

UNDERSTANDING SEX, HEALTH, AND RELATIONSHIPS AMONG Bi+ PEOPLE IN AUSTRALIA: KEY FINDINGS FROM THE FIRST Bi+ SEXUAL HEALTH AND HIV STUDY (BiSHH) 2024-25

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DEDICATION

We dedicate this report to our friend and colleague Dr Heather McCormack, a proud Wiradjuri woman, a highly respected researcher, practitioner and advocate in the field of sexual and reproductive health, and a dedicated and passionate member of the BiSHH study team. You are deeply missed, Heather.

ACKNOWLEDGEMENT OF COUNTRY

We acknowledge the Traditional Owners and their custodianship of the lands on which the University of New South Wales is located. UNSW is on the unceded territory of the Bidjigal (Kensington campus), Gadigal (City and Paddington campuses) and Ngunnawal peoples (Canberra), who are the Traditional Owners of the lands where each campus of UNSW is situated. We also acknowledge all the lands across Australia where our participants live and work. We pay respect to all Aboriginal and Torres Strait Islander peoples and their Elders past and present, whose lands, winds, and waters we all now share. We also pay respect to their knowledge and their continuing and enduring cultures, which deepen and enrich the life of our collective communities.

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FOREWORD

The Bi+ Sexual Health and HIV (BiSHH) study is more than a research project. It is a landmark moment for bi+ inclusion in research and a catalyst for action. What began as a bi+ community-led initiative has grown into Australia's first ever sexual health and HIV needs survey for and with bi+ people, those who experience multi-gender attraction.

For decades, bi+ communities have called for greater inclusion in research, policy, services, and health promotion. Despite bi+ people being the largest cohort within the LGBTQ+ community, this community's specific health needs, particularly around sexual health and HIV, have remained poorly understood and overlooked, the BiSHH study is a rigorous response to this.

We couldn't deliver this report without reflecting on how we got here. This study used a co-production model to undertake a process of collaborative design and shared decision making during this research to honour and reflect the lives of those we sought to represent. At every step, bi+ people have been at the heart of the study process, from conception, to design, and throughout analysis. Six of the eight investigators are bi+, and our twelve Community Advisory Group members are bi+, bringing invaluable expertise and lived experience to every aspect of this study. Our sample of 2,109 bi+ participants now represents one of the largest datasets of bi+ people in Australia, and is one of the most robust and diverse cohorts of multi-gender attracted people deliberately engaged with a survey focused exclusively on their experiences.

There are many people to thank for making this all possible. Eloise Monteiro, Steve Spencer and the Sydney Bi+ Network were the genesis for the study, building the case for the need to better understand the sexual health and HIV needs of bi+ people. Associate Professor Ben Bavinton and all of our allies that have helped lead and contribute to this study have given a great gift to our community.

The co-investigators, Bella Bushby, the heart and engine behind the whole study without whom none of this would have been possible, Christy E. Newman, Jen Power, Ruby Grant, Mandy Henningham, Emily Goodnow Bjaalid, and Heather McCormack. We are grateful to this extraordinary team and also to our exceptional Community Advisory Group.

The survey instrument itself reflects another achievement. With patience, care, and wisdom, the investigators and Community Advisory Group shaped a tool that not only captured the richness and complexity of bi+ experiences, but also set a new benchmark for bi+ inclusive research practice. What many thought was impossible, fitting the extraordinary diversity of bi+ lives into a research framework, we have proven possible. And it was only possible because of the tireless labour of the researchers, our allies, advisors, and community members who refused to view any task as insurmountable.

This report does not mark the end of our journey; the ripples of change created by this study extend well beyond the words contained in these pages. This is a beginning. We now have evidence needed to build meaningful change. The work must not stop here. We call on policymakers, service providers, and health promoters to translate these findings into action.

To everyone who participated, we are so grateful to the contribution you made in not just your time but in giving your heart and authenticity to this work. You have opened the door to the many great possibilities that lie ahead in how we address the sexual health and HIV needs of all bi+ Australians.

- Steve Spencer, Amber Loomis & Eloise Monteiro

EXECUTIVE SUMMARY

BACKGROUND & METHODOLOGY

The Bi+ Sexual Health and HIV (BiSHH) study was the first national survey of sex, health, and relationships designed specifically for the bi+ community in Australia. The study was conducted by researchers from UNSW Sydney (the Kirby Institute and the Centre for Social Research in Health), La Trobe University (the Australian Research Centre for Sex, Health and Society) and the University of Sydney in partnership with bi+ community advocates. The study was coordinated by the Kirby Institute, UNSW Sydney. A Bi+ Community Advisory Group was formed to oversee the study. Participants were recruited between September 2024 and February 2025. The study was promoted through LGBTQ+ and bi+ community organisations, mailing lists, and paid advertising on social media and LGBTQ+ dating and “hook up” apps. The survey was provided in English and restricted to participants aged 18 years and above, who were bi+ and resided in Australia.

ABOUT THE PARTICIPANTS

Responses from 2,109 participants are included in this report, representing those who completed the entire survey. As questions were not compulsory, the total sample size varies across questions. Participants were recruited from all states and territories across Australia, with most residing in a major city (76.6%). The median age was 32 years old, ranging from 18 to 85. In total, 83 participants (3.9%) were Aboriginal and/or Torres Strait Islander, and 83.9% (n=1,770) were born in Australia. Under half (45.6%, n=961) were employed full-time, and 40.2% (n=848) earned an annual income of \$50,000 or below. The total sample included 785 cis women (37.2%), 573 non-binary or gender diverse people (27.2%), 500 cis men (23.7%), 138 trans men (6.5%), and 104 trans women (4.9%). When selecting one sexual identity, most participants (43.9%, n=926) identified as bisexual, followed by queer (23.6%, n=497) and then pansexual (11.7%, n=247). Half (53.2%, n=1,122) of all participants reported a long-term illness or disability. More than a quarter (28.0%, n=591) of participants had “probable serious mental illness” as indicated by the Kessler Psychological Distress Scale (K6).¹ Most (88.6%, n=1,518) were engaged with general healthcare, having either a regular GP or clinic they attended.

SEXUAL PARTNERS

- Most (89.2%, n=1,881) participants had been in at least one ongoing committed relationship (i.e. partner, girlfriend/boyfriend, spouse) in their lifetime
- Over half (59.4%, n=1,252) were in a current ongoing committed relationship; 50.1% (n=1,057) with one partner and 9.3% (n=195) with multiple partners (e.g. non-monogamous, polyamorous).
- Most (76.9%, n=1,621) participants had had sex with an ongoing casual partner (i.e. lover, fuckbuddy, friends with benefits) in their lifetime, with 37.1% (n=783) in the last 12 months.
- Most (72.8%, n=1,535), participants had had sex with a random/hook up partner (i.e. one night stand) in their lifetime, with 34.0% (n=716) in the last 12 months.

SEXUAL PRACTICES

- Most (94.2%, n=1,986) participants had had some form of sex in their lifetime, with 77.8% (n=1,641) in the last 12 months.
- In the last 12 months, 32.0% (n=675) had only had sex with their ongoing committed partner/s, while 23.5% (n=496) had had sex with their ongoing committed partner/s and a casual or hook up partner.
- Practices varied between partner types, with oral sex, sex toy use, and kink that did not involve blood being common.
- Condomless vaginal/front hole sex was more common with ongoing committed partners compared with hook up partners (65.7%, n= 740 versus 38.1%, n=273), while condomless anal sex was more common among hook up partners compared with ongoing committed partners (39.7%, n=284 versus 29.8%, n=355).
- In the last 12 months, 44.8% (n=945) reported sex with someone from a dating and hook up app, 26.0% (n=548) had group sex, 17.4% (n=367) used drugs for sexual purposes (e.g. sexualised drug use), and 4.5% (n=94) had done sex work.

SEXUAL AND REPRODUCTIVE HEALTH

- Most (88.8%, n=1,873) participants had accessed a sexual health-related service in Australia at least once in their lifetime.
- Half (51.3%, n=1,082) of all participants felt 'comfortable' or 'very comfortable' talking about sexual health with their healthcare professionals, and three-quarters (74.1%, n=1,563) felt they had at least one health provider with whom they could have a conversation about sexual or reproductive health.
- In the last 12 months, participants accessed sexual health information from: searching online (70.4%, n=1,484); their doctor or other healthcare professional (60.2%, n=1,269); social media (53.5%, n=1,128); and community health organisations (48.4%, n=1,020). Participants also were more likely to access sexual health information from LGBTQ+ friends (62.3%, n=1,313) compared to non-LGBTQ+ friends (26.2%, n=553) or family (10.5%, n=222).
- Within general sexual healthcare settings: 50.6% (n=947) felt 'mostly' or 'always' comfortable talking about being bi+; 42.7% (n=800) felt clinics were 'mostly' or 'always' knowledgeable and inclusive of bi+ people; and 15.8% (n=296) were 'mostly' or 'always' provided with information that was specifically relevant for bi+ people.
- Within LGBTQ+ sexual health services and programs: 48.7% (n=1,026) felt that LGBTQ+ services could be more bi+ inclusive; 47.1% (n=994) felt welcome; and 41.1% (n=867) felt LGBTQ+ services served their needs as a bi+ person. Most (70.4%, n=1,485) agreed that they would feel more included if they saw visual signs of bi+ support, and 55.8% (n=1,176) preferred intake forms to ask about sexual identity.
- The majority (81.3%, n=1,715) reported having at least one STI test in their lifetime and half of all participants (50.5%, n=1,065) had had an STI test in the last 12 months.
- More than one-third (36.1%, n=762) of all participants had ever had an STI diagnosis, while 7.5% (n=159) had been diagnosed with an STI in the last 12 months.
- Two-fifths (41.6%, n=878) of all participants had used some form of contraception in the past two years to prevent pregnancy, with condoms the most used (30.9%, n=652).

HIV PREVENTION AND CARE

- There were 31 (1.5%) participants living with HIV. Over two-thirds (68.6%, n=1,446) of participants were HIV-negative and 27.7% (n=627) did not know their HIV status.
- In total, 70.9% (n=1,495) of participants had had at least one HIV test in their lifetime and 42.3% (n=893) had tested at least once in the last 12 months.
- Most participants were aware of PrEP (86.2%, n=1,816). However, only 58.2% (n=1,208) were aware that a person living with HIV who has an undetectable viral load cannot pass on HIV (i.e. 'Undetectable = Untransmittable').
- In total, 6.7% (n=145) of participants were currently using PrEP. Cis men comprised 64.3% of the PrEP users, and trans women comprised 9.1%.
- About one-fifth (21.8%, n=460) of participants who were not living with HIV or currently taking PrEP were interested in taking PrEP in the future.

SEXUAL VIOLENCE AND COERCION

- This section of the survey was completed by 1,939 participants. Of these, 63.3% had had at least one incidence of sexual violence perpetrated against them since the age of 18.
- Most participants were bi+ at the time of the violence (79.3%, n=974) and about half (49.8%, n=612) indicated that the perpetrator knew about their bi+ identity, attraction, or sexual history.
- Nearly two-thirds (62.3%) had told someone else about the most recent sexual violence. Over half (58.2%, n=715) told someone in their social network, while less than one-third (29.2%, n=358) told a service or health professional.
- More than one-third (37.7%, n=463) had told no one about the most recent experience of sexual violence.

SOCIAL ENGAGEMENT AND INCLUSION

- Participants reported high social engagement with: heterosexual people (63.1%, n=1,331); bi+ people (50.4%, n=1,062); and gay/lesbian people (47.6%, n=1,004).
- Participants reported bi+ negativity and discrimination from both heterosexual people and gay/lesbian people, but more often from heterosexual people than gay/lesbian people.
- Less than half of all participants were out about being bi+ to 'most' or 'all' of their: immediate family (42.7%, n=901); healthcare professionals (42.0%, n=886); heterosexual/straight people in their lives (39.0%, n=822); people at work or school (16.6%, n=351) or extended family (12.7%, n=268).
- Over half (57.9%, n=1,221) felt 'mostly' or 'very' included in bi+ spaces, while 52.4% (n=1,104) felt that way about mixed LGBTQ+ spaces.

ALCOHOL AND DRUG USE

- About half (48.8%, n=1,029) drank alcohol less than weekly, 19.5% (n=412) on one or two days a week, and 2.0% every day. In total, 16.6% (n=349) never drank alcohol.
- Just under half (46.9%, n=989) of all participants had ever used illicit drugs, with 23.7% (n=500) in the last 12 months.
- In total, (4.8%, n=101) of participants had ever injected illicit drugs, with 1.6% (n=33) injecting in the last 12 months.
- Two-fifths (42.2%, n=889) of participants had ever been concerned or felt their alcohol use, drug use or both had a negative impact on their life.

CONCLUSIONS AND RECOMMENDATIONS

The BiSHH study provides detailed insights into the lives of 2,109 bi+ people in Australia, highlighting a rich diversity of sexual and gender identities, relationship dynamics and sexual practices. LGBTQ+ community was important for our participants, and most were engaged with LGBTQ+ and bi+ specific media and online content. Participants were also more likely to feel included in bi+ spaces and LGBTQ+ spaces, and were more often out about their sexual identity to other bi+ people and gay/lesbian people compared with heterosexual people. Key issues revealed in the BiSHH findings include high rates of sexual violence and coercion, mental ill-health, inadequate experiences of service inclusivity, limited disclosure and comfortability with healthcare providers, and high drug use. Policy and practice recommendations should prioritise these key issues with strategies to: strengthen bi+ inclusion in sexual health services; promote bi+ visibility in LGBTQ+ services and develop tailored interventions to better support engagement; and distinguish the needs and experiences of bi+ people within national and state-based policies including within clinical guidelines. Further research should prioritise qualitative methods, perspectives underrepresented in our sample (e.g. people from non-English speaking backgrounds, those born overseas, and people living with HIV), community-led and participatory research approaches, and dedicated funding for further ongoing bi+ specific studies.

INTRODUCTION

'Bi+' is an inclusive, community-developed umbrella term used to describe sexual identities that involve attraction to people of more than one gender. Common bi+ identities include but are not limited to bisexual, pansexual, queer, fluid, multi-gender attracted, polysexual, omnisexual, bicurious, biromantic, panromantic, heteroflexible, homoflexible and more. However, some bi+ people also identify with terms like gay, lesbian, or heterosexual/straight.

Bi+ people make up the largest portion of the combined LGBTQ+ population (i.e. people who are lesbian, gay, bisexual, transgender, or queer, plus other diverse sexualities and genders). Moreover, global estimates indicate bi+ identities are on an upwards trend, especially among young people.²⁻⁷ However, population and household surveys have proven largely unreliable in estimating numbers of people who experience multi-gender attraction. In 2024, the Australian Bureau of Statistics (ABS) estimated that 1.7% (337,100) of the Australian population aged 16 years and over were bisexual and 1.5% were gay or lesbian, with a further 0.4% (83,700) identifying with a 'different term' that may be inclusive of bi+ identities such as pansexual or queer.³

There is very little sexual health and HIV research specifically focusing on bi+ people in Australia. Existing research often combines bi+ people with lesbians, gay men or LGBTQ+ people, masking differences between them.⁸ Inclusion of bi+ people in sexual health research is frequently focused on sexual behaviour and public identification rather than self-understanding or intermittent experience. Consequently, bi+ people who have only had lifetime or recent sexual experiences with one gender may not be recognised as bi+ in such research. The use of sexual behaviour-based indicators to identify bi+ people also means they are rarely researched as a distinct population.

