Victorian Pride Lobby

Submission: Senate Standing Committees on Community Affairs - Universal Access to Reproductive Healthcare

15 December 2022

Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest LGBTIQ+ community-controlled health services for people living with and affected by HIV, and the lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ+) communities. Thorne Harbour Health primarily services Victoria and South Australia, but also leads national projects. Thorne Harbour Health works to protect and promote the health and human rights of LGBTIQ+ people and all people living with HIV.

Thorne Harbour Health provides the following services to support the sexual and reproductive health and wellbeing of LGBTIQ+ people:

- LGBTIQ+ inclusive general practice and specialist care for people living with HIV or hepatitis C, and bulk billing general practice services to the trans and gender diverse (TGD) community.
- free rapid HIV testing as well as sexual health screenings and treatment services for men who have sex with men (MSM).
- training programs consisting of a variety of training packages created to improve TGD sensitivity, reduce stigma and discrimination, and build health sector capacity to meet the needs of TGD people.

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Victoria Pride Lobby

The Victorian Pride Lobby (VPL) works toward equality and social justice for the Victorian LGBTIQA+ community. To do this, we will work constructively, cooperatively, and respectfully with trans and gender diverse, intersex, asexual, and other organisations that support our mission and vision.

The vision of the Lobby is that LGBTIQA+ people no longer face discrimination in law or practice in Victoria, and that the diversity of Victoria's LGBTIQA+ communities is valued and celebrated.

We are a non-partisan organisation that is not affiliated with any political party. We are a non-profit, mission-driven community-based lobbying group that collaborates with community organisations, advocates, and representatives to effect positive change in the areas of human rights, equality, and policy development.

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Executive Summary

Thorne Harbour Health and Victoria Pride Lobby welcome the opportunity to provide a submission for the Inquiry into Universal Access to Reproductive Healthcare.

LGBTIQ+ Australians, in particular, transgender and gender diverse (TGD) people have faced unique barriers to accessing reproductive and sexual health services. Simultaneously, women's health care providers are increasingly providing clinical services for this population, such as gender transition-related care (e.g., gender-affirming hormone therapy or surgeries), routine obstetric and gynecological services, and specialised care such as assisted reproductive technologies.

"Women's health" implies a field that only serves cisgender women (people who were assigned female at birth and identify as female); thereby excluding TGD people who do not identify as women but require these services. Expert commentary notes that transgender persons, including young people, face particularly pronounced difficulties in accessing appropriate healthcare and related information on sexual and reproductive health and rights[1].
Therefore, policy directions relating to reproductive health services should not be sitting under the Women's Health Strategy. Instead, a national standalone reproductive health strategy – that is inclusive of the needs of LGBTIQ+ communities – needs to be developed to address the barriers for people of all gender identities and sexual orientations to access quality reproductive health services.

For this submission, we are going to address the following terms of reference:

b) cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas;
e) sexual and reproductive health literacy;
f) experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare; and
i) any other related matter.

Recommendations

The Australian Government should develop a standalone national reproductive health strategy that coordinates relevant policy responses across all jurisdictions in Australia, which includes:

- Development of a nationally coordinated approach to ensure legal and subsided access to assisted reproductive technologies such as gamete preservation and in vitro fertilisation (IVF);

[1] Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, A/HRC/38/43 (2018), [44]; Committee on the Rights of the Child, General Comment 20 (2016) on the implementation of the rights of the child during adolescence, [33].

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- Investment in capacity building of all staff involved or associated with service delivery continuum of reproductive or/and sexual healthcare that is provided to members of LGBTIQ+ communities;

- Evaluation of the scope and the provision of non-directive pregnancy support service under Medicare and the development of a new pregnancy counselling service model, in consultation with TGD communities;

- Development of resources and guidelines that support practitioners and TGD Australians to make informed decisions about treatment and the prospect of having a genetically-related child;

- Investment in health promotion projects that raise awareness of cervical cancer within LGBTIQ+ communities;

- Development of a national reproductive health education framework that includes appropriate information of contraception and pregnancy for TGD Australians;

- Development of a nationally consistent referral framework for General Practitioners and other medical professionals, through the Primary Health Care 10 Year Plan 2022–2032, to ensure continuity of care for TGD people who seek pregnancy termination services;

- Funding research that explores the needs of TGD people who access reproductive health services and the prospect for TGD people to have genetically-related children; and

- Investment in new LGBTIQ+ community-controlled reproductive and sexual health services, in particular, in regional and remote Australia.

