed to any one identity.

Lesbian: an individual who identifies as a woman and is sexually and/or romantically attracted to other people who identify as women.

Gay: an individual who identifies as a man and is sexually and/or romantically attracted to other people who identify as men. The term gay can also be used in relation to women who are sexually and romantically attracted to other women.

Bisexual: an individual who is sexually and/or romantically attracted to both men and women.

Pansexual: an individual whose sexual and/or romantic attraction to others is not restricted by gender. A pansexual may be sexually and/or romantically attracted to any person, regardless of their gender identity.

Asexual: a sexual orientation that reflects little to no sexual attraction, either within our outside relationships. People who identify as asexual can still experience romantic attraction across the sexuality continuum.

Heterosexual: an individual who is sexually and/or romantically attracted to the opposite gender.

Queer: a term used to describe a range of sexual orientations and gender identities. Although once used as a derogatory term, the term queer now encapsulates political ideas of resistance to heteronormativity and homonormativity and is often used as an umbrella term to describe the full range of LGBTIQ+ identities.

Societal attitudes /issues

Homophobia and biphobia refer to negative beliefs, prejudices and stereotypes about people who are not heterosexual.

Transphobia refers to negative beliefs, prejudices and stereotypes that exist about transgender and gender diverse people.

Heterosexism is the set of beliefs that privilege heterosexuality, heterosexual relationships and cisgendered identities over non-heterosexual relationships and non-normative gender identities (Leonard, Mitchell, Patel, & Fox, 2008). Heterosexism provides the "social backdrop" for homophobic and transphobic prejudices, violence and discrimination (Fileborn, 2012).

Heteronormativity is the view that heterosexual relationships are the only natural, normal and legitimate expressions of sexuality and relationships. These assumptions are reinforced through cultural beliefs and practices and through social and political institutions such as the law, family structures and religion (Fileborn, 2012).

Homonormativity: a term that describes the privileging of certain people or relationships within the queer community (usually cisgendered, white, gay men). This term also refers to the assumption that LGBTIQ+ people will conform to mainstream, heterosexual culture, for example by adopting the idea that marriage and monogamy are natural and normal.

Cisnormativity assumes that everyone is cisgendered and that all people will continue to identify with the gender they were assigned at birth. Cisnormativity erases the existence of trans and gender diverse people.

Misgendering is an occurrence where a person is described or addressed using language that does not match their gender identity (National LGBT Health Alliance, 2013b). This can include the incorrect use of pronouns (she/he/they), familial titles (father, sister, uncle) and, at times, other words that traditionally have gendered applications (pretty, handsome, etc.). It is best to ask a person, at a relevant moment, what words they like to use.

Source: Australian Institute of Family Studies https://aifs.gov.au/cfca/publications/lgbtiq-communities