Submission to the Senate Standing Committees on Community Affairs, inquiry on universal access to reproductive healthcare

Background

On 28 September 2022, the Senate referred an inquiry into the universal access to reproductive healthcare to the Senate Community Affairs References Committee for inquiry and report by 31 March 2023.

There is a current consultation listed on the Senate Standing Committees on Community Affairs website, which is open until 11.59 pm AEDT on 15 December 2022. We appreciate the opportunity to provide a submission. This submission is written in response to the Committee Terms of Reference.

We consent to this submission being published on the inquiry website and shared publicly online.

FPNT response to Senate inquiry Terms of Reference

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:

a. cost and accessibility of contraceptives, including:

i. Pharmaceutical Benefit Scheme (PBS) coverage and Therapeutic Goods Administration (TGA) approval processes for contraceptives,

ii. Awareness and availability of long-acting reversible contraceptive and male contraceptive options, and

iii. Options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;

Recommendations:
Publicly-funded contraception services in primary health care clinics and public hospitals should be available to provide no-cost contraception to all clients, regardless of visa status.

Public hospitals should provide all methods of postpartum and post-abortion contraception, including postpartum IUD, at no cost to clients

LHNs should develop referral centres for complex contraceptive procedures, with priority Category 2 access (within 90 days) for contraceptive procedures in theatre. Referral centres should develop capacity for office-based complex IUD and contraceptive implant procedures.

National key performance indicators for contraceptive care should be developed and reported against by State and Territory PHNs and LHNs to ensure timely and acceptable access to abortion services

Contraception access in the Northern Territory

Data on contraceptive use in the NT and Australia is limited, as there is no routine national and Territory population-based contraception data that is regularly collected. Data on contraceptive use are derived from small surveys and Medicare data, both with limitations.

A 2015 survey found that 70% of people requiring contraception in the Northern Territory (NT) reported current contraception use, comparable to the national average of 67% (**Family Planning New South Wales [FPNSW] 2020**). NT has the highest proportion of intrauterine device (IUD) and contraceptive implant use among the States and Territories, at 18% and 7.1%, respectively. These are higher than the 2015 national average for IUD and contraceptive implant use of 4.5% and 5.1%, respectively. Data from MBS and PBS appears to confirm the high uptake of contraceptive implants in the NT; however, MBS and PBS claims of hormonal IUD are lower in the NT than other jurisdictions. (**FPNSW 2020)** This discrepancy in Medicare and survey data highlights the need for population-based routine data collection on contraception in NT and Australia.

<u>Contraceptive landscape in NT</u>

Contraceptive consultations and commodities

- Contraception is accessed through Primary Health Care clinics (e.g. private GP, FPNT, AMS)
- Most private GP charge an out-of-pocket fee for clients accessing contraceptive care
- Clients who are Medicare eligible can access bulk-billed contraceptive consultations at FPNT in Greater Darwin, although this will likely to transition to mixed-billing in early 2023.
- Contraceptive methods incur out-of-pocket costs, with subsidies for Medicare eligible clients for some methods through PBS
- Aboriginal and Torres Strait Islander clients can access contraceptive services and commodities at no cost through AMSs

Emergency contraception

- Emergency contraception pills are available from pharmacies without prescription. No data is available on whether there are pharmacists that are conscientious objectors to emergency contraception in NT.
- No data is available on the uptake of Copper IUD as emergency contraception in NT, but it is likely to be low due to health service limitations to provide urgent Copper IUD insertions.

Contraceptive procedures (IUD and implants)

- Contraceptive implant insertions and removal are widely available in Primary Health Care clinics, although private GPs charge an out-of-pocket fee.
- Remote area nurses provide contraceptive implant insertions and removals in remote community clinics
- IUD insertions are available through FPNT in Greater Darwin, some AMSs and private GP clinics. IUD insertions at AMSs are bulk-billed.
- In Greater Darwin, clients preferentially attend FPNT for IUD insertion procedures because of the lower out-of-pocket costs (e.g. approximately $250 in a private GP clinics vs $120 in FPNT)
- RDPH and KH provide regular specialist gynaecology outreach services to remote communities in Top End and Big Rivers region, which includes insertion of IUD procedures. This is publicly funded.

