

LGBTIQA+ People and Cancer

A guide for people with cancer, their families and friends



For information & support
call **Cancer Connect 13 11 20**

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Check the publication date above to ensure this copy is up to date.

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Note to reader

Always consult your doctor about matters that affect your health. This booklet is intended as a general introduction to the topic and should not be seen as a substitute for medical, legal or financial advice. You should obtain independent advice relevant to your specific situation from appropriate professionals, and you may wish to discuss issues raised in this booklet with them. All care is taken to ensure that the information in this booklet is accurate at the time of publication. Please note that information on cancer, including the diagnosis, treatment and prevention of cancer, is constantly being updated and revised by medical professionals and the research community. Cancer Council Australia and its members exclude all liability for any injury, loss or damage incurred by use of or reliance on the information provided in this booklet.

Cancer Council

Cancer Council is Australia's peak non-government cancer control organisation. Through the 8 state and territory Cancer Councils, we provide a broad range of programs and services to help improve the quality of life of people living with cancer, their families and friends. Cancer Councils also invest heavily in research and prevention. To make a donation and help change the future of cancer, visit cancerconnect.org.au or call 13 11 20.



Cancer Council acknowledges Traditional Custodians of Country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respects to Aboriginal and Torres Strait Islander cultures and to Elders past and present.



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About this booklet

This booklet aims to help you understand how cancer and its treatment may affect you if you are part of the LGBTIQ+ communities – lesbian, gay, bisexual, transgender, someone with variations in sex characteristics (intersex), queer, asexual and other diverse sexualities and genders.

Many people feel shocked and upset when told they have cancer. You may have specific concerns or questions about how your sexual orientation, gender or sex characteristics may affect your treatment and your interactions with health professionals. This information may answer some of your questions and help you think about what to ask your cancer care team (see page 74 for a question checklist). We also include information about support services and a brief guide for health professionals on providing inclusive care (see page 69).

This booklet does not need to be read from cover to cover – just read what is useful and relevant to you. Some terms that may be unfamiliar are explained in the glossary (see page 75). You may also like to pass this booklet to family, chosen family and friends for their information.

How this booklet was developed – This information was developed with help from LGBTIQ+ organisations, health professionals and LGBTIQ+ people affected by cancer. It is based on the *Out with Cancer* study into diverse sexualities, genders and sex characteristics.¹⁻⁴



If you or your family have any questions or concerns, call **Cancer Connect on 13 11 20**. We can send you more information and connect you with support services in your area. You can also visit the Cancer Connect website at cancerconnect.org.au.



Contents

LGBTIQA+ people and cancer	4
LGBTIQA+ people and cancer risk	6
Cancer screening for LGBTIQA+ people	7
Key questions	8
Do I need to tell my cancer care team that I am LGBTIQA+?	8
What details could I disclose?	9
What can I expect as an LGBTIQA+ person with cancer?	10
What can my family and carers expect?	11
How can I find LGBTIQA+ friendly cancer services?	12
What can I do if I feel uncomfortable with my cancer care team?	14
Where can I get support?	15
Coping with cancer	16
How you might feel	16
Diversity of experience	17
Fear of discrimination	18
Emotional impact of disclosure	19
Dealing with discrimination	24
Is discrimination unlawful?	24
Other types of complaints	26
Body image, gender and cancer	27
Removal of a body part	28
Loss of hair from the head and body	30
Weight changes	30
Bowel changes	31
Other changes to your appearance	31

Sexual intimacy and cancer 33

Treatment side effects and sexual intimacy	33
Sexual activity and LGBTIQ+ young people	40
Sexual activity and single people	41

Fertility after cancer 42

How cancer treatments affect fertility	42
Checking fertility after treatment	44
Emotional impact of infertility	45

Trans and/or gender-diverse people 46

Cancer care as a trans and/or gender-diverse person	46
Challenges you might face	47
How cancer affects trans and/or gender-diverse people	49
Cancer treatment and gender affirmation	51
Impact of cancer treatment on body image	53

Intersex people and cancer 54

Cancer care as an intersex person	54
Challenges you might face	55

LGBTIQ+ people with advanced cancer 59

Palliative care	59
Advance care planning	62

Life after treatment 65

Caring for someone with cancer 67

Tips for health professionals 69

Support and information 70

Question checklist 74

Glossary 75

Key to icons

Icons are used throughout this booklet to indicate:



More information



Tips

Is this Cancer Council booklet helpful?
Please follow this QR code for a quick 3-minute survey, or call 13 11 20 to provide your feedback.



SCAN ME



LGBTIQA+ people and cancer

Cancer affects everyone differently. It can affect many parts of your life, including the way you look and feel, how you have sex and experience intimacy, and your fertility. Cancer may cause physical changes that affect your sense of identity, as well as practical issues such as getting the right cancer screening and hospital care.

Research shows that as an LGBTIQA+ person diagnosed with cancer, you may have to deal with some unique challenges. These may include health professionals making assumptions about your sexual orientation, gender or sex characteristics. This can make some people feel invisible.

You may also worry about telling health professionals about your sexual orientation, gender or sex characteristics because you fear negative reactions (see the *Coping with Cancer* chapter, page 16).

Other challenges may include:

- depression and anxiety because of a history of stigma, violence, exclusion and discrimination (minority stress)
- seeing health professionals who do not have LGBTIQA+ knowledge
- limited LGBTIQA+ specific peer support
- concerns about access to gender-affirming care
- trouble having your partner/s or chosen family recognised
- less or no support from your family of origin.

Many LGBTIQA+ people have experienced discrimination and other negative experiences throughout their lives because of their sexual orientation, gender and/or sex characteristics. Sometimes,

discrimination may be a result of unconscious bias, assumptions or a lack of understanding. Other times, it may be deliberate.

If you have been discriminated against or refused health care in the past, you may not feel safe seeking health care. You may also feel unsure about sharing personal information with your cancer care team, even though it could help them provide more holistic care.

This booklet discusses how to manage these practical, physical and emotional issues, and ways to find inclusive cancer care.

Language and terms used in this booklet

The words used to describe sexual orientation, gender and sex characteristics change over time, and you may not use the terms we've used in this booklet.

Sexual orientation – How a person thinks about their sexual identity, how they behave and who they are sexually, romantically or physically attracted to. Examples include heterosexual, gay man, lesbian, bisexual, pansexual and asexual. Sexual orientation is different to gender identity.

Gender – How a person thinks about their gender including whether they identify as a man, woman, agender, genderqueer, genderfluid, or a combination of

2 or more of these. Gender can be binary (man or woman) or non-binary. Gender may align with the sex assigned at birth (cisgender) or it may be different (transgender).

Sex characteristics – A person's physical characteristics, including genitals, gonads (ovaries and testicles), reproductive organs, hormonal patterns and chromosomal patterns. Sex characteristics can change over a person's lifetime and may be different from the sex assigned at birth.

Intersex – An umbrella term used to describe people with variations in sex characteristics that do not fit medical and social norms for female or male bodies.



In Australia, about 170,000 people are diagnosed with cancer (excluding common skin cancers)⁵ each year, and about 1.6 million people are living with or beyond cancer. LGBTIQ+ people make up an estimated 5% of the population. This means about 8500 LGBTIQ+ people are likely to be diagnosed with cancer each year, and about 80,000 are cancer survivors.

LGBTIQ+ people and cancer risk

We don't know what causes many cancers, but some risk factors are more common among LGBTIQ+ people. Risk factors for intersex people depend on their variation. Cancer risk has often been used as a reason for medical treatment of intersex people in childhood (see page 56).

Delaying or avoiding cancer screening

Some LGBTIQ+ people may think that screening tests do not apply to them, feel unsafe in the healthcare system, or worry about discrimination. Trans, gender-diverse and intersex people may also not receive reminders because healthcare systems can't record both gender identity and anatomy. Some LGBTIQ+ people may find screening distressing. Missing screening can delay cancer diagnosis and treatment.

Higher risk for smoking- and alcohol-related cancers

Studies show LGBTIQ+ people report higher rates of smoking and alcohol use because of issues such as minority stress and lack of support. Smoking or drinking alcohol increase the risk of several cancers.

Higher risk of HPV (human papillomavirus)

HPV is a common infection that can cause cancers, including cervical, anal, throat, penile, vulvar and vaginal cancer. It can spread through sex, oral sex, fingers and shared sex toys. The HPV vaccine helps protect against the virus. Visit hpvaccine.org.au and thebottomline.org.au.

Living with HIV

HIV can increase the risk of certain skin cancers (e.g. Kaposi sarcoma, Merkel cell carcinoma and melanoma), anal, cervical, liver, lung, mouth and throat cancers, and lymphoma.

Lower pregnancy rates

Pregnancy before age 30 and breastfeeding may lower the risk of breast cancer. Pregnancy and using oral contraceptives may also lower the risk of certain gynaecological cancers (e.g. ovarian and uterine cancer). Some LGBTIQ+ people are less likely than cisgender heterosexual women to have a child before age 30 or use an oral contraceptive, so they may not get these protective effects.

Cancer screening for LGBTIQ+ people

Screening is organised testing to find cancer before any symptoms start. Finding cancer early often makes it easier to treat. In Australia, there are screening programs for breast, cervical, bowel and lung cancer. Most people with a Medicare card and in certain age groups will be invited by mail to be screened.

LGBTIQ+ people may face barriers to screening (see opposite page).

Anyone with a cervix (including lesbian women, trans men and non-binary people), and some intersex people, should have cervical screening. You can collect your

own sample in a private space at a healthcare clinic or sometimes at home – ask your doctor or nurse if this is an option for you.

Australia does not have a formal prostate screening program, but people with a prostate, including those having gender-affirming care, should talk to their doctor about the benefits and risks of prostate checks.

Ask your doctor what screening tests are right for you. For more information, visit canwe.org.au or transhub.org.au/cancer-screening.

Key questions

Q: Do I need to tell my cancer care team that I am LGBTIQ+?

A: It's your choice what you tell your healthcare team about your sexual orientation, gender or variation in sex characteristics. However, sharing this information can help them provide person-centred care. This is care that treats you the way you'd like to be treated and listens to your needs, preferences and values. It means that you are an equal partner with your healthcare professional in planning your treatment and ongoing care (known as shared decision-making).

Research shows that many LGBTIQ+ people do not disclose their sexual orientation, gender or sex characteristics to health professionals for fear of discrimination or harassment. To get the best possible care, it's important to feel comfortable with your healthcare team.

Knowing more about your experiences and how they have affected your health – such as your sexuality, fertility and any past trauma – can help your cancer care team provide safe and inclusive care. It also makes it easier for your partners (e.g. same-gender or trans partners) and chosen family to be recognised and involved in your care.



Much of this booklet focuses on the experiences of people with marginalised sexualities and gender identities. Intersex people who are cisgender and heterosexual may prefer to read the information specific to intersex people on pages 54–58 and then refer to Cancer Council's general cancer information resources. General information is also available from InterAction for Health and Human Rights. Visit interaction.org.au.

Q: What details could I disclose?

A: Health professionals are experienced in discussing sensitive health information and are required to keep your information confidential under the Health Practitioner Regulation National Law (if they are a registered health practitioner). If the information is not already on your medical records and you think it's relevant to your cancer care, you may want to tell them about your:

- sexual orientation
- gender, pronouns, preferred name
- variations of sex characteristics
- preferred terminology for body parts
- medical history (e.g. surgeries, gender-affirming hormone therapy)
- concerns about preserving fertility
- concerns about the impact of cancer on gender-affirming care
- concerns about sex and intimacy
- history of trauma, including medical trauma, if it feels safe.

You may be reluctant to disclose these details, especially if previous experiences have affected your trust in health professionals or you are not “out” in all areas of your life. But being open and sharing information with your cancer care team:

- helps them consider all possibilities when trying to diagnose the cause of your symptoms (such as ovarian cancer in a trans man)
- ensures they have all the information they need to offer informed, safe and trauma-informed care for you
- means they can connect you with the right support services.

Ultimately, it's your choice how much information you share. You may tell only health professionals you see regularly, or ask that some details are not included in your patient record (however, doctors should include clinically relevant information). See pages 22–23.

Q: What can I expect as an LGBTIQ+ person with cancer?

- A:** In Australia, everyone has the right to: safe and competent health care; be free from unlawful discrimination (see pages 24–26); accept or refuse treatment; and privacy and confidentiality. This means your healthcare professionals should:
- respect your body, sexual orientation and gender
 - respect your partner/s and family
 - listen to and respect your treatment goals
 - respond to your care needs, preferences and values
 - involve you in decisions about your treatment and ongoing care
 - recognise when you may need for extra support, such as clearance letters for gender-affirming care during cancer treatment
 - only collect or disclose your health information to others with your consent, or when required by law.

After a cancer diagnosis, you will need to make many decisions. To help you get the best care and treatment, it's important to be involved in your care and feel able to ask questions.