In existing sexual health research, there are mixed findings about bi+ people. However, available data suggests bi+ individuals, regardless of their gender, experience poorer outcomes in this area of health and wellbeing.⁹⁻¹³ Research also shows that bi+ people report poorer outcomes compared to heterosexual and lesbian/gay people in other areas impacting health and quality of life, such as mental health,^{14,15} substance use,¹⁶ and intimate partner and family violence.¹⁷

One factor increasingly recognised as impacting the health and wellbeing of bi+ people is biphobia. Biphobia is a form of stigma based on harmful stereotypes and bi-erasure. Biphobic beliefs include assumptions that bi+ people are confused, greedy, promiscuous, or deceitful, and that bi+ identities are illegitimate, untruthful, or "not really" part of the LGBTQ+ community. This prejudice can be expressed within both heterosexual and lesbian/gay communities, which is known as 'double discrimination'.¹⁸ Bi+ men, in particular, have historically been stigmatised as a 'bridge' for HIV transmission to women and the heterosexual population, reinforcing fear and misinformation.¹⁹ Stigma and perceived lack of bi+ inclusive care can create barriers to healthcare access for bi+ people, including access to sexual healthcare. Many bi+ people may feel unsafe disclosing their sexual identity and practices to health professionals, which can limit access to appropriate STI prevention, testing and care.

The burden of HIV, STIs, and related indicators impacting sexual health are not well understood among bi+ people in Australia. This gap was the driving motivation for developing the Bi+ Sexual Health and HIV (BiSHH) study. The following report provides an overview of the sample, data and key findings from the first national survey on bi+ people's sexual health and HIV needs in Australia.

METHODS

AIM

The BiSHH study aimed to understand the sex, health, and relationships of bi+ people in Australia, with a particular focus on sexual health and HIV needs, in order to address the substantial gap in research on this set of issues in this population.

STUDY DESIGN AND DATA COLLECTION

A cross-sectional survey was completed anonymously by bi+ people across Australia from 16 September 2024 to 28 February 2025, hosted on the online platform, Qualtrics.

ELIGIBILITY

Participants were eligible if they met the following criteria:

1. Identified with one or more of the terms fitting under the bi+ umbrella or had had sex with, or attractions to, more than one gender.
2. At least 18 years of age or over.
3. Resided in Australia.
4. Could complete the survey in English.

MEASURES

The questionnaire included 167 items on: demographics; sexual and gender identity; attraction; sexual behaviour; sexual and romantic relationships; general and sexual healthcare; HIV-related healthcare; sexual violence and coercion; discrimination; alcohol and drug use; mental health; and social networks. The survey instrument included closed and open-ended questions. Depending on participants' demographics and experiences, some were given fewer questions using survey logic functions. The average completion time was 20–25 minutes.

ROLE OF THE BI+ COMMUNITY ADVISORY GROUP

A Bi+ Community Advisory Group (Advisory Group) was formed to guide the research project and ensure accuracy, appropriateness, and relevancy of the research design to the bi+ community in Australia. Twelve bi+ identified people from across Australia were selected through an expression of interest process. The Advisory Group provided expert advice on the: research design; study logo and materials; survey questions; survey flow, readability and logic; recruitment strategies; initial findings and interpretations of the results; report; and strategies to share the results. The Advisory Group were engaged throughout the process of the study and met six

times online and once in-person, and provided multiple rounds of feedback by email. Advisory Group members were remunerated with gift vouchers for attending meetings and providing feedback.

SURVEY DEVELOPMENT AND ETHICAL APPROVAL

Survey questions were developed through several rounds of review by the research team, in consultation with the Advisory Group. The questionnaire was also reviewed by representatives from partner LGBTQ+ community organisations. The study was approved by the human research ethics committee at UNSW Sydney (H230269) and two state-based LGBTQ+ community research ethics review committees (ACON and Thorne Harbour Health).

RECRUITMENT

The online survey was promoted using paid and unpaid advertising. Paid advertising was conducted through LGBTQ+ dating and hook up apps and social media platforms. Platforms included Grindr, Squirt, Her, Facebook, and Instagram. Unpaid community-based advertising was largely conducted by LGBTQ+ community organisations and grassroots bi+ organisations, which promoted the survey on their social media channels, mailing lists, and at community events. Existing research lists and registers (including the George Institute's Join Us research register) were also utilised to invite potential participants who previously agreed to be contacted for future research studies.

At the conclusion of the survey, participants were invited to provide their email address to enter an optional prize draw and/or to be notified about future research studies. To protect the anonymity of participants, email addresses were not linked to survey responses. Four winners of the prize draw were randomly selected and sent an online voucher by email.

DATA ANALYSIS

Data were analysed in Stata v.18. Data were cleaned and checked for inconsistencies and incomplete responses were removed. Data presented in this report are mainly descriptive using cross-tabulations and chi-square tests to show significant differences between subgroups of participants. In some cases, open-text responses were recoded into quantitative categories. Selected open-text responses have also been presented throughout the report.

STUDY SAMPLE AND PARTICIPANT DEMOGRAPHICS

SAMPLE

In total, 3,914 people started the survey, of which 1,447 were excluded due to not meeting the eligibility criteria or not providing sufficient data. To ensure completeness of the data in this report, we only included respondents who completed the survey to the end; thus, an additional 353 responses were excluded. The final sample for this report is 2,109.

DEMOGRAPHIC CHARACTERISTICS

Table 1 shows participants' demographic characteristics. Participants ranged from 18 to 85 years old, with a median age of 32 years old. Participants were recruited from all states and territories across Australia. Most resided in New South Wales (30.3%) and Victoria (28.4%). Participation was largely representative of the Australian population with a slight under-representation from Queensland and over-representation from the Australian Capital Territory.²⁰ The majority of participants lived in a major capital city or other major city (76.6%), whereas 23.0% lived in a regional, remote or very remote area.

In total, 3.9% of participants identified as Aboriginal and/or Torres Strait Islander, which is representative of

the Australian population (3.8%).²¹ Most participants were born in Australia (83.9%), and most were of Anglo-European ancestry (86.4%). Of those born overseas, 73.9% had been living in Australia for more than 10 years.

About half (54.8%) were university educated and 27.8% were current students. Most participants were employed in either full-time (45.6%) or part-time/casual (32.8%) work, with 21.6% not working (e.g. retired, receiving government payments or currently unemployed). Annual gross income of participants varied, with 40.2% earning \$50,000 or below, which is lower than the general Australian population's median annual income of \$74,100.²²

One-fifth of (19.5%) participants were currently married. A smaller portion (11.9%) were not currently married but had been previously or were widowed, and 68.7% had never been married. Nearly one-quarter (23.0%) of participants had children, with 16.9% planning to have their first or additional children in the future.

Table 1. Demographics

	N (%)
Age	
18 – 24	414 (19.6)
25 – 34	836 (39.6)
35 – 44	425 (20.2)
45 – 54	231 (11.0)
55 – 65	137 (6.5)
65+	66 (3.1)
State/territory	
New South Wales	638 (30.3)
Victoria	598 (28.4)
Queensland	351 (16.6)
Western Australia	199 (9.4)
South Australia	154 (7.3)
Australian Capital Territory	86 (4.1)
Tasmania	67 (3.2)
Northern Territory	16 (0.8)

Geographical region^a	
Inner suburbs of major capital cities	522 (24.8)
Middle suburbs of major capital cities	515 (24.4)
Outer suburbs of major capital cities and other major cities	578 (27.4)
Regional, remote and very remote	486 (23.0)
<i>Missing</i>	8
Aboriginal and/or Torres Strait Islander	83 (3.9)
Region of birth	
Australia	1,770 (83.9)
High-income English-speaking country ^b	211 (10.0)
Asia	52 (2.5)
Europe	31 (1.5)
Other (including Latin America/Caribbean)	45 (2.1)
Time in Australia	
Less than 1 year to 5 years	45 (2.1)
6 to 10 years	43 (2.0)
Over 10 years	249 (11.8)
<i>Missing</i>	2
Ethnicity/cultural background^c	
Anglo-European background only	1,822 (86.4)
Non-European background only	105 (5.0)
Anglo-European and Non-European background	182 (8.6)
University education	1,155 (54.8)
Current student	587 (27.8)
Employment	
Full-time	961 (45.6)
Part-time or casual	692 (32.8)
Not working	456 (21.6)
Annual income	
\$0	117 (5.6)
\$1 - \$25,000	386 (18.3)
\$25,001 - \$50,000	345 (16.4)
\$50,001 - \$75,000	324 (15.4)
\$75,001 - \$100,000	365 (17.3)
\$100,001 - \$150,000	348 (16.5)
\$150,000 or more	115 (5.5)
Prefer not to say	109 (5.2)

^a These classifications are based on the ABS Australian Statistical Geography Standard (ASGS) Edition 3²³ combined with the Bureau of Communications Arts and Regional Research (BCARR) City Ring Classification.²⁴

^b Countries classified as 'high-income English-speaking' were Canada, Ireland, New Zealand, United Kingdom, and United States of America.

^c The ABS Ancestry Standard²⁵ (adapted to include top 20 ancestries of the Australian population) was used to list ancestries, and participants could choose up to two. Participants were classified as 'Anglo-European background only' if their ancestries were from the United Kingdom, Ireland, the United States, Canada and Europe only; as 'non-European background only' if their ancestries were from outside United Kingdom, Ireland and Europe only; and as 'Anglo-European and non-European background' if they had ancestries from within and outside of the United Kingdom, Ireland and Europe.

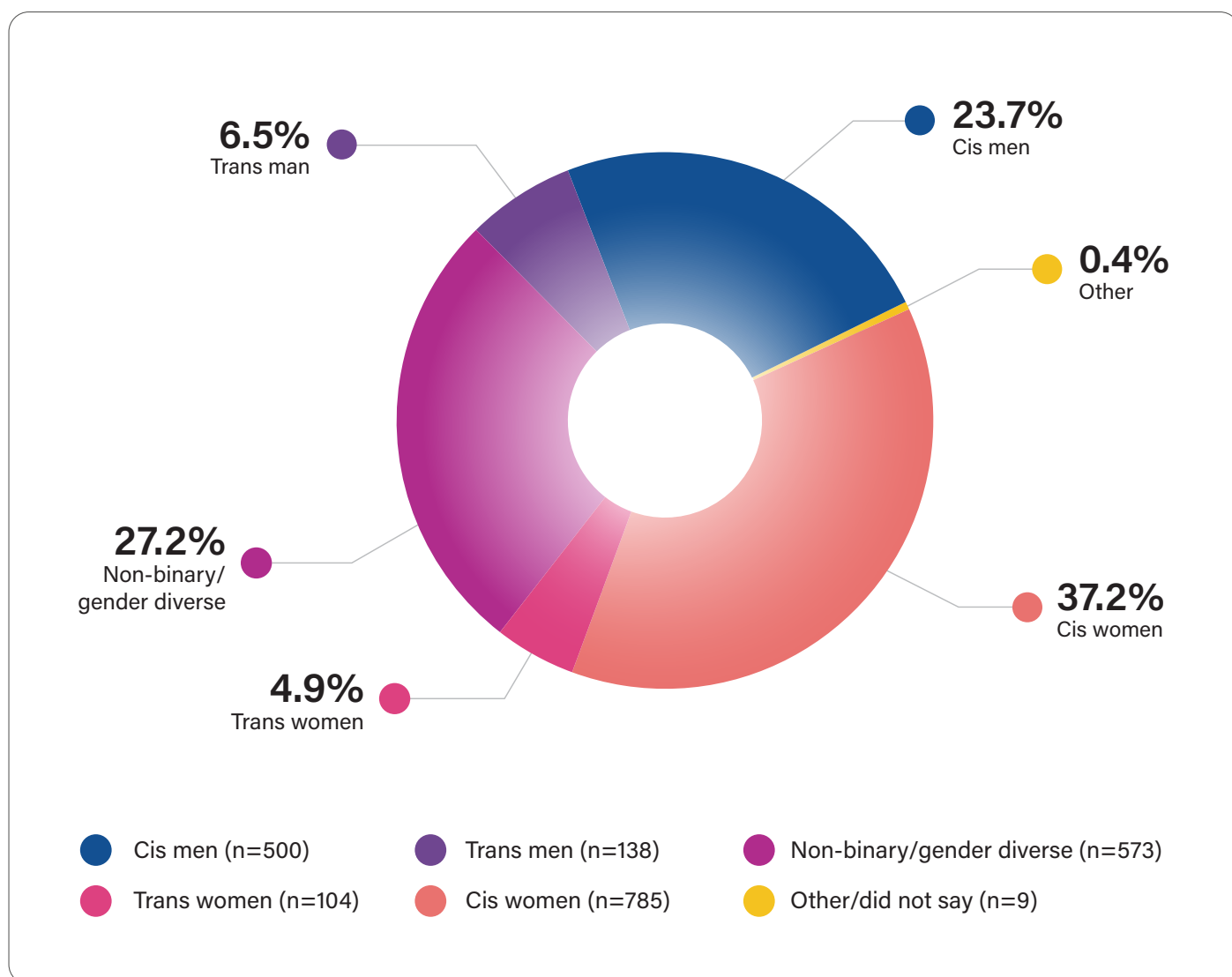
SEX AND GENDER

Participants were asked about sex, gender, and innate variations of sex characteristics using the Australian Bureau of Statistics standard.²⁶ When asked to describe their gender, 42.3% identified as a woman or female, 30.3% as a man or male, and 27.2% as non-binary or gender diverse. About two-thirds (65.0%) of all participants were recorded female at birth and one-third (34.6%) male. There were 1.8% of participants who reported innate variations of sex characteristics.

To enable comparisons, we organised the wide range of sex and gender identity responses into five simplified gender categories (cis women, trans women, non-binary/gender diverse, trans men, and cis men), shown in Figure 1. We created these groups to enable meaningful comparisons of differences in the experiences of cis and trans participants while recognising that these groupings are oversimplified and do not fully capture the rich gender diversity in the sample.

The non-binary/gender diverse category includes participants who were recorded male and female at birth. Almost one-quarter (24.0%) of participants self-identified with this category and a further 3.2% of participants were recoded into this category from their open-text responses. Participants who identified with both a binary (e.g. man/woman) and non-binary identity in the open-text response were categorised as non-binary/gender diverse. The non-binary/gender diverse category also encompasses a range of gender identities such as gender non-conforming, genderfluid, genderqueer and agender, meaning that not all participants in this category identified as 'non-binary' themselves. In total, 60.9% of all participants were cis and 38.6% were trans and/or non-binary/gender diverse.

Figure 1 Gender



In subsequent sections, we often stratify the data by these five gender categories. In those cases, the 9 participants who reported another gender or who did not answer the sex and gender questions are not presented.

SEXUAL IDENTITY

Participants were able to select multiple sexual identities from a list of 15 pre-specified choices and were given the option to write in three additional sexual identities not listed. The most commonly selected identities were 'bisexual/bi' (69.7%), 'queer' (48.7%), and 'pansexual/pan' (29.4%). The most common open-text response was demisexual (0.5%). Just under half of participants (44.1%) chose one identity only, and the number of sexual identities selected ranged between 1 and 11, with a median of two identities per participant.