Postpartum contraception

- Postpartum clients in RDPH can receive the contraceptive injection or a one month supply of the progesterone only pill on discharge
- Postpartum contraceptive implant insertion in RDPH is only provided to clients from remote communities. Other clients in Greater Darwin have to access contraceptive implant insertion through private GP clinics, DDHS or FPNT
- Postpartum IUD insertion is not routinely offered after vaginal or caesarean births in RDPH
- Contraceptive implants and IUD are routinely inserted following surgical abortions; however, clients need to supply their own contraceptive devices with associated out-of-pocket costs

Complex contraceptive procedures

A) Complex contraceptive implant removal

- There is no access to ultrasound-guided or office-based impalpable contraceptive implant removal in NT. All clients are referred to the general surgical services for complex implant removals in theatre.
- There is no publicly available data on complex contraceptive implant removal wait times. Anecdotally, clients in Greater Darwin can expect long wait times in the public sector, or access care through the private sector with high out of pocket costs. Clients in ASH, KH and GDH are likely to access surgical removal of impalpable implants with shorter wait times, due to lower surgical caseloads.

B) Complex IUD insertions or removals

- There is no access to ultrasound-guided or office hysteroscopic removal of IUDs in the NT. All clients for complex IUD removals are referred to the public gynaecology service for removal under sedation.
- There is no publicly available data on wait times for IUD procedures under sedation. Data on hysteroscopy wait times, which may include hysteroscopic removal of IUD, can be confounded by hysteroscopies performed for suspected endometrial pre-malignant and malignant conditions that are categorised as urgent. Anecdotally, clients in Greater Darwin can face significant wait times for IUD insertions or removals under sedation when referred to the public gynaecology service at RDPH. There are few alternatives in Greater Darwin to access this service, as private gynaecologists in Greater Darwin are not taking new gynaecology clients.
- Anecdotally, access to IUD procedures under sedation in ASH, KH and GDH are more timely, due to lower surgical caseloads.

Permanent contraception – tubal ligation and vasectomies

- Clients face significant wait times before they can access a tubal ligation or vasectomy through the public sector in Greater Darwin at RDPH.
- The median wait time for a tubal ligation in RDPH in 2020 – 2021 is 255 days. In comparison, the median wait time for tubal ligation in ASH and KH, and nationally in the same period are much shorter, at 37, 28 and 112 days respectively. (**Australian Institute of Health and Welfare [AIHW] 2022).** Clients have limited options for tubal ligation outside the public sector as private gynaecologists in Greater Darwin are not accepting new gynaecology clients.
- There is no publicly available data on vasectomy wait times in NT public hospitals, but anecdotally, clients have waited more than 12 months to access the procedure in the public sector. Clients can access vasectomy through the private sector with significant out-of-pocket costs of approximately AUD 2,000

Issues in contraceptive access in NT

- Contraception can incur significant out-of-pocket costs to clients, especially when:
    - Clients are using methods not covered by PBS, including most combined oral contraceptive pills, the combined hormonal ring and the drospirenone progesterone only pill
    - Clients are not eligible for Medicare
    - Clients are requesting IUD insertion
    - Clients require complex removal of contraceptive implant
    - Clients are requesting vasectomy
- Access to immediate postpartum contraceptive procedures, especially IUD insertion, in public hospitals can be limited
- For some clients, timely contraceptive procedures can be impossible to access in the NT, due to long wait times in the public sector and limited private sector options. These include access to:
    - IUD insertion and removal under sedation, and
    - tubal ligations.
- Least invasive, office-based complex contraceptive procedures – such as ultrasound guided contraceptive implant and IUD removal – are not available in the NT
- All of these barriers listed above prevent access to acceptable contraceptive use for clients in NT, and puts them at risk of unplanned pregnancies.
- There is limited publicly available data on contraceptive services in the NT and across Australia.

