Australian Government
Department of Defence

UNDERSTANDING TRANSITIONING GENDER IN THE WORKPLACE

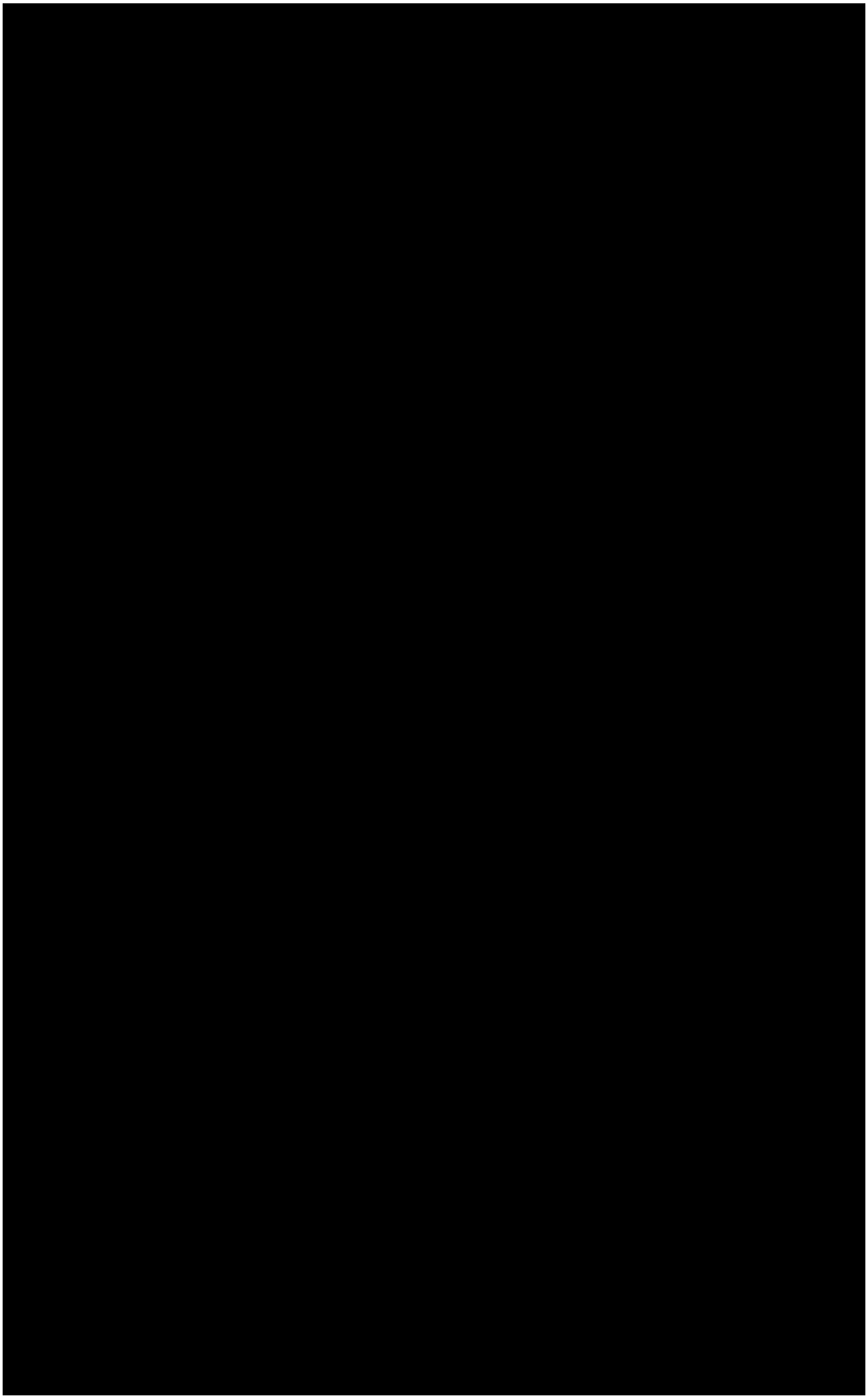
Contents

UNDERSTANDING TRANSITIONING GENDER IN THE WORKPLACE

EDITION 1
AMENDMENT LIST

1. The following list details all amendments made to this publication.
2. All printed copies should be replaced in entirety with the latest version available from the Fairness and Resolution Branch website.

Amendment No.	**Date**	**Remarks**	**Approved by**
1.0	05 AUG 11	Original	DRR
1.01	08 AUG 11	Minor formatting changes	DRR
1.02	17 AUG 11	Amendment List added on page 2, minor grammatical changes and page numbers from 2 - 18 amended	DRR
1.03	09 NOV 11	Subject heading added to contents page Updated DFAT policy on passport applications	DRR



[redacted]

What accommodation and/or ablutions should be used?

Once social realignment commences, the dress and bearing of the transitioning person will need to be aligned with their affirmed gender. At this point, the transitioning person must be permitted to use the ablution facilities appropriate to their affirmed gender if they so choose. A transitioning person may choose to use separate facilities such as an accessible toilet for disabled people. However, it will be discriminatory to insist that the transitioning person permanently use facilities for the disabled or facilities of their assigned gender.

Should the situation arise where open communal same sex showers are the only showers available (i.e. field exercises/deployments), the transitioning person and their commander or manager should discuss and agree upon an appropriate arrangement to ensure the needs of all people are met. This situation would only apply prior to the transitioning person undergoing gender realignment surgery.

People working within the same work environment as the transitioning person should be given the opportunity to discuss any concerns they may have with their commander or manager.

[redacted]

ANNEX A

ADMINISTRATION OF TRANSITIONING ADF MEMBERS

Note that the needs of every transitioning member will differ, and not every member will pass through all the phases of transition. This diagram is intended as a guide only; every member should be managed on a case-by-case basis.

Medical Diagnosis

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Medical certificate presented to Commander/Manager

↓

Discussion between Commander and Service member including but not limited to:

Leave Arrangements	Would the member like to take leave prior to commencing the social realignment phase (e.g. to allow time to acquire a more gender appropriate appearance)?
Posting Action	Does the member wish to relocate to another unit and/or locality? If so, Commander/Manager to assist and discuss with Career Management Agency.
Uniforms	Commander/Manager to assist so that procurement of uniforms runs smoothly and without embarrassment to either the transitioning member or the Clothing Store staff.
Change of Name	Most transitioning members will want to be known by a more gender appropriate name. They may initially choose to be known as their chosen gender appropriate name. Note that until legal change of name paperwork is submitted, Defence records cannot be amended. Consider issuing a letter of authority to explain the difference between ID photo and member's appearance and name.
Housing	The member may need the assistance of their Commander/Manager with regards to Service residence, Rental Assistance or appropriate living-in accommodation.
Mentor & Case Manager	Does the member want assistance in finding a Case Manager or Mentor to assist them throughout their transition?
Ablutions	Discuss with the member which toilet and shower facilities they would prefer to use.
Family Assistance	Has the member arranged to speak with the Defence Community Organisation for assistance for themselves and their family?
Informing the workplace	When, how and where this should occur needs to be agreed between the member and their Commander/Manager.

↓

Workplace colleagues are informed and member commences transition in the workplace

↓

Ongoing liaison between Medical Officer and Commander/ Manager may be necessary

↓

Member subject to regular MEC Review

↓

Subject to medical fitness, member may be required to complete fitness tests of affirmed gender

Ablutions appropriate to affirmed gender may be used.