Participants who chose two or more sexual identities (55.9%) were then asked to select one sexual identity

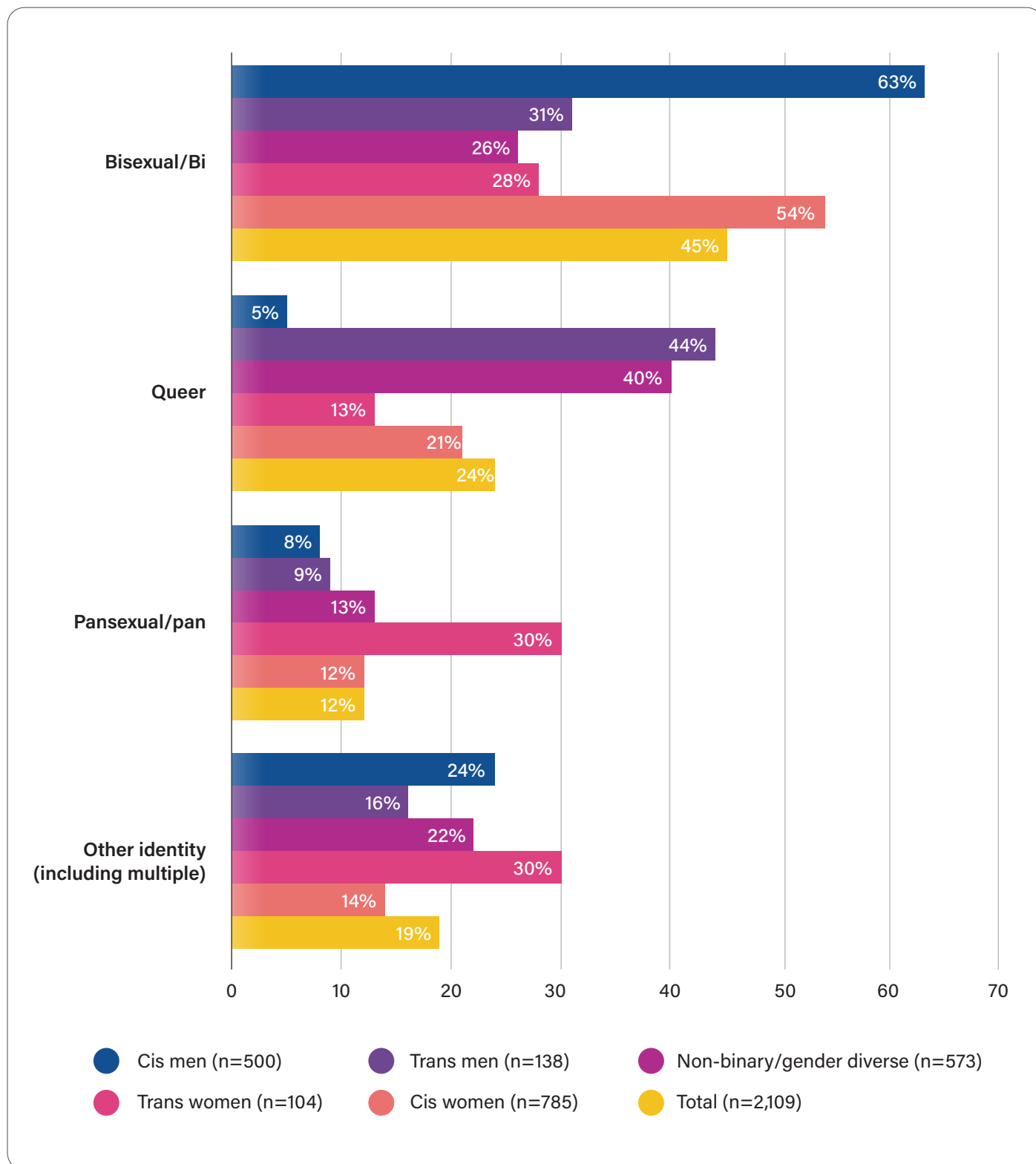
they most identified with. They were also given the option to state that they could not choose one single identity, as multiple sexual identities were equally important to them. Table 2 shows the sexual identity participants identified with most, if they had to choose one for the purpose of analysing data. Just under half of participants (43.9%) identified as bisexual/bi, followed by queer (23.6%), and pansexual/pan (11.7%). There were 168 participants (8.0%) who indicated that multiple identities were equally important to them.

Table 2. Sexual identity participants identified with most

Sexual Identity	N (%)
Multiple identities equally important	168 (8.0)
Bisexual/Bi	926 (43.9)
Queer	497 (23.6)
Pansexual/Pan	247 (11.7)
Gay	57 (2.7)
Lesbian	34 (1.6)
Bi+	31 (1.5)
Bicurious	25 (1.2)
Heteroflexible	24 (1.1)
Asexual	21 (1.0)
Heterosexual/Straight	18 (0.9)
Fluid	16 (0.8)
Multi-gender attracted	11 (0.5)
Demisexual	10 (0.5)
Omnisexual	7 (0.3)
Homoflexible	7 (0.3)
Another sexual identity provided	7 (0.3)
Polysexual	3 (0.1)

Figure 2 presents a collapsed version of the most common sexual identities chosen by participants, by gender. Cis men were more likely than people of other genders to identify as bisexual/bi and less likely to identify as queer. Cis women were more likely to identify as bisexual/bi. Trans men and non-binary/gender diverse participants were more likely to identify as queer. Trans women were more likely to identify as bisexual/bi or pansexual/pan.

Figure 2 Sexual identity by gender



ATTRACTION

We asked participants a series of statements to understand more about their experiences of attraction and how gender identity, gender expression, and sexual identity influence this experience. Table 3 reports participants who 'agreed' or 'strongly agreed' with each statement about attraction.

Interestingly, 68.3% of participants were 'attracted to people regardless of their gender' while 61.2% were 'attracted to people of particular gender/s more than others.' Participants were more likely to report that gender presentation or expression influenced their attraction than gender identity. Half (50.9%) agreed that 'a person's gender expression or presentation matters to my

attraction' compared to 27.6% who felt a 'person's gender identity matters to my attraction.'

Two-fifths (41.2%) of participants felt 'a person's sexuality matters to my attraction.' Two-thirds (68.5%) reported that they 'experience sexual and romantic attraction differently.' Over half (58.0%) of participants agreed that they 'feel more comfortable dating a bi+ person' and 39.9% agreed that they 'prefer my sexual partners to be bi+.' Trans and non-binary/gender diverse participants were more likely than their cis counterparts to feel more comfortable dating and to prefer their sexual partners to be bi+.

Table 3. Experiences of attraction^a

Sexual Identity	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
I'm attracted to people <i>regardless</i> of their gender.	1,440 (68.3)	566 (72.1)	78 (75.0)	404 (70.5)	80 (58.0)	309 (61.8)	<0.001
I'm attracted to people of <i>particular</i> gender/s more than others.	1,291 (61.2)	438 (55.8)	72 (69.2)	347 (60.6)	98 (71.0)	333 (66.6)	<0.001
A person's <i>gender identity</i> matters to my attraction.	583 (27.6)	194 (24.7)	33 (31.7)	139 (24.3)	46 (33.3)	168 (33.6)	<0.01
A person's <i>gender expression or presentation</i> matters to my attraction.	1,074 (50.9)	391 (49.8)	54 (51.9)	303 (52.9)	84 (60.9)	236 (47.2)	NS
A person's <i>sexuality</i> matters to my attraction.	868 (41.2)	283 (36.1)	41 (39.4)	265 (46.3)	61 (44.2)	215 (43.0)	<0.01
I experience sexual and romantic attraction <i>differently</i>	1,444 (68.5)	497 (63.3)	74 (71.2)	411 (71.7)	95 (68.8)	363 (72.6)	<0.01
I feel more <i>comfortable</i> dating a bi+ person.	1,188 (56.3)	390 (49.7)	70 (67.3)	415 (72.4)	85 (61.6)	224 (44.8)	<0.001
I <i>prefer</i> my sexual partners to be bi+.	821 (38.9)	236 (30.1)	48 (46.2)	305 (53.2)	61 (44.2)	169 (33.8)	<0.001

^a Participants who 'agreed' or 'strongly agreed' with each statement are reported.

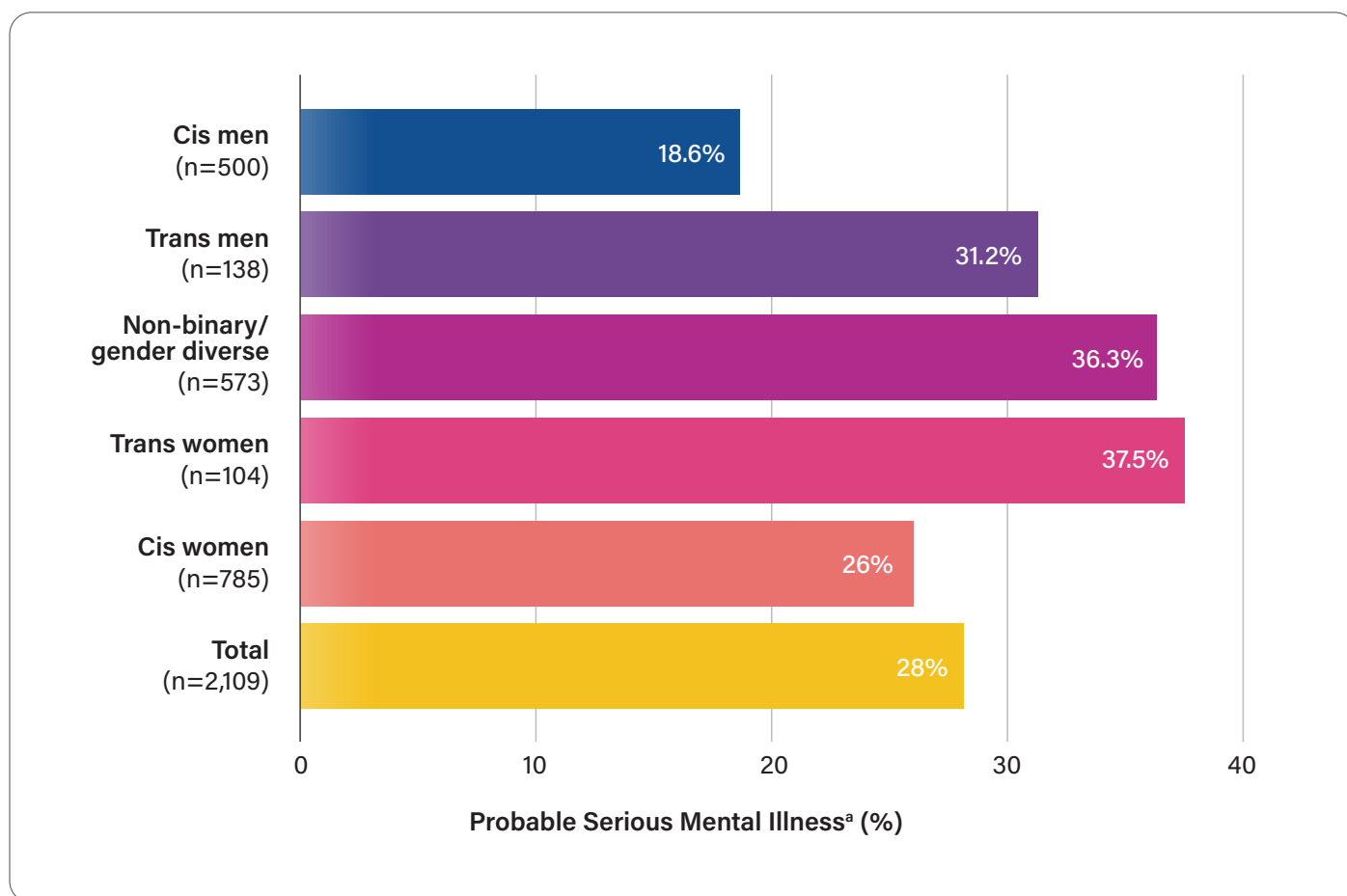
GENERAL HEALTH

Most participants were engaged with general healthcare. Most (72.3%) had a regular general practitioner (GP), and a further 16.2% attended a regular health clinic but did not have a regular GP. Around two-thirds (65.2%) of participants rated their overall access to healthcare in Australia as 'good' or 'great', while 25.5% reported 'okay' access. Cis men were more likely to rate their healthcare access higher than people of other genders.

About half (53.2%) of all participants reported having a long-term illness or disability. This is higher than the 18% of all people in Australia who are estimated to have a disability and the further 22% who are estimated to have a long-term health condition but no disability.²⁷

We used the 6-item Kessler Psychological Distress Scale (K6) to briefly screen for psychological distress.¹ Using this scale, 28.0% of participants had a score indicating a probable serious mental illness. This is more than double the proportion with probable serious mental illness in the general Australian population (17.0%),²⁸ however this was lower than what was reported by pansexual (75.9%) and bisexual (66.7%) participants in the national Private Lives 3 survey.¹⁷ Psychological distress was higher among trans and non-binary/gender diverse participants compared to cis participants.

Figure 3 Mental Health



^a Scores between 19-30 on the on the Kessler Psychological Distress Scale (K6) indicate probable serious mental illness.¹

¹These data used the 10-item Kessler Psychological Distress Scale (K10) to screen psychological distress. The K6 is a shortened version of the K10. Both scales are highly robust and levels indicating probable serious mental illness can be compared, noting the K10 has a slightly higher sensitivity for detecting serious mental illness.