Recommendations

Publicly-funded contraception services in primary health care clinics and public hospitals should be available to provide no-cost contraception to all clients, regardless of visa status

- The Commonwealth government should increase PBS coverage for all prescribed methods of contraception. Increasing access to all forms of contraception, including short-acting reversible contraception such as different formulations of the oral contraceptive pills and the hormonal vaginal ring, can promote a person-centred approach to contraceptive care, support client's reproductive autonomy and increase satisfaction in contraception use (**Holt et al 2020)**
- The Commonwealth government should increase the contraceptive method mix in Australia by reviewing regulatory barriers to introducing contraceptive methods that are available internationally, including the subcutaneous contraceptive injection and the contraceptive hormonal transdermal patch. (**FPNSW 2020)**
- The Commonwealth government should work closely with State and Territory governments to develop funding arrangements through PHNs and LHNs to provide publicly funded contraception services for all clients, regardless of visa status, including copper IUD insertions for emergency contraception
- Public hospitals should provide public contraception clinics with Category 2 access to theatre procedures under sedation (within 90 days of booking)
- Public hospitals should provide routine postpartum and post-abortion contraceptive procedures. No-cost contraceptive medications and devices should routinely be provided to all clients accessing birthing or abortion service in public hospitals.
- States and Territory LHNs should develop referral centres for complex contraceptive procedures in the public sector that offer least invasive, office-based or ultrasound guided complex contraceptive procedures. Office-based procedures can reduce the reliance on

theatre access and potentially reduce wait times. (**Matulich et al 2019, Townsend et al 2022)** This is particularly important for complex contraceptive implant removal in the NT, as the NT has the highest contraceptive implant insertion rate across jurisdictions in Australia (4.1 per 100 in 2018) and a high prevalence of contraceptive implant use in remote communities whose members are predominantly Aboriginal and Torres Strait Islander people (**FPNSW 2020)**. The prevalence of deep contraceptive implant insertions in existing literature is 6 per 1,000 insertions (**Reed et al 2019)**

National key performance indicators for contraceptive care should be developed and reported against by State and Territory PHNs and LHNs to ensure timely and acceptable access to abortion services

- The Commonwealth government should work collaboratively with State and Territory governments, and other stakeholders, to develop a set of key performance indicators for contraceptive care against which State and Territory PHNs and LHNs are required to report annually. Commonwealth funding agreements with PHNs and LHNs must be tied to these reportable indicators to ensure stakeholder accountability in contraceptive care provision. The Commonwealth can look to other jurisdictions that have developed national indicators in contraceptive care, such as the UK. (**NICE 2016)**
- Performance indicators should include:
    - Wait time to contraceptive procedures
    - Satisfaction with wait time
    - Satisfaction with contraceptive method offered
    - Proportion of clients offered postpartum and post-abortion contraceptive procedures prior to discharged, when requested by clients

a. cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas;

Recommendations

Publicly funded abortion services at no-cost to clients should be available to all clients, regardless of visa status, gestation and indication. No-cost abortion services should be inclusive of all methods of abortion and available through community health services and public hospitals, appropriate to clinical complexity.

Publicly funded client transport schemes that subsidises travel and accommodation for clients who need to travel to receive abortion services that is appropriate to their clinical needs should be available for all clients, regardless of visa status.

National key performance indicators for abortion care should be developed and reported against by State and Territory PHNs and LHNs to ensure timely and acceptable access to abortion services.

Medicare rebates for eMA (Early Medical Abortion) should be increased to allow more General Practices to provide no-cost eMA.

Legislative, regulatory and health financing interventions should be introduced to allow nurse- or midwife-led models of eMA provision.

<u>What works in the Northern Territory?</u>

The majority of abortions in the NT are publicly funded at no cost to the clients who are Medicare eligible. This includes all methods of abortions, including early medical abortions (eMA), surgical abortions (SA) and inpatient medical abortions (iMA).