Member purchases and wears uniform of affirmed gender

Member to be referred to as chosen name with correct pronouns used (e.g. him/her, she/he)

Member submits legal change of name documentation

↓

Defence records amended to reflect name change (inc. ID card, personal files, health records etc.)

Administratively, recognition of affirmed gender within Defence should occur once the transitioning member has presented a medical certificate to their Commander/Manager stating the member's commencement of gender transition. A member's gender can only be changed in PMKeyS once the member presents a birth certificate which reflects the change of gender.

ANNEX C

ANNEX D

MYTHS AND MISCONCEPTIONS

Wanting to transition gender is caused by boys being dressed like girls in childhood or girls being dressed as boys in childhood.

FALSE While it is true that many transitioning people report having their first gender identity issue arise when they were young children, they were no more dressed like girls in childhood than any other males in society and vice versa for females. There is no evidence to suggest that this is a causative factor.

Transitioning people are gay.

FALSE A transitioning person, just like anyone else may be heterosexual, homosexual or bisexual.

Transitioning is about sex.

FALSE Gender Identity Disorder is a widely acknowledged medical condition about gender. While sex is most easily understood as whether a person has male or female genitalia, gender is a cultural expression of sex identity (often but not always based on stereotypes of masculinity and femininity). Gender can be understood as a person looking, dressing or acting as male or female.

Transitioning people choose to live like that.

FALSE Whilst there are choices involved in dealing with transitioning, often these are made simply in order to survive. Transitioning people might choose how to live with the condition but have as much choice in having the condition as other people have in what colour their eyes are or what blood group they are born with.

Gender identity disorder only affects men and is fairly rare.

FALSE Approximately one in 11,000 males and one in 30,000 females have the condition. Note that the prevalence of the condition is often understated as most statistics only look at those people who have completed surgery.

ANNEX E

REFERENCES AND RESOURCES

References

The following policy documents may provide further detail and guidance on issues relating to transitioning gender in the workplace:

Defence Instruction (General) Administrative 08-1 – *Public Comment and Dissemination of Information by Defence Members*
Defence Instruction (General) Administrative 32-2 – *Issue of Official Passports and Visas to Defence Personnel*
Defence Instruction (General) Personnel 16-1 – *The Provision of Health Care to Defence Members*
Defence Instruction (General) Personnel 16-15 – *Australian Defence Force Medical Employment Classification System*
Defence Instruction (General) Personnel 31-8 – *Forfeiture, Restoration and replacement of decorations medals and war badges*
Defence Instruction (General) Personnel 35-3 – *Management and Reporting of Unacceptable Behaviour*
Defence Instruction (General) Personnel 36-2 – *Australian Defence Force Policy on Individual Readiness*
Defence Instruction (General) Personnel 50-1 – *Equity and Diversity in the Australian Defence Force*
Defence Instruction (General) Personnel 53-1 – *Recognition of interdependent partnerships*
Departmental Personnel Instruction 1/2001 – *Equity and Diversity in the Department of Defence*
The Defence Enterprise Collective Agreement 2009
The Decision Maker's Handbook: *Making personnel related decisions for ADF members and APS employees*
Defence Workplace Relations Manual

Additional Resources

Pride in Diversity www.prideindiversity.com.au
The Gender Centre www.gendercentre.org.au
Human Rights Campaign www.hrc.org/documents/HRC-Workplace-Gender-Transition-Guidelines.pdf
Diversity Council Australia www.dca.org.au
Gender identity www.med.monash.edu.au/gendermed/identity
Gender Education and Advocacy www.gender.org
The National LGBTI Health Alliance www.lgbt.health.org.au
HRC Workplace Gender Transition Guidelines www.hrc.org/documents/HRC
HRC Transgender Visibility www.hrc.org/documents/transgender_visibility_guide
Passports www.passports.gov.au/web/sexgenderapplicants

OFFICE OF DEPUTY CHIEF OF NAVY
CORRESPONDENCE DISTRIBUTION SHEET

DCN/IN/2015/ 1145

Please Reference DCN Number in any Response

SUBJECT: 1145 - 151029 - RAN Noting Brief - Item 197 - Gender Transition and the Implications for Shared Living and Accommodation

RESPONSE REQUIRED *IN* DCN OFFICE NLT:

				ORIGINATOR ID		
A - ACTION	I - FOR INFO		C - COMMENT	D - DRAFT REPLY	E - FOR SIGNATURE	F - FILE
OFFICER	CODE	INITIAL	REMARKS			
PSO DCN		30/10.				
DCN	EK	30/10				
Reg	A.		Dist to DGNP.			

DOCUMENT TRACKING NUMBER: DCN/IN/2015/ 1145

NAVY USN-RAN STRATEGIC WORKFORCE AND PERSONNEL STEERING GROUP (SWPSG)

RAN NOTING BRIEF – ITEM 197 – GENDER TRANSITION AND THE IMPLICATIONS FOR SHARED LIVING AND ACCOMMODATION

Purpose

- This noting brief provides a formal response to the USN request for information on Navy/ADF policy on personnel undergoing gender transition and the implications on shared living and accommodation arrangement, notably on ships and shared barracks accommodation.

Background/Information

- Following RADM van Balen, RAN discussion with RDML Burke, USN, at the most recent SWSPG talks, a request for information (RFI) was received on transgender accommodation and messing.

- There is currently no single overarching policy which covers transitioning gender and accommodation in the Navy or the Australian Defence Force (ADF). However, guidance is provided in the Defence publication: *Understanding Transitioning Gender in the Workplace Guide (2011)* and the *Air Force Diversity Handbook – Transitioning Gender in Air Force (2013).*

- [redacted]

Issues/Challenges

- There are no significant issues or challenges related to accommodation and messing in the RAN for personnel undergoing gender transition. Personnel will not be posted to ships whilst transitioning and therefore messing issues are not a problem at sea.

- Ashore, most living areas have unisex bathrooms. There are very few female only or male only accommodation blocks. For those living in modern complexes, apartments are shared with the general rule being that Navy would not mix genders in the same apartment. Where rooms have an ensuite, the main bathroom remains an option for use. Locks are installed on all bedrooms. Where there is any concern, cases are managed individually.

- Once social realignment commences, the dress and bearing of the transitioning person will need to be aligned with their affirmed gender. At this point, the transitioning person must be permitted to use the ablution facilities appropriate to their affirmed gender if they so choose. A transitioning person may choose to use separate facilities such as an accessible toilet for disabled people. However, it will be discriminatory to insist that the transitioning person permanently use facilities for the disabled or facilities of their assigned gender.

- Should the situation arise where open communal same sex showers are the only showers available (i.e. field exercises or deployments), the transitioning person and their commander or manager should discuss and agree upon an appropriate arrangement to ensure the needs of all personnel are met. This situation would only apply *prior* to the transitioning person undergoing gender realignment surgery. People working within the same work environment as the transitioning person should be given the opportunity to discuss any concerns they may have with their commander or manager.

- The existing accommodation policy for broader Defence is currently owned by Defence Estate and Infrastructure and does not specifically discuss transgender issues or other diversity related issues. It is incumbent upon the Services to manage any issues on a case by case basis.

- [redacted]

- [redacted]
    - Social realignment is arguably the aspect into which the workplace has the most input. A calm and sensible approach to ablutions and accommodations needs to be taken. Negotiating with the member as to what accommodations and what ablution facilities they are comfortable using (particularly early in transition) will go a long way to avoiding any negative impacts. Most people in the early stages of transition are trying to be accepted and will not be seeking to alienate or offend their affirmed gender co-workers.