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i. Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas

Access to assisted reproductive technologies

IVF

There is a lack of national consistency in relation to accessing IVF services within Australia. While the federal government has introduced nationwide laws which outline IVF cloning practices as illegal, Victoria, NSW, South Australia and Western Australia have introduced specific legislation governing IVF practices[2]. Each of these pieces of State legislation established a state regulatory body, which issues licenses to clinics that provide IVF services. If there is no state-based legislation, then the National Health and Medical Research Council (NHMRC) ethical guidelines apply.

The lack of national consistency has historically undermined access for lesbian couples to IVF, for example, lesbians were required to be considered "medically infertile" in order to access IVF and associated procedures in South Australia[3]. In other states where there is no law governing IVF practices, some fertility clinics have interpreted the Medicare eligibility criteria to exclude lesbians and single women from accessing Medicare rebates where their infertility is deemed to be "social" infertility as opposed to "medical" infertility[4]. To increase access to IVF, the NSW[5] and Victorian[6] governments have provided a cash rebate and expanded the definition of the persons permitted to provide counselling to those involved in the assisted reproductive treatment process. While these measures have benefited many lesbian couples, a national coordinated approach is still required to ensure that lesbian couples have legal and access to Medicare-rebated IVF services all across Australia.

Cryopreservation of gametes

Unlike IVF where Medicare rebates are available to a certain extent, people using oocyte cryopreservation and storage for non-medical indications bear the full cost, which is not subsidised by government or private health insurance. International studies have shown that gender-affirming hormone therapy (GAHT) can negatively impact upon the reproductive potential of TGD people.[7]. Therefore, there is a growing need for TGD people to preserve

[2] ACT Health. (2022). 'Assisted Reproductive Technology: Regulation and Access.' Accessed 14th December 2022. Available at: https://www.parliament.act.gov.au/__data/assets/pdf_file/0003/2062911/Assisted-Reproductive-Technology-Regulation-and-Access-ACT-Government-Response.pdf
[3] Peterson, M. M. (2005). Assisted reproductive technologies and equity of access issues. Journal of Medical Ethics, 31(5), 280-285.
[4] Dempsey, D., Power, J., & Kelly, F. (2022). A perfect storm of intervention? Lesbian and cisgender queer women Conceiving through Australian fertility clinics. Critical Public Health, 32(2), 206-216.
[5] NSW Health. (2022). '$2,000 IVF rebates for NSW women.' Accessed 14th December 2022. Available at https://www.health.nsw.gov.au/news/Pages/20220529_00.aspx
[6] Assisted Reproductive Treatment Amendment Bill 2021 (Vic)
[7] Mattawanon, N., Spencer, J. B., Schirmer, D. A., & Tangpricha, V. (2018). Fertility preservation options in transgender people: a review. Reviews in Endocrine and Metabolic Disorders, 19(3), 231-242.

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gametes before commencing GAHT. While recognising that TGD Australians have undergone either an informed consent process that determines their capacity to make informed decisions or a gender assessment by a psychologist prior to commencing GAHT, it is key to recognise that all people, including TGD people, can change their minds about wanting children at some point in their lives. Therefore, the Australian Government should take active steps to explore possible policy interventions that will allow TGD people to access no to low-cost gamete preservation services.