SEXUAL PARTNERS

PARTNER TYPES

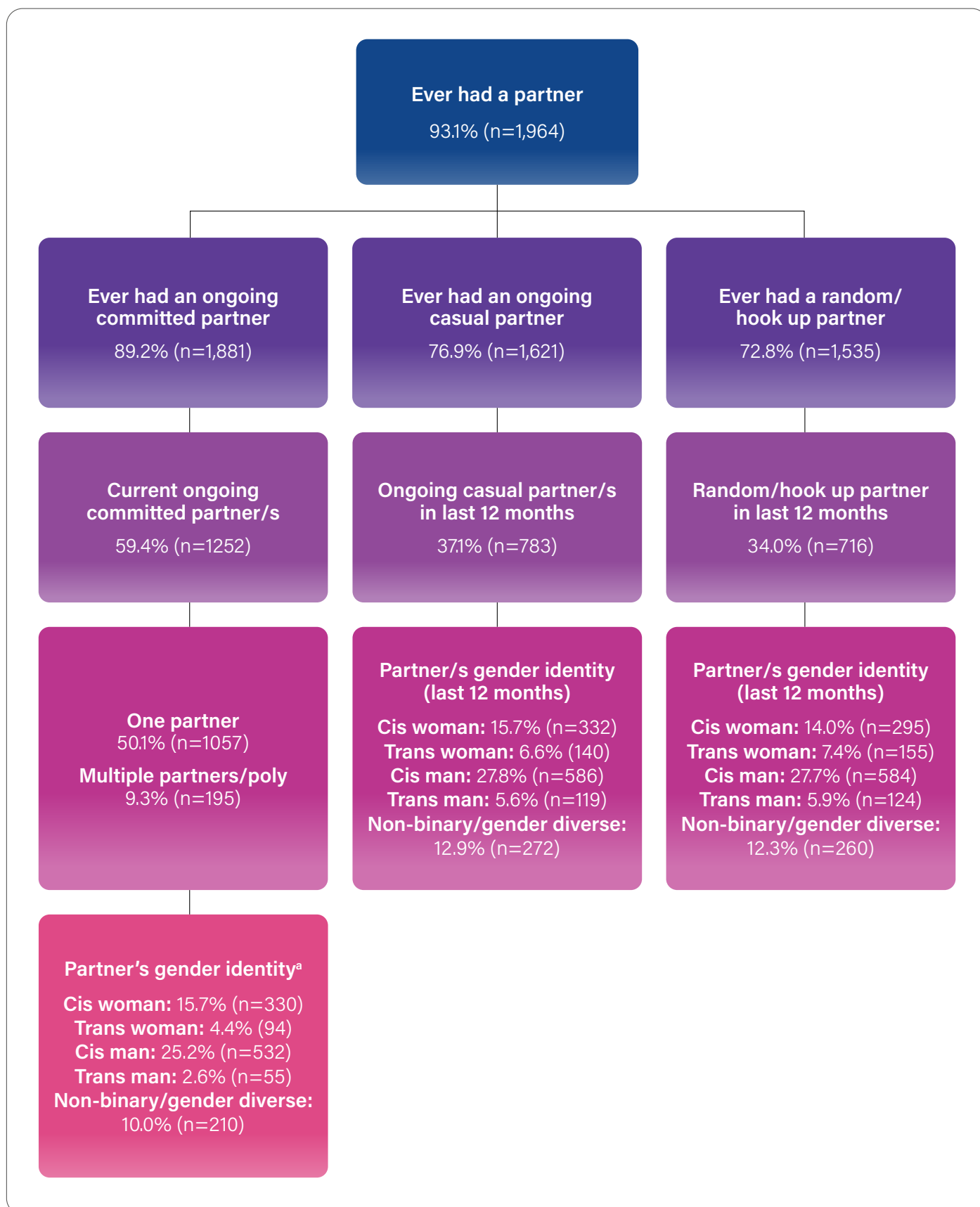
Based on feedback from our Advisory Group, we asked participants about experiences with three different types of sexual partners as well as any relationship arrangements involving multiple partners, including polyamorous relationship structures. The three sexual partner types were described as ongoing committed partners (monogamous and non-monogamous), ongoing casual partners, and random/hook up partners. The definitions we provided to participants of these partner

types are outlined in Figure 4. While these categories cannot encompass all the ways our participants meet, connect with, and in some instances, build relationships with their sexual partners, we chose to offer these three unavoidably broad categories for describing different partner types rather than asking participants to tell us about the sex they had with only one partner, which would have painted a far narrower picture of the sex lives of our participants.

Figure 4 Definitions provided of partner types

ONGOING COMMITTED PARTNERS	Sexual connections that are continuing and involve explicit definitions of and commitments to an ongoing relationship. Some terms used to describe these types of connections include primary partner, anchor partner, husband/wife/spouse, and boyfriend/girlfriend/joyfriend.
ONGOING CASUAL PARTNERS	Sexual connections that are continuing but in a more casual, undefined arrangement. Some terms used to describe these types of connections include lover, fuckbuddy, friends with benefits, booty call, and situationship.
RANDOM/HOOK UP PARTNERS	Sexual connections that were not anticipated and not expected to be repeated or ongoing. Some terms used to describe this type of sexual connection include hook up, one night stand, one nighter, rando, and fling.

Figure 5 Relationship and sexual partner types of participants



^a Participants in relationships with multiple partners and where a main partner could not be identified by the participant are not included (n=29).
Note: Denominator for all percentages is the full sample (n=2,109)

ONGOING COMMITTED RELATIONSHIPS

Most (89.2%) participants reported having had at least one ongoing committed relationship in their lifetime. Over half (59.4%) of all participants were in a current ongoing committed relationship at the time of the survey: 50.1% with one partner and 9.3% with multiple partners (e.g. non-monogamous, polyamorous).

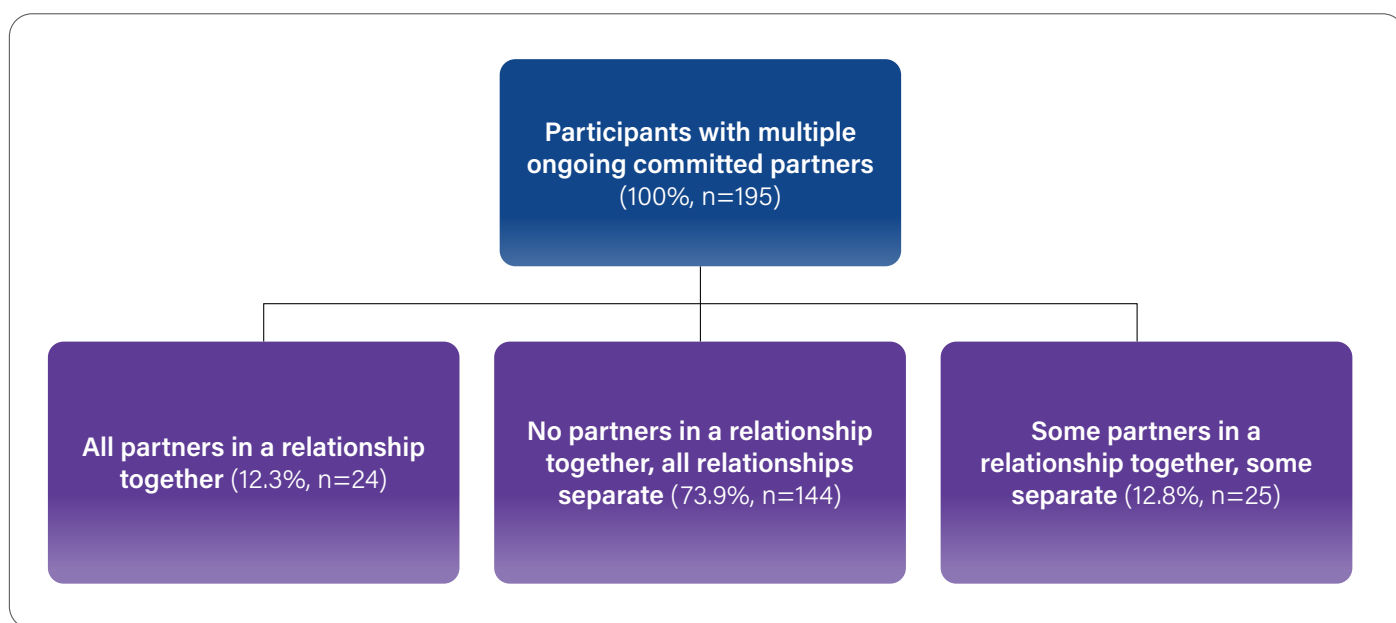
We asked participants about their current ongoing committed partner (n=1,057), including those who had multiple partners but could identify one 'main' partner (n=164), totalling 1,221 participants. Most of these participants (89.5%) indicated their partner knew they were bi+, while 7.3% indicated their partner did not know and 3.2% were not sure if their partner was aware or not. The most common sexual identities of current ongoing committed partners were heterosexual/straight (38.8%) followed by bisexual (24.2%), queer (10.5%), pansexual (9.0%), lesbian (7.0%), and gay (6.2%). Figure 5 presents more detail of the gender identity of participants' partners.

MULTIPLE PARTNERS AND POLYAMOROUS DYNAMICS WITHIN ONGOING COMMITTED RELATIONSHIPS

For those in ongoing committed relationships with multiple partners (n=195), the number of partners a participant had ranged from two to more than 10. Two-thirds of participants with multiple partners had two partners (68.2%), followed by three partners (14.4%), while 8.7% had four or more partners. Trans women were the most likely sub-group to report current ongoing committed relationships with multiple people.

Among participants with multiple partners, 73.9% had separate partners who were not in relationships with each other. About 12.8% had relationships where some partners were in relationships together and some separate, and 12.3% were in relationships where all partners were in a relationship together. Figure 6 details this further.

Figure 6 Relationship dynamics of participants with multiple partners



Note: There were 2 participants who indicated they had another arrangement and are not shown.

ONGOING CASUAL PARTNERS AND RANDOM/HOOK UP PARTNERS

In this survey, we asked about participants' sexual partners across their lifetime as well as in the last 12 months. Participants were slightly more likely to have ever had an ongoing casual partner (76.9%) compared to a hook up partner (72.8%), and this was also true in the last 12 months (37.1% versus 34.0%, respectively). However, in the last 12 months, participants were likely to report higher numbers of hook up partners compared to ongoing casual partners.

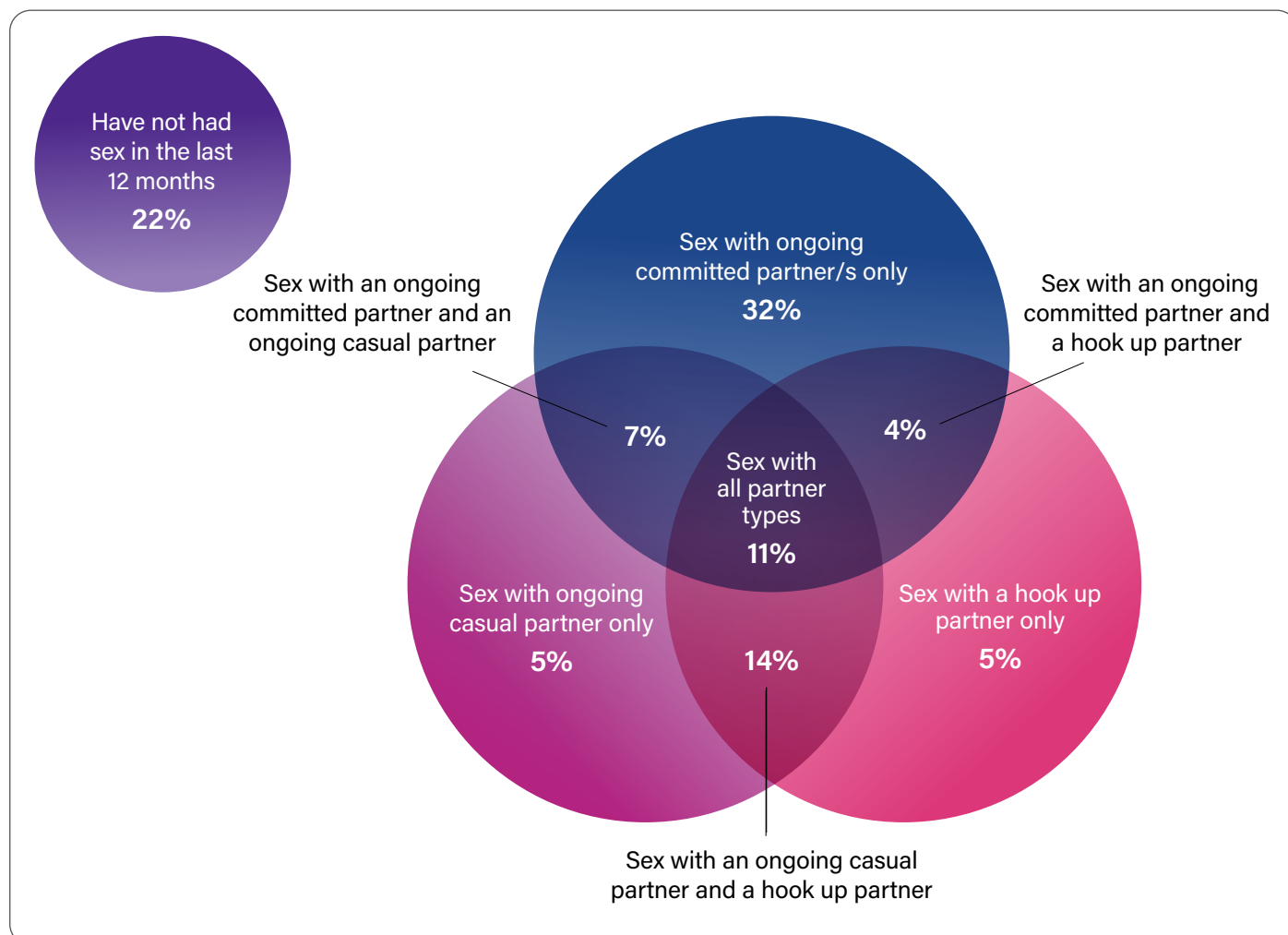
Gender identities of participants' partners in the last 12 months are shown in Figure 5. Cis men were most likely to report recent ongoing casual partners and random/hook up partners in the past 12 months.

SEXUAL PRACTICES

Most (94.2%) participants reported having had any kind of sexual contact with another person in their lifetime. Most (77.8%) had had sex in the last 12 months.

In the last 12 months, 32.0% of all participants had had sex only with an ongoing committed partner/s, while 21.5% had had sex with an ongoing committed partner/s and an ongoing casual or hook up partner. Figure 7 illustrates participants sexual history and sex partner dynamics in the last 12 months.

Figure 7 Participants sexual history and sex partner dynamics in the last 12 months



Note: Denominator for all percentages is the full sample (n=2,109).

Figure 8 shows the proportion of sexual practices reported at least once in the last 12 months by partner type. The proportion of sexual practices varied between partner types, and tended to follow a consistent pattern, often sequentially (ascending or descending) from ongoing committed partners to ongoing casual partners to hook up partners. For example, the use of sex toys was more likely with ongoing committed partners (85.4%) compared to ongoing casual partners (71.5%) and hook up partners (53.4%).

Participants were also more likely to have penis in vagina/front hole sex with or without a condom with ongoing committed partners (with condom: 74.2%, no condom: 65.7%) followed by ongoing casual partners

(with condom: 69.5%, no condom: 49.6%), then hook up partners (with condom: 63.7%, no condom: 38.1%). Conversely, anal sex with and without a condom was more common with hook up partners (with condom: 54.3%, no condom: 39.7%) compared to ongoing casual partners (with condom: 51.6%, without condom: 36.3%) and ongoing committed partners (with condom: 38.6%, without condom: 29.8%).

Kink practices which did not involve blood was reported by more than half of participants with each partner type. Kink practices that involved blood was less commonly reported and more often practiced with ongoing casual partners compared with other partner types.