Actions Taken

- Due to the urgent nature of the RFI the following documents and references were immediately forwarded (via email) for dissemination to USN colleagues:
    - The Defence Guide to Understanding Transitioning Gender in the Workplace (2011);
    - Defence People Group Intranet content pertaining to Transitioning Gender;
    - Air Force Diversity Handbook – Transitioning Gender in Air Force (2015);
    - Australian Government Guidelines on the Recognition of Sex and Gender (2013);
    - Two points of contact (one academic and one US military) for extant research on issues of transgender service in the US military;
    - Research papers pertaining to the Australian and Canadian experience;
    - Useful references and links to supporting information.
- This topic has also been added a new item in the RFI section on the SWPSG Action Tracker to ensure progress and discussion is tracked going forward.

POC

- This topic has also been added a new item in the RFI section on the SWPSG Action Tracker to ensure progress and discussion is tracked going forward.

POC

DCNs point of contact is **LCDR Jennifer Macklin RAN**, Director, Diversity and Inclusion.

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Attachments

A. References and Resources
B. Department of Defence, Surgeon General, Health Directive No. 234, *Medical Management of Gender Dysphoria and Gender Realignment in Defence (2015)*

[redacted]
MH Miller
CDRE, RAN
DGNP

29 Oct 15

Contact Officer: LCDR Jennifer Macklin	Phone: +61 2 6144 7237

Release to the USN:

AUTHORISED / NOT AUTHORISED

[redacted]
MJ van Balen
RADM, RAN
DCN

30 Oct 15

Attachment A

REFERENCES AND RESOURCES

Guidance

- *Understanding Transitioning Gender in the Workplace*, Australian Department of Defence (2011)
- *Transitioning Gender in Air Force*. Air Force Diversity Handbook (2013).

Academic Paper

- *The 3R Model for Transition*, by MAJ Donna Harding - DEFGLIS: Defence Gay and Lesbian Information Service. (Attachment C).

Policy References

The following policy documents provide further detail and guidance on issues *relating* to transitioning gender in the workplace:

- Health Directive No. 234, *Medical Management of Gender Dysphoria and gender realignment in Defence Members (2015) – Surgeon General.*
- Defence Instruction (General) Administrative 08-1 – *Public Comment and Dissemination of Information by Defence Members*
- Defence Instruction (General) Administrative 32-2 – *Issue of Official Passports and Visas to Defence Personnel*
- Defence Instruction (General) Personnel 16-1 – *The Provision of Health Care to Defence Members*
- Defence Instruction (General) Personnel 16-15 – *Australian Defence Force Medical Employment Classification System*
- Defence Instruction (General) Personnel 31-8 – *Forfeiture, Restoration and replacement of decorations medals and war badges*
- Defence Instruction (General) Personnel 35-3 – *Management and Reporting of Unacceptable Behaviour*
- Defence Instruction (General) Personnel 36-2 – *Australian Defence Force Policy on Individual Readiness*
- Defence Instruction (General) Personnel 53-1 – *Recognition of Interdependent partnerships.*

Additional Resources and Links

- Pride in Diversity www.prideindiversity.com.au
- The Gender Centre www.gendercentre.org.au
- Human Rights Campaign: www.hrc.org/documents/HRC-Workplace-Gender-transition-Guidelines.pdf
- Diversity Council Australia www.dca.org.au
- Gender Identity www.med.monash.edu.au/gendermed/identity
- Gender Education and Advocacy www.gender.org
- The National LGBTI Health Alliance www.lgbt.health.org.au
- *HRC Workplace Gender Transition Guidelines* www.hrc.org/documents/HRC

Australian Government
Department of Defence

SURGEON GENERAL AUSTRALIAN DEFENCE FORCE

HEALTH DIRECTIVE NO 234

Note: Surgeon General Australian Defence Force Health Directives are produced to disseminate health policy and guidance. Health Directives are of a permanent nature and remain in force until cancelled. They are reviewed every three years and repromulgated only where a significant change of content is necessary. Publications can be accessed on the Defence Intranet (http://intranet.defence.gov.au/home/documents/adfdocs/healthindex.htm)

13 APRIL 2015

MEDICAL MANAGEMENT OF GENDER DYSPHORIA AND GENDER REALIGNMENT IN DEFENCE MEMBERS

References:

A. Diagnostic and Statistical Manual of Mental Disorders (DSM) 5, 2013
B. World Professional Association for Transgender Health Standards of Care Version 7, 2013 (http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351)
C. Australian and New Zealand Professional Association for Transgender Health (http://www.anzpath.org/)
D. Defence Centre of Diversity Expertise (http://intranet.defence.gov.au/People/sites/diversity/comweb.asp?page=121000&Title=Sexual Orientation)
E. Health Insurance Commission Act 1973 (http://www.comlaw.gov.au/Details/C2014C00286)
F. Defence Instruction (General) Personnel 16–1 – *Health Care for Australian Defence Force personnel* (http://intranet.defence.gov.au/home/documents/DATA/ADFPUBS/DIG/GP16_01.PDF)
G. Medicare Benefits Schedule (www.mbsonline.gov.au)
H. Pharmaceutical Benefits Schedule (http://www.pbs.gov.au/pbs/home)
I. Health Bulletin 06/2012 – *Travel Arrangements for Australian Defence Force Members Attending Health Appointments or for the Purpose of Active Health Treatment* (http://intranet.defence.gov.au/home/documents/DATA/ADFPUBS/DHB/HB06_12.PDF)
J. Health Manual, Volume 2, Provision of Health Care – General Principles (http://defweb.cbr.defence.gov.au/home/documents/data/ADFPUBS/HLTHMAN/VOLUME2/HLTHMAN_VOL2.PDF)
K. Military Personnel Policy Manual (MILPERSMAN), Part 3, Chapter 2 – 'Australian Defence Force Medical Employment Classification System' (http://intranet.defence.gov.au/home/documents/data/DEFPUBS/DEPTMAN/MILPERSMAN/MILPERSMAN.pdf)

L. Health Manual Volume 3 Retention Standards (http://defweb.cbr.defence.gov.au/home/documents/adfdocs/hlthman/hlthmanv3.htm)

INTRODUCTION

1. Gender dysphoria is defined as 'discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth' (reference A). Prevalence is estimated to be 1:12000 for male to female (MtF) and 1:30000 for female to male (FtM), but this is likely to be an underestimate.

2. The management of gender dysphoria and gender realignment is complex, and requires an understanding of the underlying conditions and treatment options. The way this condition manifests is variable and treatment options need to be tailored to the individual. The International Standards of Care, at reference B, are the primary clinical guidance and are designed to meet the diverse health care needs of transsexual, transgender and gender nonconforming people. Australian guidance as well as a list of professionals specialising in this field are at reference C.

3. Terminology is culturally dependent and rapidly evolving. It is important to be respectful and seek the correct use of terminology among different groups. A list of accepted terms and definitions are in annex A.

AIM

4. The aim of this policy is to provide information regarding the diagnosis and clinical management of gender dysphoria and gender realignment in Defence members, including deployability and what management will be funded at public expense.

5. Management of gender dysphoria and gender realignment in childhood and adolescence will not be addressed in this Health Directive. Intersex disorders (disorders of sex development) are also not addressed. Reference D covers aspects related to administrative and command management of gender dysphoria and gender realignment.

