Caroline Mulcahy
Sexual Health Victoria
901 Whitehorse Road
Box Hill VIC 3128
cmulcahy@shvic.org.au

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100, Parliament House
Canberra ACT 2600

14 December 2022

To Whom It May Concern,

RE: SHV submission to Senate Standing Committees on Community Affairs in response to inquiry on universal access to reproductive healthcare

I write to you on behalf of Sexual Health Victoria (SHV); formerly Family Planning Victoria. SHV is a state-wide, not-for-profit organisation that has been providing high quality, evidence-based sexual and reproductive health clinical services, training and education for over 50 years. SHV is a member of the Family Planning Alliance Australia, the nation's peak body in reproductive and sexual health. The FPAA promotes advances in public health through policy insight and advocacy and represents leading health and education agencies across Australia.

SHV supports the senate inquiry on universal access to reproductive healthcare and appreciates the opportunity to provide a submission. We acknowledge that this enquiry is focussed on women and people with a uterus; and support an inclusive gender-based approach to models of reproductive health care and service delivery. We also recognise that there is still much to do to improve reproductive health and literacy of boys, men and gender diverse people.

The attached submission has been prepared in collaboration with the FPAA in response to the Committee Terms of Reference. We consent to this submission being published on the inquiry website and shared publicly online.

If you wish to discuss this submission, please contact me at cmulcahy@shvic.org.au or 0418 108 267. Thank you for your consideration of this submission.

Sincerely,

Caroline Mulcahy

Caroline Mulcahy, she/her
Chief Executive Officer, Sexual Health Victoria
Director, Family Planning Alliance Australia

Sexual Health Victoria
Care
Education
Advocacy

SHV submission to the Senate Standing Committees on Community Affairs in response to the inquiry on universal access to reproductive healthcare.

SHV recommendations

Bodily autonomy is a basic human right. SHV regard universal access to reproductive healthcare as fundamental to bodily autonomy; enabling all people to make reproductive choices and decisions without geographical, social, cultural, legal, religious, economic or political barriers. Prioritisation of universal access to reproductive healthcare, including contraception and abortion, is particularly pertinent during the current economic climate, and with communities continuing to experience the health, social and economic impacts of the COVID-19 pandemic and associated restrictions[1-4].

Universal access requires government commitment to address the intersecting structural barriers to safe, inclusive reproductive healthcare that are underpinned by pervasive gender inequity. Some of the key systemic barriers relate to geographic location[5-8]; country of origin, citizenship, length of residency or visa[9-11]; gender, sex characteristics or sexual identity[12]; ability/disability; occupation; and socioeconomic status[8].

SHV strongly supports recommendations made in FPAA's submission for this inquiry, as summarised below.

Establish a national taskforce to develop and monitor a comprehensive plan to deliver the National Women's Health Strategy's commitment to universal access to sexual and reproductive health care. This taskforce must include representation from all States and Territories, and consultation with service providers and people with lived experience across metropolitan, regional, rural and remote locations. This taskforce should be inclusive of Aboriginal and Torres Strait Islander people, people with disability, migrant and refugee communities and gender and sexually diverse people. A comprehensive plan with specific and achievable targets is essential for progress, accountability and visibility that instills confidence among the community and health workforce.

Ensure *affordability* of reproductive health services, including abortion and contraception:

- Free contraception (including long acting reversible contraceptives; LARC) for all people under 25 years.
- Abortion services free of cost to all individuals.
- Comprehensive review of Medicare items and rebates, and PBS coverage for all reproductive services.

Ensure *availability* of essential reproductive services

- Appropriate remuneration and reimbursement for GPs providing LARC and medical abortion care.
- Appropriate remuneration and reimbursement for nurse-led contraceptive and medical abortion care.
- Amendment to the medical abortion Risk Management Plan and regulatory reforms for medical abortion.
- Streamlining TGA approval processes to enable a broader choice of contraceptive options.
- Greater inclusion of reproductive healthcare in pre-service medical education.
- Strong investment in reproductive health training for the current health workforce.
- A focus on workplace retention strategies; particularly in regional and remote locations.