Figure 8 Sexual practices with different partner types in the last 12 months

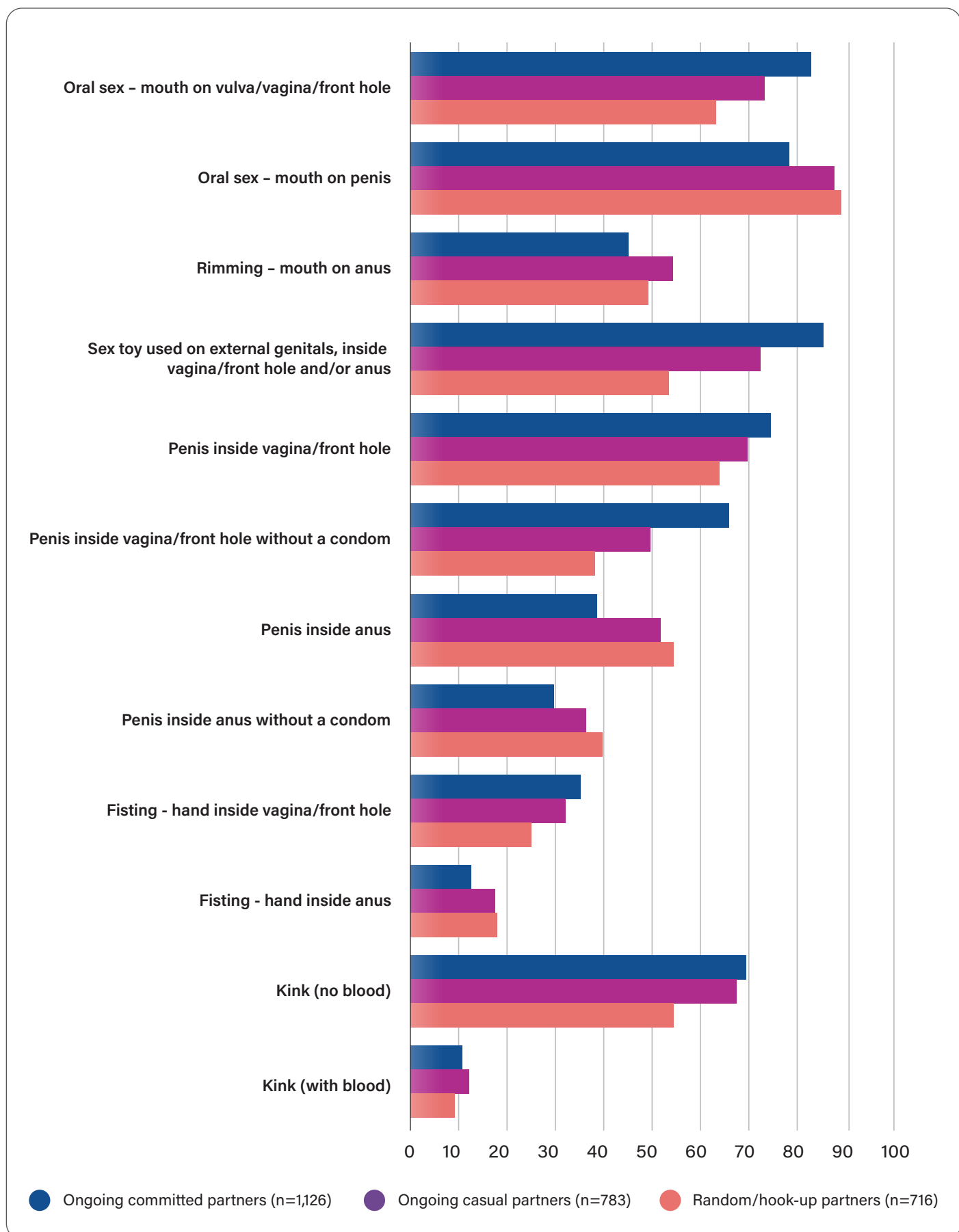


Table 4 presents some additional sexual behaviours participants had engaged in during their lifetime and within the last 12 months. Most participants (74.6%) reported having had sex with someone they met through an online dating/hook up app in their lifetime, including 44.8% in the last 12 months. Cis men were more likely than other genders to report having had sex with someone they met through a dating/hook up app. More than half (58.6%) of participants had had group sex in

their lifetime, with 26.0% reporting this in the last 12 months. Group sex was more common among cis men. About one-third (34.5%) of participants had ever used drugs for sexual purposes (i.e. chem sex, party'n'play, wired sex), with 17.4% in the last 12 months. In total, 15.1% of participants had participated in sex work in their lifetime, with 4.5% in the last 12 months. Trans women and non-binary/gender diverse people were more likely to have had recently or ever participated in sex work.

Table 4. Sexual behaviours

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Sex with someone met on dating/hook up app							
Ever	1,573 (74.6)	555 (70.7)	79 (76.0)	420 (73.3)	97 (70.3)	415 (83.0)	<0.01
In the last 12 months	945 (44.8)	288 (36.7)	46 (44.2)	233 (40.7)	54 (39.1)	320 (64.0)	<0.001
Group sex							
Ever	1,236 (58.6)	415 (52.9)	60 (57.7)	327 (57.1)	66 (47.8)	364 (72.8)	<0.001
In the last 12 months	548 (26.0)	145 (18.5)	34 (32.7)	134 (23.4)	19 (13.8)	214 (42.8)	<0.001
Drugs for sexual purposes (i.e. chem sex, party'n'play, wired sex)^a							
Ever	727 (34.5)	270 (34.4)	41 (39.4)	204 (35.6)	49 (35.5)	160 (32.0)	NS
In the last 12 months	367 (17.4)	121 (15.4)	21 (20.2)	99 (17.3)	29 (21.0)	95 (19.0)	NS
Sex work							
Ever	319 (15.1)	95 (12.1)	24 (23.1)	131 (22.9)	26 (18.8)	42 (8.4)	<0.001
In the last 12 months	94 (4.5)	28 (3.6)	10 (9.6)	34 (5.9)	5 (3.6)	16 (3.2)	<0.05

^aDrugs for sexual purposes was defined as taking drugs before or during sex acts for the purposes of enhancing or altering sexual experiences such as ecstasy, speed, cocaine, crystal, G, ketamine, and LSD.

SEXUAL AND REPRODUCTIVE HEALTH

SEXUAL HEALTHCARE ENGAGEMENT

Table 5 outlines participants' engagement and experiences with sexual healthcare in Australia. Most (88.8%) had accessed a sexual health-related service in Australia at least once, with cis men reporting lower use (79.8%). The most commonly accessed sexual health services were general practice (82.3%), followed by a sexual health clinic (46.7%). Half (51.3%) of all participants felt 'comfortable' or 'very comfortable' talking about sexual health with their healthcare professionals.

In the last 12 months, participants accessed sexual health information most commonly by searching online (70.4%), from their doctor or other healthcare professional (60.2%), social media (53.5%), and community health

organisations (48.4%). Trans and non-binary/gender diverse participants were more likely to access sexual health information from their doctor or other healthcare professional compared to cis participants. Trans men were more likely to access sexual health information from LGBTQ+ community organisations compared to participants of other genders. Participants were more likely to access sexual health information from LGBTQ+ friends (62.3%) compared to non-LGBTQ+ friends (26.2%) or family (10.5%). Cis men were less likely to access sexual health information from LGBTQ+ friends than participants of other genders.

Table 5. Sexual health engagement

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Ever accessed sexual healthcare	1,873 (88.8)	723 (92.1)	96 (92.3)	521 (90.9)	126 (91.3)	399 (79.8)	<0.001
Sexual health service usage^a							
General practice	1,736 (82.3)	702 (89.4)	87 (83.7)	494 (86.2)	116 (84.1)	330 (66.0)	<0.001
Sexual health clinic	984 (46.7)	319 (40.6)	59 (56.7)	269 (47.0)	86 (62.3)	245 (49.0)	<0.001
Community run LGBTIQ+ service or clinic	336 (15.9)	46 (5.9)	27 (26.0)	149 (26.0)	46 (33.3)	66 (13.2)	<0.001
Hospital	462 (21.9)	186 (23.7)	23 (22.1)	156 (27.2)	34 (24.6)	62 (12.4)	<0.001
Family planning clinic	277 (13.1)	160 (20.4)	3 (2.9)	89 (15.5)	13 (9.4)	12 (2.4)	<0.001
Comfortable talking about sexual health with healthcare professionals	1,082 (51.3)	425 (54.1)	69 (66.4)	292 (51.0)	65 (47.1)	228 (45.6)	<0.001
Sources of sexual health information^b							
Search online	1,484 (70.4)	535 (68.2)	68 (65.4)	447 (78.0)	97 (70.3)	334 (66.8)	<0.001
My doctor or other healthcare professional	1,269 (60.2)	440 (56.1)	78 (75.0)	380 (66.3)	99 (71.7)	268 (53.6)	<0.001
Friends who are LGBTQ+	1,313 (62.3)	478 (60.9)	81 (77.9)	429 (74.9)	88 (63.8)	234 (46.8)	<0.001
Social media	1,128 (53.5)	441 (56.2)	41 (39.4)	343 (59.9)	85 (61.6)	212 (42.4)	<0.001
Community health organisation	1,020 (48.4)	323 (41.2)	50 (48.1)	339 (59.2)	95 (68.8)	207 (41.4)	<0.001
Friends who are not LGBTQ+	553 (26.2)	274 (34.9)	21 (20.2)	132 (23.0)	22 (15.9)	102 (20.4)	<0.001
My family	222 (10.5)	87 (11.1)	8 (7.7)	73 (12.7)	14 (10.1)	39 (7.8)	NS

^a Participants who had ever accessed a sexual health service.

^b Sources accessed in the last 12 months.

EXPERIENCES OF LGBTQ+ SEXUAL HEALTH PROGRAMS OR SERVICES

Table 6 reports participants who 'strongly agreed' and 'agreed' with a series of statements exploring experiences in sexual healthcare settings, particularly with what we termed 'mainstream' LGBTQ+ services (that is, services for the LGBTQ+ community that are not *specific* to bi+ people).

Less than half (41.1%) of all participants felt LGBTQ+ services served their needs as a bi+ person, 47.1% felt welcomed in a LGBTQ+ service as a bi+ person, and 25.5% had avoided using an LGBTQ+ service. Less than half (47.5%) of participants felt that LGBTQ+ sexual health services were bi+ friendly. Trans and non-binary/gender diverse participants were more likely to agree that LGBTQ+ services met their needs, were bi+ friendly

and that they felt welcome at LGBTQ+ services. Trans and non-binary participants were also less likely than people of other genders to have avoided LGBTQ+ services.

Close to half (48.7%) of participants felt that LGBTQ+ services could be more bi+ inclusive. Most (70.4%) agreed that they would feel more included if they saw visual signs of bi+ support and 55.8% preferred intake forms to ask about sexual identity. Cis men were less likely than participants of other genders to feel that services could be more bi+ inclusive, prefer intake forms to ask about sexual identity, or feel included if they saw visual signs of bi+ support.

Table 6. Attitudes towards LGBTQ+ sexual healthcare^a

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
I feel LGBTQ+ services serve my needs as a bi+ person.	867 (41.1)	243 (31.0)	59 (56.7)	276 (48.2)	88 (63.8)	199 (49.8)	<0.001
I feel welcomed in a LGBTQ+ service as a bi+ person.	994 (47.1)	284 (36.2)	69 (66.4)	347 (60.6)	102 (73.9)	188 (37.6)	<0.001
I have chosen not to use or avoided using an LGBTQ+ service.	537 (25.5)	226 (28.8)	22 (21.2)	109 (19.0)	24 (17.4)	153 (30.6)	<0.001
I feel LGBTQ+ sexual health services are bi+ friendly.	1,002 (47.5)	294 (37.5)	65 (62.5)	319 (55.7)	98 (71.0)	222 (40.4)	<0.001
I feel LGBTQ+ services could be more bi+ inclusive.	1,026 (48.7)	406 (51.7)	49 (47.1)	334 (58.3)	77 (55.8)	155 (31.0)	<0.001
I prefer intake forms to allow me to indicate my sexual identity.	1,176 (55.8)	435 (55.4)	71 (68.3)	393 (68.6)	95 (68.8)	176 (35.2)	<0.001
I would feel included if I saw visual signs of bi+ support.	1,485 (70.4)	603 (76.8)	77 (74.0)	453 (79.1)	105 (76.1)	239 (47.8)	<0.001

^a Participants who 'agreed' or 'strongly agreed' with each statement are reported.

EXPERIENCES WITH SEXUAL HEALTH SERVICES

Table 7 reports participants who indicated 'most of the time' and 'all of the time' to a series of statements about experiences in sexual healthcare settings. This included general services and 'mainstream' LGBTQ+ services as described above.

Only 15.8% of participants reported being provided with information that was specifically relevant for bi+ people. Cis women (8.3%) were least likely to report being given relevant information. About 9.5% of participants felt clinical staff mostly or always seemed confused about what sexual health tests to provide them. Another 9.5% of participants felt they mostly or always had to educate clinical staff about their sexuality, and trans women (21.9%) were more likely to always or mostly feel they had to do this education. In total, 42.7% of participants felt clinics were knowledgeable and inclusive of bi+ people.

Just under one-quarter (23.8%) of participants felt clinical staff made assumptions about their sexuality and sex life. Smaller proportions of participants reported that clinical staff always or mostly were dismissive of their sexual identity (6.5%) or asked inappropriate or intrusive questions (4.9%). Only half (50.6%) of all participants had felt comfortable talking about being bi+ in a sexual healthcare setting and 4.1% reported mostly or always having a negative experience related to their bi+ identity and accessing sexual health testing.

Table 7. Experiences with sexual healthcare settings^a

	Total ^b (n=1,873)	Cis women (n=723)	Trans women (n=96)	Non-binary / gender diverse (n=521)	Trans men (n=126)	Cis men (n=399)	p-value
I felt comfortable talking about being bi+	947 (50.6)	331 (45.8)	70 (72.9)	296 (56.8)	77 (61.1)	171 (42.9)	<0.001
The clinics I've visited were knowledgeable and inclusive of bi+ people	800 (42.7)	263 (36.4)	55 (57.3)	206 (39.5)	66 (52.4)	208 (52.1)	<0.001
I was provided with information that was specifically relevant for bi+ people	296 (15.8)	60 (8.3)	27 (28.1)	69 (13.2)	29 (23.0)	110 (27.6)	<0.001
Clinical staff seemed confused or unsure about which sexual health tests to provide me	177 (9.5)	54 (7.5)	14 (14.6)	61 (11.7)	17 (13.5)	31 (7.8)	NS
Clinical staff asked inappropriate or intrusive questions about my sex life	91 (4.9)	16 (2.2)	8 (8.3)	46 (8.8)	7 (5.6)	13 (3.3)	<0.001
Clinical staff made assumptions about my sex life	446 (23.8)	207 (28.6)	21 (21.9)	157 (30.1)	23 (18.3)	36 (9.0)	<0.001
Clinical staff were dismissive of my sexual identity	121 (6.5)	49 (6.8)	8 (8.3)	42 (8.1)	6 (4.8)	16 (4.0)	<0.001
I felt that I had to educate the clinical staff about my sexuality	177 (9.5)	47 (6.5)	21 (21.9)	76 (14.6)	13 (10.3)	19 (4.8)	<0.001
I had a negative experience related to my bi+ identity and accessing sexual health testing	76 (4.1)	17 (2.4)	7 (7.3)	30 (5.8)	6 (4.8)	16 (4.0)	NS

^a Participants who indicated 'most of the time' and 'all of the time' to each statement are reported.

^b This question was only shown to participants who had ever accessed a sexual health service (n=1,873).

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Most (81.3%) participants reported having had at least one STI test in their lifetime and half (50.5%) of participants had had an STI test in the last 12 months.

The most common types of STI testing were a urine sample (44.1%), followed by a blood test (42.8%). Over one-third (36.1%) of all participants had had an STI diagnosis in their lifetime, more than double the lifetime STI estimates for the general population (16%).²⁹⁻³¹ Cis women were most likely to report an STI diagnosis in their lifetime (41.7%). In total, 7.5% of participants had

been diagnosed with an STI in the last 12 months. See Table 8 for more detail.

Among the 393 participants who had never had an STI test, the most common reasons were believing they were not at risk (60.3%), they had never been offered one (45.0%), never having thought about it (29.0%), not having had sex (25.5%), not knowing where to get tested (19.9%), and feeling uncomfortable talking about sex with healthcare providers (19.1%).