POLICY

Gender dysphoria

6. Gender dysphoria is defined, at references A and B, as distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. Transsexual, transgender and gender nonconforming individuals or those diagnosed with gender dysphoria are not inherently disordered. Often gender dysphoria is aggravated by minority stress, cultural discrimination and a lack of understanding of the true nature of the condition. It is not inherent to being transsexual, transgender or gender-nonconforming but is rather socially induced.

7. Treatment of gender dysphoria is aimed at finding a gender role and expression that is comfortable for the individual, even if these differ from those associated with sex assigned at birth or from prevailing gender norms and expectations. This may not resemble the binary male/female options currently broadly accepted in the Australian community. It may in fact include a spectrum of gender expression. The aim is not to align with a binary male/female choice, but to find a gender role and expression that is comfortable and reduces the dysphoria – often referred to as the affirmed gender role.

Therapeutic approaches for gender dysphoria and gender realignment

8. Treatment can vary depending on the needs of the individual. Some key considerations are in annex B. Health care should be provided by professionals experienced in the management of gender dysphoria and transition. A list of experienced and qualified professionals is contained within reference C. Treatment options can include none, one or a combination of the following:

a. Changes in gender expression and role

b. Hormone therapy to feminise or masculinise the body

c. Surgery to change primary and/or secondary sex characteristics and/or

d. Psychotherapy for purposes such as exploring gender identity, role and expression; addressing the negative impact of gender dysphoria and the stigma on mental health; enhancing peer and social support, or promoting resilience

9. In addition to these treatment options, peer and social support groups and community (including workplace) education should be considered to, minimise the social stigma, increase knowledge and education with up to date and current information, and increase support for individuals with gender dysphoria. In the Defence environment, further details can be found at reference D.

Mental health considerations

10. All mental health professionals conducting assessments prior to commencement of any feminising/masculinising medical interventions should meet the qualifications and experience criteria at reference B to be considered ‘qualified mental health professionals’ in this field, and be listed as experts at reference C. In Australia, generally, this would refer to psychiatric assessment(s). There may not be an appropriate mental health professional in the location of the individual seeking treatment, and travel to an appropriate professional may be required. This assessment is a requirement before commencement of any medical or surgical interventions.

11. Mental health professionals providing care should have familiarity and competence in treating gender dysphoria and gender-nonconformity, and exhibit sensitivity in providing care. Details around appropriate experience and qualifications are described at reference B. Components of this mental health care may be delivered by Defence mental health professionals and specialists, with liaison and support from the experts at reference C.

12. Mental health support may consist of:

a. Psychotherapeutic assistance to explore gender identity and expression, or facilitation of a coming out process

b. Assessment and referral for feminising/masculinising medical interventions – this is a requirement before commencement of hormones or surgical treatments

c. Psychotherapy for coexisting mental health conditions, or other unrelated reasons

13. Family members and community (including the workplace) may also require psychological support. To find out more support options, Defence members are encouraged to engage with the Defence Centre of Diversity Expertise.

14. Members presenting with gender dysphoria may have a range of related or unrelated mental health conditions. Possible concerns include anxiety, depression, self harm, a history of abuse and neglect, substance abuse, sexual concerns or others. The normal clinical treatment of these coexisting conditions should be included in the treatment plan.

Hormone therapy

15. Feminising/masculinising hormone therapy where clinically indicated to treat gender dysphoria will induce physical changes that are more congruent with a patient's gender identity. Initiation of hormone therapy may be undertaken by an appropriately qualified and experienced health professional in the context of comprehensive primary care. A coordinated approach to psychosocial issues is recommended after a psychosocial assessment (by an appropriately qualified mental health specialist) has been conducted and informed consent has been obtained.

16. The criteria required to be met prior to commencement of hormone therapy are contained in reference B and a summary of key therapeutic considerations are in annex B.

17. For Female to Male (FtM) members, most of the physical changes associated with hormone administration occur and stabilise within six months, with the expected maximum effect by two years of treatment. Three monthly testosterone injections generally result in more stable hormone levels over time and are easier to manage in the deployed environment than fortnightly injections. In situations where administration of regular testosterone is delayed for short periods (usually for operational reasons), reversion to female secondary sexual characteristics is generally slow and aside from facial hair, not likely to be obvious or significant. The main symptom experienced in these situations is per vaginam break through bleeding.

18. For Male to Female (MtF) members, most treatment regimes involve daily oral oestrogen. Those who have not undergone orchidectomy may also need anti-androgen medications when oestrogens alone are not fully effective in suppressing the effects of endogenous testosterone. This is usually daily oral spironolactone or cyproterone and would usually be commenced within the first year of treatment. If hormone treatment is interrupted for brief periods, changes consistent with masculinisation from endogenous testosterone are less problematic than for FtM transition.

Surgical Options

19. Surgery may be required to alleviate gender dysphoria, but is not always necessary for gender realignment. Breast reduction or augmentation is more commonly performed, however genital surgery is less common. The criteria required to be met prior to proceeding with surgery are contained in reference B and a summary of key therapeutic considerations are in annex B.

Prognosis

20. Evidence suggests that treatment of gender dysphoria, whatever form that takes, can result in resolution of the gender dysphoria symptoms without the need for ongoing psychological therapy. For those who undergo medical or surgical reassignment, the incidence of regret is approximately 1%, but of this group most do not have persisting psychiatric symptoms that affect their functioning in an occupational setting.

21. Where there are coexisting mental health conditions the prognosis is no different than the usual prognosis for the condition.

Entitlements

22. Equity with Medicare under the provisions of reference E, and described in reference F, is the guiding principle for considering health care entitlements at public expense for Defence members. In the management of gender dysphoria, these general principles also apply. This is detailed in the Medical Benefit Schedules (MBS) (reference G) and Pharmaceutical Benefits Schedule (reference H). This would generally mean the following health care requirements (including any travel to attend appointments in accordance with reference I) with appropriately qualified or experienced professionals are provided at public expense:

a. Psychological and psychiatric care or assessments as clinically appropriate to assess or manage gender dysphoria or coexisting conditions

b. Clinical assessment (including specialist involvement with endocrinologists or primary care providers who specialise in gender dysphoria and reassignment), baseline pathology testing and regular monitoring for the management of gender realignment

c. Hormone treatment requirements

d. Surgical procedures that meet MBS clinical indication requirements

e. Any routine clinical care unrelated to gender dysphoria or its management, as for all other members.

23. Procedures that will not be provided at public expense, but for which members should be afforded paid medical absence leave as appropriate include:

a. Any gender realignment surgery (including chest, breast, genital and other) including surgical consultations that do not meet MBS clinical indication requirements. This includes any surgery for cosmetic reasons

b. Hair electrolysis or removal procedures.

24. Surgical procedures that are conducted overseas will not be supported or approved. Under the provisions of reference F any treatment of complications on return to Australia, or ongoing need for ongoing psychological support or treatment that would normally be covered under reference G or reference H would be covered at public expense.

25. Support to non-service family members or other civilians will not be provided by or funded by Joint Health Command.

26. Any other procedures that are not clearly addressed above should be assessed on a case by case basis through Garrison Health Operations in accordance with reference J.

MEDICAL EMPLOYMENT CLASSIFICATION IMPLICATIONS

27. In accordance with reference K and reference L, all members who require treatment for gender dysphoria or realignment should have their Medical Employment Classification (MEC) considered.

28. Some people with gender dysphoria may not require treatment or have any associated coexisting mental health conditions, and therefore may not require a MEC review.