The availability of no-cost eMA has resulted in its high demand in the NT, with the majority of abortions (73% in 2017-18) performed as early medical abortions (eMA) up to 9 weeks gestation through GP-led community health services. (**Northern Territory Department of Health [NT Health], 2019)** This likely benefits the public healthcare sector, as eMA are a more cost-effective method than hospital-based SA or iMA. (**Shankar et al 2017, Lattof et al 2020**) Most are at no-cost to clients who are Medicare eligible when accessed through GPs in Family Planning NT (FPNT) and Aboriginal medical services (AMS) such as Danila Dilba Health Service (DDHS), Miwatj, Wurli Wurlijang and Central Australian Aboriginal Congress (CAAC). FPNT is able to provide no-cost eMA to Medicare-eligible clients through funding from the NT government that supplements Commonwealth funding through MBS and PBS. AMSs are able to provide no-cost eMA through funding from Commonwealth and NT governments.

A nurse-led model of eMA provision is utilised at FPNT in its Palmerston branch, in line with evidence of safety and effectiveness of nurse-led eMA services. (**Olavarrieta et al 2015**) In this model, all components of the eMA service is provided to the client by a practice nurse, although a medical practitioner is involved briefly to provide the MS2Step prescription to the client. This model increases access to eMA to clients in Greater Darwin by reducing wait times. This model is funded by the NT government.

First trimester surgical abortions and iMA are available at all public hospitals in NT that provides obstetrics and gynaecology (O&G) services. This includes:

- Royal Darwin and Palmerston Hospitals (RDPH)
- Alice Springs Hospital (ASH)
- Katherine Hospital (KH)
- Gove District Hospital (GDH)

Abortions after the 1st trimester are available in ASH and RDPH. Surgical abortion up to 20 weeks is available in RDPH and inpatient medical abortion is available without gestational limit in both sites. In 2017-18, over 99% of all abortions in NT were performed in the first trimester. (**NT Health 2019)**, However, the proportion of 2nd and 3rd trimester abortions may have increased with improvement in abortion service capacity in both RDPH and ASH and likely to approach values quoted in other studies, between 4 – 9% (**Shankar et al 2017, Wright et al 2021)**

RDPH provides a Territory-wide complex abortion care service, including a feticide service for abortions after 21 weeks and 6 days. RDPH is also one of only two public hospitals in Australia that provides abortion services for all indications beyond 24 weeks gestation. This represents a small minority of cases, with only 1-2% of abortions being performed after 20 weeks in SA and WA, where publicly available abortion is reported (**Wright et al 2021)**

Abortion services are unavailable in only one of the five public hospitals in the NT (Tennant Creek Hospital – TCH), which does not provide O&G services.

Abortion services in the NT operate under a Territory-wide hub-and-spoke model, with clear referral pathways between primary care, the regional hospitals (ASH, KH, GDH and TCH) and RDPH as the tertiary referral centre for complex abortion care. This is supported by the Patient Assistance Travel Scheme (PATS) that subsidises travel and accommodation costs for Medicare-eligible clients who need to travel to access appropriate abortion services not available locally, including any interstate travel.

PATS also subsidises travel and accommodation costs for a support person to accompany the client for the duration of their abortion care. This includes travel and accommodation for clients seeking eMA who do not have suitable accommodation to complete their eMA locally, including when there is lack of privacy at home or when road access to emergency health services from their usual residence is limited by distance or transport issues. (**NT Health 2017)**

b. workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals;

Recommendations:

Abortion

- Inclusion of abortion in undergraduate and postgraduate medical, nursing, midwifery and Aboriginal and Torres Strait Islander worker and practitioner training. This training should include clinical, public health, legal and ethical aspects of abortion care. There is support from medical students, midwives and sexual health nurses to include abortion in training programs, even among conscientious objectors to abortion. (**Cheng and de Costa 2021, Desai et al 2022).** Training should include direct observation of abortion care through clinical placements in abortion services. Provision of abortion services in public hospitals are therefore necessary, as the primary training sites for health practitioner students. Training should include de-stigmatisation activities, such as values clarification and attitude transformation training that has been demonstrated to increase knowledge and shift attitudes towards abortions among clinicians. (**Turner et al 2018)**

- Abortion should be included as a mandatory knowledge-based component of specialist O&G training. This is supported by trainees and Fellows of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). (**Cheng et al 2019).** Abortion should also be included in General Practice specialist training program to encourage uptake of early medical abortions among GPs. (**Dawson et al 2017**) Conscientious objectors should be required to participate in knowledge-based component of abortion training, but are able to opt out from the practical skills components directly associated with abortion care.