If you are concerned about the security of your health information, talk to your healthcare provider or ask to see a copy of their privacy policy. For more information, visit the Office of the Australian Information Commissioner at oaic.gov.au.

► See our *Protecting Your Health Information* fact sheet.



Each person's experience of cancer is different. It can depend on the type of cancer, whether it has spread, and their age and general health. Cancer Council has free booklets and fact sheets on more than 40 cancer types and their treatments. Call Cancer Connect on 13 11 20 or visit cancerconnect.org.au.

“I was open about being a lesbian with a life partner and 2 children. My wife, Melissa, was acknowledged and respected by my doctors and the team. This openness was important because I became very ill during treatment and lost the capacity to speak.” JULIE (LESBIAN, OROPHARYNGEAL CANCER)

Q: What can my family and carers expect?

A: Australian laws recognise how important carers are in supporting family, partners and friends. Under the *Carer Recognition Act 2010* (Commonwealth), carers should have the same rights, choices and opportunities as other Australians, regardless of their sex or sexuality. Similar laws exist in all states and territories, although the details vary. Laws about carers generally apply to unpaid carers and to government and government-funded agencies that support them, not to paid care workers. These laws set out a range of rights for carers, including the right to:

- be treated with respect and be considered as a partner by healthcare workers or providers
- support for their own health and wellbeing
- participate in family, social and community life
- opportunities to work and study.

Children and young people who are carers also have the right to the same opportunities as their peers.

Partners or carers of LGBTIQ+ people may experience lack of recognition or discrimination. For example, health professionals may mistakenly assume a partner is a friend and exclude them

from discussions about your care, or direct conversations to other family members. If you have told your cancer care team about your relationship and your partner continues to be excluded, see *How to deal with discrimination* on page 25. In Australia, spouses and de facto partners generally have similar rights. A de facto partner may need to provide evidence of the relationship to access some legal rights. Your spouse or partner can usually be involved in discussions about your treatment (see pages 67–68). Also see page 62 for information on appointing a substitute decision-maker.

Q: How can I find LGBTIQ+ friendly cancer services?

A: LGBTIQ+ friendly health services create an environment that feels safe and is supportive, respectful and non-judgemental. They don't make assumptions about pronouns, your body, partners and families of choice. This is known as culturally safe care.

Connecting with a health service that understands the needs of LGBTIQ+ people can help you feel safe and supported. They should include anyone you want to be part of your care plan, including your partner/s, family or chosen family. Where you live might affect availability of LGBTIQ+ friendly health services.

“It’s great that clinics have ways of displaying their friendliness and openness such as the gay flag on the front door. We need visual signs to give us that comfort.” RODNEY (GAY MAN, SKIN CANCER)

How to spot an LGBTIQ+ friendly service



Look for signs of inclusion

These can include LGBTIQ+ flags, rainbow ticks, posters and photos or statements about the service's commitment to LGBTIQ+ communities. You may see these on the service's website, in their window or in the waiting room.



Find out about their experience and policies

Contact the service to ask if they regularly see LGBTIQ+ people and have an anti-discrimination policy. It may be easier for a friend or family member to ask these questions.



Ask for recommendations

Your friends may know of LGBTIQ+ friendly services. Ask what they did and didn't like. If you have an LGBTIQ+ friendly GP, ask them to refer you to a supportive cancer specialist.



Visit websites

The DocDir website (docdir.com.au) lists doctors and mental health professionals who are welcoming to LGBTIQ+ people. The AusPATH website (auspath.org.au) lists health professionals committed to working with transgender people.



Check forms and website

Before your appointment, check whether intake forms ask about sexual orientation, gender, variations in sex characteristics, and pronouns. Check the website for inclusive language and details about training or accreditation.



Trust your judgement

Sometimes you may just have a feeling about whether a health professional or service will be right for you. It's okay to trust your instincts.

Q: What can I do if I feel uncomfortable with my cancer care team?

A: Finding health professionals you trust is important at all stages of cancer. You shouldn't miss out on treatments, help with side effects, or follow-up care because you feel uncomfortable or have had a bad experience in the past.

If you're treated as a public patient in a public hospital, you'll be seen by the specialist/s appointed by the hospital. If you have concerns, you may be able to talk to a specialist nurse, a patient representative or a patient advocate. Some hospitals have an LGBTIQ+ patient navigator who provides culturally-safe support to LGBTIQ+ people and advises health professionals about inclusive care. To find organisations that may help you navigate the health system as an LGBTIQ+ person, visit qlife.org.au/resources/directory.

You can ask to see a different specialist or be treated at another hospital or treatment centre. If you feel comfortable, talk to your cancer care team about your concerns first; they may be able to address these issues or help with the change. Sometimes, it's not possible to change services (e.g. if the cancer needs specialised care).

You have the right to make a complaint about any aspect of your health care. This applies whether you're treated in a public or private hospital or treatment centre. You can usually find details about the



You may feel that everything is happening too fast and that you don't have the time to get a second opinion. Ask your cancer specialist how soon treatment should begin and how much time you have to make decisions. You can get a second opinion or change your doctor even if you have started treatment.

complaints process on the healthcare service's website, or for public hospitals on the government department's website. You can also check with the cancer care coordinator, nursing unit manager, social worker, or one of the nurses looking after you. If you're unhappy about the ethical or professional behaviour of a health service, contact the health complaints organisation in your state or territory.

If you think you have been discriminated against because of your sexual orientation, gender or intersex variation, see pages 24–26.

Q: Where can I get support?

A: Most people with cancer find it helpful to have support from others. This can include your family, friends or wider community. You might lean on your partner/s or chosen family for support and comfort, particularly if you have limited or no contact with your family of origin. Not everyone wants support from others; some people are happy to manage alone. If you would like support, there are many ways to find it.

- Call Cancer Connect on 13 11 20, visit cancerconnect.org.au, or join Cancer Council's Online Community at cancercouncil.com.au/OC.
- Use the LGBTIQ+ Health Australia member directory to find good sources of support. Visit lgbtiqhealth.org.au.
- Contact QLife on 1800 184 527 or visit qlife.org.au to connect with others in a safe space.
- Speak to your general practitioner (GP), social worker, psychologist or other health professionals. They can link you with local services.
- If you're aged 12–25 and diagnosed with cancer, you can chat with other young people at canteenconnect.org.
- Find practical and financial assistance (see pages 70–73).

Coping with cancer

Finding out you have cancer can be difficult for anyone to deal with. Research has shown that the experiences of cancer and its treatment can be different for LGBTIQ+ people (see pages 4–7).

How you might feel

After a cancer diagnosis and throughout treatment, it's common to feel a range of strong emotions including anger, fear, anxiety, sadness, grief and resentment. Research shows that LGBTIQ+ people may have greater risk of mental and emotional distress after a cancer diagnosis for several reasons. You may feel anxious about disclosing personal information to health professionals, fear discrimination because of your sexual orientation, gender or intersex variation, or worry about how cancer and its treatment will affect your identity or relationships.

Some people have experienced stigma or shame for being LGBTIQ+. They may blame themselves for delaying getting cancer symptoms checked, or feel judged by others. It's natural to feel vulnerable while having cancer treatment. If you are distressed, anxious or feeling low or depressed, appropriate support and information is available (see pages 70–73).

► See our *Emotions and Cancer* and *Just Diagnosed* booklets.

“Cancer sucks but it has forced me to choose how I genuinely want to live the rest of my life. That choice has opened doors and possibilities I had never dreamed of.” NADIA (TRANSGENDER WOMAN, PROSTATE CANCER)

Diversity of experience

A person's life can be shaped by their sexual orientation, gender or sex characteristics, as well as other factors. These include age, race, language, culture, spirituality, disability, education, relationships and financial situation, and past experiences with the health system.

These factors can overlap to affect health and wellbeing, as well as cancer care. Aside from discrimination for being LGBTIQ+, some people may also have had to deal with ageism, sexism, racism or discrimination related to disability.

Some LGBTIQ+ communities may have specific experiences that affect their health and wellbeing. These include:

- **transgender, gender-diverse and non-binary people** – may be less likely to use mainstream services because they have often experienced transphobic attitudes, misgendering or difficulties getting gender-affirming treatment
- **intersex people** – may have had negative experiences with health professionals, such as prior surgery to make their body “fit” medical and social norms for male or female bodies, or medically unnecessary surgery as a child. They may also have seen health professionals who have limited knowledge of intersex variations
- **young people** – may experience distress because of being bullied at school, rejected by family, or working out how to come out
- **older people** – grew up at a time when being homosexual or transgender was considered an “illness” or a “crime”, and may have experienced discrimination, family rejection or isolation
- **Aboriginal and Torres Strait Islander people** – brotherboys or sistergirls may face added discrimination from being both LGBTIQ+ and Aboriginal or Torres Strait Islander (from the wider community, their own community, or both).

Other communities that may face challenges, include:

- **people from culturally and linguistically diverse backgrounds** – may face discrimination from within their community as well as from LGBTIQ+ communities, leading to feelings of stigma and shame
- **people with disability** – may face discrimination from being both LGBTIQ+ and a person with disability, which can make it harder to access services and have their sexual orientation, gender or needs recognised
- **people living in regional or rural areas** – may be socially isolated, and have less support and limited access to LGBTIQ+ specific services.

Fear of discrimination

Some LGBTIQ+ people have experienced discrimination because of their sexual orientation, gender identity or intersex variation, and may worry about being discriminated against during their cancer care. This fear may be stronger for people who have had negative experiences with religious organisations in the past, and are having cancer treatment in a faith-based hospital.

Discrimination can include inappropriate comments, poorer care, or excluding your partner/s from discussions or your hospital room. This behaviour can affect your physical and mental health. For information about dealing with discrimination, see pages 24–26.

“I was incredibly worried about how we’d be treated as a queer couple ... Turned out that we had no problems at all, but it was horrible that my brain thought of that first.” CHARLIE (QUEER, NON-BINARY)

Dealing with feelings of sadness

If you continue to feel sad, numb or irritable, find it hard to get up in the morning, or lose interest in activities that you once enjoyed, you may be experiencing depression. This is quite common after a cancer diagnosis.

Everyone has their own way of coping with their emotions. It's important to give yourself, and those around you, time to deal with the strong emotions that cancer can cause. For support, call Cancer Connect on 13 11 20. People aged 12–25 can also call Canteen on 1800 945 215.

If you think you may be depressed, talk to your GP, because counselling or medication – even for a short time – may help. Some people can get a Medicare rebate for sessions with a psychologist.

To connect with LGBTIQ+SB peer support, call QLife on 1800 184 527 or visit qlife.org.au. For information about coping with depression and anxiety, call Beyond Blue on 1300 22 4636 or visit beyondblue.org.au. For 24-hour crisis support, call Lifeline 13 11 14 or visit lifeline.org.au.

Emotional impact of disclosure

At the time of diagnosis, you may not have told others you're LGBTIQ+, or you may have shared this with some people but not others. Some people want to share personal information with their cancer care team, while others feel it's not relevant or fear discrimination (see pages 8–9). Some may not have a choice because information is linked to their diagnosis or treatment, or is already in their medical records.

It can be hard to talk to your cancer care team about your sexual or gender, whether you're out or not. But sharing this information can help you discuss your needs, preferences and values. It also helps your team recommend appropriate treatments, provide relevant information and connect you with LGBTIQ+ support groups.

During treatment, you'll see many health professionals and may have to explain your situation several times. You may need to decide whether to share information with each professional you meet. This can feel stressful and tiring, especially if you're unsure how someone will react. Inviting people in is a process; it's okay to take it one step at a time.

Sharing personal information with your cancer care team

Common benefits

- You don't have to hide who you are and can be yourself.
- You may be more satisfied with your cancer care.
- Your partner/s (if you have them) are more likely to be recognised and included.
- It can make it easier to talk about how treatment affects sex and intimacy with your cancer care team.
- Your cancer care team can tailor information for you.
- Referrals can be made to LGBTIQ+ friendly health services
- You may be less likely to have your symptoms or concerns overlooked.

Common concerns

- Fear of negative reactions and being made to feel unsafe.
- Worry about receiving discriminatory care or a lower standard of care.
- Anxiety about having to disclose personal information many times.
- If you're not out to your family, you may worry about being alienated from them at a time of need.
- Concerns that your private discussions may not be kept confidential.

“Coming out over and over again, because of multiple doctors and specialists, is hard.”

LAURIE (QUEER, COLORECTAL AND OVARIAN CANCER)

“I came out as gay just before I was diagnosed. I was still very uncomfortable with myself. And then I was diagnosed with cancer and that took precedence.” CARTER (GAY MAN, LEUKAEMIA)

When you may not have a choice

Sometimes it may be medically necessary to share information with your cancer care team, so they have the information they need to make a diagnosis or recommend treatment. This could include which reproductive organs you were born with, whether you have an intersex variation, or whether any sex characteristics have changed over your life.