Access to LGBTIQ+ culturally safe reproductive healthcare

International expert commentary has concluded that LGBT and intersex persons are "disproportionately affected by intersectional discrimination in the context of sexual and reproductive health."[8]

As described by the United Nations Committee on Economic, Social and Cultural Rights:

> *"Non-discrimination, in the context of the right to sexual and reproductive health, also encompasses the right of all persons, including lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for their sexual orientation, gender identity and intersex status. Non-discrimination and equality require not only legal and formal equality but also substantive equality. Substantive equality requires that the distinct sexual and reproductive health needs of particular groups, as well as any barriers that particular groups may face, be addressed. The sexual and reproductive health needs of particular groups should be given tailored attention."*[9]

Whilst it has been noted that mainstream health services, such as public hospitals, non-LGBTIQ+ specialist sexual and/or reproductive health services, or private abortion clinics, were the most frequently accessed by LGBTIQ+ people, they feel the least respected when attending those services, compared to LGBTIQ+ community-controlled and/or specialised services[10]. Gynecological and reproductive services are exclusively marketed and provided towards heterosexual cis-female clients. In this regard, groups such as transgender men will only feel inclined to access such services when they appear culturally safe and trustworthy and that it is known that medical service providers are competent and knowledgeable of issues relating to LGBTIQ+ communities in the field of sexual and/or reproductive health[11]. The lack of cultural safety can culminate in intentional or unintentional misgendering. Due to perceptions of possible reprisal, TGD Australians may be unwilling to disclose particular innate characteristics about themselves during medical consultations relating to sexual or reproductive health. This may, in

[8] United Nations Committee on Economic, Social and Cultural Rights, General Comment 22, E/C.12/GC/22 (2 May 2016) [30].
[9] Committee on Economic, Social and Cultural Rights, General comment No. 22. (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2 May 2016) E/C.12/GC/22, [23] - [24].
[10] Private Lives 3, p. 58.
[11] Sbragia, J. D., & Vottero, B. (2020). Experiences of transgender men in seeking gynecological and reproductive health care: a qualitative systematic review. JBI Evidence Synthesis, 18(9), 1870-1931.

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effect, lead to poorer health outcomes, as the clinician cannot appropriately tailor services provided.

Even where clinical services present themselves as having requisite accreditation demonstrating they are 'LGBTIQ+ friendly' such as the Rainbow Tick[12], consumer perception of services, including of unintentional stigmatisation or discrimination by service providers, can result in the unacceptable early exit of consumers from programs. This results in suboptimal health outcomes for sexual and reproductive health, as previous and anticipated experiences of stigma and discrimination from service providers deter and delay seeking health.[13]

> *"I had an IUD inserted while under sedation for a surgical termination, and my experience at the clinic with nursing staff and doctors for the termination was really horrific and traumatising. After IUD insertion you are meant to have at least 2 checkups - one after 6 weeks, and one after 3 months, to ensure it was inserted correctly and there are no perforations - however I did not attend these sessions as a result of my experience at the clinic. I still to this day haven't had it checked, and it will be coming up to the due date for it to be removed shortly." - THH Practitioner*

Ideally, for all sexual and reproductive health service providers, all staff should endeavour to ensure culturally safety and be supported by approved policies and procedures to attend to safety concerns and address discrimination perpetrated by fellow patients/clients and staff. The Australian Human Rights Commission defines cultural safety as:

> *"An environment that is safe for people: where there is no assault, challenge or denial of identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and true listening."*[14]

Moreover, any and all sexual or reproductive health provided to TGD Australians must be appropriate. The word 'appropriate' here connotes that medical services accessed by TGD persons are provided by competent and knowledgeable medical providers, where the environment is perceived as safe by the consumer insofar as they are comfortable in disclosing potentially medically pertinent information relating to their gender expression or innate sex characteristics.

In this regard, any and all staff that is associated or related to clinical services in affirming a patient's gender identity must play a role in facilitating an affirming, accepting, non-judgemental and inclusive environment.

[12] See, Jones et al. (2020). 'Rainbow Tick Standards' *Rainbow Health Victoria.*
[13] Carman et al. (2020). 'Research Matters: Why do we need LGBTIQ-inclusive services?: A fact sheet by Rainbow Health Victoria' (Rainbow Health Victoria, 2020)
[14] Australian Human Rights Commission. (2011), *Social Justice Report.* Canberra, Australia.

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To achieve this, proactive training or professional development must enhance capacity in assisting diverse clientele is required at all strata of sexual and reproductive healthcare provision.