- Early medical abortion (eMA) should be included in the scope of practice of primary health care nurses. Financial support programs should be developed to facilitate training in eMA for primary health care nurses. (**Moulton et al 2021**)

- GPs providing eMA should be supported to train in point-of-care ultrasound for confirmation of intrauterine pregnancy and estimation of gestation, especially in rural settings with limited access to community radiology providers (**Deb et al 2020**)

Contraception

- GPs should be supported financially to train in LARC procedures. (**Mazza et al 2017)** The cost of IUD training is approximately AUD 2,000, and involve a short term clinical placement of three to four half-day sessions. The out-of-pocket costs and the opportunity costs from the days taken to complete the placement can be a deterrent for GPs to train in IUD insertion procedures

- Long acting reversible contraceptive (LARC) procedures should be included in the scope of practice for primary health care nurses. Financial support should be provided to facilitate training programs in LARC provision for primary health care nurses. (**Mazza et al 2017, Moulton et al 2021)**

- Antenatal contraceptive counselling should be included in the scope of practice for midwives to encourage person-centred postpartum contraception provision. (**Cameron et al 2017, Gallagher et al 2019**)

- Training programs for postpartum IUD insertions should be developed for doctors and midwives working in birthing services. (**Cooper & Cameron 2018)**

- Public hospitals designated as referral complex contraception services should develop a workforce trained in least invasive, office based contraceptive procedures to reduce reliance on theatre capacity for such procedures (**Matulich et al 2019, Townsend et al 2022)**

c. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;

Recommendations

LGBTQIA+ inclusive practice should therefore be embedded in any service providing reproductive and sexual healthcare across all levels - from primary to tertiary care.

The specific RSH needs among LGBTQIA+ people should be embedded as core competencies within training curriculum of health workers across disciplines (medicine, nursing, midwifery, etc) and specialties (general practice, gynaecology, paediatrics).

Gender affirming care should be acknowledged and appropriately funded in the public sector as an essential and life-saving intervention among trans and gender diverse people, and basic understanding of gender affirming care should be included in the core competencies of all health workers providing sexual and reproductive healthcare.

Gender affirming surgeries should be provided in public hospitals.

Permanent genital reconfiguration surgery or hormonal therapy with permanent effects should deferred until children with innate variations in sex characteristics develop the decision-making capacity to consent to the procedures or treatments.

Access to affordable and LGBTQIA+ inclusive RSH healthcare, including gender affirming care, in NT is limited

Currently there is limited access to affordable RSH services for LGBTQIA+ people in the NT, with most centred in Darwin. In Darwin, one GP clinic provides a monthly, bulk-billed LGBTQIA+ specific clinic staffed by visiting GPs and a sexual health physician with special interest in LGBTQIA+ health. FPNT provides bulk-billed SRH services (except IUD

insertions) inclusive of LGBTQIA+ people. One GP provides gender affirming care through a mixed-billing clinic. (**Northern Territory Primary Health Network [NTPHN] 2019)**

Access to affordable allied health services associated with gender affirming care, such as speech pathology, pelvic health physiotherapy and psychology is also limited and centred in Darwin. (**NTPHN 2019**)

The centralisation of dedicated services that can provide RSH services for the specific needs of LGBTQIA+ people in NT may worsen inequity between urban and rural/remote areas if such services are likely centred within urban and larger regional centres. In the NT, the Patient Assistance Travel Scheme (PATS) that subsidises travel and accommodation for clients needing to travel for specialist services not available locally do not support travel to access GP services, including specialised GP services such as gender affirming care. Clients therefore have to pay significant out-of-pocket costs to access care. **(NTPHN 2019**)

Although specialised services can ensure inclusivity, it may however put clients at risk of outing themselves to access care. This is especially difficult for young people and people who experience perceived or enacted LGBTQIA+ stigma within their community.