People with an intersex variation may not have a choice about how much to reveal to their cancer care team if these details are listed on their medical records or in diagnostic reports. This can be upsetting. You may want to share your preferred terms for body parts and discuss how your intersex variation may affect your cancer care (see pages 54–58).

You can work with your doctors and treatment team to ensure your information is shared and discussed with respect, and that you are not outed or discriminated against.

What if I’m not out?

You may not be out to all your family and friends, and may not want your cancer care team to share personal information with others. If you decide to share information about your sexual orientation, gender or intersex variation with your cancer care team, it may be reassuring to know that health professionals are only permitted to collect, disclose and use your health information with your consent or as legally permitted (e.g. to support your treatment). If you’re worried, talk to your healthcare team.

Sharing personal information with health professionals

You deserve to be treated with respect by all the health professionals who look after you. If you find the thought of disclosing your sexual orientation, gender

Decide beforehand



Before your appointment, find out more about the hospital or treatment centre you want to attend. Think about how much information you want to share and who you want to share it with.

Have someone with you



Consider having a support person, such as a spouse, partner/s, family member or close friend, with you to help with the discussion and to provide support. You can also request support from a healthcare professional, such as a cancer care coordinator or social worker. Your support person can help you debrief and provide assistance with making a complaint if you receive a negative reaction. If you don't feel safe, you can choose to leave the room.

Practise conversations



You may feel more confident talking to your health professionals if you practise what you want to say with your spouse, partner/s, family and friends.

Do it in writing



If you're not a confident speaker, write down what you want to say to your health professionals. You can also ask your GP to include information about you in their referral letter to other specialists, such as your sexual orientation, intersex variation, pronouns or preferred name.

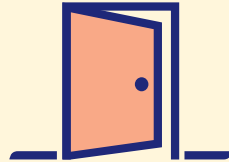
or intersex variation stressful, some of the following tips and suggestions may help you.

Share your pronouns



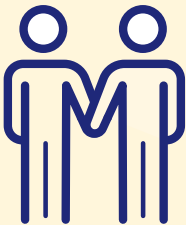
Consider including your pronouns when you introduce yourself. You could say "My name is Parker Jones and I use they/them pronouns". If you are misgendered, you could provide a simple correction such as "Oh, I use they/them pronouns, thanks". Wearing a pronoun badge is another way to remind people of your pronouns.

Ask for privacy



If you're in a ward or open area, ask to speak in a quiet, private place where you won't be overheard.

Introduce your partner/s



If you have a spouse or partner/s, encourage them to come to your appointments. This lets your doctor know who's important to you. Before your first appointment, it's okay to phone or email your doctor to find out if they are LGBTIQ+ friendly.

Try communication tools



You can use the Genders, Bodies and Relationships Passport to make telling your health professionals about your gender, body and relationships easier. Visit lgbtiqhealth.org.au/passport to order a copy.

Seek support



Contact QLife, a national peer support and referral service for LGBTIQ+SB people. Call 1800 184 527 or visit qlife.org.au.



Dealing with discrimination

Discrimination is when you're treated unfairly because of a particular attribute. Many people worry about discrimination if they tell their health professionals they are LGBTIQ+.

Most health professionals try to provide respectful care, but discrimination can still happen. Discrimination can be deliberate or due to a lack of understanding. Sometimes explaining your needs can help.

It can also help to know your rights. You have the right to be treated fairly and with respect, and Australia has anti-discrimination laws to protect LGBTIQ+ people from discrimination in health care.

Is discrimination unlawful?

Under the *Sex Discrimination Act 1984* (Commonwealth), it's unlawful for health professionals, hospitals and treatment centres to discriminate against a person on several grounds, including that person's sex, sexual orientation, gender identity, intersex status, or marital or relationship status. Most states and territories also have laws to protect people from discrimination in health care.

Examples of discrimination include:

- refusing to provide you with care because you are LGBTIQ+
- providing you with a lower standard of care because of your sexual orientation, gender identity or sex characteristics
- making offensive comments or jokes about LGBTIQ+ people
- not acknowledging your spouse or partner/s as emergency contacts
- using incorrect names and pronouns on purpose.

How to deal with discrimination

- 1 If you feel comfortable and safe doing so, raise the issue with the healthcare service. All hospitals and health services should have a procedure for patients to provide feedback and complaints. Check with the cancer care coordinator, social worker or nursing staff.

- 2 Make notes about the behaviour or incident. List dates and names of people who saw the behaviour. This will help you remember what happened.

- 3 Think about what you would like to happen to resolve the issue. A quick conversation may help to sort out any simple misunderstandings.

- 4 If your complaint is about a specific person and you don't want to talk to them directly – or you have spoken to them and the issue remains unresolved – speak to the cancer care coordinator, nursing unit manager or social worker at the hospital or treatment centre.

- 5 Most complaints are resolved through meetings, mediation or conciliation. This is an informal way of agreeing on an outcome. If mediation or conciliation doesn't help, you may have the option to go to an administrative tribunal in relation to a public health service or to court for a legal judgment that must be followed.

- 6 To lodge a complaint, contact the Australian Human Rights Commission (call 1300 656 419 or visit humanrights.gov.au) or the discrimination agency in your state or territory. Check with these organisations or seek legal advice to work out which organisation is best for your situation before you lodge a complaint.

If you wish to talk to a lawyer, Cancer Council may be able to refer you to a lawyer for legal advice (which may be free if you cannot afford to pay). Call Cancer Connect on 13 11 20 to find out if this service is available in your area.



The Australian Charter of Healthcare Rights sets out the rights you can expect when using health services, including the right to receive health care in a respectful environment. There is also a charter for LGBTIQ+ people. Visit safetyandquality.gov.au.

Harassment and inappropriate behaviour

People may have different ideas about what is offensive or unacceptable behaviour. Just because the person did not mean to be offensive does not make it okay. For example, a nurse continuing to use your previous name (deadnaming) or the wrong pronoun after you have repeatedly corrected them, can be very distressing.

You have the right to complain if you feel that you've been intimidated, bullied or harassed by health professionals, other hospital staff or other patients, or if you experience hurt, humiliation or distress because of their actions, whether these were intentional or not.

Other types of complaints

Health complaints organisations – If you are unhappy about the ethical or professional conduct of a health practitioner, you can contact the health complaints organisation in your state or territory. Serious cases may be referred to the Australian Health Practitioner Regulation Agency (AHPRA). For more information, visit ahpra.gov.au.

Medical negligence – This booklet does not cover breaches of duty of care by health providers. If you are considering making a medical negligence claim, seek independent legal advice.

► See our *Cancer Care and Your Rights* fact sheet.

Body image, gender and cancer

Cancer and its treatment can change the way you look. This can affect how you feel about yourself (body image), regardless of sexual orientation, gender or sex characteristics. Even if other people can't see the changes, they may still affect your body image.

This chapter discusses some common physical changes to appearance after treatment. These may also affect how you feel about sex and intimacy (see pages 33–41). The changes you experience will depend on the type of cancer and treatment you have. Some changes may be permanent, while others may improve over time.

Changes to your body can also affect your confidence, self-esteem and sense of identity. You may feel less attractive, socialise less, or feel disconnected from your community. In some cases, body changes may help your body feel more aligned with your identity.

Gender-affirming hormone therapies

Some cancers grow in response to hormones such as oestrogen and testosterone. These are called hormone-dependent cancers because the hormones signal cancer cells to grow. If you have a hormone-dependent cancer and are taking gender-affirming hormones, your doctor may talk with you about

adjusting your hormone treatment (see page 53). This can be difficult, especially if it affects how you look. Changes in your appearance may trigger gender dysphoria and affect your wellbeing.

If you feel anxious, talk to your doctor or call QLife on 1800 184 527.

Removal of a body part

Surgery to treat some types of cancer may mean removing a part of the body that affects how you look. After surgery, you may choose to live with your new body shape, wear a prosthesis or have a reconstruction. For some people, the surgery can affirm their gender. Only you can decide what feels right for you. Examples of body changes that people may experience include:

Removal of a breast – Breast cancer treatment may include breast-conserving surgery (removing part of a breast) or a mastectomy (removing one or both breasts). Having a mastectomy is different from top surgery (see page 49).

After a mastectomy, you may choose to have a breast reconstruction or “go flat”. Some people who go flat choose to have a tattoo to cover scars or express themselves. Your decision may depend on whether the surgery helps your body better reflect your gender. Your cancer care team may talk to you about reconstruction, but the choice is yours. For more information on body image and gender identity after breast cancer surgery, visit bcna.org.au.

Removal of the ovaries – Removal of the ovaries can affect how you experience sexual intimacy. This can often be managed with menopausal hormone therapy. See pages 35–36.

Removal of the uterus (hysterectomy) – Most people can still have orgasms as the clitoris and labia remain and control much of sexual sensation. However, orgasms may feel different. See page 35.

Removal of parts of the vulva – Surgery for vulvar cancer may remove part or all of the labia and, in some cases, the clitoris. This can

affect your sense of identity, confidence and sexual pleasure. A fulfilling sex life is still possible, but it may take time to adapt. Talk to your doctor; they may refer you to a sexual health physician.

Removal of a testicle – Some people who have had a testicle removed may have less confidence and feel less sexually desirable. For cisgender men, the loss of a testicle may make them feel less masculine. Some people adjust quickly to having one testicle, while others find that it takes some time. If you're self-conscious about how your scrotum looks, you may want to consider having an artificial testicle (called a prosthesis) inserted.

Trans women or non-binary people with testicles may also have a testicle removed for cancer. For some, this could affirm their gender; for others, it could feel distressing.

Removal of the prostate – During surgery, the tubes from the testicles are sealed and the prostate and the small glands called seminal vesicles are removed. This means semen is no longer ejaculated during orgasm. The pleasure from rubbing or stimulating the prostate during anal sex will also be lost. This may also affect erectile function. Talk to your doctor about ways to manage these changes.

Shortening or removal of the penis – After prostate cancer treatment, your penis may be a bit shorter (only by about 1-2 cm) or be a different shape. After treatment for cancer of the penis, all or part of the penis may be removed (partial or total penectomy). If the size of your penis is affected, you may avoid intimacy for fear of rejection. Your cancer care team can recommend a range of methods to change how the penis looks.

► Visit pcfa.org.au to download their booklet *Understanding Prostate Cancer for LGBTIQ+ People*.

Loss of hair from the head and body

Hair loss or hair thinning is a common side effect of some cancer treatments. It's usually temporary. If you experience hair loss, you may have a range of different emotions such as anger, anxiety and feeling low or depressed. Hair loss can make you feel self-conscious about your appearance and be a constant reminder that you have cancer.

For some LGBTIQ+ people, head and body hair can be an important part of how they express their sexual orientation and gender. It can be a way of signalling that they have rejected gendered expectations of how they should look, or beards or long hair may help affirm their identity. Losing hair because of cancer treatment can challenge this expression of identity and self-image. For others, short hair after treatment may make them feel more visible as an LGBTIQ+ person.

People manage hair loss in different ways. You may choose to wear a wig, scarf or hat, or leave your head uncovered. Some people shave their head before treatment starts so they feel in control of the hair loss.

► See our *Understanding Hair Loss* fact sheet.

Weight changes

Some cancer treatments may cause you to lose weight (body fat or muscle). This may be because you lose your appetite, or you have taste changes or trouble swallowing. Some medicines (e.g. steroids or androgen deprivation therapy) may cause you to put on weight.

Everyone responds differently to weight changes. Your reaction may depend on your age or how important your appearance is to you. For some, their changed body shape may feel more affirming, but others may feel less comfortable about their body after changes to their weight.

“Body wise, the most obvious thing that has changed is my hair. So, I guess, the way I present is a lot more obviously lesbian at the moment.” ELLEN

(LESBIAN, CANCER OF THE UTERUS)

Bowel changes

Chemotherapy and radiation therapy can irritate the lining of the bowel and rectum. Symptoms may include passing smaller, more frequent bowel movements (stools, also called faeces or poo), needing to get to the toilet more quickly, blood in the stool, or feeling that you can't completely empty the bowel.

These changes may mean that you avoid going out for fear of having an accident, or you avoid sexual activity (see page 34). Talk to your treatment team if you are finding it hard to cope with this side effect.

Other changes to your appearance

Surgical scars – Surgery can cause scarring. Sometimes people worry because a scar looks or feels red, tight or uncomfortable. This may make you feel self-conscious, even if others can't see it. Ask your doctor about creams that may help the scar heal and become lighter in colour. In some cases, you may choose to have surgery to make a scar less noticeable.

Other skin changes – Some targeted therapy, immunotherapy and hormone therapy drugs can cause itchy, red and dry skin. Radiation therapy can also cause skin issues. Skin changes can make you feel self-conscious. Your doctor may be able to suggest creams to help.

Lymphoedema – If most of the lymph nodes are removed from your armpit, groin or pelvic area, lymph fluid may no longer drain properly, and your arm or leg may swell. This is called lymphoedema. This may be permanent, but the pain and swelling can usually be managed.