Capacity building of medical professionals, as it pertains to assisting TGD, non-binary and intersex consumers, should at a minimum seek to:

- Raise awareness of these communities' issues, and address specific needs of transand gender diverse, non-binary and intersex persons when accessing sexual and reproductive health services;
- Foster empathy and self-reflection;
- Emphasise the importance of cultural safety and intersectionality;
- Provide opportunities to acquire and practice specific affirmative practice tools and skills;
- Encourage collaboration and shared learning across disciplines; and
- Build pathways for specialisation in TGD, non-binary or intersex sexual or reproductive health.

Activities could include, training interventions and learning resources, practice guidance tools and frameworks, clinical practice guidelines, practice and workforce qualification benchmarking, or policy statements from Peak bodies such as Australian Medical Association or the Royal Australian College of General Practitioners.

Inclusive practice training similar to what has been described above will operate to counter unconscious and explicit TGD and gender diverse, non-binary or intersex-specific biases, reduce assumptions made prior to engagement that can lead to misgendering or stigmatising interactions based on appearance alone, and create better understanding of the complex nature of identity in clinical services. Paired with this, incentives should be funded and promulgated for relevant clinicians to undertake this type of training.

Importantly, as there is diverse experiences within the trans and gender diverse, non-binary and intersex communities, it is essential that any training provided cannot consider these communities as a homogenous group, or that promulgates the assumption that all individuals who fall within these communities have the same experiences.

ii. Sexual and reproductive health literacy

There is no national consistency in terms of how information on pregnancy and contraception are taught across different jurisdictions. The Women's Health Strategy specifically stipulates sex education be ''inclusive of sex, gender and sexual diversity, be sex positive and culturally and linguistically safe and appropriate". However, its successful delivery will require national leadership on developing a sex and reproductive health education framework that can apply to

all schools in Australia and recognise that everyone of reproductive potential, no matter sex or gender, may have contraceptive needs. Practitioners at Thorne Harbour Health continue to find that TGD people often access information on pregnancy and contraception through the internet and other community members due to a lack of robust and consistent information in the public domain. While no clinical evidence has demonstrated a consistent understanding of how estrogen- and progestin-containing contraceptive methods interact with GAHT, it is still important for sex education to use gender inclusive language to discuss pericoital contraception and provide specific resources for TGD youth to access culturally safe services to meet their contraception needs.

iii. Experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare

TGD Australians, including transgender women and transgender and gender diverse people who were assigned female at birth, often do not consider 'women's services' as an appropriate place to meet their service needs. Sexual health services often operate under a public health lens where service objectives gravitate towards the prevention of sexually transmitted infections (STIs) and other blood borne viruses (BBVs). However, when this line of services are provided in a medical setting designated as 'women's health service', the unique needs of TGD people are often overlooked. A report on the sexual health of TGD people reveals that some TGD Australians "feel judged or 'put in a box' by health professionals" making assumptions about their gender, sexual identity and practices[15]. Across women's health services, cisgendered language is pervasive, from bathroom signage to health intake forms. Therefore, the success of any updates to a prospective Women's Health Strategy will need to ensure that the current service systems provide a respectful inclusive care environment, which in turn, improves patient experience and engagement in care, ultimately improving health outcomes.

Self-collection cervical screenings

The awareness of cervical screening needs to be raised among TDG populations. Sexual health providers can sometimes prioritise sexual health checkups over reproductive health checks related to cervical screening. Despite improvements in testing through self-collection screening, this is not being communicated effectively to TGD people with a cervix. This is one example of how TDG people experience healthcare differently and improved systems that bridge that gap are essential for the holistic health of TDG people. Therefore, better health promotion initiatives must be launched to improve TDG populations' awareness and access to cervical screening services.

[15] Albury, K. et.al. (2020). Transand Gender Diverse People's Dating App Use: Sexual Health Factsheet.