Ensure *safety and equity of access* to reproductive services

- Harmonisation of abortion laws across Australia.
- Medicare funding for telehealth delivery of medical abortion.
- Funding for fly-in fly-out abortion and LARC services for regional and remote communities.
- Review of Medicare rebates and item numbers for transgender and gender diverse people.

- Further funding for comprehensive sexuality education in-schools and community settings, including professional development for teachers and youth and community workers.
- Further funding for clinical guidelines and professional development opportunities in providing safe, inclusive and culturally appropriate reproductive healthcare.
- Comprehensive review and public consultation on the introduction of reproductive health leave.

SHV response to Senate inquiry Terms of Reference (ToR)

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

Barriers

- TGA processes are lengthy and expensive. This delays community access to new contraceptives.
- Australia has a low uptake of LARCs compared to other countries[13-15]. The cost of LARC is prohibitive for many people[8], particularly those without Medicare access. Lower cost versions of Mirena IUD are available in other countries, but not within Australia. In addition, Mirena IUDs are licensed for 5 years in Australia, compared to 8 years in the US[16], creating increased cost for Australian consumers.
- Health providers are not adequately remunerated and reimbursed for LARC procedures and are out of pocket when providing bulk-billed services. This is not sustainable, even with low cost services.
- Nurses and midwives are not funded by Medicare to provide and/or support contraceptive services despite having capacity to do so, and nurse practitioners are insufficiently remunerated these services.

Enablers

- Enable a more comprehensive and affordable **choice** of effective contraceptive options in Australia by:
  - Streamlining TGA approval processes for new contraceptives.
  - Increasing PBS coverage to include the new progestogen-only pill with 24-hour window and copper IUD (including copper IUD use as emergency contraception).
- Enable community **access** to safe and reliable contraceptive options by:
  - Providing contraception (incl. LARC procedures) free of cost to all people under the age of 25.
  - Increasing Medicare rebates for LARC procedures and equipment across the board.
  - Approving Medicare funding for nurse-led services and support.
  - Streamlining TGA approval processes to encourage companies to seek approval for lower-cost generic versions of currently available contraceptive e.g. Levonorgestrel-releasing IUDs.
  - Enabling pharmacists to prescribe oral contraceptives within a doctor-supported framework.
- Invest more resources into LARC accessibility rather than emergency contraceptive pills.

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

Access to termination of pregnancy should be on the basis of health care need and should not be limited by age, socioeconomic disadvantage, or geographic isolation[17].

The inequities in reproductive healthcare access, particularly in regional and remote areas, are well recognised. Access to abortion services is described by medical professionals as "a huge lottery". In Australia, around one quarter of all pregnancies are unplanned, and one-third of these pregnancies end in abortion[18]. Unplanned pregnancy occurs more frequently in non-urban areas[19], yet abortion access in regional and remote Australia is disproportionately limited by fewer abortion providers[20].

Abortion is a time-critical procedure that increases in complexity and risk with gestation[23]. Despite this, abortion access in Australia is limited and inequitable, with many individuals facing significant and intersecting financial, social, geographical and health provider hurdles to access necessary information, support and medical care[24]. Addressing these barriers to abortion care is critical in enabling universal access.

Barriers

- Legal: people around Australia are currently unable to access the same abortion care, rights, or education due to State-based legislative variations.
- Medical: RANZCOG requirements for ultrasound prior to medical abortion that can delay or prohibit access to a medical abortion due to out-of-pocket costs or difficulties accessing a service. Ultrasounds are not a requirement in many international guidelines[25]. In addition, in Australia, a gestational limit of 63 days is applied to use of MS 2-Step, despite its known safety and efficacy for home-based abortions of up to 70 days gestation, and approval for use up to 70 days gestation in the US and UK[25].
- Workforce:
  - Low number of abortion providers; disproportionately low in regional, rural and remote locations.
  - Low proportion of pharmacists dispensing abortion medication.
  - Very limited inclusion of abortion in undergraduate and postgraduate medical training[24].
  - Existing models of nurse and midwife led care do not include authority to provide abortion medication.
  - Absence of reliable and accurate national abortion data; limiting workforce planning.
- Financial: limited publicly funded abortion services, and significant out-of-pocket costs for private care[24].
- Geographical: lack of abortion services within reasonable geographical proximity.
- Service accessibility: limited supports available to facilitate abortion access for those with additional needs, e.g., relating to low English literacy, restricted mobility or young age.
- Religious barriers: reluctance of faith-based hospitals to provide abortions unless medically indicated.
- Social barriers: stigma and prejudice associated with abortion that can inhibit individuals from seeking care; and deter health professionals from seeking training and/or providing abortions[24,26].