Table 8. STI testing, diagnosis and HPV vaccination

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Ever tested for STIs	1,715 (81.3)	674 (85.9)	85 (81.7)	454 (79.2)	106 (76.8)	388 (77.6)	<0.001
STI test in last 12 months	1,065 (50.5)	380 (48.4)	58 (55.8)	293 (51.1)	70 (50.7)	259 (51.8)	<0.05
Types of STI testing							
Urine sample	931 (44.1)	314 (40.0)	54 (51.9)	264 (46.1)	60 (43.5)	234 (46.8)	<0.01
Blood test	903 (42.8)	295 (37.6)	52 (50.0)	255 (44.5)	57 (41.3)	240 (48.0)	<0.001
Throat swab	489 (23.2)	104 (13.3)	35 (33.7)	133 (23.2)	41 (29.7)	174 (34.8)	<0.001
Anal swab	361 (17.1)	39 (5.0)	30 (28.9)	100 (17.5)	29 (21.0)	162 (32.4)	<0.001
Vaginal or front hole swab	498 (23.6)	267 (34.0)	2 (1.9)	165 (28.8)	55 (39.9)	--	<0.001
Ever had any STI diagnosis	762 (36.1)	327 (41.7)	25 (24.0)	183 (31.9)	52 (37.7)	172 (34.4)	<0.001
STI diagnosis in last 12 months	159 (7.5)	64 (8.2)	5 (4.8)	39 (6.8)	12 (8.7)	39 (7.8)	NS
HPV vaccination	1167 (55.4)	563 (71.7)	38 (36.5)	368 (64.2)	93 (67.4)	103 (20.6)	<0.001

HPV VACCINATION AND CERVICAL SCREENING

Just over half (55.4%) of all participants had been vaccinated for human papillomavirus (HPV; Table 8). Highest levels were seen in cis women (71.7%), with lower levels among cis men (20.6%) and trans women (36.5%).

Table 9 presents cervical screening frequency among participants recommended for regular cervical screening (people with a cervix aged between 25 and 74 years, n=1,366). Two-thirds (68.9%) had been screened within the last five years, which is the recommended guideline.³²

One-quarter (24.4%) of participants who were eligible for a cervical screen had never been screened, and this was more common among trans men and non-binary/gender diverse people compared to cis women. Trans men were also more likely than cis women and non-binary/gender diverse people to have been screened more than five years ago indicating they were less up to date with the current cervical screening guidance of every five years.

Table 9. Cervical screening frequency among participants with a cervix

	Total ^a (n=1,366)	Cis women (n=785)	Non-binary/ gender diverse (n=433)	Trans men (n=138)	p-value
Cervical screening					
Never	333 (24.4)	159 (20.3)	122 (27.5)	52 (37.7)	<0.001
Within the last 5 years	941 (68.9)	574 (73.1)	298 (67.3)	69 (50.0)	
More than 5 years ago	83 (6.1)	48 (6.1)	19 (4.3)	16 (11.6)	
Don't know	9 (0.7)	4 (0.5)	4 (0.9)	1 (0.7)	

^a Participants recommended for regular cervical screening (people with a cervix aged between 25 and 74 years)

CONTRACEPTION

Participants were asked to indicate what types of contraception they had used in the last two years to prevent pregnancy. Participants who were recorded male at birth were shown a reduced list of contraception options without hormonal or menstrual cycle-based choices.

About 41.6% of participants had used at least one type of contraception in the last two years, while 19.4% participants indicated that contraception use had not been relevant for them.

Condoms were the most common form of contraception used by all participants (30.9%). Of participants recorded female at birth (n=1,370), the pill (15.1%) was the most common hormonal contraception option used, followed by an intrauterine device (IUD) (14.1%), emergency contraception/the morning after pill (7.9%), and the implant (7.0%). The withdrawal method was used by 12.5% of all participants and permanent surgical methods were used by 5.2%.

CONFIDENCE COMMUNICATING ABOUT SEX

Table 10 reports participants who 'strongly agreed' and 'agreed' with a series of statements about their preferences and confidence communicating about sex. About three-quarters (74.1%) felt they had at least one health provider with whom they could have a conversation about sexual or reproductive health, with cis men less likely to agree with this statement.

In discussions with sexual partners, most participants felt confident talking about consent (87.7%), preventing

unintended pregnancy or STIs (81.7%), and their sex life in general (77.6%). Most (69.1%) felt confident talking to their friends about sex and sexual relationships. Cis men stood out as less likely than people of other genders to report feeling confident talking to sexual partners or friends about sex and relationships.

Table 10. Preferences and confidence communicating about sex^a

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
I feel I have at least one health provider with whom I could have a conversation about sexual or reproductive health.	1,563 (74.1)	592 (75.4)	89 (85.6)	444 (77.5)	123 (89.1)	307 (61.4)	<0.001
I feel confident talking to my sexual partners about our sex life.	1,636 (77.6)	633 (80.6)	90 (86.5)	473 (82.6)	106 (76.8)	328 (65.6)	<0.001
I feel confident talking to my sexual partners about preventing unintended pregnancy or STIs.	1,724 (81.7)	683 (87.0)	89 (85.6)	494 (86.2)	108 (78.3)	344 (82.4)	<0.001
I feel confident talking to my sexual partners about consent.	1,850 (87.7)	706 (89.9)	95 (91.4)	508 (88.7)	122 (88.4)	412 (85.3)	<0.001
I feel confident talking to my friends about sex and sexual relationships.	1,457 (69.1)	626 (79.8)	82 (78.9)	431 (75.2)	99 (71.7)	214 (42.8)	<0.001

^a Participants who 'agreed' or 'strongly agreed' with each statement are reported.

STRATEGIES TO IMPROVE THE EXPERIENCES OF BI+ PEOPLE WITHIN SEXUAL HEALTH SERVICES

Participants were asked the open-ended question, 'please tell us what you think clinics and services could do to improve the experiences of bi+ people within sexual health services.' Below are some selected quotations from the 553 participants who responded to this question.

'Don't assume not only the gender of a person's current partner but (once you know that) don't assume the genders of their past and/or future partners! Just ask!'
– Non-binary/gender diverse person, 18

'Promoting staff to ask not assume in regards to details of bi+ people's relationships, sexual connections and activities' – Trans man, 29

'Being more open to allow people to fit in between the buckets that society has formed' – Cis man, 29

'I think more visual signs of bi+ support would make me feel more comfortable asking questions I need to know about sexual health...' – Cis man, 37

'Don't make assumptions about what people engage in sexually.'
– Non-binary/gender diverse person, 34

'Be better informed about what questions to ask regarding practices and risk factors.'
– Non-binary/gender diverse person, 26

'I feel safer at openly queer clinics'
– Non-binary/gender diverse person, 29

'Some sexual health services don't know what to do with me or my risk profile...'
– Cis woman, 31

'They could extend their knowledge beyond MSM (men who have sex with men, but do not identify as bi or gay). I am a bi+, trans woman, that is a very difficult label in society right now. The services for trans women are non-existent in our state, which makes the bi-erasure more extreme.'
– Trans woman, 48

'We often feel like an afterthought to gay or lesbian sexual health services; and while our needs intersect with theirs, there are some specific needs we have.'
– Trans woman, 35

HIV PREVENTION AND CARE

HIV STATUS AND TESTING

There were 31 (1.5%) participants living with HIV. Over two-thirds (68.6%) of participants were HIV-negative and 627 (29.7%) did not know their HIV status. In total, 70.9% of participants had had at least one HIV test in their lifetime and 42.3% had tested at least once in the last 12 months. Trans women and cis men were more

likely to have done both (Table 11). Of the 523 participants who had never tested for HIV, the most common reasons were that they did not believe they were at risk for HIV (67.9%), and that they had never been offered a test by a healthcare provider (53.4%).

Table 11. HIV status and testing

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
HIV status							
Living with HIV	31 (1.5)	<5 (<1.0)	<5 (<1.0)	9 (1.6)	<5 (<1.0)	17 (3.4)	<0.001
Negative	1,446 (68.6)	525 (66.9)	83 (79.8)	382 (66.7)	96 (69.6)	355 (71.0)	
Don't know	627 (29.7)	256 (32.6)	20 (19.2)	182 (31.8)	41 (29.7)	124 (24.8)	
Prefer not to say	4						
Ever had a HIV test	1,495 (70.9)	532 (67.8)	84 (80.8)	392 (68.4)	97 (70.3)	385 (77.0)	<0.001
HIV test in last 12 months	893 (42.3)	271 (34.5)	58 (55.8)	247 (43.1)	58 (42.0)	256 (51.2)	<0.001

PEOPLE LIVING WITH HIV

As only a small number of participants living with HIV completed the survey, there are limitations to the conclusions we can draw. Of the 31 participants living with HIV, over half (54.8%) were cis men, and 29% were non-binary/gender diverse. Nearly all of the participants living with HIV had an undetectable viral load (96.8%). Over half (58.1%) had ever used a peer navigation or peer support service/program for people living with HIV. Of those who had ever used such a service (n=18), 61.1% disclosed their bi+ identity when using the service and most felt very or somewhat supported with this disclosure (72.7%). In the last 12 months, 64.5% 'rarely' or 'never' reported experiencing HIV related stigma while 22.6% 'sometimes' and 12.9% 'always' or 'often' experienced HIV-related stigma.

'The stigma I experienced kept me away...I have missed out on finding my tribe because of HIV. But I am now finding my bi+ + tribe and I love it! Where I belong!' – Cis woman, 37

'It's really hard to find other bi+ people living with HIV, it can be lonely, but I can see that is slowly changing.' – Cis man, 32

HIV PREVENTION KNOWLEDGE

Most participants (86.2%) were aware of pre-exposure prophylaxis (PrEP) with fewer (61.2%) aware of post-exposure prophylaxis (PEP; Table 12).

Over half (58.2%) of participants 'strongly agreed' or 'agreed' that 'a PLHIV who has an undetectable viral load cannot pass on HIV (i.e. 'Undetectable = Untransmittable'), with cis men and trans women less likely to agree to this statement (50.4% and 53.9%, respectively).

PEP AND PrEP USE

A small proportion (3.2%) of participants had ever used HIV post-exposure prophylaxis (PEP; Table 12). In total, 12.1% of participants had ever used HIV pre-exposure prophylaxis (PrEP), 6.7% currently and 5.1% in the past. PEP and PrEP use was more common among cis men and trans men compared to participants of other genders.

Of the current or previous PrEP users (n=252), daily PrEP use (53.7%) was the most common form of dosing, followed by on-demand (33.7%). About one-fifth (21.8%) of participants were interested in taking PrEP in the future, with a further 38.9% unsure if they wanted to take PrEP in the future. Cis men, trans men and trans women were more likely to be interested in taking PrEP in the future.

Table 12. PrEP/PEP knowledge and access

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Know about PEP	1289 (61.1)	422 (53.8)	70 (67.3)	383 (66.8)	108 (78.3)	301 (60.2)	<0.001
Know about PrEP	1,816 (86.1)	646 (82.3)	95 (91.4)	501 (87.4)	131 (94.9)	435 (87.0)	<0.01
PEP use^a	67 (3.2)	8 (1.0)	4 (3.9)	16 (2.8)	8 (5.8)	30 (6.0)	<0.001
PrEP use^{b,c}							
Never used	1,825 (86.5)	773 (98.5)	74 (71.2)	518 (90.4)	110 (79.7)	343 (68.6)	<0.001
Previous use	107 (5.1)	6 (0.8)	17 (16.4)	20 (3.5)	17 (12.3)	47 (9.4)	
Current use	145 (6.7)	2 (0.3)	13 (12.5)	26 (4.5)	10 (7.3)	92 (18.4)	
Interested in taking PrEP in the future^b							
No	543 (25.8)	323 (41.2)	21 (20.2)	121 (21.1)	24 (17.4)	53 (10.6)	<0.001
Yes	460 (21.8)	74 (9.4)	30 (28.9)	150 (26.2)	45 (32.6)	161 (32.2)	
Unsure	639 (30.3)	243 (31.0)	31 (29.8)	196 (34.2)	51 (37.0)	113 (22.6)	

^a Those who had ever used PEP.

^b The 31 people living with HIV were not shown this question.

^c Only shown to those who were aware of PrEP (n=1,816).

SEXUAL VIOLENCE AND COERCION

Participants were asked, ‘since the age of 18, have you ever been pressured, coerced, or forced into doing something sexual you did not want to do or could not consent to?’ Participants were given the option to skip this section and 170 (8.1%) chose to do so.

Table 13 presents sexual violence and disclosure of participants who chose to complete this section (n=1,939). In total, 63.3% (n=1,228) of participants reported having sexual violence perpetrated against them since the age of 18, which is more than four and a half times higher than the general Australian population.³³

Cis women participants were more than three times as likely as women in the general population to have experienced sexual violence perpetrated against them.³³ Trans men, trans women, and non-binary/gender diverse participants were more than four and a half times as likely to have had sexual violence perpetrated against them than the general population.³³ Cis men participants were half as likely to have had sexual violence perpetrated against them compared with people of other genders, but

their reported incidence were still over five times higher than in the general male population.³³

Of those who had sexual violence perpetrated against them since the age of 18 (n=1,228), 79.3% indicated that they were bi+ at that time, while 5.9% didn’t remember or were not sure. Half (49.8%) indicated that the perpetrator knew about their bi+ identity, attraction or sexual history, while 14.8% were not sure.

Nearly two-thirds (62.3%, n=765) had told someone else about the most recent sexual violence and over half (58.2%, n=715) told someone in their personal life such as a friend, partner, family, co-worker or another person. Less than one-third (29.2%, n=358) told a service such as a mental health professional, medical professional, a crisis helpline, a sexual assault, domestic violence support or LGBTQ+ service, the police or another service. Cis men were less likely to have told someone in their life or a service about their experience of sexual violence.

Table 13. Sexual violence and disclosure

	Total (n=1,939)	Cis women (n=745)	Trans women (n=95)	Non-binary/ gender diverse (n=535)	Trans men (n=130)	Cis men (n=426)	p-value
Sexual violence since the age of 18	1,228 (63.3)	540 (72.5)	65 (68.4)	383 (71.6)	92 (70.8)	143 (33.6)	<0.001
Told someone in their personal life	715 (36.9)	329 (44.2)	41 (43.2)	240 (44.9)	50 (38.5)	53 (12.4)	<0.001
Told a service	358 (18.5)	161 (21.6)	22 (23.2)	123 (23.0)	29 (22.3)	21 (4.9)	<0.001

SOCIAL ENGAGEMENT AND INCLUSION

We explored the extent to which participants felt engaged with bi+, LGBTQ+ and heterosexual communities, as a sense of belonging within a community can affect the extent to which people are able to seek support for sex, health, and relationships. A sense of community can also reduce isolation and the negative impact of stigma, which can enable people to engage more confidently, assertively and safely in their sex lives.

SOCIAL ENGAGEMENT WITH BI+, GAY/LESBIAN AND HETEROSEXUAL PEOPLE

The social engagement scales in Table 14 were adapted from the 'Gay Social Engagement Scale',³⁴ a well-established two-item scale measuring social engagement traditionally among gay men. We adapted the scale by asking separately about bi+, gay/lesbian and heterosexual people.

Participants reported high social engagement with heterosexual people (63.1%), followed by bi+ people

(50.4%) and gay/lesbian people (47.6%). Cis men were more likely to report lower social engagement with bi+ people and gay/lesbian people and higher social engagement with heterosexual people. Trans and non-binary/gender diverse participants were more likely to report higher social engagement with bi+ people and gay/lesbian people compared with cis participants.