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Pregnancy planning

A recent Australian study surveyed 409 transgender and non-binary adults and found that, of participants who were not already parents, 33% hoped to have children in the future[16]. In fact, TGD people can and already have had genetically-related children despite biological and social barriers. For example, research has indicated that GAHT may limit TGD Australians' ability to conceive or reproduce[17]. Anti-androgens and estrogens have been found to impair sperm production[18], which could present as a problem for persons who are assigned male at birth and wish to undergo gender affirming hormonal treatment.

Meanwhile, some available studies support that trans and gender diverse individuals who wish to have genetically related children, regret missed opportunities for family planning and may be willing to delay or interrupt GAHT to undergo procedures aimed at pregnancy planning[19]. Therefore, it is critical that any engagement with those who undergo such procedures or treatment for service providers to discuss the risk of infertility that are associated with such interventions, in line with the World Professional Association for Transgender Health guidelines[20].

Unfortunately, there remains a lack of available resources for medical professionals to assist transgender or gender diverse people who wish to have genetically-related children in accessing appropriate services. Therefore, resources and guidelines that are co-developed by medical professionals and TGD communities require improvement in order to support practitioners and individuals to make informed decisions about treatment and the prospect of having a genetically-related child.

Additionally, concerns regarding fertility of TGD persons can be a large cause of psychological distress. For example, hormonal treatment to allow TGD men to give birth may induce an increase in gender dysphoria[21], thereby creating risks associated with poor mental health of the patient and associated risks to the fetus. Similarly, research has noted that the conception, birth, and post-partum experiences of trans and gender diverse people may induce mental distress

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[16] Chen D, et al. (2018) Attitudes toward fertility and reproductive health among transgender and gender-nonconforming adolescents. J Adolesc Health. 63:62–8. doi: 10.1016/j.jadohealth.2017.11.306.

[17] For example, testosterone administration in transgender men has been found to induce negative effects on reproductive function: Moravek, M. B. et.al. (2020). Impact of exogenous testosterone on reproduction in transgender men. *Endocrinology*, *161*(3), bqaa014.

[18] See, eg, de Nie I, et.al. (2018). Spermatogenesis abnormalities following hormonal therapy in transwomen. *BioMed Research International*, *2018*, 7919481.

[19] See, Vyas, N. et al. (2021). Access, barriers, and decisional regret in pursuit of fertility preservation among transgender and gender-diverse individuals. *Fertility and Sterility*, *115*(4), 1029–1034; Defreyne, J., Van Schuylenbergh, J., Motmans, J., Tilleman, K. L., & T'Sjoen, G. G. R. (2020). Parental desire and fertility preservation in assigned female at birth transgender people living in Belgium. *Fertility and Sterility*, *113*(1), 149–157; Armuand, G., Dhejne, C., Olofsson, J. I., & Rodriguez-Wallberg, K. A. (2017). Transgender men's experiences of fertility preservation: A qualitative study. *Human Reproduction*, *32*(2), 383–390.

[20] WPATH, 'Standards of Care - Version 8' <https://www.wpath.org/publications/soc>.

[21] Rodriguez-Wallberg, K. (2022). Fertility preservation in transgender males. In M. Grynberg & P. Patrizio (Eds.), *Female and male fertility preservation* (pp. 239–245). Springer International Publishing; Armuand, G., Dhejne, C., Olofsson, J. I., & Rodriguez-Wallberg, K. A. (2017). Transgender men's experiences of fertility preservation: A qualitative study. *Human Reproduction*, *32*(2), 383–390.

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due to dysphoric related body changes[22]. Similarly, as feelings of gender dysphoria reduce during gender affirming procedures or treatment, these feelings may influence preconceived notions of family planning[23], and in this regard service providers must host discussions of pregnancy planning at consistent and multiple periods throughout a person's gender transition[24]. The provision of pregnancy counselling services is inconsistent across Australia, as these services are often provided as part of the process to obtain informed consent at abortion or fertility clinics and/or in hospitals, or are non-directive pregnancy support services under Medicare where decision-based counselling is explicitly excluded. There is no affordable option for TGD people to seek strength-based and decision-based pregnancy counselling unless they are willing to pay a private fee for a pregnancy counsellor whose qualification and experience are not certified by Medicare. Therefore, the Australian Government should review and evaluate the scope and the provision of non-directive pregnancy support service under Medicare and work with TGD communities to develop a new affordable service model to meet the needs of TGD Australians who require any pregnancy support.