It is important to note that the poor RSH outcomes experienced by LGBTQIA+ people are not often due to inherent biological risks based on their gender identity, sexual orientation or sex characteristics; instead, the poor outcomes are likely due to limited access to safe and quality SRH services, as a result of cis-heteronormative attitudes and behaviours of community members and service providers. Cis-heteronormativity is the assumption of a gender binary that defines acceptable sex characteristics (male/female), gender roles (man/woman) and intimate relationships (heterosexuality between man and woman). Cis-heteronormative attitudes and behaviours minimise or deny the experience of LGBTQIA+ people, or may assign stereotypes to them (e.g. assumptions of promiscuity, sexual behaviours or parental roles). Cis-heteronormative attitudes and behaviours are stigmatising to LGBTQIA+ people. They may choose to protect themselves from this stigma by concealing their LGBTQIA+ identity (or behaviours seen to be associated with LGBTQIA+ identities) from RSH service providers. This can reduce the safety and quality of SRH care received as providers may not be aware of important aspects of the clients circumstances that could contribute to their RSH risk, or to the effectiveness of a particular management plan. LGBTQIA+ people may also avoid accessing SRH care altogether to evade stigma.

LGBTQIA+ inclusive practice should therefore be embedded in any service providing sexual and reproductive healthcare across all levels - from primary to tertiary care. LGBTQIA+ inclusive practice involves a whole-of-organisation approach, where a service is cognisant of the harms of cis-heteronormativity and avoids perpetuating it within discriminatory policies or processes, or interpersonal microaggressions when LGBTQIA+ clients accesses a service, regardless of whether their LGBTQIA+ identity is disclosed to the provider. LGBTQIA+ inclusive practice does not require clients to disclose their LGBTQIA+ identities to access safe and quality care, but creates an environment where clients feel safe to choose disclosure.

The specific RSH needs among LGBTQIA+ people should be embedded as core competencies within training curriculum of health workers across disciplines (medicine, nursing, midwifery, etc) and specialties (general practice, gynaecology, paediatrics).

Competencies at a minimum should include understanding of gender identity and expression, sexual orientation, and sex characteristics; an understanding of cis-heteronormativity, how it presents in sexual and reproductive healthcare and how it impacts LGBTQI people's access to RSH care; and LGBTQIA+ inclusive language and practices. Additionally, gender diversity and sexuality analyses should be embedded in the teaching of conditions (e.g. PCOS, endometriosis) and areas of practice (e.g. contraception, abortions, menopause health) within RSH.

Gender affirming care should be acknowledged and appropriately funded in the public sector as an essential and life-saving intervention among trans and gender diverse people, and basic understanding of gender affirming care should be included in the core competencies of all health workers providing sexual and reproductive healthcare. A common misconception arising from cis-heteronormativity that needs to be dispelled is that gender affirming care is largely cosmetic. Gender affirming care is life-saving because it reduces suicidality in trans and gender diverse people experiencing gender dysphoria, which is the psychological distress from perceiving a mismatch between their gender identity and the gender they were presumed at birth. Gender affirming care includes social affirmation (e.g. name change, wearing clothes that affirms gender identity, legal sex marker change in identity documents), medical affirmation (e.g. masculinising and feminising hormonal therapy), and surgical affirmation. Each gender affirmation journey is unique; some trans and gender diverse people may or may not want hormonal or surgical affirmation, and being trans and gender diverse does not require hormonal or surgical affirmation. However, all health services, including sexual and reproductive health services, should be trans-inclusive to support the social affirmation of any trans and gender diverse client seeking any services. Therefore, all health workers should have at a minimum a basic competency in gender affirming care to avoid harming clients through misgendering and causing gender dysphoria during service provision.

Although not all trans and gender diverse people would seek gender affirming surgery, access to such procedures are important to those who require them. Gender affirming surgery may also be required for legal affirmation of gender identity is some jurisdictions. For example, in NSW and QLD, gender affirming surgery is still required for a person to change the legal sex marker in their birth certificate, which is required to change the legal sex marker of their other state-based identification document. Access to affordable gender affirming surgery is limited, despite demand for gender affirming surgery among some TGD people (Bretherton et al 2021) Gender affirming surgeries largely occur in the private sector and comes with significant out-of-pocket costs, as it is not usually available in the public health sector (except hysterectomies and oophorectomies), making them inaccessible to many trans and gender diverse people with limited financial resources. TGD people with the financial resources will access gender affirming surgery overseas due to limited access to suitable surgical services in Australia, especially for genital reconfiguration surgery (or 'bottom' surgery). Although client often receive high quality surgical care when having procedures overseas, such complex procedures would ideally be followed up by the treating surgical team themselves, which is not always possible when procedures are performed overseas. The whole range of gender affirming care, including gender affirming surgery, should receive appropriate public funding as essential, life-saving interventions. **Gender affirming surgeries should be provided in public hospitals**.