► See our *Understanding Lymphoedema* fact sheet.

Stoma – You may need a temporary or permanent opening in the body (stoma) after surgery for some types of cancer (e.g. bowel or bladder cancer). A stoma allows stools (poo) or urine (wee) to collect in a bag attached to your abdomen. The bag can then be emptied. It can take time to get used to a stoma. You may worry that it can be seen under clothing, but it's not usually noticeable. For information about sexual intimacy when you have a stoma, see pages 34–35.



Ways to adjust to changes in appearance

- Keep in mind that body image is based on a mix of emotional and physical factors, not just on a body part or physical characteristic.
 - Look at your “new” body in the mirror to get used to the changes, and wear outfits that make you feel good.
 - Ask about reconstructive surgery, prosthetic devices and/or cosmetic solutions. These are not for everyone, but may help improve self-esteem and body image.
 - Exercise regularly. It can help improve body image and quality of life. An exercise professional can tailor an exercise program for you.
 - Connect with people who have similar experiences through social media or LGBTIQ+ support groups. They may have tips for adapting to body changes.
 - Talk to your GP or a psychologist if you have trouble adjusting.
- See our *Living Well After Cancer* booklet.

Sexual intimacy and cancer

For many people, sexual intimacy is an important part of life. Cancer treatment can affect your desire to have sex (libido), sexual response, body image and feelings about sex and intimacy, and relationships.

The stress of dealing with cancer can also affect your sex life. While these changes can be difficult to manage and hard to talk about, cancer may also strengthen relationships and lead to new ways to express intimacy. Many people are able to have a satisfying sex life after cancer.

Treatment side effects and sexual intimacy

Side effects vary from person to person, and depend on the type of treatment you have. Some people have no side effects, while others have many. Talk to your cancer care team about ways to manage side effects.

Changes to sex drive or desire – Tiredness, pain, anxiety, hormone changes, and lower confidence can reduce your libido and make it harder to reach orgasm. For some people, libido may return to their usual levels after treatment ends, but for others, low libido continues. Ageing can also affect hormone levels and reduce libido. You might also feel anxious about how your partner/s will react to changes in your body.



Health professionals may assume that returning to sexual activity is a recovery goal. For asexual people, this can feel alienating. It is important that your care team understands what intimacy means to you, and what matters most in your recovery.

Pain during sex – Surgery or radiation therapy to the pelvic area or rectum may make sex painful. Pain may improve after treatment ends but it can continue. If you have ongoing discomfort during sex, talk to your doctor. They may suggest seeing a pain specialist or pelvic floor physiotherapist. Anxiety can also cause your pelvic floor muscles to become tense and worsen pain, so it may help to see a psychologist.

Incontinence – Cancer treatment for the prostate, bladder, bowel, uterus, vulva, vagina or penis may affect bladder or bowel control (urinary or faecal incontinence). This may be temporary or permanent. You may worry about leaking urine or faeces during sex. Some people find using a sex blanket, protective sheets, or having sex in the shower helpful.

Weak pelvic floor muscles can affect bladder and bowel control. A continence nurse or physiotherapist can show you exercises to help strengthen these muscles. Cancer Council's *Exercise for People Living with Cancer* booklet also outlines how to do these exercises. Start these exercises before treatment and keep doing them after treatment.

Leaking urine at orgasm – After surgery for prostate or vulvar cancer, you might leak a small amount of urine when having an orgasm. This is usually temporary but is sometimes ongoing. You may feel embarrassed and nervous at the thought of leaking urine during oral sex and/or masturbation. This can be managed the same way as incontinence.

Sex with a stoma – Surgery for some bowel, anal, ovarian or bladder cancers may create a stoma. A stoma is an opening in the abdomen that allows faeces and urine to be collected in a small plastic bag. You may have a stoma for a short time or permanently. If you feel self-conscious, wear clothing that covers the stoma and use tape to secure the bag. A stomal therapy nurse can suggest products such as smaller pouches or

a stoma cap. Never use the stoma opening for sex – the surrounding tissue is delicate and can be easily damaged.

Changes to the vagina – Cancer treatment may cause temporary or permanent changes to the vagina. Surgery may shorten the vagina. Pelvic radiation therapy can narrow the vagina and cause thinning of the vaginal walls and dryness. If you have a surgically created vagina (vaginoplasty), ask your doctor how radiation therapy may affect you.

Penetration with fingers, a penis or sex toys may be difficult, painful or cause bleeding. A narrower vagina will also make pelvic examinations uncomfortable. Talk to your cancer care team as soon as possible about ways to keep your vagina open and flexible. Treatment may be more effective if started early. Your team may recommend vaginal dilators to stretch the vagina. Using extra lubrication may make penetration more comfortable. Choose a water-based or silicone-based lubricant without perfumes or colouring. Ask your doctor if vaginal oestrogen is an option for you. It may also help to talk to a psychologist.

Changes to the vulva – Cancer treatment to the vulva can change the appearance and texture of the labia, making the tissue feel harder (called fibrosis). This might also affect the clitoris and sexual enjoyment. Surgery for vulvar cancer may remove part or all of the labia and, in some cases, the clitoris. See pages 28–29.

Removal of the uterus – Orgasms will still be possible but they may feel different because there is no uterine contraction. See page 28.

Early menopause – Some cancer treatments can cause menopause symptoms or early menopause. Treatments include surgery to remove both ovaries; hormone therapy to block oestrogen; and radiation therapy

and chemotherapy, which can damage the ovaries. Menopause symptoms can include a dry vagina, painful sex, hot flushes and mood changes, all of which can affect libido. Menopausal hormone therapy can help, but it's not always suitable (e.g. for people with hormone-dependent cancers). Talk to your cancer care team about your options.

Changes to the anus – Radiation therapy to the abdomen or pelvic area may irritate the lining of the bowel and rectum. This can cause bowel problems, and the skin inside the anus may be more sensitive. This can increase the sensitivity and pain of anal sex. You may need to use dilators and extra lubrication to make receptive anal sex more comfortable. Sensitivity to the anal area may improve after a few months, but some changes are permanent.

Changes to the prostate – Pleasure experienced from stimulating the prostate during sex may change with certain prostate cancer treatments. After radiation therapy, the prostate may feel less sensitive. You won't feel the same pleasure if the prostate is removed with surgery (radical prostatectomy). It may take time to adjust to this change and for you to become more aware of other pleasurable sensations.

Changes to the penis – Surgery for prostate or penile cancer may shorten or shrink the penis. After prostate cancer surgery, the difference is often small, usually only about 1–2 cm. Changes in size may happen because of scar tissue or the nerves not working properly. See page 29.

Erection changes – After surgery for prostate cancer or bowel cancer, getting and keeping a firm erection can be difficult (erectile dysfunction). How long the problem lasts depends on your age, your erections before treatment and whether erectile nerves were affected. Radiation therapy or taking androgen deprivation therapy can also cause erection

problems. You don't need an erect penis to have an orgasm. However, firmer erections are needed for penetrative sex. Erection problems can make penetrative sex more difficult or painful, and you may find this makes you feel anxious and frustrated. Pelvic floor exercises can help improve erections. Using erection aids (e.g. a vacuum pump or constriction ring) or medicines can also help. Ask your doctor about these methods. They may suggest you see a sexual health physician.

Other ways to experience pleasure include masturbation or oral sex. Honest and open communication about what has changed, as well as non-sexual touching can help maintain intimacy in a relationship.

Ejaculation changes – After some types of surgery and radiation therapy, such as for prostate cancer, you may ejaculate less semen or none at all (dry orgasm). Semen may also be a different colour. If this affects your sex life, talk to your partner/s.

Safety concerns for partner/s

Your doctor may recommend using barrier protection or avoiding sexual activity for a time. This helps protect your partner/s from exposure to cancer treatment, and can also prevent pregnancy. Ask your doctor how long you need to use protection.

Chemotherapy – These drugs may pass into body fluids. Use condoms, internal condoms or dental dams for penetrative or oral sex. Wear latex

gloves for penetration with hands. Clean sex toys after use, and do not share them between partners without using a new condom.

Internal radiation therapy (brachytherapy) – If you have radioactive seeds inserted to treat prostate cancer, your doctor will talk to about avoiding anal sex and using barrier protection (e.g. condoms) during treatment and for a time after.

Adapting to changes in your sex life

Changes to how you enjoy sexual intimacy and activity can be challenging and upsetting. Give yourself time to adjust. There are several ways to adapt how you

Talk about what has changed



Share any concerns about having sex or being intimate with your partner/s. Tell them when you are ready to have sex, what feels comfortable, what doesn't and if they should do anything differently.

Try other forms of intimacy



Show affection by cuddling, holding hands, lying together naked, kissing and massaging. Talking about change can help avoid misunderstandings and reduce pressure to go further.

Explore different ways to have sex



If the way you used to have sex has changed, you could try different sexual positions; exploring other erogenous zones; manual sex, including fingering and fisting; mutual masturbation; oral sex; genital rubbing; personal lubricants (lube); vibrators and other sex toys; erotic images and stories; sexual fantasies and kink.

Plan ahead



Using lubricants (lube) and erection devices, taking medicines, or managing incontinence or a stoma may mean you need to plan when to have sex. Some people say they miss spontaneity, others find that scheduling sexual activity gives them something to look forward to.

have sex during or after cancer treatment. You might find some of the following tips useful. Also see our *Sex, Intimacy and Cancer* booklet.

Focus on other aspects of your relationship



Many people in relationships do not see sex as important. How you feel about sex may also change as you get older. Spend time together doing things you both enjoy and that bring you closer. This helps make sure sex isn't the only way you show affection or share intimacy.

Use relaxation and meditation techniques



Feeling relaxed can help with sexual pleasure. Use free apps and podcasts to guide you through relaxation and meditation techniques. Many treatment centres run meditation programs.

► Listen to our *Finding Calm During Cancer* podcast series.

Explore what has changed on your own



Touch and masturbation can help you understand any changes in how you feel in a way that you have complete control over. You can work out what feels good to, or what feels sore or numb, without feeling self-conscious or pressure to “perform” or to keep going if you don't want to. Once you feel comfortable exploring your body, you can show your partner/s what feels good and works best.

Seek assistance



Ask your healthcare team how to manage any sexual changes. Your doctor can also refer you to a sexual health physician, sex therapist or psychosexual counsellor. See pages 70–73 for other sources of support and information.

Communicating with your partner/s

Coping with cancer or treatment may affect your relationship with sexual partners. Your established roles may change, your partner/s may worry that sex will hurt you, or you might feel too tired for intimacy.

Talking openly during treatment can help you work through these changes together. If changes after cancer treatment are getting in the way of a fulfilling sex life, ask your GP or cancer specialists for a referral to a counsellor, sexual health physician or sex therapist.

Sexual activity and LGBTIQ+ young people

Adolescence and the young adult years are often a time for exploring your sexuality and identity, including your sexual orientation and gender. A cancer diagnosis can make this process more complex. If you've recently started exploring your identity, needing to have treatment for cancer may interrupt this.

Feeling isolated – If you already feel different or isolated from people your own age because of your sexual orientation, gender or intersex variation, cancer can make you feel even more lonely.

Worrying about disclosure – Getting diagnosed and treated for cancer means seeing many health services. It can be hard to talk about your sexual orientation, gender or intersex variation with others when you are still working it out or have only recently come out. Some young people hide their identity from health professionals, because they fear being judged, discriminated against or outed to family.

Canteen offers face-to-face or online counselling. It also runs online forums and camps. Call 1800 226 833 or visit canteen.org.au.

Some health services have adolescent and young adult support teams for young people with cancer. If you're feeling anxious or depressed, you can also call QLife on 1800 184 527.

Sexual activity and single people

If you're single, you may feel nervous about hook-ups or starting a new relationship during or after treatment. You may wonder when or if you have to tell a new person about your cancer diagnosis. This could depend on whether the relationship is casual or becoming longer term.

It may help to take new relationships slowly and share personal information when you feel you can trust the person. You can talk about how to adapt your sexual activity, try activities without penetration, or change the length and intensity of your sexual encounters. You can also talk to a psychosexual or relationship therapist for more suggestions.

You might decide that you want to focus on your health and wellbeing or that you don't have the energy for hook-ups or a new relationship.



Tips for hooking up

- Set boundaries via messages before meeting.
- Consider mentioning your cancer diagnosis on your dating profile.
- Share details of your diagnosis and side effects when you feel ready. You don't have to reveal everything at once. You can disclose information over several conversations, in person or via text.
- Practise what you want to say so it feels more natural.
- Talk to a psychosexual or relationship counsellor for strategies and support.



Fertility after cancer

Many LGBTIQ+ people hope to start a family. The path to becoming a parent is different for everyone. Having biological children is one way of starting a family, and this is possible for some LGBTIQ+ people. But this can be made difficult if cancer treatments affect your fertility.

Before starting treatment, it's important to discuss how cancer treatments may affect your ability to conceive a child or maintain a pregnancy (fertility) and your options for fertility preservation. You can still consider your fertility after treatment, but there may be fewer options.