Enablers

Access to abortion can be facilitated through the following actions:

- Legal: harmonisation of abortion laws across Australia to create service and access consistency and transparency for healthcare providers and consumers of reproductive health care.
- Medical: amending risk management plans and regulatory reforms for medical abortion medications.
- Workforce: refer to item C below.
- Financial: free-of-cost abortion services for all individuals, including those without Medicare access.
- Faith-based hospitals that receive public funding must be expected to provide a full suite of sexual and reproductive services, including abortion.
- Similarly, all pharmacists should be expected to provide a full suite of reproductive health medications.

- Geographical: Medicare-funded telehealth delivery of medical abortion services, and increased availability of ultrasound services, particularly in regional and remote locations.
- Service awareness and accessibility:
  - Funding abortion information and support services, such as 1800 My Options, Australia-wide.
  - A 24-hour government funded national help line for those undergoing medical abortion.
  - Progressing with plans to remove training requirements for pharmacists to dispense MS-2 Step.

c. 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;

Barriers

Reproductive health services are well-recognised to be under-resourced and fragmented, particularly in regional, rural and remote Australia. This under-resourcing perpetuates access inequities, increases risks to patient safety, and feeds back into the exhaustion experienced by health professionals.

Enablers

Critical services including abortion and contraceptive care can be safely provided by a range of health care practitioners. However, significant investment is needed in capacity building for both pre-service and active health professionals. We propose the following recommendations for building and retaining a strong multidisciplinary reproductive healthcare workforce:

- Increasing the scope of practice and Medicare funding for nurse practitioners, nurses and midwives.
- Investment in pre-service medical education through greater inclusion of reproductive health in undergraduate and postgraduate training, including medicine, general practice, nursing, midwifery, obstetrics and gynaecology. Education providers may benefit from partnering with community-based providers of reproductive health care in addition to hospitals.
- Investment in clinical guidelines and medical publications that normalise abortion as health care.
- Subsidised education accredited by peak reproductive health bodies to upskill current health workforce.
- RACGP development of a GP sub-specialty in sexual and reproductive health that recognises specialist skills developed by doctors undertaking the FPAA Sexual and Reproductive Health Certificate.
- Greater collaboration between hospitals and FPAA agencies to minimise wait times for critical services.
- Financial incentive for primary care practitioners to provide LARC services. Current Medicare rebates do not sufficiently cover the costs associated with LARC services and equipment.
- Greater financial incentive, training opportunities and workplace flexibility options to address challenges of healthcare recruitment and retention in regional, rural and remote locations.
- Establish specific Medicare numbers for abortion care, to enable accurate tracking of services provided.

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

Barriers

Best practice models address the systemic barriers to healthcare access. Barriers include the prohibitive costs of healthcare, restrictions on access to Medicare, lack of services provided in languages other than English, and lack of culturally safe and appropriate services.

Enablers

A best practice approach to reproductive healthcare is culturally responsive, inclusive, safe and accessible for at-risk and marginalised communities. This includes:

- Medicare access for all individuals.
- Using a critical intersectional lens to identify and address barriers to reproductive healthcare access.
- Bringing culturally appropriate reproductive health care into mainstream programs by collaborating with migrant and refugee women's organisations to develop best practice guidelines for culturally responsive service delivery. This must include cohesive models of collaboration between primary and secondary care to facilitate a safe, supported care pathways.
- Sustainable funding for refugee and migrant women's reproductive health programs, in recognition that 51.5% of Australia's population have migrated or sought refuge from another country.
- Ongoing investment to support and develop a professionally recognised and appropriately remunerated bilingual, bicultural health workforce to meet the needs of our multicultural Australian population.
- Further engagement with Aboriginal and Torres Strait Islander communities to establish sustainable culturally appropriate and safe healthcare models that facilitate access.
- Prioritisation of workforce retention initiatives to enable longer-term therapeutic relationships to be established between healthcare providers and Aboriginal and Torres Strait Islander communities.
- Greater inclusion of cultural sensitivity training in undergraduate, postgraduate and current workforce education programs; to actively address stigma and shame associated with reproductive health services.