Pregnancy termination and abortion

Unplanned pregnancies have been recorded amongst TGD individuals[25], whereby, for example, research has noted that pregnancy can still occur after[26] or during[27] taking exogenous testosterone, demonstrating the misconceptions associated with testosterone being a reliable form of contraception. However, the current service system is neither accessible, nor culturally safe for TGD Australians to seek pregnancy termination services.

Affordability

While the need for abortion service is well-recorded, the public health system is inadequate to meet the needs of TDG Australians who have an unplanned pregnancy. Abortion services can be provided in public hospitals but the waitlist is often too long, given that the service needs to

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[22] See, eg, Charter, R., Ussher, J. M., Perz, J., & Robinson, K. (2018). The transgender parent: Experiences and constructions of pregnancy and parenthood for transgender men in Australia. *International Journal of Transgender Health*, *19*(1), 64–77; Hoffkling, A., Obedin-Maliver, J., & Sevelius, J. (2017). From erasure to opportunity: A qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. *BMC Pregnancy and Childbirth*, *17*(Suppl 2), 332.

[23] See, eg, Nahata, L., Tishelman, A. C., Caltabellotta, N. M., & Quinn, G. P. (2017). Low fertility preservation utilization among transgender youth. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *61*(1), 40–44.

[24] See, eg, Ibid; Hudson, J., Nahata, L., Dietz, E., & Quinn, G. P. (2018). Fertility counseling for transgender Ayas. *Clinical Practice in Pediatric Psychology*, *6*(1), 84–92.

[25] See, Abern, L., & Maguire, K. (2018). Contraception knowledge in transgender individuals: Are we doing enough? *Obstetrics and Gynecology*, *131*(1), 65; Jones, R. K., Witwer, E., & Jerman, J. (2020). Transgender abortion patients and the provision of transgender-specific care at non-hospital facilities that provide abortions. *Contraception: X*, *2*, 100019; Light, A., Obedin-Maliver, J., Sevelius, J., & Kerns, J. (2014). Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstetrics and Gynecology*, *124*(6), 1120–1127.

[26] See, eg, Light, A., Obedin-Maliver, J., Sevelius, J., & Kerns, J. (2014). Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstetrics and Gynecology*, *124*(6), 1120–1127.

[27] See, eg, Moseson, H., Fix, L., Gerdts, C., Ragosta, S., Hastings, J., Stoeffler, A., … Obedin-Maliver, J. (2021). Abortion attempts without clinical supervision among transgender, nonbinary and gender-expansive people in the United States. *BMJ Sexual and Reproductive Health*, *48*(1), 22–30.

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be provided in a time-sensitive manner. Alternatively, medical abortion services provided by private clinics can cost from $100 up to $600 and surgical abortion can cost up to $700[28]. In regional and remote areas where there is no easy access to a public hospital, private clinics become the only options for TGD people. Thorne Harbour Health holds concerns that while lack of public abortion services impact every person who seeks to terminate their pregnancy, it magnifies the economic disadvantage that is already experienced by TGD Australians who are more likely to earn less than their cisgender peers[29].

The expansion of culturally safe public abortion services to local and community health hubs is key to realising the benefits of affordable medical abortion services. While surgical abortion might not be feasible to be undertaken in a community setting, the provision of medical abortion, provided by a LGBTIQ+ community-controlled health organisation, is well within the scope of community general practice and presents a unique opportunity for nurse-led abortion care. Therefore, by leveraging the existing medical and health workforce within the LGBTIQ+ community-controlled sector, abortion services can be more affordable for TGD people in Australia.

Lack of consistency in referral practices

The inconsistent referral practices from GPs are a major barrier for TGD people to access pregnancy termination services in Australia. Despite the legalisation of abortion in all states, doctors are neither expected nor required to provide or directly participate in treatments to which they conscientiously object or which they are not certified; however, they cannot impede or deny access to legally available treatments[30]. This means that GPs are expected to direct the patient to a provider of services if they cannot directly be involved in care.