Cis-heteronormativity also manifests as harmful conditions for people with innate variations in sex characteristics (some may identify as intersex people) accessing reproductive and sexual healthcare. Health services continue to recommend and perform genital reconfiguration surgery on children with innate variations in sex characteristics to 'normalise' their genital appearance based on binary definitions of sex characteristics. This practice is rooted in the contested cis-heteronormative belief that the gender identity of a child is based on socialisation that 'matches' the appearance of their genitals: if a child has genitalia that does not fit binary definitions of 'male' or 'female', then it would prevent parents from socialising their child to fit a 'suitably' binary gender. The parents' anxiety or fear that being unable to assign a binary category to their child's sex characteristics and gender identity will expose their child to stigma and discrimination is used as justification for early gender surgery on the child. Advocacy groups supporting the rights of people with innate variations in sex characteristics, such as Intersex Human Rights Australia, advocate for **permanent genital reconfiguration surgery or hormonal therapy to be deferred until children with innate variations in sex characteristics develop the decision-making capacity to consent to the procedures**. This is in line with the human rights approach to the care of children with innate variation in sex characteristics recommended in the Australian Human Rights Commission 2021 report on the topic, which also outlines a set of principles that guide this human rights approach to children and adults with variations in sex characteristics.

It is acknowledged that some genital surgery in childhood is performed on people with innate sex characteristics variation to protect life-preserving bodily functions (such as a procedure to relieve anatomical obstruction to urination that could otherwise cause organ damage and impair long term bladder and kidney function). Such procedures are life-saving and should be distinguished from procedures that alter the appearance or function of genitalia primarily to prevent perceived harms from stigma and discrimination based on binary notions of sex characteristics and gender identity.

It is useful to point out the inconsistency in the availability of gender surgery in public hospitals based on innate variations of sex characteristics and gender identity. State- and Territory-based policy largely prevent the provision of most gender surgeries for gender affirmation, except where an innate variation of sex characteristics exist. This fails to validate the diverse experiences of trans and gender diverse people and privileges gender affirmation surgeries in some people i.e. those with innate variations in sex characteristics, and not others.

Meaningful engagement and inclusion of LGBTQIA+ people in service co-design and delivery include creating workplaces that are safe for LGBTQIA+ health workers.

d. best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

Recommendations:

- Ensure culturally appropriate healthcare workers are involved throughout planned education and training programs for the workforce.
- Introduce Medicare claim item numbers for specialised registered nurses working within reproductive sexual health.

- Prioritisation of workforce retention, to enable trust within remote community healthcare settings.

e. experiences of people with a disability accessing sexual and reproductive healthcare;

Recommendations:

- Insufficient reproductive sexual health information and resources in Australia.
- Increase education and training opportunities for the disability workforce.

f. availability of reproductive health leave for employees; and

Recommendations:

- FPNT clinical workforce are not replaced when employees take leave. The NT healthcare service does not have any back up. During the past three years of the COVID-19 pandemic FPNT like similar healthcare services across Australia were required to cancel clinics when the workforce was restricted to leave. This caused high risk clients to have delayed services eg: managing heavy menstrual bleeding, cervical screening for cancer, sexually transmitted infections.

- Medical, nursing students and Aboriginal health workers all require early training in reproductive and sexual health to manage and improve outcomes.

g. any other related matter.

Recommendations

- Cyber Security: client secure medical information database systems are forever being upgraded at a cost not recognised by funding donors. Reproductive and sexual health is a very sensitive service with judgement and discrimination often attached.

THE END_____