e. sexual and reproductive health literacy;

Sexual and reproductive health literacy begins in early childhood and continues throughout the lifespan. Comprehensive sexuality education (CSE) provided through schools, community and families offers a foundation from which young people develop sexual and reproductive health literacy.

Barriers

The Australian Curriculum includes components of CSE; however, these guidelines are ambiguous, open to interpretation and omit key topics. Australian research shows that young people perceive school based CSE as valuable; however, the inclusion, quality and relevance of CSE teaching is inconsistent. This may be attributed in part to lack of specific CSE guidelines within Curriculum. Other contributing factors include teacher skills and confidence to teach CSE, absence of school policies and a non-supportive school culture.

Enablers

SHV advocates for the inclusion of CSE within the Australian Curriculum and community-based educational programs, based on the following principles[27]:

- Explicit and specific inclusion of CSE across the Australian Curriculum from F-12 supports young people to develop the life-long knowledge, skills and attitudes needed to experience positive, respectful and healthy relationships and optimal reproductive health.
- CSE should be accessible to all young people irrespective of their age, ability, socio-cultural context and/or engagement with mainstream schooling; including young people with disability, and those disengaged from mainstream schooling. Parallel community based CSE programs are vital, to ensure young people outside of mainstream schooling are afforded the same opportunities

for learning and support.
- High quality professional development programs and accreditation for school leaders, teachers and welfare workers are critical, to ensure they are equipped with the knowledge, skills and confidence to provide CSE in accurate, responsive and supportive ways both in and out of the classroom.
- CSE training should be included in all pre-service teacher tertiary education.
- Government funding is essential to enable effective integration, implementation and evaluation of CSE within schools and the broader community.

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

The inclusion, safety and protection of human rights of people with disability is fundamental to any strategies designed to enable universal access to reproductive healthcare.

Barriers

People with disability experience severely restricted access to safe, inclusive, accessible reproductive health care due to numerous systemic barriers including:

- Medical ableism and dominance of the medical model[28]. Women with Disabilities in Australia's recent report indicated most young women do not make their own decisions about menstruation and contraception. Parents, guardians and doctors are making these decisions on behalf of women with no strategies in place to improve their understanding of their reproductive choices and rights[28].
- Insufficient reproductive health information, resources and services that meet the needs of people with disability and enable them to make informed choices about their health and wellbeing.
- Lack of health professional skills in providing safe, inclusive care for people with disability, including communicating with people with cognitive and intellectual disability.
- Difficulties associated with having a carer or family member assist with help seeking, making decisions, and/or having assessments or procedures that are sensitive in nature.
- Prohibitive out of pocket costs for reproductive health services.

Enablers

- Investment in disability-inclusive reproductive health education in undergraduate and postgraduate training, including medicine, general practice, nursing, midwifery, obstetrics and gynaecology.
- Investment in clinical guidelines and professional development on safe, inclusive care for people with disability, including legal aspects of care, human rights approaches and supported decision making.
- Development of a national strategy in consultation with people with disability to improve access to safe, inclusive and comprehensive reproductive healthcare and information.

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

Transgender and gender diverse (TGD) people report great difficulty accessing safe, supportive, quality care, and long wait times for gender affirming care. In the *Australian Trans and Gender Diverse Sexual Health Survey,* 56% of participants described their access to medical gender affirming care as 'OK', 'poor' or 'non-existent'[29].