As of August 2019, there were only 1345 certified GP prescribers of medical abortion in Australia out of an estimated 35,000 practising GPs, and it remains unclear how many are actively providing this service[31]. For the remainder of GPs, there is no existing resource that can guide them to make referrals to a TGD-inclusive service for pregnancy termination. While Thorne Harbour Health provides TGD-specific healthcare and has made referrals for pregnancy termination in Melbourne, we acknowledge that there is a lack of clinics with expertise in TGD care across Victoria to ensure continuity of care. While we assertively advocate for more community-controlled TGD and gender diverse clinics across Australia in general, an immediate solution for the government to scale up the access for pregnancy termination service is to work

[28] 1800myoptions. (2022). How much does an abortion cost?. Accessed 6th December 2020. Access at: https://www.1800myoptions.org.au/information/how-much-abortion-costs

[29] NSW Council of Social Service. (2015). *Beyond the myth of 'pink privilege': Poverty, disadvantage and LGBTI people in NSW*. Sydney, Australia.

[30] Hendrie, D. (2018). GPs and conscientious objection to treatments. Accessed 6th December 2020. Available at: https://www1.racgp.org.au/newsgp/clinical/conscientious-objection-to-treatments-frequently-a

[31] Mazza, D. et al, (2020). Medical abortion. Australian Journal of General Practice, 49(6), 324-330.

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with Primary Health Networks to develop healthcare pathways for TGD reproductive health if they cannot be directly involved in the treatment process.

iv. any other related matter

Scarcity of clinical studies on TGD Australians and their service needs

TGD Australians with respect to both sexual and reproductive healthcare remain an understudied and unrepresented cohort. It is critical that any prospective reform has solid and consistent data to best-serve the community it seeks to assist.

Funded studies must be conducted into their needs with respect to sexual and reproductive health to fill the gap of academia and informed practice regarding this area. With a void of academic literature or scientific studies regarding this area, any prospective reform with respect to policy, legal or regulatory frameworks or actual service delivery **cannot** best reflect the communities' needs.

Similarly, further targeted research is required to understand the contraindications and consequences of GAHT or surgical intervention on fertility. In this regard, further funding and associated research must support further exploration into this area. As espoused by Rodriguez-Wallbery et al:

> *"[r]esearch should be conducted to examine effects of medical interventions on fertility, timing of FP [family planning], gamete preservation and outcome of the fertility treatments. Strategies to inform and educate transgender and gender diverse patients can lead to optimization of reproductive care and counseling and decision making of FP [family planning] for this population."*[32]

For example, although research has initially indicated that gender affirming hormone treatment or surgical interventions may have negative impacts on future reproductive capacity, data from studies evaluating the effect of long-term GAHT on fertility are lacking. Likewise, the effects of protracted anti-androgens and estrogen use on creation of new sperm cells has produced results revealing that creation could still be possible, albeit these results remain significantly limited[33].

[32] Rodriguez-Wallberg, K. et al. (2022) Reproductive health in transgender and gender diverse individuals: A narrative review to guide clinical care and international guidelines, International Journal of Transgender Health, DOI: 10.1080/26895269.2022.2035883

[33] See, eg, Adeleye, A. et al. (2019). Ovarian stimulation for fertility preservation or family building in a cohort of transgender men. *Journal of Assisted Reproduction and Genetics*, *36*(10), 2155–2161.

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Conclusion

Thorne Harbour Health and Victoria Pride Lobby welcome the opportunity to provide a submission for the Inquiry into Universal Access to Reproductive Healthcare. While the Women's Health Strategy outlines tangible steps to ensure national consistency in the provision of women's health services, there is still a lack of recognition to ensure that these services can best serve the TGD community in Australia. Our submission highlights the tremendous potential for existing and future health services to meet the needs of TDG Australians, when investment is made to improve the inclusivity and availability of services. We welcome future opportunities to work with the Australian Government and the Committee to implement our recommendations.

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