If having children might be important to you in the future, discuss fertility with your cancer care team before treatment starts. This gives you time to understand and consider your options.

How cancer treatments affect fertility

Cancer and its treatment may affect your fertility. This will depend on the type of cancer, whether you've had surgery, chemotherapy or radiation therapy, and your age.

Infertility caused by cancer treatment can be temporary. You may have difficulty conceiving during treatment or for months or years after treatment. Sometimes, infertility is permanent. Some treatments can also cause early menopause. You'll be advised to avoid conceiving during cancer treatment and for a period of time after treatment, because some treatments can harm an unborn baby.

Ways to preserve fertility

There are different ways to preserve fertility before and after treatment. Keep in mind that these methods don't work all of the time. For more information about options before and after treatment, see our *Fertility and Cancer* booklet.

Options before treatment

Ask your cancer care team about the cost of having fertility preservation and storing eggs, embryos or sperm. Options include:

- freezing eggs or embryos
- freezing ovarian tissue
- surgically moving one or both ovaries out of the field of radiation to preserve their function (oophoropexy)
- preserving the uterus, fallopian tubes and ovaries during surgery
- for early cervical cancer, surgically removing part or most of the cervix, the upper part of the vagina and nearby lymph nodes, but leaving the uterus, fallopian tubes and ovaries and most of the vagina in place (trachelectomy)
- suppressing the ovaries with a long-acting hormone called GnRH analogue treatment before chemotherapy to cause a temporary menopause and protect eggs
- freezing or banking sperm
- using testicular sperm extraction (TESE)
- shielding the testicles during radiation therapy to protect them.

Options after treatment

Your options will depend on how cancer treatment has affected your fertility. Ways to become a parent after treatment include:

- using donor eggs from your partner, another known donor or an overseas donor (on an altruistic, non-commercial basis)
- using donor sperm from your partner, another known donor or overseas donor (on an altruistic, non-commercial basis)
- asking someone (a surrogate) to carry your embryo if you do not have a uterus or it is medically unsafe for you to carry a pregnancy. Only altruistic surrogacy (where the surrogate's expenses are covered but no other payment is made) is legal in Australia. Commercial surrogacy is illegal
- adopting a child
- fostering a child for emergency, respite, short- or long-term care (in Australia, there are more opportunities to foster than to adopt).

Checking fertility after treatment

After treatment, you may want to do some tests to see how your fertility has been affected. These may include blood tests, sperm count or ultrasound. Some tests, such as vaginal ultrasound, may be challenging for some LGBTIQ+ people. The results will help your doctors recommend the best options for having a child after cancer treatment.

Pregnancy after cancer treatment

You might be advised to wait up to 2 years after treatment ends before trying to get pregnant. There are many ways to approach conceiving a child, either on your own or with a partner.

Options if you or your partner can become pregnant

- Your partner could have their eggs fertilised with donor sperm through IVF and then carry the pregnancy.
- If your eggs were collected before treatment or are undamaged after treatment but you've had your uterus removed, you could consider reciprocal IVF. This means you go through the IVF cycle and once the embryos mature, they are transferred to your partner to carry the pregnancy. This is legal in most Australian states and territories. In Western Australia, reciprocal IVF is currently only available for medical infertility, but laws are changing.
- If your eggs have been damaged, but you have your uterus and your partner has ovaries, your partner's eggs could be fertilised with donor sperm and then you carry the pregnancy.
- If neither of you can provide eggs, you could use donated eggs.

Options if you and your partner produce sperm

You will need an egg donor and a surrogate to start a family. If your sperm has been damaged, your partner may be able to provide sperm. If neither of you can provide sperm, you could use donated sperm.

Options if you are single

You may be able to use donated eggs or sperm, including from overseas. Laws about donor eggs and sperm vary between countries, and there may be restrictions on exporting or importing them into Australia, so it's important to get legal and medical advice.

Emotional impact of infertility

People respond to infertility in different ways. Common reactions include: shock at how cancer or its treatment has affected fertility; grief for future plans; and anger or depression about changes to life plans and loss of control. People who didn't get a chance to think about their fertility until after treatment often say the emotions are especially strong.

It may help to consider other ways of becoming a parent, such as adoption or fostering, or you may decide to stop trying to have a child.

Infertility and relationships

Cancer and infertility can cause tension within a relationship. How your relationship is affected may depend on how long you have been together, expectations about becoming parents, the strength of your relationship before cancer and infertility, and how well you communicate.

Changes to your fertility may mean renegotiating who will provide eggs or sperm or who will carry the pregnancy. If your partner is unwilling or unable to be the biological parent, you might feel like you've missed the opportunity to have a family. Seeing a fertility counsellor can help.

If you're starting a new relationship, you may want to share your cancer diagnosis and its impact on fertility when you can trust the person.



Trans and/or gender-diverse people

This chapter discusses some of the ways cancer treatment may affect you as a transgender (trans) and/or gender-diverse person. For example, making decisions about treatment can be difficult when cancer develops in your chest or in a reproductive organ.

Having cancer treatment and managing side effects often means doctors will refer to the sex you were assigned at birth. You can ask your doctor to talk about you as your affirmed gender.

If you find the information in this chapter distressing, read the parts you feel comfortable with now and come back to others when you feel ready. You can also contact QLife on 1800 184 527 (3 pm–9 pm) for support.

Cancer care as a trans and/or gender-diverse person

Your cancer care team should offer care, support and information that meets your needs, respects who you are, and helps you to make informed decisions about treatment. Your team should treat you as an individual and work with you in a way that respects your privacy and dignity. But research shows that because health professionals have less confidence and experience in treating trans and/or gender-diverse people, they may struggle to provide inclusive and gender-affirming care.

Discrimination and past negative experiences (see pages 24–26) are common reasons why a cancer diagnosis may be particularly challenging for trans and/or gender-diverse people.

Challenges you might face

Lack of experience – It may be harder to find cancer specialists who understand how trans health needs affect cancer care. It can be difficult dealing with health professionals who think of sex as binary, and you may fear being misgendered.

Misgendering – Health professionals may incorrectly assume your gender or that of your partner and use the wrong words or pronouns when referring to you. You might find this misgendering upsetting, and it could undermine your trust and confidence.

Outdated forms – Medical forms may not include options to record your gender, pronouns or sexual orientation. It can also get complicated if the gender or name you use on the form doesn't match the details on official documents, such as your Medicare card.

Using gender-affirming hormones for a long time – Taking feminising hormones (such as oestrogen or testosterone blockers) may slightly increase the risk of breast cancer over time, but the risk is still much lower than for cisgender women. Current evidence shows that taking testosterone does not increase cancer risk. For most people, the benefits of gender-affirming hormones outweigh any small change in cancer risk.

Services that are gendered – Some cancers are screened and treated in a cisgender way (e.g. ovarian cancer in a women's hospital). This can feel isolating if you are trans and/or gender diverse. Cancer care teams may also be less experienced treating people whose bodies don't match typical gender expectations (e.g. a woman with prostate cancer), which can make care feel awkward. Support services may also be gendered (e.g. for prostate or breast cancer), which can make it harder to find the right support.



Ways to manage challenges

- See a health professional who is affirming of your gender. To find a suitable doctor, use word of mouth or visit transhub.org.au or auspath.org.au.
- Look for services that are trans friendly. See page 13.
- Plan ahead as cancer care teams may request clearance letters from your gender-affirming care team.
- Tell your cancer care team about your relevant anatomy, the sex you were assigned at birth, and any hormone therapy you're taking. This can help the team recommend treatments and give you information that is right for you.
- Ask the receptionist to update your record with your name and pronouns, or consider wearing a pronoun badge or pin.
- Practise what you want to say to your doctor before an appointment to help the words come out more easily. Or read from a pre-prepared letter. Avoiding eye contact may make it easier.
- Let your health professionals know what language you prefer with for body parts.
- Bring someone you trust to your appointments for support. They can speak for you if you don't know what to say.
- Use the Genders, Bodies and Relationships Passport to make telling your health professionals about your gender, body and relationships easier. Visit lgbtiqhealth.org.au/passport for more information and to order a copy.
- Explain what is important to you. This may include concerns about continuing gender-affirming treatment.
- Visit canwe.org.au or transhub.org.au to find screening programs that are right for you.
- If you think you've been treated inappropriately, consider making a complaint. For more information, see *Dealing with discrimination*, pages 24–26.

How cancer affects trans and/or gender-diverse people

Cancer can cause extra distress for trans people who have cancer in a part of their body that doctors may not expect due to their gender. For example, a trans man may have cervical cancer or a trans woman may develop prostate cancer. It's important to screen the parts of your body that you have.

If you've had surgery to remove certain body parts (e.g. a mastectomy or top surgery, or surgery to remove reproductive organ/s), talk with your surgeon and healthcare team about what (if any) cancer risk remains after that surgery.

Breast cancer – Everyone has breast tissue in the breast and chest area, which means anyone can get breast cancer. But risks can vary.

- Trans and gender-diverse people who develop breasts at puberty have a similar level of risk to cisgender women.
- Trans women and gender-diverse people who develop breasts from taking gender-affirming hormones have a higher risk than cisgender men, but a lower risk than cisgender women.
- Trans men and other people who have had gender-affirming top surgery have a lower risk of developing breast cancer than cisgender women, but may still need to screen for breast cancer.



Having a mastectomy to treat cancer is different from gender-affirming top surgery. A mastectomy removes all the breast tissue from part or all of the chest area and often the nipple. Top surgery usually keeps some breast tissue to form into a masculine chest and the nipple is often retained. You may have had top surgery before you were diagnosed with cancer.



Some trans and gender-diverse people prefer the term chest cancer instead of breast cancer. In this booklet, we use the term “breast cancer” because it refers to cancer of the breast tissue. Everyone has some breast tissue, which is why some cisgender men also get breast cancer. Cancer can also affect other organs in the chest, including the lungs and trachea.

Prostate cancer – The prostate is not removed during gender-affirming genital surgery (e.g. vaginoplasty). This means all trans and gender-diverse people who were born with a prostate can get prostate cancer.

It’s common for the prostate to grow larger with age. You may be at higher risk of prostate cancer if you have a family history of prostate cancer, or if you started gender-affirming hormone therapy later in life and cancer had already started to grow in your prostate.

Taking feminising hormones (such as oestrogen or testosterone blockers) or having your testicles removed, reduces your risk of prostate cancer by lowering testosterone levels. Although the risk of prostate cancer is likely to be low, keep in mind the following:

- if your doctor does not know your trans status, they may not ask about prostate symptoms
- PSA blood test results may look different if you’re taking hormones such as oestrogen
- you may not have any prostate cancer symptoms, or urinary symptoms may be mistaken for effects of gender-affirming surgery.

Other cancers of the reproductive and sexual organs – There are many cancers that affect reproductive organs, including cancer of the cervix, ovaries, vagina, vulva, testicles or penis.

Some trans people have gender-affirming surgery to create a vagina or penis. Cancer can also develop in these body parts, but this is very rare. If you have concerns, talk to your doctor.

“At the time of my diagnosis I was still passing as female and I was able to ‘fit in’ in the necessary environments like gynae offices. The psychological impact of having gynaecological parts involved was not lost on me.” JAX (TRANS MAN, OVARIAN CANCER)

Cancer treatment and gender affirmation

Some cancer treatments can affect your identity. Talk to your cancer care team about what is important to you, so this can be considered when planning your treatment.

Surgery

Surgery to treat cancer may cause physical changes that make you feel uncomfortable or increase gender dysphoria. In some cases, surgery can affirm your gender, reduce gender dysphoria, or even lead to gender euphoria (when your body and gender feel aligned).

If you need to stay in hospital, ask which ward you will be on. You may be able to stay in a private room or mixed-gender ward. It can feel isolating to receive treatment in settings that do not reflect your gender.

Radiation therapy

If you’ve had gender-affirming treatment, such as surgery to create a penis (phalloplasty or metoidioplasty) or a vagina (vaginoplasty), radiation therapy to the pelvic area may affect these organs.

If you've had surgery to make a penis – Pelvic radiation therapy can usually be given in a way that avoids this area. If you also still have a vagina (sometimes described by trans people as a front hole), radiation therapy may make this area dry, narrow or cause bleeding.

Your treatment team may suggest using dilators after treatment to help keep the vagina/front hole open. Dilators can help with cervical screening or sex, but it's your choice whether or not to use them.

If you've had surgery to make a vagina – Pelvic radiation therapy may narrow the vagina or make the skin more fragile and sensitive. Keeping the vagina open and supple can make penetrative sex more comfortable and it's also important for having medical examinations in the future.

You may be offered dilators to prevent scarring and shortening of the vagina. Some people find using a dilator upsetting. Talk to your doctor about your recovery goals, so they can understand what you'd like and how you feel.