29. For both MtF and FtM gender reassignment involving hormone treatment, from the time of commencement of hormone treatment, stability in hormone regimes usually requires access to appropriate health care for at least six - 12 months. Members are not generally deployable during this time.

30. Treatment with anti-androgens, daily spironolactone or cyproterone is generally not compatible with the deployed or field environment due to the method of action and side effect profile.

31. Anyone undergoing gender realignment either through psychological counselling, hormone treatment, surgical treatment or a combination of each is likely to be non-deployable for a period of time to permit access to appropriate care and monitoring, stabilisation or hormone treatment and post operative recovery time. For those undergoing psychological counselling or management the duration of non-deployability will be different in each case.

32. For those undergoing commencement and stabilisation of hormonal treatment, MEC 3 is likely to be the appropriate MEC for up to 12 months. Some may anticipate a longer period of stabilisation and J32 may be appropriate for this group. In circumstances where J32 is more appropriate, Central Medical Employment Classification Review (CMECR) should be initiated in accordance with reference K and reference L.

33. For those undergoing surgical treatment, a post operative period of six months for wound recovery and confirmation of the absence of complications is likely to be needed. For those undergoing genital surgery, up to six - twelve months may be required to stabilise hormone treatment and monitoring may be required. This would generally mean a non-deployable MEC of at least six to nine months.

34. For those who are likely to be non-deployable for more than twelve months, a CMECR should be initiated in accordance with reference K and reference L.

35. This would include but may not be limited to:

a. anyone with anticipated extended non-deployable periods for ongoing gender dysphoria management

b. where management is not yet stable after twelve months

c. where anti-androgens in addition to oestrogen are required to suppress testosterone effects

d. where the treatment is anticipated to require more than twelve months of active changes in management or

e. where coexisting conditions are likely to affect deployability in the long-term and of themselves warrant CMECR action.

36. For Defence members who have undergone a gender realignment and where clinical management has stabilised (including not less than six monthly monitoring, no significant post-operative complications, no significant coexisting conditions), a deployable MEC consistent with definitions at reference K is likely to be appropriate.

37. Those Defence members who undergo gender realignment will need to seek command approval to amend their identification documents to their affirmed gender. Civilian specialists are the legal authority for notification of gender changes and will provide notification, as per normal civilian practice. Garrison medical staff will need to ensure the following documentation is provided to command confirming gender change:

a. a completed Form PM532 *Medical Employment Classification (MEC) Advice* confirming appropriate MEC (even if it does not change) on receipt of specialist notification of change of gender, ensuring the date of Form PM532 is after the date of specialist notification letter and

b. a copy of the civilian specialist notification of change of gender.

SUMMARY

38. The management of gender dysphoria and gender realignment is complex, and requires management to be tailored to the individual. Entitlements for treatment at public expense align with entitlements for all other Defence members and include treatments that are available to Australian citizens at public expense. All Defence members who require treatment for gender dysphoria or realignment should have their MEC considered for appropriateness, particularly whilst undergoing active changes to their treatment requirements.

[redacted]

RM Walker
Rear Admiral, RAN
Surgeon General Australian Defence Force

Annexes:
A. Common terminology and definitions
B. Clinical treatment considerations

SPONSOR: DMM

EARLIER HEALTH BULLETIN/DIRECTIVE CANCELLED: Nil

REVIEW THREE YEARS FROM DATE OF PUBLICATION OR REVIEW

ANNEX A

COMMON TERMINOLOGY AND DEFINITIONS

Disorders of sex development. Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Also described as intersex.

Female-to-male (FtM). Describes individual's assigned female at birth who are changing or who have changed to a more masculine body or gender role.

Gender dysphoria. Distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth.

Gender identity. A person's intrinsic sense of being male, female, or an alternative gender.

Gender identity disorder. Previous term used in Diagnostic and Statistical Manual of Mental Disorders IV-TR for gender dysphoria.

Gender non-conforming. Describes individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Male-to-female (MtF). describes individual's assigned male at birth who are changing or who have changed to a more feminine body or gender role.

Minority stress. Chronically high levels of stress faced by members of stigmatised minority groups. The most well understood causes are interpersonal prejudice and discrimination.

Sex. Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. For most people, gender identity and expression are consistent with sex assigned at birth. For transsexual, transgender, and gender-nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Transgender. Describes a diverse group of individuals who cross or transcend culturally defined categories of gender.

Transition. Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role.

Transsexual. Describes individuals who seek to change or who have changed their primary and/or secondary sex characteristics through medical (hormones and/or surgery) interventions, typically accompanied by a permanent change in gender role.

ANNEX B

CLINICAL TREATMENT CONSIDERATIONS

1. Treatment can vary enormously depending on the needs of the individual, and are discussed in detail in Diagnostic and Statistical Manual of Mental Disorders (DSM) 5, 2013. Health care should be provided by professionals experienced in management of gender dysphoria and transition. Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria. Treatment options can include none, one or a combination of the following:

a. Changes in gender expression and role

b. Hormone therapy to feminise or masculinise the body

c. Surgery to change primary and/or secondary sex characteristics and/or

d. Psychotherapy for purposes such as exploring gender identity, role and expression; addressing the negative impact of gender dysphoria and stigma on mental health; enhancing peer and social support, or promoting resilience.

2. The criteria for hormone therapy and a summary of considerations include:

a. Persistent, well documented gender dysphoria (requires generally around four lengthy psychiatric consultations over a one to two month period)

b. Capacity to provide informed consent (including age)

c. If significant medical or mental health concerns are present, they must be reasonably well controlled

3. Other treatments which individuals may consider include:

a. Voice and communication therapy to facilitate transition to their chosen gender

b. Hair removal through electrolysis, laser treatment or waxing

c. Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks and

d. Changes in name and gender marker on identity documents

4. For female-to-male (FtM) patients the following changes are expected:

a. Deepening voice (irreversible, and usually within the first few months of treatment)

b. Clitoral enlargement – variable

c. Growth in facial hair and body hair – towards a normal male hair distribution

d. Acne increase – particularly in the first few months of treatment

e. Cessation of menses (within first few months of treatment) – but some persistence of break through bleeding or spotting is not uncommon

f. Vaginal atrophy (and may require treatment prior to pap smears or to maintain intercourse with a male partner)

g. A shift in muscle to fat distribution and ratio towards a normal male distribution (usually over two years plus)

h. Breast size does not generally change and breast reduction surgery is usually undertaken at some point.

5. Most of these physical changes occur and stabilise within six months for FtM transitions, with the expected maximum effect by two years of treatment. Treatment commencement and stabilisation typically consists of fortnightly intramuscular (IM) testosterone, with baseline bloods, and then two monthly bloods until stabilised. Long-term treatment may consist of fortnightly IM testosterone, three monthly IM testosterone, daily testogel (transdermal). Newer administration methods such as underarm spray daily are likely to become commercially available. Three monthly testosterone generally results in more stable hormone levels over time. Once stabilised (usually within six months) bloods and monitoring are conducted six to twelve monthly.

6. Commencement of treatment will often result in rapid changes in appearances (softening of skin, deepening of voice, acne increase in the short-term, cessation of menses).

7. Testosterone is contraindicated in pregnancy, and patients at risk of becoming pregnant require highly effective birth control. Continuation of contraception (usually in the form of condoms or depo Provera) for those who continue to have intercourse with males is important, particularly where there are gaps in the regular testosterone maintenance schedule.

8. In situations where administration of regular testosterone is delayed (usually for operational reasons), reversion to female secondary sexual characteristics is generally slow and aside from facial hair, not likely to be obvious or significant. The main symptom in these situations is per vaginam bleeding. Generally the preferred treatment options in operational or field environments (simply for ease of administration) are three monthly testosterone or transdermal gel.