Barriers

- Stigma and prejudice within medical professions. In the Australian *TRANScending Discrimination in Health and Cancer Care* survey, 69% of TGD respondents had not sought medical care due to inability to find a doctor they are comfortable with; and 1 in 5 had been refused general healthcare[30].
- Lack of professional training in TGD reproductive healthcare. Australia is experiencing an exponential demand for primary and specialty TGD healthcare and capacity building is urgently needed[29-32].
- Prohibitive costs of reproductive care, including gender affirming care and fertility preservation.

Enablers

- Inclusion of gender-neutral Medicare item numbers to increase access to reproductive health services.
- Publicly funded reproductive health services, including contraception, abortion and gender affirmation.
- Appropriate use of gender language in government and medical policy and resources.
- Inclusion of gender diversity in all levels of health care education, enabling healthcare providers to develop competency and confidence to provide safe, inclusive and unbiased care.
- Investment in gender-inclusive clinical guidelines and resources for health professionals that normalise gender diversity and provide guidance on inclusive care.

h. availability of reproductive health leave for employees

Women and people with uteruses wear disproportionate costs of reproduction. Reproductive health-related needs, in most circumstances, do not reflect illness that justifies use of allocated personal leave. Menstruation, contraceptive care, fertility care, pregnancy, miscarriage, abortion and post-natal care are a part of daily living for many women and people with a uterus and are highly valuable for our community. However, the burden of reproduction and its impact on workforce participation is largely unrecognised in health and workplace policies. Lack of access to paid leave for reproductive health increases the already high cost of care.

SHV supports the view that reproductive health leave has the capacity to improve women's well-being and address barriers to workforce participation. We recommend that the federal government:

- Evaluate existing reproductive health leave policies and invest in research to explore the feasibility and impact of reproductive health leave on women's and people with uterus's engagement in the workforce.
- Undertake a public consultation on reproductive health leave to establish community support.

Sexual Health Victoria
Care
Education
Advocacy

References

1.Bateson DJ, Lohr PA, Norman WV, Moreau C, Gemzell-Danielsson K, Blumenthal PD, et al. The impact of COVID-19 on contraception and abortion care policy and practice: experiences from selected countries. BMJ Sex Reprod Health. 2020;46(4):241-3.

2.Coombe J, Kong F, Bittleston H, Williams H, Tomnay J, Vaisey A, et al. Contraceptive use and pregnancy plans among women of reproductive age during the first Australian COVID-19 lockdown: findings from an online survey. Eur J Contracept Reprod Health Care. 2021;26(4):265-71.

3.Sturgiss E, Dut GM, Matenge S, Desborough J, Hall Dykgraaf S, Mazza D, et al. COVID-19 and access to sexual and reproductive healthcare for young people: An overview of the international literature and policy. Aust J Gen Pract. 2022;51(4):271-7.

4.Stanton T, Bateson D. Effects of the COVID-19 pandemic on family planning services. Curr Opin Obstet Gynecol. 2021;33(5):425-30.

5.Noonan A, Black KI, Luscombe GM, Tomnay J. What women want from local primary care services for unintended pregnancy in rural Australia: a qualitative study from rural New South Wales. Aust J Prim Health. 2022.

6.Subasinghe AK, McGeechan K, Moulton JE, Grzeskowiak LE, Mazza D. Early medical abortion services provided in Australian primary care. Med J Aust. 2021;215(8):366-70.

7.Wagg E, Hocking J, Tomnay J. What do young women living in regional and rural Victoria say about chlamydia testing? A qualitative study. Sex Health. 2020;17(2):160-6.

8.Holton S, Rowe H, Kirkman M, Jordan L, McNamee K, Bayly C, et al. Barriers to Managing Fertility: Findings From the Understanding Fertility Management in Contemporary Australia Facebook Discussion Group. Interact J Med Res. 2016;5(1):e7.

9.Tarzia L, Douglas H, Sheeran N. Reproductive coercion and abuse against women from minority ethnic backgrounds: views of service providers in Australia. Cult Health Sex. 2021:1-28.

10.Botfield J, Newman C, Kang M, Zwi A. Talking to migrant and refugee young people about sexual health. Australian Journal for General Practitioners. 2018;47:564-9.

11.Botfield JR, Newman CE, Zwi AB. Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: a structured scoping review. Sex Health. 2016;13(1):1-9.