If you've had other genital surgery – Other genital surgeries, including zero-depth vaginoplasty (to create a vulva) and metoidioplasty (to create a penis from the clitoris), may also be affected by radiation therapy. Talk to your surgeon and treatment team about what to expect and how you can look after yourself.

“Surgery for cancer alleviated me of some of the parts that were at the core of my gender dysphoria symptoms. I felt more whole than I had in my entire life.” JAX (TRANS MAN, OVARIAN CANCER)



All people with a cervix should have a cervical cancer screening test every 5 years. It's now possible to collect the sample for screening yourself. For information about self-collection, visit canwe.org.au or cancercouncil.org.au.

Impact of cancer treatment on body image

Some cancer treatments may change how you look or affect a part of your body that aligns with your gender. For example, hair loss or a changes in your body shape may be upsetting if your appearance is an important part of your identity. These changes may affect your body image and sense of self, and can be difficult to cope with.

You may also feel relieved if the changes affirm your gender. For example, surgery to treat cancer may remove a body part you would prefer not to have. Or you may feel distressed if the changes make you feel less comfortable in your body. How you react will depend on the type of cancer and treatment you have. See the *Body image, gender and cancer* chapter on pages 27–32.

Using gender-affirming hormones during treatment

If you're taking gender-affirming hormones, you may be able to continue taking them during cancer treatment. This will depend on the type of cancer and the treatment you have.

Stopping or reducing hormones can cause physical changes and may bring back gender dysphoria.

Your reasons for taking hormones are also important, and you may feel the benefits of continuing them outweigh the risks for you. Your cancer care team should help you weigh up these effects alongside the cancer treatment outcomes. Ask whether gender-affirming hormone therapy could affect any cancer treatment side effects.



Intersex people and cancer

This chapter discusses some of the ways having an innate variation of sex characteristics (an intersex variation) might affect cancer treatment. About 2% of people are born with one of at least 40 known variations of sex characteristics. Common variations include complete androgen insensitivity syndrome (46,XY), Swyer syndrome (complete gonadal dysgenesis, 46,XY) and Klinefelter syndrome (47,XXY).

Cancer care as an intersex person

Your cancer care team should offer you care and information that meets your needs, respects who you are, and supports you to make informed decisions about treatment. They should treat you as an individual and work with you in a way that respects your privacy and dignity. As an intersex person, you may have some added challenges. For example:

- it may be harder to find cancer specialists who understand health issues related to the intersex variation you have
- clinical practice guidelines that set out recommended cancer treatment pathways may not cover your situation, which can make it harder for you to make informed decisions
- you may avoid cancer screening because treatment you had as a child to make your body fit social norms has affected you throughout your life
- surgery for cancer may be a reminder of surgery imposed on you as a child, which can be distressing and traumatising
- you may feel vulnerable if you've experienced harassment, violence, stigma, exclusion or discrimination (minority stress).

“An emphasis on intersex care is vital and long overdue in the health service; we are so overlooked as a community.” ALEX (PANSEXUAL, NON-BINARY, INTERSEX, SKIN CANCER)

Working in partnership with your cancer specialists to make treatment decisions may help you deal with these challenges. Research shows that many health professionals report a lack of confidence and knowledge in treating intersex people. If you have a GP or other specialist looking after your ongoing medical care, they can provide your cancer specialists with any information that is relevant to your cancer care. This may include details about your intersex variation, the sex assigned to you at birth, your gender, your anatomy and any hormone therapy you take.

If you don't have a GP or other specialist you trust, think about what you want to say and how much you want to share with your cancer specialists. If possible, take someone with you to your appointments for support. To get the correct cancer diagnosis and treatment, your doctor needs to understand your medical history, which may be confronting.

Challenges you might face

Prior surgery without your consent – Intersex people may have had surgery as children to assign a sex, to make their body fit gendered norms, or to reduce the cancer risk (see next page). This surgery may have changed the appearance or removed parts of the genitals and reproductive organs. It may have happened before you could make your own decisions, or before your parents had enough information to give informed consent. Some people later reject the assigned sex and identify with a different gender, and some surgeries may not have been medically necessary. These experiences can cause distress and grief.



Some states and territories now have laws that protect children with variations of sex characteristics from restricted or special medical treatment involving non-essential medical procedures, setting out strict rules and independent oversight.

Feelings of distrust – You may have lost trust in family and health professionals because decisions about your body were made without your consent when you were a child. You may not have found out about past surgeries or other medical interventions until you were an adult. Being told that doctors needed to “fix” your body can make some people feel ashamed and stigmatised. Some intersex people distrust the medical profession because they were made to feel like research subjects, photographed or asked insensitive questions.

Cancer risk – Some syndromes that cause intersex variations increase the risk of cancer. For example, people with Klinefelter syndrome (47,XXY) have an increased risk of non-Hodgkin lymphoma and breast cancer. The risk of gonadal cancer (cancer in the tissue that becomes testicles and ovaries) is higher in people with some variations such as Swyer syndrome (complete gonadal dysgenesis, 46,XY). While surgery to remove the gonads may reduce cancer risk, it has often been done on people with very low risk. For some people, ongoing monitoring can be a better way to manage cancer risk.

Some people with an intersex variation have had surgery to create a vagina or penis. Cancer can develop in these body parts, but this is very rare. Talk to your doctors about the cancer risk for your variation.

Cancer screening – Talk to your doctors about screening tests that are suitable for you (see page 7). Depending on your variation, the sex assigned at birth or any medical interventions you’ve had, you may not

receive appropriate screening reminders for breast or cervical cancer, or you may receive notifications that don't apply to you. If you find the idea of screening tests difficult, talk to your GP or nurse. Ask them to explain what will happen. For bowel and some cervical screening tests, you may be able to collect the sample yourself (see page 7).

Taking hormones – You may have been prescribed hormones to supply the body with the sex hormones that it can't produce naturally or to bring on sexual development at puberty. If you've had surgery to remove the gonads, you may need lifelong hormone replacement therapy. This can be confronting if you did not consent to the surgery. You may also be on hormone therapy to affirm your gender if the sex assigned at birth does not match your gender as an adult.

Some cancers grow in response to hormones. Depending on the type of cancer and treatment you have, you may not be able to keep taking hormones prescribed for your intersex variation. It's important to discuss this with your cancer specialists, so you can make informed decisions about future treatment.

Terms used – Health professionals may use several terms to describe intersex variations, including differences or disorders of sex development (DSD). You may find some terms offensive or distressing. Let your cancer care team know the terms you would like them to use.

Ongoing side effects – Previous surgery may have led to scarring, infertility, incontinence or loss of sexual function, which can all cause anxiety and mental distress.

“I've had constant fears that I'll get cancer.”

TERRI (INTERSEX WOMAN)

Gendered treatment – Some cancers are diagnosed and treated in a gendered way. This may make you feel excluded or stigmatised for not matching other people’s ideas of what it is to be a man or woman. Outdated forms may not include options to record intersex variations. Being made to feel different can lead to distress when talking with health professionals about cancer.

Body image – Surgery to treat cancer may remove a body part. You may feel comfortable with this change, or you may feel upset or distressed. If you’ve previously had a body part removed without your consent, losing another body part may bring up strong emotions. Talk to your treatment team about how you’re feeling before surgery. For more information about body image, see pages 27–32.

Fertility – Some intersex people are fertile and others are not. This depends on your intersex variation and whether you had surgery during childhood to remove testicles or ovaries. Decisions that affect fertility are often made during childhood, usually without the person’s consent. This can lead to feelings of loss and grief.

Cancer treatments can also affect fertility. If your fertility has already been affected by your intersex variation, another change to your fertility can be especially difficult. Talk to a fertility specialist before treatment starts for information specific to you.



Talking to intersex-aware psychologists, counsellors, psychiatrists or other health professionals may help reduce distress. Peer support may also be available through InterAction at interaction.org.au. For more ways to find support, see pages 70–73.



LGBTIQA+ people with advanced cancer

Advanced cancer is cancer that has spread from the original site or has come back. Although medical treatments may not be able to cure advanced cancer, they may slow its growth or spread, often for many months or for years.

- ▶ See our *Living with Advanced Cancer* booklet and listen to *The Thing About Advanced Cancer* podcast.

Palliative care

Palliative care is person-centred care that helps people with a progressive, life-limiting illness live as comfortably as possible. The main goal is to maintain your quality of life by dealing with your physical, emotional, cultural, social and spiritual needs. Palliative care also supports families and carers, including with bereavement care.

Depending on what services are available where you live, you can have palliative care at home, at a residential aged care facility, or in a hospital or specialist palliative care unit.

- ▶ See our *Understanding Palliative Care* booklet.

Barriers to inclusive palliative care

After experiencing a lifetime of discrimination and stigma, LGBTIQA+ people may worry about receiving palliative and end-of-life care that is safe and meets their needs. Your concerns about receiving inclusive palliative care may also be influenced by any unpleasant experiences and negative attitudes you may have had when friends had palliative care during the HIV/AIDS epidemic.

Reasons why some LGBTIQ+ people may avoid or delay accessing palliative care services include:

- distrust of healthcare providers because of past experiences
- fear of discrimination, harassment, judgement or having to hide their identity
- concerns that health professionals will make assumptions about their gender, body or sexual orientation
- fears that health care will not affirm their gender
- concerns about physical safety or receiving respectful personal care
- concerns about their partner/s or chosen family being excluded
- lack of support with advance care planning (see pages 62–63) and access to palliative care
- fears about social isolation and facing the end of life.

Other aspects of identity, such as age, race, culture, disability, and where you live, can also influence how you feel about palliative care.

Respectful, inclusive care

All LGBTIQ+ people have the right to palliative care that is safe, respectful and inclusive. It's unlawful for palliative care services to discriminate against LGBTIQ+ people (see pages 24–26).

Some LGBTIQ+ people who use palliative care services disclose their sexual orientation, gender or intersex variation, while others don't. It's your choice, but letting your palliative care providers know more about you can help them best meet your needs.

When looking for palliative care providers, ask how they make people feel safe, included and respected. This may give you an opportunity to raise any specific care needs related to your sexual orientation, gender or intersex variation.

For ways to identify LGBTIQ+ friendly services, see page 13. For more information on palliative care for LGBTIQ+ people, visit lgbtiqhealth.org.au/palliative_care.

Recognising family

Palliative care recognises the importance of involving spouses, partner/s, family and carers in decisions about your care, with your consent. The palliative care team will also provide family and friends with emotional support and referrals to counselling and grief support.

Some LGBTIQ+ people are estranged from their family of origin and surround themselves with chosen family. Others are not out to their family, or their family is hostile to their identity. Sometimes, conflicts can arise between the family of origin and the chosen family.

To ensure that the people you want to make decisions on your behalf are recognised by the palliative care service, you should appoint one or more substitute decision-makers (see next page).

Intimacy and palliative care

Sexual activity and intimacy remain important to many people, even when cancer is advanced. It's okay to talk to your healthcare team about the impact of any treatment on your sex life or ability to be intimate.

If you have a spouse or partner/s, try to spend intimate time together, rather than only as “patient” and “carer”. If you're in residential palliative care, ask if a double bed is available so you can have some private time. Intimacy can provide comfort and maintain connection. Even if sexual intimacy is no longer possible or desired, you may enjoy physical closeness through cuddling, touching, massage or simply lying beside each other.

Advance care planning

When diagnosed with a life-limiting illness, it can be a good idea to plan for your future health care. Talking about preferences with your family, friends and treatment team helps ensure that your wishes are respected if you lose the ability (capacity) to make your own decisions.

Everyone has their own preferences, and they may change over time. Making your wishes clear can give you peace of mind, protect your rights, and ensure that the people you want involved in your care are included. Advance care planning usually includes the following steps.

Prepare an advance care directive – You can write down your goals and instructions for your future medical care in this document. It also records your values and treatment preferences. Doctors, family, carers and substitute decision-makers can follow this record if you become unable to communicate or make decisions.

► See our *Advance Care Planning* fact sheet.

Appoint a substitute decision-maker – You can legally appoint one or more people to make treatment decisions for you if you become incapable of making them yourself. A substitute decision-maker should be someone you trust, and who understands your values and preferences for care. They do not have to be your next of kin or a carer. Depending on where you live, this paperwork may be known as an enduring guardian, enduring power of attorney or medical treatment decision-maker. A social worker may be able to help you with appointing a substitute decision-maker.

Appoint an enduring power of attorney – If you are unable to look after your own financial and legal affairs, you can legally give one or more people the power to make financial or legal decisions for you.

Voluntary assisted dying

Voluntary assisted dying (VAD) is when a person with an incurable, life-limiting condition or illness chooses to end their life with the help of a doctor or health practitioner, using specially prescribed medicines from a doctor. “Voluntary” means it is the unwell person’s choice to end their life.

VAD is legal in all Australian states and territories except the Northern Territory (NT). The NT passed VAD legislation in August 2026, and these laws are expected to come into effect in 2028. See Queensland University of Technology’s End of Life Law in Australia website at end-of-life.qut.edu.au/assisteddying.