9. For male-to-female (MtF) patients the following changes are expected:

a. Breast growth (variable and occurs slowly, often supplemented by breast augmentation surgery)

b. Decreased erectile function

c. Decreased testicular size (significant involution within first year is usual)

d. Skin softening and reduced oiliness (usually within few months of treatment)

e. Thinning and slowed growth of body and facial hair (often slow, often managed with hair removal strategies)

f. Redistribution of body fat and alteration of muscle:fat ratio into a more typical female distribution

g. No change occurs in already present male pattern baldness (although loss stops within a few months of treatment commencing) or voice pitch.

10. Most treatment regimes involve daily oral oestrogen. Ethinyl oestradiol is not recommended due to the associated risk of deep vein thrombosis (DVT), and transdermal oestrogen not usually practical in the training or deployed environments. Approximately 50% who have not had bilateral orchidectomy also needing androgen-reducing medications ('anti-androgens'). This is usually either spironolactone or cyproterone administered as a daily oral dose. This is usually in situations where oestrogens alone are not fully effective in suppressing the effects of endogenous testosterone and would usually be commenced within the first year of treatment.

11. The use of progestins (with the exception of cyproterone) in feminising hormone therapy is controversial and not routinely used in Australia. Current evidence does not demonstrate that progestins enhance breast growth nor lower serum free testosterone, and the health risks associated with progestins (weight gain, mood disorders and lipid changes, increased cardiovascular risk and breast cancer risk) are potentially significant.

12. If treatment is interrupted, changes consistent with masculinisation from endogenous testosterone are less problematic and obvious than for FtM transition.

13. For both MtF and FtM gender reassignment involving hormone treatment, from the time of first presentation where gender dysphoria is persistent and clear, stability in hormone regimes are usually achieved within six to twelve months.

Reproductive health

14. Many transgender, transsexual and gender-nonconforming people will want to have children, and hormone therapy will limit fertility. Counselling and discussions prior to hormone treatment regarding options and fertility affects of hormone treatment should occur prior to commencement of hormones. MtF should discuss sperm preservation options, although there is some evidence that cessation of oestrogen for a period of time may allow the testes to recover. For FtM patients, egg or embryo freezing should be discussed although again cessation of testosterone briefly may allow for the ovaries to recover and release eggs.

Preventive care

15. Clinical evidence for long term screening risks is not clear at this time. In areas such as cardiovascular risk factors, osteoporosis and some cancers (breast, cervical, ovarian, uterine and prostate) general guidelines may over- or underestimate the cost-effectiveness of screening for those on hormonal therapy.

16. Long-term screening can usually be expected to align with gender once hormone treatment is commenced, as well as considerations for residual hormone sensitive tissues. Whilst risks for residual hormone sensitive tissues are likely to be less, screening does need to be considered, but clinicians may need to balance this with the potential psychological distress and physical discomfort that is associated with screening (such as pap smears for FtM patients).

a. MtF – adjust screening schedule to include breast screening (as per female schedule), and consider prostate screening (as per age based recommendations), although it should be recognised that prostate screening is likely to overestimate risk due to testosterone suppression, and measured levels will be difficult to interpret (reference ranges for males are not appropriate). Cardiovascular screening as per female risk assessment screening requirements.

b. FtM – Cardiovascular screening as per male risk assessment screening requirements on commencement of testosterone, breast examination/screening for residual breast tissue (with or without surgery) as per female age requirements. Pap smear screening should ideally continue but vaginal atrophy is likely to make the procedure difficult and painful, and testosterone administration should be highlighted on the pathology slip as it will affect the histological appearance.

Surgical considerations

17. Genital surgery for gender dysphoria requires two psychiatric opinions that concur, as well as generally living in an identity congruent role for a 12 month pre operative period.

18. For MtF patients, oestrogen administration needs to be ceased four to six weeks prior to any significant surgery (risk of DVT). Surgical options include:

a. Breast augmentation

b. Genital surgery – penectomy, orchidectomy, vaginoplasty, clitoroplasty, vulvoplasty

c. Facial feminisation surgery, liposuction, voice surgery, thyroid cartilage reduction, rhinoplasty, gluteal augmentation, hair reconstruction and/or

d. Orchidectomy which will usually then result in a significant lowering of the oestrogen dose (as well as cessation of other anti-androgenic medications)

19. For FtM patients, surgical options include:

a. Breast reduction and masculinisation surgery

b. Genital surgery – hysterectomy/salpingo-oophorectomy, urethral reconstruction with a metoidioplasty or phalloplasty, vaginectomy, scrotoplasty, erectile or testicular prostheses/implants and/or

c. Liposuction, pectoral implants.

20. Surgical complications for MtF genital surgery include poor skin healing and necrosis, urethral stenosis, urovaginal or rectovaginal fistulas, and vaginas that are too short or small for coitus. Surgical techniques overseas tend to provide greater surgical options and are often preferred over Australian techniques but is not supported or approved at public expense in Defence members.

21. For FtM aside from the hysterectomy/oophorectomy surgery, complications for surgery tend to be more problematic. Metoidioplasty does not usually result in a capacity for standing urination. Phalloplasty (usually a free vascularised flap) has significant morbidity including frequent urinary complications. The surgery is usually conducted in several separate stages, is technically difficult, has significant complications and is not currently available in Australia. For these reasons many FtM patients never undertake genital surgery other than hysterectomy and salpingo-oophorectomy.

- *HRC Transgender Visibility* www.hrc.org/documents/transgender_visibility_guide
- Australian Passports www.passports.gov.au/web/sexgenderapplicants
- Booklet for Parents and Family Members: http://cdn0.genderedintelligence.co.uk/2012/11/17/17-18-49-Booklet_for_parents_and_family_members1108.pdf
- Transgender Law Centre (USA) http://transgenderlawcenter.org/wp-content/uploads/2014/01/TitleVII-Report-Final012414.pdf

AUSTRALIAN ARMY
Headquarters Forces Command
Victoria Barracks, PADDINGTON NSW 2021

HQFORCOMD/OUT/2017/X7021794

See distribution

COMD FORCOMD DIRECTIVE 49/17

SEX AND GENDER DIVERSE MEMBERS WITHIN FORCOMD

References:

A. Defence Diversity and Inclusion Strategy 2012-2017
B. DI(G) PERS 50-1–Equity and Diversity in the Australian Defence Force
C. DPI 1/2001–Equity and Diversity in the Department of Defence
D. MILPERSMAN, Part 1, Chapter 3
E. Australian Government Guidelines on the Recognition of Sex and Gender, updated Nov 2015
F. Sex Discrimination Act 1984 (Cth)
G. Understanding Transitioning Gender in The Workplace[1]
H. Good Decision-Making In Defence: A Guide For Decision-Makers And Those Who Brief Them
I. Defence Health Manual, Volume 2, Part 9, Chapter 13 – Medical Management of Gender Dysphoria and Gender Realignment in Defence Members
J. Army Dress Manual
K. Defence Honours and Awards Manual Volume 1, Chapter 44
L. Privacy Act 1988 (Cth)
M. IOC Consensus Meeting on Sex Reassignment and Hyperandrogenism November 2015[2]
N. MILPERSMAN, Part 11, Chapter 7

INTRODUCTION

1. FORCOMD remains committed to having a diverse workforce and inclusive workplaces that make the most of the skills and talents of all personnel. Gender diverse members contribute to the capability outcomes of Defence and increase the diverse perspectives of The Australian Defence Force (vide Ref A). The roles and responsibilities of staff regarding Sex and Gender Diverse (SGD) members are currently undefined in policy. Whilst there are unique circumstances, which may require special measures be taken, FORCOMD members should not feel as though they need to act any differently towards SGD members. Available policy (vide Ref A-C) is clear in its focus on equity, diversity and inclusion, and applies to all personnel including SGD members. Commanders are responsible for ensuring that these principles are respected and adhered to at all times, especially when unique situations arise with little other information or guidance available.