Table 14. High social engagement with bi+, gay/lesbian and heterosexual people^a

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Bi+ people	1,062 (50.4)	389 (49.6)	70 (67.3)	411 (71.7)	97 (70.3)	93 (18.6)	<0.001
Gay/lesbian people	1,004 (47.6)	385 (49.0)	64 (61.5)	313 (54.6)	89 (64.5)	152 (30.4)	<0.001
Heterosexual people	1,331 (63.1)	590 (75.2)	46 (44.2)	248 (43.3)	41 (29.7)	400 (80.0)	<0.001

^a Adapted from the 'Gay Social Engagement (GSE)' scale.³⁴ We asked the number of friends and amount of time spent socially with each group of people, scored between 0-7. High social engagement was defined as a score between 4-7.³⁴

INCLUSION IN COMMUNITY SPACES

Table 15 presents participants' feelings of inclusion within community spaces. Over half (57.9%) of participants reported higher (i.e. 'mostly' or 'very' included) feelings of inclusion in bi+ spaces, followed by mixed LGBTQ+ spaces (52.4%). Cis men were less likely to feel included in bi+ spaces or LGBTQ+ spaces compared to participants of other genders. Trans and non-binary/gender diverse participants were less likely than cis participants to feel included in heterosexual spaces.

Table 15. Higher feelings of inclusion within community spaces^a

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Bi+ specific spaces	1,221 (57.9)	466 (59.4)	70 (67.3)	402 (70.2)	81 (58.7)	199 (39.8)	<0.001
Lesbian and queer women focused spaces	656 (31.1)	395 (50.3)	46 (44.2)	158 (27.6)	6 (4.4)	50 (10.0)	<0.001
Gay men focused spaces	294 (13.9)	60 (7.6)	7 (6.7)	40 (7.0)	19 (13.8)	168 (33.6)	<0.001
Mixed LGBTQ+ spaces	1,104 (52.4)	390 (49.7)	67 (64.4)	371 (64.8)	90 (65.2)	184 (36.8)	<0.001
Heterosexual spaces	777 (36.8)	391 (49.8)	19 (18.3)	83 (14.5)	14 (10.1)	266 (53.2)	<0.001

^a Higher feelings of inclusion were defined as 'mostly' or 'very' included.

BI+ AND LGBTQ+ COMMUNITY INVOLVEMENT

We adapted the Gay Community Involvement Index³⁵ to understand and differentiate between bi+ and LGBTQ+ specific community involvement. Table 16 reports participants who 'strongly agreed' and 'agreed' with a series of statements about their involvement with bi+ specific communities and then within wider LGBTQ+ communities.

Overall, our sample of participants were engaged with bi+ and LGBTQ+ communities. Participants were most likely to engage with LGBTQ+ specific (74.5%) and bi+ specific (60.7%) media and online content.

Non-binary participants were more likely than other gender groupings to be involved with LGBTQ+ and bi+ communities while cis men were the least likely to be involved.

'We are often made to feel less welcome in queer spaces relative to other LGBTQ+ people and have our queerness minimised, and therefore that we may need lots more indication of bi+ friendliness... Being bi+ (as a cis woman) generally means feeling sort-of-but-not-fully accepted in straight spaces and healthcare, and sort-of-but-not-fully accepted in queer spaces and healthcare.' – Cis woman, 31

Table 16. Involvement with bi+ specific and LGBTQ+ communities^{a,b}

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary /gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Bi+ specific							
I am involved or volunteer with a bi+ community group, organisation or unofficial group.	265 (12.6)	93 (11.9)	20 (19.4)	108 (18.9)	12 (8.7)	32 (6.4)	<0.001
I am involved with the bi+ community online.	772 (36.6)	307 (39.1)	46 (44.2)	267 (46.6)	44 (31.9)	104 (20.8)	<0.001
I engage with media (TV, films, music, books, newspapers) and online content (blogs, social media) focused on bi+ people.	1,276 (60.5)	570 (72.6)	50 (48.1)	409 (71.4)	90 (65.2)	152 (30.4)	<0.001
I frequent bi+ bars, clubs, parties and events.	442 (21.0)	164 (21.0)	28 (26.9)	151 (26.4)	21 (15.2)	77 (15.4)	<0.005
I go to events, meet ups or places where I know I can socialise with other bi+ people.	650 (30.8)	234 (29.8)	48 (46.2)	244 (42.6)	29 (21.0)	94 (18.8)	<0.001
LGBTQ+							
I am involved or volunteer with an LGBTQ+ community group, organisation or unofficial group.	550 (26.1)	181 (23.1)	45 (43.3)	213 (37.2)	53 (38.4)	56 (11.2)	<0.001
I am involved with the LGBTQ+ community online.	1,240 (58.8)	477 (60.8)	81 (77.9)	425 (74.2)	102 (73.9)	149 (29.8)	<0.001
I engage with media (TV, films, music, books, newspapers) and online content (blogs, social media) focused on LGBTQ+ people.	1,563 (74.1)	665 (84.7)	79 (76.0)	510 (89.0)	124 (89.9)	179 (35.8)	<0.001
I frequent LGBTQ+ bars, clubs, parties and events.	823 (39.0)	342 (43.6)	53 (51.0)	262 (45.7)	52 (37.7)	112 (22.4)	<0.001
I go to events, meet ups or places where I know I can socialise with other LGBTQ+ people.	998 (47.3)	374 (47.6)	63 (60.6)	350 (61.1)	73 (52.9)	135 (27.0)	<0.001

^a Adapted Gay Community Involvement Index.³⁵

^b Participants who 'agreed' or 'strongly agreed' with each statement are reported.

BI+ NEGATIVITY AND BIPHOBIA

We used an adapted version of the Brief Anti-Bisexual Experiences Scale³⁶ to estimate experiences of discrimination from gay/lesbian and heterosexual people towards bi+ people. Participants reported one and a half times higher levels of bi+ negativity and discrimination (also known as biphobia) from heterosexual people than compared to gay/lesbian people.

OUTNESS ABOUT BI+ IDENTITY

Participants were asked if they were out about their sexual identities, behaviours or attractions to different groups of people in their lives (Table 17). Overall, participants were more likely to be out to 'most' or 'all' other bi+ people (69.3%) and gay/lesbian people (67.3%) in their lives. Less than half of all participants were out to 'most' or 'all' of their immediate family (42.7%), healthcare professionals (42.0%), heterosexual people in their lives (39.0%), people at work or school (16.6%) or extended family (12.7%). Cis men were less likely to be out across all groups of people.

Table 17. Outness about bi+ identity, behaviours or attractions to groups of people in participants lives^a

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Immediate family	901 (42.7)	349 (44.5)	53 (51.0)	318 (55.5)	72 (52.2)	104 (20.8)	<0.001
Extended family	268 (12.7)	102 (13.0)	17 (16.4)	96 (16.8)	20 (14.5)	31 (6.2)	<0.001
Bi+ people	1,461 (69.3)	607 (77.3)	79 (76.0)	476 (83.1)	105 (76.1)	188 (37.6)	<0.001
Gay/lesbian people	1,419 (67.3)	570 (72.6)	73 (70.2)	457 (79.8)	102 (73.9)	212 (42.4)	<0.001
Heterosexual/straight people	822 (39.0)	390 (49.7)	36 (34.6)	260 (45.4)	45 (32.6)	87 (17.4)	<0.001
People at work/school	351 (16.6)	163 (20.8)	16 (15.4)	115 (20.1)	17 (12.3)	39 (7.8)	<0.001
Healthcare professionals	886 (42.0)	280 (35.7)	71 (68.3)	293 (51.1)	78 (56.5)	162 (32.4)	<0.001

^a Higher feelings of inclusion were defined as 'mostly' or 'very' included.

ALCOHOL AND DRUG USE

ALCOHOL USE

We used a modified version of the alcohol frequency item within the Alcohol Use Disorders Identification Test³⁷ to understand how often participants consumed alcohol. About half (48.8%) drank alcohol less than weekly, followed by one or two days a week (19.5%), while 16.6% never drank alcohol. See Table 18 for more detail on participants' alcohol use. Participants were less likely to drink alcohol every day compared to the general Australian population (2.0% versus 5.2%, respectively).³⁸ Cis men were more likely than other gender groups to consume alcohol every day while cis women were less likely.

DRUG USE

Just under half (46.9%) of all participants had ever used illicit drugs (Table 18), which is representative of the general Australian population (47.0%).³⁹ Participants were more likely to have used illicit drugs in the last 12 months (23.7%) compared to the general Australian population (18%).³⁹

Participants were more likely to have ever injected illicit drugs in their lifetime (4.8%) compared to the general Australian population (1.4%).³⁸ Participants were also more likely to have injected drugs in the last 12 months (1.6%) compared to the general Australian population (0.2%).³⁸ Cis women were more likely to report drug use while cis men were more likely to have injected drugs.

ALCOHOL AND DRUG USE THAT IMPACTS WELLBEING

Participants who reported alcohol and drug use were asked if they had ever been concerned with their use or felt it had a negative impact on their life. Just under one-quarter (23.1%) reported being concerned or feeling a negative impact on their life due to their alcohol use, 6.7% due to their drug use and 12.3% due to both their alcohol and drug use.

Table 18. Alcohol and drug use

	Total (n=2,109)	Cis women (n=785)	Trans women (n=104)	Non-binary/ gender diverse (n=573)	Trans men (n=138)	Cis men (n=500)	p-value
Alcohol use^a							
Never	349 (16.6)	97 (12.4)	19 (18.3)	120 (20.9)	29 (21.0)	82 (16.4)	<0.001
Less than weekly	1,029 (48.8)	392 (49.9)	50 (48.1)	300 (52.4)	80 (58.0)	203 (40.6)	
1 or 2 days a week	412 (19.5)	181 (23.1)	20 (19.2)	84 (14.7)	17 (12.3)	108 (21.6)	
3 to 4 days a week	200 (9.5)	81 (10.3)	6 (5.8)	40 (7.0)	9 (6.5)	63 (12.6)	
5 to 6 days a week	77 (3.7)	29 (3.7)	6 (5.8)	20 (3.5)	1 (0.7)	21 (4.2)	
Every day	42 (2.0)	5 (0.6)	3 (2.9)	9 (1.6)	2 (1.5)	23 (4.6)	
Drug use^b							
Never	1,103 (52.3)	348 (44.3)	55 (52.9)	297 (51.8)	84 (60.9)	313 (62.6)	<0.001
Over 12 months ago	489 (23.2)	201 (25.6)	25 (24.0)	138 (24.1)	25 (18.1)	99 (19.8)	
In the last 12 months	500 (23.7)	233 (29.7)	24 (23.1)	131 (22.9)	29 (21.0)	81 (16.2)	
Prefer not to say	17						
Injecting drug use^c	101 (4.8)	24 (3.1)	3 (2.9)	31 (5.4)	8 (5.8)	35 (7.0)	<0.001

^a Adapted alcohol frequency item within the Alcohol Use Disorders Identification Test.³⁷

^b Participants indicated they had used at least one of the following drugs: ecstasy, MDMA, cocaine, crystal methamphetamine, heroin, GHB/GBL, ketamine, speed.

^c Lifetime use.

CONCLUSION

The BiSHH study is the first national survey on the sexual health and HIV needs of bi+ people in Australia. The study was developed through meaningful consultation and leadership from bi+ researchers, advocates, and community members. Our findings provide detailed insights into the lives of bi+ people in Australia, highlighting a rich diversity of sexual and gender identities, relationship dynamics and sexual practices. These data contribute much needed evidence to inform policy and practice responses and to better support this largely overlooked but significant sub-population within LGBTQ+ communities.

SEXUAL PRACTICES, RELATIONSHIPS, AND STI TESTING

Participants reported a broad range of sexual practices, and sexual partners of diverse gender and sexual identities. A variety of relationship types, including multiple partners, polyamorous and other non-monogamous relationship arrangements, were also reported. Most participants were sexually active (78%) in the last 12 months and engaged in a wide range of sexual practices. This included practices that may place participants at increased risk for STIs or HIV, such as having multiple sexual partners in last 12 months and engaging in condomless sex. Condomless vaginal/front hole sex was more commonly practiced with ongoing committed partners compared to hook up partners (66% versus 38%), while condomless anal sex was more common among hook up partners compared to ongoing committed partners (40% versus 30%).

Most participants had been tested for STIs (81%) and HIV (71%) at least once in their lifetime. Roughly half had been tested for STIs (51%) and HIV (42%) in the last 12 months. Over one-third (36%) of participants had been diagnosed with an STI in their lifetime, which is double that estimated among the general Australian population.²⁹⁻³¹ These findings support previous research that has identified an increased STI risk among bi+ people of all genders compared to the general population.⁹⁻¹¹

HIV PREVENTION

The findings identified gaps in bi+ people's knowledge about HIV. When asked about the effectiveness of Undetectable = Untransmittable (U=U) in preventing HIV transmission, over half (58%) of participants agreed that a PLHIV who has an undetectable viral load cannot pass on HIV.

Only 7% of all participants were currently using PrEP. Current PrEP usage was highest among cis men (19%) and trans women (13%), which may reflect lower perceived or actual HIV risk. Approximately one-fifth (22%) of participants were interested in taking PrEP in the future, including >30% of cis men, trans men, and

trans women. Although HIV prevention efforts have traditionally focused on gay men, these findings suggest that these messages may not be reaching some priority populations at risk of HIV such as bi+ cis men, trans women and trans men who have sex with men. Further work is also needed to consider bi+ cis women who may be at increased HIV risk and could benefit from PrEP.

SEXUAL VIOLENCE

Participants reported a high prevalence of adult sexual violence perpetrated against them (63%). Just over one-third (37%) had told someone in their personal life about the most recent experience of sexual violence and just 19% had accessed a service for support. These findings highlight the urgent need to understand and address drivers of sexual violence towards bi+ people and to increase prevention efforts and support services that are inclusive of, and appropriate for, people with bi+ identities and lived experiences.

SOCIAL ENGAGEMENT AND COMMUNITY CONNECTION

Bi+ communities and wider LGBTQ+ communities play prominent roles in many of our participants' lives. Participants were most likely to feel included in bi+ spaces (58%), followed by LGBTQ+ spaces (52%), and were more often out about their sexual identity to other bi+ people (69%) and gay/lesbian people (67%) compared with other groups such as immediate family (43%) or heterosexual/straight people (39%). Only 17% of participants were out at work or school, and just 13% were out to their extended family. Community connection and a sense of community belonging are indicators of health and wellbeing, as they can affect the extent to which people are able to seek healthcare and support regarding sex, relationships, and sexual health.⁴⁰ This was evident among our sample who reported that LGBTQ+ friends (63%) were important sources of sexual health information compared to non-LGBTQ+ friends (26%).

INCLUSION IN LGBTQ+ SEXUAL HEALTH SERVICES

Findings suggest there are currently a range of barriers to bi+ people feeling included within LGBTQ+ services, with only 47% of participants reporting feeling welcome in 'mainstream' LGBTQ+ sexual health services or programs. In addition, only 41% of participants felt LGBTQ+ services serve their needs as a bi+ person, and about half (49%) felt that LGBTQ+ services could be more inclusive of bi+ people. Most (70%) participants agreed they would feel more included in LGBTQ+ sexual health services if they saw visual signs of bi+ support and 56% would prefer intake forms to allow them to indicate their sexual identity. These findings suggest that there may be a need for LGBTQ+ sexual health services to implement targeted strategies to strengthen bi+ inclusion within their services and programs, though it should be recognised that bi+ people are not one homogenous group and will have varied needs and preferences within services.