12.Taylor J, Power J, Smith E, Rathbone M. Bisexual mental health: Findings from the 'Who I Am' study. Aust J Gen Pract. 2019;48(3):138-44.

13.French RS, Gibson L, Geary R, Glasier A, Wellings K. Changes in the prevalence and profile of users of contraception in Britain 2000-2010: evidence from two National Surveys of Sexual Attitudes and Lifestyles. BMJ Sex Reprod Health. 2020:bmjsrh-2019-200474.

14.Lindh I, Skjeldestad FE, Gemzell-Danielsson K, Heikinheimo O, Hognert H, Milsom I, et al. Contraceptive use in the Nordic countries. Acta Obstet Gynecol Scand. 2017;96(1):19-28.

15.Grzeskowiak LE, Calabretto H, Amos N, Mazza D, Ilomaki J. Changes in use of hormonal long-acting reversible contraceptive methods in Australia between 2006 and 2018: A population-based study. Aust N Z J Obstet Gynaecol. 2021;61(1):128-34.

16.Mirena. USA approved product information. Bayer HealthCare Pharmaceuticals Inc. Updated August 2022.

17.RANZCOG. Termination of Pregnancy. 2016.

18.Taft AJ, Shankar M, Black KI, Mazza D, Hussainy S, Lucke J. Unintended and unwanted pregnancy in Australia: A cross-sectional national random telephone survey of prevalence and outcomes. MJA. 2018;209(9):407-8.

19.Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, et al. Prevalence and distribution of unintended pregnancy: The Understanding Fertility Management in Australia National Survey. Australian and New Zealand Journal of Public Health. 2016;40(2):104-9.

20.Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, et al. Abortion: Findings from women and men participating in the Understanding Fertility Management in contemporary Australia national survey. Sexual health. 2017;14(6):566-73.8

21. Sedgh G, Singh S, Hussain R. Intended and unintended pregnancies worldwide in 2012 and recent trends. Stud Family Plann. 2014;45(3):301–14. PMC4727534. pmid:25207494

22.Foster DG, Biggs MA, Ralph L, Gerdts C, Roberts S, Glymour MM. Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. American Journal of Public Health. 2018;108(3):407-413.

23.Marie Stopes Australia. Situational Report: Sexual and Reproductive Health Rights in Australia (Feb 2021 update). MSA: Melbourne.

24.Sifris R, Penovic T. Barriers to abortion access in Australia before and during the COVID-19 pandemic. Women's Studies International Forum. 2021;86:102470

25.Women's Sexual and Reproductive Health COVID-19 Coalition. Evidence-based practice and policy recommendations regarding early medical abortion. Victoria, Australia: SPHERE. 2020

26.Keogh LA, et al. Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers. BMC Medical Ethics. 2019;20:Article number 11.

27.FPAA. Position statement: comprehensive sexuality education for school-aged young people. 2021.

28.Women With Disabilities Australia (WWDA). Towards Reproductive Justice for young women, girls, feminine identifying, and non-binary people with disability (YWGwD): Report from the YWGwD National Survey. November 2022. WWDA: Tasmania.

29.Callander D, Wiggins J, Rosenberg S, Cornelisse VJ, Duck-Chong E, Holt M, Pony M, Vlahakis E, MacGibbon J, Cook T. The 2018 Australian Trans and Gender Diverse Sexual Health Survey. 2019. Sydney, NSW: The Kirby Institute.

30.Kerr L, Fisher CM, Jone, T. TRANScending Discrimination in Health & Cancer Care: A Study of Trans & Gender Diverse Australians, (ARCSHS Monograph Series No. 117). 2019. Bundoora: ARCSHS, La Trobe University.

31.Cheung AS, Ooi O, Leemaqz S, Cundill P, Silberstein N, Bretherton I, Zajac JD. Sociodemographic and clinical characteristics of transgender adults in Australia. Transgender Health. 2018;3(1):229-238.

32.Telfer M, Tollit M, Feldman D. Transformation of health-care and legal systems for the transgender population: the need for change in Australia.J Paediatr Child Health. 2015;51:1051–1053.