[1] http://drnet/People/Diversity/Documents/Understanding_Transitioning_Gender_in_the_Workplace_V1_03.pdf

[2] https://docs.wixstatic.com/ugd/2bc3fc_c2d4035ff5684f41a813f6d04bc86e02.pdf

AIM

2. The aim of this directive is to ensure consistency of practice, mitigate risk of discrimination and empower commanders to successfully lead SGD members. In the absence of Departmental policy, and whilst Army's experience is thus far limited, this directive stands as a 'living document' to be updated and reviewed as further experience is gained or until such time as robust and enduring policy is developed and released. This document is intended for the use of COs and not intended for wider dissemination. Whilst the content is not sensitive in nature, it is subject to change as further research is conducted/policy developed. It is also not to be considered policy and should not be quoted as such. This directive does not take the place nor override obligations under extant Defence policy or Government legislation.

DEFINITIONS

3. The following definitions align with extant literature (Ref D-G). Note that some terminology is culturally dependent and as such, prone to change. Commanders should therefore be respectful and seek to use terminology appropriate to the circumstances.

a. **Gender.** The term 'gender' refers to the way in which a person identifies or expresses their masculine or feminine characteristics. Gender does not necessarily accord with anatomical sexual presentation. It consists of two related aspects: gender identity, which is a person's internal perception and experience of their gender; and gender role, which is the way that the person lives in society and interacts with others, based on their gender identity. Gender is less clearly defined than anatomical sexual presentation, and does not necessarily represent a simple 'one or the other' choice. Some people have a gender identity that is neither clearly female nor clearly male, gender X (for Defence purposes) nor gender non-binary.

b. **Sex.** Vide Ref E Sex is defined as a person's chromosomal, gonadal, anatomical characteristics associated with biological sex. It should be noted that individuals may have a range of circumstances, or undergo a variety of treatments, that make it difficult to define a true biological sex. In such instances commanders are to seek guidance from a medical professional.

c. **Gender Diverse.** Those whose gender does not fall within the traditional binary notions of sex and gender (male and female). This may include people who identify as a gender different to the birth sex or as neither male nor female.

d. **Gender X.** Vide Ref E, Gender X is a term used by Defence to refer to any person who does not exclusively identify as either male or female, i.e. a person of a non-binary gender. People who fall into this category may use a variety of terms to self-identify.

e. **Indeterminate:** Vide Ref E a person of indeterminate sex or gender is either someone whose biological sex cannot be unambiguously determined or someone who identifies as neither male nor female. Many terms are used to recognise people who do not fall within the traditional binary notions of sex and gender (male and female), including non-binary, gender diverse, gender queer, pan-gendered, androgynous and inter-gender. Some cultures may have their own terms for gender identities outside male and female, for example, 'sistergirl' and 'brotherboy' are used by some Aboriginal and Torres Strait Islander People. For administrative purposes these members may be recorded as Gender X on PMKeyS/D1.

f. **Sex or Gender Diverse (SGD).** SGD is intended to be an inclusive term that, in the context of this directive, refers to, but is not limited to: gender X, gender fluid, gender queer, transgender, gender non-conformist, gender non-binary and intersex.

g. **Affirmed Gender.** Ref G defines affirmed gender as a person's own psychological identification as male or female, regardless of their biological sex.

h. **Assigned Gender.** Ref G defines assigned gender as a person's biological gender at birth.

i. **Transgender.** Ref G states that broadly speaking, anyone whose identity, appearance or behaviour falls outside of conventional gender norms can be described as transgender. The term transgender is widely accepted as an umbrella term that is used to describe all those whose gender identity is different to their biological sex. The term should only be used as an adjective; that is, individuals should be referred to 'transgender people', not 'transgenders'. Transgender men are people who were registered at birth as female but now present to the world as male. Transgender women were registered at birth as male but now present as female. The precise definition for transgender remains in constant flux. For further guidance commanders should refer to Ref E and G.

j. **Transitioning.** Ref G defines transitioning as the process whereby a transgender person moves from living as a person of their assigned gender to living in their 'true' or affirmed gender. This usually involves Hormone Replacement Therapy, a minimum of twelve months social integration and sometimes surgery.

k. **Intersex status.** Vide Ref G the term 'intersex' refers to people who have genetic, hormonal or physical characteristics that are not exclusively 'male' or 'female'. A person who is intersex may identify as male, female, intersex or as being of indeterminate sex.

l. **Sexual Orientation.** The term 'sexual orientation' refers to a person's emotional or sexual attraction to another person, including amongst others, the following identities: heterosexual, gay, lesbian, bisexual, pansexual, asexual or same-sex attracted. This is different to a person's sex or gender identity.

GUIDING PRINCIPLES

4. It is recognised that unique situations will arise that are not currently covered in policy. Most policies in Defence are gender neutral; however there are some, such as those related to accommodation, uniforms and physical requirements that only account for members recorded as male/female. Therefore until Defence amends policy/facilities/equipment to accommodate members recorded as Gender X, the following guiding principles should be applied by Commanders:

a. gender neutral options should be made available to Gender X members where they exist

b. where there is no gender neutral option reasonably available, it is expected that male/female assigned gender would form the default starting point for command consideration

c. the view points of the member, treating health care professionals, supporting staff and colleagues are all to be considered

d. where appropriate, once a command decision is made, it should be applied consistently across all gender-specific policies (exceptions may include those relating to medical circumstances).

5. Commanders must take reasonable steps to avoid treating Gender X members less favourably than other members would be treated in similar circumstances. There are situations in which it may be reasonable to propose or take action that may not accord with a member's wishes. In these circumstances, and in addition to ordinary decision-making considerations (Ref H), the following must be taken into account:

a. the nature and extent of the impact resulting from the action or proposed action on the individual potentially affected

b. the feasibility of overcoming or mitigating the impact

c. whether the impact is proportionate to the result sought by the Commander or staff.

6. In addition to extant Defence[3], Army[4] and APS values[5] the following guiding principles apply to the treatment of all members:

a. **Respect.** All members have the right to be respected and are expected to respect their colleagues, community and the values of Defence and their Service.

b. **Safety.** All members have the right to a safe working environment that is free from harassment and discrimination. The primary responsibility of Commanders is to eliminate and reduce any potential harassment, ostracising or discrimination that may negatively impact members.

c. **Inclusion.** All members should be permitted the opportunity to fully participate in the workplace and contribute to protecting and advancing Australia's strategic interests.

d. **Understanding.** The chain of command is to acknowledge that gender diverse members deserve the same respect afforded to any other member and their specific needs and administrative requirements in some instances may fall outside the scope of extant policy and procedures.

e. **Consistency.** Wherever possible and appropriate, policies are to be applied consistently once a decision has been made on which gender is to be applied.