INCLUSION AND ENGAGEMENT IN GENERAL SEXUAL HEALTH SERVICES

Findings indicated limited inclusion of bi+ people within general sexual health services (i.e., services not specifically designed for LGBTQ+ people). Only half (51%) of all participants felt 'mostly' or 'always' comfortable talking about being bi+, and just 43% felt that clinics were knowledgeable and inclusive of bi+ people. Few participants (16%) reported 'mostly' or 'always' being provided with information that was specifically relevant for bi+ people. These findings demonstrate the importance of improving clinicians' understanding of bi+ specific health needs and social issues within general sexual health services to promote inclusive care.

Despite barriers to inclusion within sexual healthcare, most participants (89%) had engaged with a sexual health service at least once in their lifetime, and 89% were engaged with general healthcare, either having a regular GP or clinic they attend. About two-thirds (65%) of participants self-rated their overall access to healthcare in Australia as 'good' or 'great'. Most (75%) participants felt they have at least one health provider with whom they could have a conversation about sexual or reproductive health. However, when asked about levels of comfort, only half (51%) felt comfortable talking about sexual health with their healthcare professionals. Additionally, just 42% of all participants were out about their sexual identity to their healthcare professionals in general, which may act as a barrier to accessing targeted and appropriate care (such as LGBTQ+ friendly mental health services or appropriate STI tests).

OTHER HEALTH AND WELLBEING PRIORITIES

Our findings also identified other key health priorities for bi+ people in Australia, including elevated rates of mental ill-health, and alcohol and illicit drug use, including injecting drug use, compared to the general population, consistent with previous research.^{15,16,41} Of the participants' who had ever reported alcohol or drug use, 23% self-reported concern or negative impact with their alcohol use, 7% with their drug use and 12% with both. These findings speak to the continued importance of prioritising and engaging bi+ communities within policies and service responses related to mental health and alcohol and drug use.

Bi+ people in our sample also faced socio-economic challenges. Over half (55%) of participants were university educated. However, only 46% were employed full-time, and 40% earned an annual income of \$50,000 or below which is lower than the general Australian population's median annual income of \$74,100.²² This discrepancy between educational attainment and income has been recognised in other research conducted with LGBTQ+ populations and can reduce access to healthcare.⁴²

EXPERIENCES ACROSS GENDER

Experiences among participants varied significantly across the five gender groupings we used in this survey. The most common difference, observed across multiple domains, was that of cis men compared to the other gender groupings. For example, cis men tended to be less socially engaged with bi+ and LGBTQ+ communities and less likely to feel included in these spaces. Compared with people of other genders, cis men were also less likely to be out about their sexual identity to others, to have accessed sexual healthcare, and to have disclosed and sought help following sexual violence. Further, cis men were more likely to have engaged in sexual practices that have increased STI and HIV risks such as group sex, sex with casual or hook up partners, and condomless anal sex, but were less likely to feel comfortable discussing sexual and reproductive health with health providers or sexual partners.

These findings highlight an important difference between cis bi+ men and communities of gay men, where there is a culture of actively negotiating sexual safety. Research has shown that bi+ men experience high levels of stigma, particularly HIV-associated stigma, due to historic public discourses positioning bi+ men as responsible (e.g. a 'bridge') for HIV transmission between gay men and heterosexual women.¹⁹ Such stigma can discourage disclosure of sexual identities, adversely impact health outcomes, and limit access to

appropriate healthcare, which may explain the difference in experiences of cis men in our sample compared to other gender groups.⁴³

Responses from trans women, trans men and non-binary/gender diverse people generally tended to be clustered together and revealed similarities across findings. For example, trans and non-binary/gender diverse participants tended to feel more included and engaged with LGBTQ+ communities, potentially reflecting dual pathways to community connection through both gender and sexuality experiences. By contrast, cis men and women may only have a single-entry point to community connection, via sexuality, and they reported feeling less included compared to trans and non-binary/gender diverse participants.

However, despite a general clustering of trans and non-binary/gender diverse people's experiences, there were specific instances where their experiences diverged. For example, trans women and cis men reported similar rates of HIV testing and PrEP use, while trans men and cis women reported similar levels of engagement with services related to reproductive health, such as cervical screening or contraception. This highlights the ongoing need to focus on trans and non-binary/gender diverse people as distinct groups of priority within sexual health and HIV responses, and to ensure that attention is given to the specific social, structural, and physical contexts that shape their health experiences.

The reported outcomes and experiences of cis women tended to sit somewhere between those of cis men and trans and non-binary/gender diverse participants. However, there were some domains where findings related to cis women were markedly different to people of other genders. These included higher levels of engagement with healthcare, and higher rates of illicit drug use, sexual violence and STI diagnoses. These findings support the importance of focusing on bi+ women as a unique population separate from heterosexual and lesbian women, particularly within sexual health contexts.⁴⁴

STRENGTHS AND LIMITATIONS OF THE STUDY

A key strength of our study was its community-led design, which involved ongoing leadership from, and consultation with, bi+ community members and investigators. These collaborative efforts are reflected in the robust sample of participants we were able to engage across Australia. Another major strength was the rich dataset generated from the survey, which included a broad range of questions on sexual health, relationships, and wellbeing. This detailed information, generously shared by our participants, enabled meaningful comparisons, identification of patterns, and will provide valuable insights for future research and translation into practice.

There are also limitations to this study that are important to note. This study was conducted as an online survey and recruitment predominantly occurred through social media, dating/hook up apps, and online networks. Participants therefore needed internet access and engagement with social media content or online networks to participate. As a result, our sample tended to skew toward a younger demographic, which is reflective of international trends showing higher proportions of bi+ populations among younger people. We recruited many responses from bi+ men through online hook up apps (Grindr and Squirt), which may have captured bi+ men who were behaviourally bi+ but not openly identifying as bi+ and/or not engaged with LGBTQ+ communities. In addition, as our recruitment strategies utilised networks of community-based organisations and grassroots bi+ groups, our sample may contain more bi+ people who were community connected and regularly engaged with sexual healthcare. The survey was only available in English which may have been a barrier for linguistically diverse people, and most of our participants were born in Australia and reported Anglo-European ancestry. We also had a limited number of responses from people living with HIV as well as smaller sample sizes of trans women and trans men compared to other groups.

'Sex and gender are becoming more fluid than ever before and it's about time our sexy health and queer spaces caught up with the behaviours of their communities.' – Cis woman, 37

'Bi people seem to just be forgotten for the most part, even though we are the large group statistically.' – Trans woman, 41

RECOMMENDATIONS

The BiSHH findings offer actionable insights for improving policy, practice and service design. Strategies should be grounded in increasing bi+ visibility, promoting awareness of the diversity of bi+ communities, embedding inclusivity, and reducing systemic bi-erasure.

Specifically, we recommend:

1. Including bi+ people as a priority population within sexual violence services and responses

- Develop bi+ specific resources and referral pathways in sexual violence services.
- Invest in workforce capacity building and peer support models to ensure bi+ people have access to safe, informed, effective forms of care and support.

2. Strengthening bi+ inclusion in mainstream sexual health services

- Develop and deliver targeted training for healthcare professionals to increase understanding of bi+ specific health needs and social issues, including the diversity of bi+ communities and intersections with gender, sexuality, and non-monogamous and polyamorous relationship structures.
- Embed an inclusive, person-centred approach to care that validates bi+ identities and experiences. This could include the addition of inclusive language and asking behaviour-based questions, and avoiding assumptions based on partner numbers and genders.

3. Increasing bi+ visibility and inclusion in LGBTQ+ services

- Include distinct and explicit signals of bi+ support within organisations through visible bi+ representation and inclusive language.
- Affirm the inclusion of bi+ people within service design and messaging through, for example, the development of best practice guidelines for inclusion and ensuring health promotion activities are designed with consideration of bi+ identities, taking into account the diversity of gender, sexuality, and sexual behaviour within this population.
- Audit service information materials and resources (print and online) to review for instances of biphobia, bi-erasure or assumptions.
- Invest in the development of tailored resources specific to the needs of bi+ people, particularly those who may be at increased risk for STIs, HIV, and unintended pregnancy.
- Ensure LGBTQ+ inclusion measures and accreditation models are adequately inclusive of bi+ experiences and needs.

- Drive targeted efforts to increase bi+ inclusion within LGBTQ+ community spaces, with a particular focus on increasing bi+ cis men's levels of community connectedness.
- Develop targeted, strengths-based interventions to support and increase bi+ cis men's confidence and capacity to talk to their sexual partners of all genders about sexual health, relationships and consent.

4. Refining STI/HIV testing and PrEP guidelines for bi+ people

- Review prevention frameworks and clinical guidelines to ensure that the distinct needs of bi+ people at increased risk of STIs/HIV are considered.
- Recognise and address the specific needs of bi+ polyamorous and/or non-monogamous people within risk assessment and protocols, as they may be overlooked within current guidelines. Strategies may involve assessing sexual networks, particularly for cis women who are sexually connected with bi+ and other men who also have sex with men.

5. Increasing awareness and prioritisation of bi+ populations in mental health and drug and alcohol service responses

- Assist health and community services focused on the diagnosis, treatment and care of people experiencing mental ill-health to understand the specific challenges for bi+ people (e.g. biphobia, stigma, discrimination, community rejection). This should include intersectional considerations for bi+ trans and non-binary/gender diverse people, who are at an increased risk of developing mental ill-health.
- Increase awareness of alcohol and drug use among bi+ people within health and community services, including LGBTQ+ specific services, to tailor efforts to support the specific social and health challenges that can exacerbate problematic use.

6. Ensuring bi+ people are identified as a priority population within relevant national and state-based policies and strategies

- Recognise the distinct needs of bi+ communities in policies and strategies, including in relation to LGBTQ+ health, sexual violence, mental health, sexual health, HIV, and alcohol and drug use.
- Ensure that sexual health and HIV policies and strategies attend to bi+ people's differing and specific risks and needs in testing, treatment, prevention and support.

- Acknowledge the higher rates of sexual violence among bi+ people in sexual violence policies and strategies, and identify and resource the implementation of actions to address and prevent biphobia and bi-erasure as drivers of violence and harm.
- Address the role of biphobia and bi-erasure in mental health and alcohol and other drugs policies and strategies, recognise how this can impact bi+ people's wellbeing, and promote bi+ visibility, inclusion and access to supportive communities as a preventative measure.
- Increase attention to bi+ women in women's health policies and strategies and identify actions to address their needs as a specific priority group. Bi+ women should not be combined with lesbian and gay women without consideration of their specific needs and areas of potential difference, particularly in sexual health and mental health.
- Increase attention to bi+ men within men's health policies and strategies, including those focused on men who have sex with men, and identify actions to address their needs as a specific priority group. Bi+ men should not be combined with gay men without considerations of their specific needs and areas of potential difference, particularly in sexual health and mental health.
- Ensure that health and social policies and strategies structured around binary gender categories are inclusive of bi+ trans men, trans women and non-binary/gender diverse people, and meaningfully consider their specific needs and areas of potential difference, particularly in sexual health and mental health.

FURTHER RESEARCH

This exploratory study was developed to address the lack of specific and rigorous data on the distinct experiences of bi+ people, separate to heterosexual and gay/lesbian people in Australia. These findings raise further questions and highlight several priority areas for future investigation.

These include:

- Qualitative research on bi+ people's sexual health, mental health, alcohol and drug use and other aspects related to wellbeing, including experiences with seeking support, to deepen understanding and inform strategies for service improvement.
- Targeted research with bi+ people from non-English speaking backgrounds or born overseas, particularly those without Medicare access, whose perspectives were underrepresented in this sample.
- Research focused on bi+ people living with HIV, whose experiences across all genders remain largely undocumented in the Australian context, with the exception of Power et al's 2021 analysis on bisexual men living with HIV.⁴⁵
- Community-led and participatory research with bi+ community input across all stages of the research process to ensure relevancy, community appropriateness and increased rigour.
- Dedicated funding for ongoing bi+ specific research with large sample sizes of bi+ people to increase the evidence on bi+ experiences as separate from those of heterosexual, gay and lesbian people. This should include ongoing research into the differences in experiences between bi+ people and heterosexual, gay and lesbian people.

The BiSHH study offers new insights into the lives of bi+ adults in Australia. Our study highlights that bi+ people are a diverse community across genders, identities and practices and cannot be simplified within a narrow definition. This means a 'one size fits all' approach will not work for bi+ communities, and supports the ongoing need for research to focus on bi+ people as their own distinct population group separate from heterosexual, gay and lesbian people. Recognising this diversity and the challenges of biphobia and bi-erasure, will be vital for health professionals, advocates and policy makers to enable improvements to the health and wellbeing of this important and growing population.

GLOSSARY

Bi+: A community driven umbrella term used to describe sexual identities that are characterised by attraction to more than one gender.

Bi or Bisexual: Attracted to more than one gender, although not necessarily at the same time, in the same way, or to the same degree.⁴⁶

Bi-erasure: Denial, dismissal or minimisation of the existence or validity of bi+ identities.

Biphobia: Negative and harmful beliefs, prejudices and stereotypes about bi+ people.

Cis or Cisgender: People who identify their gender as the same as what was presumed for them at birth (male or female).⁴⁷ In this report cisgender is shortened to cis.

Front hole: A term preferred by some trans men and non-binary people to describe their genitals, instead of vagina.⁴⁷

Gay: Typically refers to men who are exclusively attracted to other men. However, it can also be a general term for people who are romantically and/or sexually attracted to people of the same gender as themselves.⁴⁸

Gender diverse: An umbrella term for all people whose gender differs from what was presumed to them at birth.⁴⁸

Gender identity: Refers to how a person understands and identifies their gender. It describes one's innermost concept of self – how individuals perceive themselves. This may be different to sex presumed at birth and may be different to what is indicated on legal documents.⁴⁸

Heterosexual: Typically describes men who are exclusively attracted to women, and women who are exclusively attracted to men. Sometimes referred to as 'straight'.⁴⁸

Variation of sex characteristics: Are natural differences in the development of sex characteristics (e.g. chromosomes, hormones, gonads, reproductive organs, secondary sex characteristics) that don't fit medical 'norms' for female and male bodies.

Kink: Consensual sexual behaviours, interests, or practices that go beyond what are considered conventional norms, often with the intention of increasing pleasure, intimacy, and expressing desires.

Lesbian: Typically refers to women and some non-binary or gender diverse people, who are exclusively attracted to other women.⁴⁸

LGBTQ+: An acronym for lesbian, gay, bisexual, trans, queer plus other diverse gender and sexual identities.

Non-monogamous: An umbrella term for people who engage in relationships structures outside of monogamy. Non-monogamy can take many forms (e.g. open relationships, swinging), but generally includes people who are, have been, or plan to have romantic or sexual relationships with more than one person.⁴⁷

Non-binary: An umbrella term for a range of gender identities that fall outside of the two-sex binary of exclusively woman or exclusively man, and more along a gender spectrum.⁴⁸

Pan or pansexual: A sexual identity defined by attraction to people regardless of their gender identity.

Polyamorous/poly: the practice or desire of relationships with more than one person at the same time, with informed consent of all involved.

Queer: An inclusive umbrella term for sexuality and gender diverse people.⁴⁸ The term sometimes holds political implications of resistance to social norms and binaries of gender and sexuality.

Trans or Transgender: Trans is an inclusive umbrella term that describe people whose gender is different to what was presumed for them at birth. Trans people may position 'being trans' as a history or experience, rather than an identity, and consider their gender identity as simply being female, male or a non-binary identity.⁴⁷

Transphobia: Negative and harmful beliefs, prejudices and stereotypes about trans people.

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