Make a will – A will is a legal document that sets out what you want to happen to things you own (your assets) after you die. These assets are called your estate and may include your house, land, car, bank accounts, jewellery, clothes, household goods or investments. A will can also record guardianship plans for any children you have.

A will needs to be prepared and written in the right way to be legally valid. It is best to ask a lawyer to help you or contact the Public Trustee in your state or territory. If you die without a will, you are said to die intestate. Your assets are distributed to family members according to a formula set out in the law. Although any will can be challenged in court, having a valid will usually means your assets go to the people of your choice and avoids extra expenses.

Default decision-maker

If you lose the capacity to give consent for medical treatment and have not appointed a substitute decision-maker, consent for medical treatment may be given by a default substitute decision-maker. Depending on where you live, they may be known as the person responsible, default

substitute decision-maker, available consentor, statutory health attorney or medical treatment decision-maker. You may have nominated an emergency contact person on your medical forms, but this person is not legally permitted to make treatment decisions (unless they are also an authorised substitute decision-maker).

The law sets out who should make health and medical decisions (but not financial decisions) on your behalf if you lose capacity. These people are approached in a set order. Most Australian states and territories prioritise guardians, followed by partners, unpaid carers and family members, but the order and terminology used are different across the country.

Communicating openly

It can help to have the difficult conversations with your partner/s and family (chosen or otherwise) early, so you are not rushed into decision-making. You may want to choose what you would like for your funeral and take an active role in how you will be remembered.

Having certainty about these decisions early can make things easier for both you and your partner/s, and allow you to focus your energy on having treatment or feeling your best. This may be an uncomfortable conversation, but it can be proactive, honest and deeply important for those involved.



Each state and territory has different laws about advance care planning. For more information, call Advance Care Planning Australia on 1300 208 582 or visit advancecareplanning.org.au. Depending on where you live, Cancer Council may be able to refer you to a lawyer who can help with advance care planning. To find out more, call Cancer Connect on 13 11 20.



Life after treatment

For most people, the cancer experience doesn't end on the last day of treatment. Life after cancer treatment can present its own challenges. You may have mixed feelings when treatment ends, and worry that every ache or pain means the cancer is coming back.

Give yourself time to adjust to the physical and emotional changes, and to establish a new daily routine at your own pace. Your family and friends may also need time to adjust.

Finding a new normal

When treatment ends, you may see the diagnosis as an opportunity to make changes to your life. This process is often called finding a new normal. It usually happens gradually; even positive change can take time. You may:

- change the way you talk about yourself
- have a different perspective on life and seek out new experiences
- feel motivated to set up a support group in your community
- want to be more open about your sexual orientation, gender or intersex variation
- feel confronted by, or positive about, changes to your body
- place more value on spending time with family and friends
- focus on the relationships in your life that matter most
- reconsider your career goals and work values.

It may help to share how you're feeling with your family and friends, your doctor, a psychologist or counsellor.

► See our *Living Well After Cancer* booklet.

Follow-up care

After treatment, you will have regular appointments with your cancer specialists, cancer nurse or GP. These check-ups monitor your health, manage any long-term side effects from treatment, and check that the cancer hasn't come back or spread.

Many people say they feel worried before routine check-ups. They often feel easier once you've been to a few and things are going well. In the meantime, finding ways to cope with your anxiety before check-ups may help. Learning mindfulness and meditation skills, or practising deep breathing, and doing activities you enjoy can help you manage stress and anxiety.

► Listen to our *Finding Calm During Cancer* podcast.

Some treatment side effects can last for months or years. It can take time to adjust. Your treatment team can work with you to develop a plan to support your physical and emotional needs. Your GP or specialist can refer you to an allied health professional to help you manage side effects and improve your quality of life. For example, a psychologist can help with anxiety, a physiotherapist can help improve movement, or a sex therapist can help you deal with sexual changes. Some public health services also provide allied health care after cancer treatment ends.

Having to disclose personal details again and build trust with new health professionals can be stressful. It's usually worth the effort because it can help you return to your usual activities.



Whether organised screening programs (see page 7) are suitable for you after treatment will depend on the type of cancer treatment you had. For more information, talk to your GP or cancer care specialist.

Caring for someone with cancer

You may be reading this booklet because you are caring for someone with cancer. What this means for you will vary. Being a carer can bring a sense of satisfaction, but it can also be challenging and stressful. Try to look after your own physical and emotional wellbeing. Give yourself some time out and share your concerns with a counsellor or your doctor. There is a wide range of support available to help.

Support services – Support services such as Meals on Wheels, home help or visiting nurses can help you in your caring role. You can find local services, information and resources through Carer Gateway. Call 1800 422 737 or visit carergateway.gov.au (search for “LGBTI carers”).

Support groups and programs – Many cancer support groups and cancer education programs are open to carers as well as to people with cancer. Support groups and programs offer the chance to share experiences and ways of coping.

Carers Australia – Carers Australia provides information and advocacy for carers. Visit carersaustralia.com.au.

Support for young people – Canteen offers support to families with children aged 12–25 who have cancer or who have a close family member with cancer. Visit canteen.org.au.

Cancer Connect – You can call Cancer Connect on 13 11 20 or visit cancerconnect.org.au to find out more about carers’ services.

► See our *Caring for Someone with Cancer* booklet.

Specific issues LGBTIQ+ carers may face

Caring can be challenging for everyone, but LGBTIQ+ carers may have added challenges. These include:

Discrimination – You may feel uncomfortable accessing services and support groups for fear they will discriminate against you or the person you're caring for because of your sexual orientation, gender or sex characteristics. This may be based on previous experiences with health professionals.

You may also worry that your relationship with the person you care for won't be recognised and you won't be included in decision-making. Some people cope with this fear by hiding the nature of their relationship when accessing support.

Ask others for help – You don't have to do all the practical, emotional and financial tasks of caring alone. Your friends and chosen family may be keen to help, especially if the person's family of origin has rejected them due to their sexual orientation, gender or intersex variation.

Use the Gather My Crew app to organise offers of help. Visit gathermycrew.org.au.

Rights at work – If you're caring for someone in your family or household and working, you have the same rights as other employees. Talk to your employer about your caring responsibilities and how they can support you with carer's leave and flexible working arrangements.

► See our *Cancer, Work and You* booklet.

Financial help – Since federal reforms in 2008, everyone has the same rights and entitlements. This means you can access the Carer Allowance and Carer Payment if you meet the criteria. For more details, visit servicesaustralia.gov.au.

Isolation and loneliness – You might feel lonely if friends stay away or if LGBTIQ+ communities aren't as supportive as you'd expected. You may also feel too tired to socialise or enjoy your usual activities. Consider joining a support group or call QLife on 1800 184 527 for support.

Tips for health professionals

Inclusive, welcoming health care can improve how LGBTIQ+ people cope with a cancer diagnosis and treatment. Under the Australian Charter of Healthcare Rights, everyone has the right to safe, respectful and confidential health care. Health services can support LGBTIQ+ people by making a few simple changes.

- **Use preferred language** – Use each person's pronouns, preferred name, relationship terms (e.g. wife, husband), and language for body parts (e.g. breasts, chest). It can help to share your own pronouns first.
- **Avoid assumptions** – When relevant to health care, ask respectful questions about people's bodies, relationships or support needs.
- **Recognise partners and families of choice** – Include spouses, partner/s and chosen family in care plans as the person wishes.
- **Check intake forms** – Review intake forms to ensure they include a range of gender options and allow recording of both preferred name and legal name (e.g. name on the Medicare card).
- **Review language in care materials** – Avoid gendered language (e.g. men's and women's) in patient information about cancer.
- **Check facilities** – Provide gender-neutral toilets and consider ward or room placement carefully so trans and gender-diverse patients are not placed in facilities that don't match their gender.
- **Seek training** – Training can help health professionals provide inclusive care. Examples are the *Cancer LGBTIQ+ Inclusivity Toolkit* (visit.education.eviq.org.au) and Rainbow Health Australia resources.
- **Display LGBTIQ+ signs or flags** – If your healthcare service provides inclusive care, display signs in the practice and online.
- **Think about referrals** – Refer to other LGBTIQ+ friendly health professionals, where possible.

Support and information

There are many sources of support and information to help you, your chosen family and carers. The services available to you will depend on where you live. Some will be free, while others might have a cost.

Useful organisations

Advance care planning

Advance Care Planning Australia
1300 208 582
advancecareplanning.org.au

Information about planning future health care, including advance care directives.

Cancer support and information

Cancer Connect
13 11 20
cancerconnect.org.au

Information and support service for people affected by cancer. Call to speak to one of our qualified professionals, or visit our website.

Cancer Council Online Community
cancercouncil.com.au/OC

Share your thoughts and experiences with other people affected by cancer.

Cancer Council podcasts
cancercouncil.com.au/podcasts

Find information and insights in our series *The Thing About Cancer* and *The Thing About Advanced Cancer*, plus relaxation and meditation tracks in *Finding Calm During Cancer*.

Breast Cancer Network Australia
bcna.org.au

Provides information and support to people affected by breast cancer; offers LGBTIQ+ specific articles.

Canteen
canteen.org.au

Supports young people aged 12–25 affected by cancer. Also provides information for young LGBTIQ+ people with cancer.

Cancer support and information – continued

Prostate Cancer Foundation of Australia pcfa.org.au	Provides information and support on prostate cancer; has online information for LGBTIQ+ people.
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Complaints and regulatory organisations

Australian Health Practitioner Regulation Agency www.ahpra.gov.au	Registration body for health practitioners. Also investigates complaints about the conduct of health practitioners.
Australian Human Rights Commission 1300 656 419 humanrights.gov.au	Information and advice about Australia's discrimination legislation and disability standards; investigates complaints about unlawful discrimination.
Fair Work Ombudsman 13 13 94 fairwork.gov.au	Information and advice about Australia's workplace rights and rules, including awards, entitlements and national employment standards.
Office of the Australian Information Commissioner 1300 363 992 oaic.gov.au	Independent national body investigating privacy infringements and complaints.

LGBTIQ+ specific

ACON acon.org.au	NSW-based health promotion organisation specialising in HIV prevention, HIV support and LGBTQ health (including cancer).
AGMC agmc.org.au	Advocates for the rights of multicultural and multifaith LGBTIQ communities.
Australian Professional Association for Trans Health auspath.org.au	Information for professionals involved in providing care for trans people; includes a national directory of health providers.
Black Rainbow blackrainbow.org.au	Social network for Aboriginal and Torres Strait Islander people who identify as LGBQTIA+, sistergirl or brotherboy.

LGBTIQA+ specific – continued

CanQueer canteen.org.au/how-we-help/events-programs/canqueer	Online community for LGBTIQI+ young people impacted by cancer.
Can We canwe.org.au	LGBTQ+ specific information about cancer screening, prevention and support.
Gender, Bodies and Relationships Passport lgbtiqhealth.org.au/passport	Tool to communicate information about your gender, body and relationships with health professionals and services.
InterAction for Health and Human Rights interaction.org.au	Provides support, education, peer support and policy information, by and for people with intersex variations or traits.
LGBTIQ+ Health Australia lgbtiqhealth.org.au	National organisation for health services that support LGBTIQ+ communities. Keeps a list of inclusive health services for LGBTIQI+ communities.
Minus18 minus18.org.au	Provides mental health support, peer mentoring and social events for LGBTQIA+ young people from all over Australia.
National Cancer Network (US) cancer-network.org	Information on cancer risk, screening and treatment for LGBTQIA+ communities.
Qheadsapce headspace.org.au/lgbtiqaplus	National mental health service for LGBTIQA+ people aged 12–25.
ReachOut au.reachout.com/identity	Online mental health support for young people to talk about gender and sexuality.
The Bottom Line thebottomline.org.au	Information on HPV and anal cancer for gay and other men who have sex with men.
TransHub transhub.org.au	Information about gender affirmation, hormones and health needs, including cancer screening.

Referrals

DocDir
docdir.com.au

Links to LGBTQ+ friendly health professionals and clinics.

Services for carers

Carer Gateway
1800 422 737
carergateway.gov.au

Practical information, support and useful resources for carers.

Carers Australia
carersaustralia.com.au

National body working with state and territory carers associations to provide information and advocacy for carers.

Services Australia
servicesaustralia.gov.au

Provides government payments and services. Services Australia includes Centrelink and Medicare.

Sex and intimacy

Relationships Australia
relationships.org.au

Provides programs to help people build positive and respectful relationships.

Society of Australian Sexologists
societyaustraliansexologists.org.au

Regulates and accredits psychosexual therapists and sexuality educators.

Telephone and online support

Beyond Blue
beyondblue.org.au

Provides information and support for anxiety, depression and suicide prevention.

Lifeline
13 11 14
lifeline.org.au

24-hour telephone, text and online crisis support and suicide prevention.