ADMINISTRATION OF SGD MEMBERS

[redacted]

[redacted]

9. **Ablutions**. SGD members are to be afforded the choice to utilise unisex/gender neutral facilities if feasible. Where the use of 'accessible' toilets/showers occurs, the ablutions should be appropriately re-signed. The Chain of Command must consider how to accommodate SGD members in environments where ablutions may not be segregated and or private (such as some barracks ablutions, field toilets and open communal same sex showers). Commanders are to manage SGD member use of ablutions on a case by case basis taking into account the facilities, nature of training or operations, and needs/requests of the relevant member(s) and their colleagues.

[redacted]

[redacted]

[redacted]

JF Ellwood
BRIG
A/COMD FORCOMD

Tel: (02) 8335 5256

21 Jul 17

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[7]http://www.agsva.gov.au/

[8]https://www.passports.gov.au/forms/Documents/B14.pdf

[9]http://dfat.gov.au

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Theisinger, Braden CAPT

From: Theisinger, Braden CAPT
Sent: Tuesday, 7 November 2017 3:48 PM
To: Wright, Paul LTCOL
Subject: Female Participation [SEC=UNCLASSIFIED]
Attachments: 170821-Brief-HLC-Women in Infantry Pathways Facilities Implications.obr

Categories: UNCLASSIFIED

UNCLASSIFIED

Sir

I have reviewed the Noting brief for HLC regarding facilities impacts for Women in Infantry.

The minute from FORCOMD regarding gender integration infrastructure requirements expands the scope of this somewhat from 'barriers to female participation' to 'gender-related' works more generally.

I have updated the attached brief. Largely the update from FORCOMD is as expected and few changes were required to maintain the accuracy of the brief.

Many of the issues raised in the FORCOMD table relate to insufficient capacity of ablutions generally (not specific barriers to female participation).

I recommend we consider limiting the scope of this brief (possibly even smaller than it is now) to avoid confusing the issue.

The unisex issue:

There also appears to be an emerging trend of units / formations attempting to convert existing / alter plans for new facilities to be completely unisex. This will have significant cost implications, and some requests for unisex solutions have already been knocked back by E&IG due to cost.

In order to provide unisex accommodation, showers and toilets while providing an equitable standard of facilities to all, I assess individual rooms will be required and full height toilet partitions and shower partitions with adjoining change area. To maintain the same throughput / capacity this will be considerably more expensive to both construct and maintain (cleaning etc).

Current Defence Policy only covers transitioning members, and basically switches them to the facilities they identify with at a certain point in their transition with the option to use either gender / disabled throughout. With a caveat that commanders need to manage the needs of all people.

I could not find any policy covering facilities requirements for individuals who do not identify with either gender, nor does the building code cover this new category other than provisions for unisex ablutions.

Noting the uncertainty and lack of Policy top cover, I fear that commanders will continue to pursue individual segregated facilities in order to avoid the problem of coming up with a management solution should a gender X individual be posted to their unit. This will be expensive for an undefined but arguably low risk that and individual will be posted to a unit and a suitable management solution cannot be developed.

Not sure if this is an Army problem or an E&IG problem. Recommend in the absence of Defence policy, Army avoids over capitalising to implement any 'permanent' solution that may not comply with whatever is finally decided from a whole of Government / Defence point of view. Conversely there may be opportunity to rationalise ablution

facilities and shape broader policy. This is getting outside the infrastructure space now but want to ensure we do not needlessly overestimate the requirement in the absence of guidance.

Regards

Braden Theisinger | Captain | Staff Officer Grade Three Infrastructure | Army Headquarters | R2-04-A003 | Canberra | (02) 6265 2660

[redacted]

R31069511

For Action By: Routine

NOTING BRIEF FOR HLC (THROUGH DGLOG-A) ON FACILITIES IMPACTS OF GENDER INTEGRATION ACROSS ARMY

[redacted]

[redacted]

[redacted]

[redacted]

Conversion to unisex facilities

15. At this stage there is clear policy for members transitioning gender that allows individuals to use facilities corresponding to their affirmed gender. However there is no clear Defence or Government policy that addresses facilities requirements for individuals who do not identify as either male or female. Some Government departments at Federal and State level have developed policies that require provision of unisex ablutions. FORCOMD has issued interim policy (Ref I) that relies on the use of disabled ablutions where available, 're-signed

appropriately' and Command discretion to manage the requirements of individuals who do not identify as male or female. A Defence policy covering management of individuals who do not identify as either gender is currently being developed.

16. A number of units have commenced adapting or seeking to adapt their facilities to unisex in order to accommodate any combination of male, female or other gender(s) working within their units. Unisex facilities including showers, toilets and accommodation require full length (floor to ceiling) partitioning IAW Building Code requirements and will therefore have an associated cost of conversion.

ARMY – GENDER X CONSIDERATIONS

[redacted]

Facilities

- Unisex facilities – remove urinals – floor to ceiling doors
- Provisions for in the field toilets, showering

[redacted]

[redacted]

From: Noonan, Jan CAPT - RAN
Sent: Thursday, 1 November 2018 3:58 PM
To: Noonan, Jan CAPT - RAN
Subject: 181031 Email RFI in response to FOI tasking [DLM=For-Official-Use-Only]

For-Official-Use-Only

From: Walk, Jason BRIG
Sent: Thursday, 1 November 2018 10:31 AM
To: Noonan, Jan CAPT - RAN <jan.noonan@defence.gov.au>
Cc: Moorby, Debbie-Ann MS <debbie-ann.moorby@defence.gov.au>
Subject: FW: 181031 Email RFI in response to FOI tasking [DLM=For-Official-Use-Only]

For-Official-Use-Only

Jan,

Detail below. Let me know if this does not satisfy your information requirement to respond to the FOI.

Regards,
Brigadier Jason Walk
Director General Estate Services Delivery

Service Delivery Division
Estate and Infrastructure Group
Department of Defence
CP2-5-032
Campbell Park Offices ACT 2600

Mobile 0438 729 738
Phone (02) 6266 4722
Email jason.walk@defence.gov.au

From: Moorby, Debbie-Ann MS
Sent: Wednesday, 31 October 2018 12:42 PM
To: Walk, Jason BRIG <jason.walk@defence.gov.au>
Cc: Smith, Marcus MR <marcus.smith@defence.gov.au>
Subject: RE: 181031 Email RFI in response to FOI tasking [DLM=For-Official-Use-Only]

For-Official-Use-Only

HI Jason, DEWPO provided the following information…

Through the FY17-18, Estate Works Program under the Program Theme of "Gender Diversity", found a total of 46 works on the Defence Estate. These works consist of either an upgrade of an existing unisex facility or conversion to one.

Regards
Debbie

Debbie Moorby
Executive Officer - Planning
Office of the Director General
Estate Service Delivery Branch
Estate and Infrastructure Group

CP2-5-033 l Campbell Park l PO Box 7911 l CANBERRA l ACT 2610
Ph: 02 6266 2465

Estate Service Delivery Branch group mailbox: E&IG Service Delivery ESD

From: Moorby, Debbie-Ann MS
Sent: Wednesday, 31 October 2018 11:51 AM
To: Walk, Jason BRIG <jason.walk@defence.gov.au>
Cc: Smith, Marcus MR <marcus.smith@defence.gov.au>
Subject: RE: 181031 Email RFI in response to FOI tasking [DLM=For-Official-Use-Only]

For-Official-Use-Only

Hi Jason, DEWPO are looking into their work orders. There have been a few converted last financial year, should be able to advise you by tomorrow morning.

Regards
Debbie

Debbie Moorby
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