QLife
1800 184 527
qlife.org.au

Provides peer support and referrals about sexuality, identity, gender, bodies, feelings or relationships through an anonymous online and phone counselling service. Available 3 pm–9 pm.

Question checklist

Asking your health professionals questions can help you find the right support. You may want to include some of the questions below in your own list.

Treatment team

- Do you have experience dealing with LGBTIQ+ people with cancer?
 - Do you have an LGBTIQ+ inclusive policy for patients and staff?
 - Have staff had training in meeting the needs of LGBTIQ+ people?
 - How will you keep my personal information confidential?
 - Can you update my records with my gender, pronouns and preferred name?
 - Who can I talk to if I am not satisfied with my care?
 - I'm thinking of getting a second opinion. Can you recommend anyone?
-

Side effects

- What are the risks and possible side effects of each treatment? How can these be managed?
 - How will the treatment affect how I look and how my body works?
 - Will the treatment affect my sex life? Can I get support from someone who understands LGBTIQ+ sex issues?
 - Will the cancer and treatment affect my fertility? What tests can I have to check my fertility?
-

Support

- How can I connect with other LGBTIQ+ people affected by cancer?
 - What financial and practical assistance is available?
 - Where can I get help with advance care planning?
-

Family and friends

- Will you include my spouse, partner/s and family, chosen and biological, in my care?
 - Where can my spouse, partner/s, children and friends get help and advice?
-

After treatment

- Who will I see for follow-up appointments?
 - How often will I need check-ups after treatment?
-

Glossary

advanced cancer

Cancer that is unlikely to be cured. In most cases, the cancer has spread to other parts of the body (secondary or metastatic cancer).

androgen

A type of hormone that produces physical characteristics such as facial hair or a deep voice. The main androgen, testosterone, is produced by the testicles.

asexual

A person who is not sexually attracted to other people.

bisexual

A person who is attracted to more than one gender.

breast reconstruction

Surgery to rebuild the breast shape after the removal of all or part of the breast.

cervix

The lower part of the uterus that connects the uterus to the vagina.

chemotherapy

A cancer treatment that uses drugs to kill cancer cells or slow their growth.

chosen family

People who become family by developing close relationships even though they may not be related biologically or legally.

chromosomes

Threadlike structures that contain sets of instructions known as genes. Most cells in the human body have 23 pairs of chromosomes.

cisgender

A term for a person whose gender matches the sex assigned at birth. Also known as cis.

climax (orgasm)

The peak of sexual response.

clitoris

The main sexual pleasure organ for ciswomen and people with a vulva.

coming out

Disclosing your sexual orientation or gender to other people.

deadnaming

Calling a transgender person by the name they used before they transitioned.

discrimination

When someone is treated less favourably in the context of employment, education, or the provision of goods, services and accommodation because of certain protected attributes, such as being LGBTQIA+.

dry orgasm

Sexual climax without the release of semen from the penis (ejaculation).

ejaculation

When semen passes through the urethra and out of the penis during orgasm.

endosex

People who are not intersex.

erectile dysfunction (impotence)

Inability to get and keep an erection firm enough for penetration.

female

A term sometimes used for people born with a uterus, cervix and/or ovaries. Not everyone with these body parts identifies as female.

fertility

The ability to conceive a child.

gay man

A man (cisgender or trans) who is attracted to other men.

gender

The sense of whether you are a man, woman, non-binary, agender, genderqueer, genderfluid, or a combination of one or more of these.

gender-affirming treatment

Care that supports a person to live in line with their gender. This may include taking gender-affirming hormones, having surgery, voice therapy, or social changes such as a new name or pronouns. Not everyone wants or needs all of these.

gender diverse

Describes a range of genders.

gender dysphoria

Distress that can occur when a person's gender identity does not match the sex they were assigned at birth or their body's physical characteristics.

genitals

The sex organs. Often used to mean the external sexual organs (e.g. penis, vulva).

gynaecological cancers

Cancers of the following reproductive organs: cervix, fallopian tubes, ovaries, uterus, vagina and vulva.

heterosexual

Attracted to people of the opposite gender. Also known as straight.

homosexual

Attracted to people of the same gender. See also gay man and lesbian.

hormone replacement therapy

Drug therapy that supplies the body with hormones that it is not able to produce naturally.

hormones

Chemicals in the body that send information between cells. Some hormones control growth, and others control reproduction (e.g. oestrogen and testosterone).

hormone therapy

A treatment that blocks the body's natural hormones, which sometimes help cancer cells grow. Hormone therapy may also be called endocrine therapy or androgen deprivation therapy.

hysterectomy

The surgical removal of the uterus and cervix.

immunotherapy

Drugs that use the body's own immune system to fight cancer.

incontinence

The accidental or involuntary loss of urine (wee or pee) or faeces (poo).

infertility

The inability to conceive a child.

intersex

A term used to describe a person born with sex characteristics (physical, hormonal or chromosomal) that do not fit medical and social norms for female or male bodies.

lesbian

A woman (cisgender or trans) who is attracted to other women.

LGBTIQ+

A commonly used acronym referring to those who identify as lesbian, gay, bisexual, transgender, queer or questioning, asexual or other sexualities (such as pansexual), as well as intersex. Other initialisms may also be used, such as LGBTIQ+, or LGBTQ+.

libido

Sex drive/sexual desire.

lymph nodes

Small, bean-shaped structures found in groups throughout the body. Lymph nodes help protect the body against disease and infection. They may also be called lymph glands.

lymphoedema

Swelling caused by a build-up of lymph fluid when lymph vessels or nodes have been damaged or removed and can't drain properly.

male

A term usually used for people born with a penis and/or testicles. Not everyone with these body parts identifies as male.

mammogram

A low-dose x-ray of the breast; used to screen for breast cancer.

mastectomy

Surgery to remove all breast tissue.

masturbation

Stimulation of your own or a partner's genitals, without sexual intercourse, for pleasure or orgasm.

menopause

When someone stops having periods (menstruating). This can happen naturally, after certain cancer treatments, or if the ovaries have been removed.

minority stress

Ongoing stress arising from the stigma, discrimination and hostility that minority groups such as LGBTIQ+ people face.

misgender

When a person is referred to by words or language that is incorrect for them.

non-binary

Identifying as a gender that is neither man nor woman. This is an umbrella term for any number of gender identities that sit within, outside or across the spectrum of woman or man. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender, etc.

oestrogen

A sex hormone made mainly by the ovaries.

It is also used in gender-affirming hormone therapy and hormone therapy for cancer.

oophorectomy

Surgery to remove an ovary. If both ovaries are removed, it's called a bilateral oophorectomy.

orchidectomy

Surgery to remove one or both testicles. Also called orchiectomy.

orgasm

Sexual climax.

osteoporosis

Thinning and weakening of the bones that can lead to bone pain and fractures.

ovary (plural: ovaries)

A reproductive organ that contains eggs (ova). It produces the hormones oestrogen and progesterone.

pansexual

A person who is attracted to people regardless of gender.

penetrative sex

Insertion of a body part or sex toy into the vagina, anus or mouth.

penis

The main external sex organ in cis men and people with a penis. Urine and semen pass out of the body through the penis.

premature/early menopause

Menopause that occurs before the age of 40.

premature ejaculation (PE)

The inability to delay ejaculation.

progesterone

A sex hormone made mostly by the ovaries. It prepares the uterus lining for pregnancy.

prostate

A gland that is part of the reproductive system for people born with a penis. It produces fluid that makes up part of semen.

prostatectomy

Surgery to remove all or part of the gland known as the prostate.

prosthesis

Artificial replacement for a removed or damaged body part.

queer

A range of non-normative genders and sexualities. Once used as a slur, queer now encapsulates political ideas of resistance to heteronormativity, homonormativity and cisnormativity and is sometimes used as an umbrella term to describe the full range of LGBTIQA+ identities or to describe people with diverse gender or sexual orientation.

radiation therapy

The use of targeted radiation to kill or damage cancer cells so they cannot grow, multiply or spread. Also called radiotherapy.

reproductive system

The organs needed for producing a baby. May include the ovaries, fallopian tubes, uterus, cervix and vagina, and the testicles, prostate and penis.

semen

The fluid ejaculated from the penis during sexual climax. It contains sperm from the testicles and fluid from the prostate and seminal vesicles.

seminal vesicles

Two small glands that lie near the prostate and produce part of the semen.

sex

Penetrative intercourse and other activities such as oral sex, and self-stimulation or masturbation.

sex characteristics

A person's physical characteristics, including sexual anatomy, reproductive organs, hormonal patterns and chromosomal patterns. Some people are born with variations of sex characteristics (intersex variations).

sex hormones

The hormones that control sexual development, arousal and reproduction. The main ones are oestrogen, progesterone and testosterone.

sexual orientation

How a person thinks about their sexual identity, how they behave and the people they are attracted to. See also asexual, bisexual, heterosexual, homosexual, pansexual. Under Commonwealth discrimination legislation, the term “sexual orientation” refers to sex only; in some state and territory laws, it also refers to gender.

side effect

Unintended effect of a drug or treatment.

sperm

The sex cell made in the testicles.

stoma

A surgically created opening to the outside of the body.

targeted therapy

Drugs that target specific features of cancer cells to stop the cancer growing and spreading.

testicles (also called testes)

Two oval-shaped glands that produce sperm and the male sex hormone testosterone. They are found in the scrotum.

testosterone

A sex hormone produced by the testicles. It is also used in some gender-affirming hormone therapy.

top surgery

Removal of breast or chest tissue. A type of gender-affirming surgery.

transgender (trans)

A term for a person whose gender is different from the sex they were assigned at birth.

urethra

The tube that carries urine from the bladder,

as well as semen from the testicles, to the outside of the body.

uterus

A hollow organ in which a fertilised egg (ovum) grows and a fetus is nourished until birth. Also called the womb.

vagina

A muscular canal that extends from the entrance of the uterus to the vulva.

vaginal dilator

A plastic or silicone device that is inserted into the vagina to gently stretch the vaginal walls.

vaginal stenosis

Narrowing of the vagina.

vulva

The external sexual organs (genitals) in ciswomen and people with vaginas. It includes the mons pubis, labia majora and minora, and clitoris.

Can't find a word here?

For more cancer-related words, visit connect.cancer.org.au/glossary.

References

The first edition of this booklet (2023) was called *LGBTQI+ People and Cancer*. It was developed by Cancer Council NSW as part of the Western Sydney University research project *Out with Cancer: LGBTQI+ experiences of cancer survivorship and care*. The research project was funded by the Australian Research Council, and partner organisations including Cancer Council NSW, Breast Cancer Network Australia, Prostate Cancer Foundation of Australia, Canteen, ACON, LGBTQI+ Health Australia and Sydney Children's Hospital Network. This booklet contains quotes from cancer survivors who took part in the study. For more information, visit westernsydney.edu.au/thri/research/culture-society/out-with-cancer.

Other references include:

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How you can help

At Cancer Council, we're dedicated to improving cancer control. As well as funding millions of dollars in cancer research every year, we advocate for the highest quality care for cancer patients and their families. We create cancer-smart communities by educating people about cancer, its prevention and early detection. We offer a range of practical and support services for people and families affected by cancer. All these programs would not be possible without community support, great and small.

Join a Cancer Council event: Join one of our community fundraising events such as Daffodil Day, Australia's Biggest Morning Tea, Relay For Life, Girls' Night In and other Pink events, or hold your own fundraiser or become a volunteer.

Make a donation: Any gift, large or small, makes a meaningful contribution to our work in supporting people with cancer and their families now and in the future.

Buy Cancer Council sun protection products: Every purchase helps you prevent cancer and contribute financially to our goals.

Help us speak out for a cancer-smart community: We are a leading advocate for cancer prevention and improved patient services. You can help us speak out on important cancer issues and help us improve cancer awareness by living and promoting a cancer-smart lifestyle.

Join a research study: Cancer Council funds and carries out research investigating the causes, management, outcomes and impacts of different cancers. You may be able to join a study.

To find out more about how you, your family and friends can help, please call your local Cancer Council.

The right support.



Cancer is never one story.
Every diagnosis, every person,
and every path is different. You
don't have to figure it out alone.

Cancer Connect can help you find
the information and support that
are right for you.

You can explore trusted information
on our Cancer Connect website at your
own pace, or call 13 11 20 to talk to our
qualified professionals. We will listen to
your concerns, answer your questions,
and connect you with support.

Wherever you are on your path,
Cancer Connect can help make the
next step feel clearer.

Right when you need it.



Call 13 11 20



Visit cancerconnect.org.au



If you need information in a language other than English,
an interpreting service is available. Call 131 450.



If you are deaf, or have a hearing or speech impairment,
you can contact us through the National Relay Service.
accesshub.gov.au

*Cancer Council services and programs vary in each area.
13 11 20 is charged at a local call rate throughout Australia (except from mobiles).*



For information & support,
call **Cancer Connect 13 11 20**
or visit **cancerconnect.org.au**

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cancercouncil.com.au

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cancer.org.au/nt

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