

The involuntary or coerced sterilisation of people with disabilities in Australia

This submission is from the Department of Paediatric and Adolescent Gynaecology at the Royal Children's Hospital, Melbourne. This clinical service has 3 part-time gynaecologists, with a total of 47 years experience providing care to young women with disabilities.

Sonia Grover
Paddy Moore
Yasmin Jayasinghe

Department of Paediatric and Adolescent Gynaecology
Royal Children's hospital
50 Flemington Rd
Parkville 3052

Introduction

As the Royal Children's Hospital tends to provide mostly centralized statewide specialized paediatric service for Victoria and for much of Tasmania, our experience reflects the services provided to girls and young women with disabilities in these 2 states. Additionally, as 2 of the clinicians work in adult womens' health services, we have tended to transfer the young women who have been under our care at RCH to ourselves in the adult settings.

Between 5–10% of our outpatient clinical work at RCH relates to the care of young women with disabilities.

In our roles at RCH, we have undertaken a number of research projects relating to the sterilizing procedures in young women with disabilities in Victoria[1], we have audited the management options that we have taken for menstrual management in young women with disabilities[2], looked at the impact on quality of life and outcomes of offering less invasive options of menstrual care to young women with disabilities[3] and written reviews on the topic[4, 5].

As gynaecologists our care relates to young women and our experience with regards to the issue of sterilizing procedures in young men is thus limited – except our awareness of the unreliability of males in general in acting responsibly in regards to contraception. The data that is readily accessible regarding vasectomies has been included in this report in our efforts to acknowledge the issue of sterilising procedures in males.

Summary Points

- All women with disabilities have the right to access high quality medical care for their gynaecological, sexual and reproductive health
- Many young people with disabilities will have complex medical needs often with implications regarding possible options for menstrual management and contraception and will require a multidisciplinary approach.
- Often early and appropriate intervention will avoid the need for recourse to sterilising procedures
- Education of health professionals, and education and respite care facilities for families and carers is essential. At present this is fragmented and limited. We believe funding for this should be a priority.
- There is obviously a need for uniformity in approach for assessment in cases where a sterilising procedure is being considered with particular attention needed to assess and advocate for the interests of the young person with a disability.
- We believe there should be a court appointment of a representative for the person with a disability in all such cases referred to the Family Court or Tribunal in a similar way as occurs currently in Victoria.
- All clinicians involved in the provision of the complex care needs of people with disabilities should be able to be reimbursed with some equality for the time input that is essential to provide this care.
- We are aware that boys and men with disabilities also need special consideration and advocacy around the issues of sterilisation, in their case vasectomy.

Our submission structure has followed the questions as outlined by Senate Community Affairs committee.

(a) The types of sterilisation practices that are used, including treatments that prevent menstruation or reproduction, and exclusion or limitation of access to sexual health, contraceptive or family planning services

Sterilising procedures are by definition those that remove a person's fertility permanently.

For women, this can be a

- i) hysterectomy (which can be undertaken with a variety of surgical techniques or approaches including a total abdominal hysterectomy, subtotal hysterectomy, laparoscopically assisted hysterectomy, total laparoscopic hysterectomy or vaginal hysterectomy)

- ii) tubal ligation (a variety of techniques to achieve this exist. While women are warned about the irreversibility of the procedure in reality it may be possible to reverse a tubal ligation although success is limited. The reversal requires complex surgery and has complications and risks. Reversal options are not readily available under the public hospital system due to recent changes in healthcare agreements. Additionally, pregnancy is not impossible following a tubal ligation as a pregnancy could be achieved with assisted reproduction technology i.e. through IVF. Furthermore there is a 3/1000 chance of failure rate of tubal ligation, where the tube recanalizes and natural pregnancy may occur unexpectedly).

- iii) "Essure" transcervical tubal obstruction – a permanent irreversible nonsurgical technique of blocking the tubes. This is usually performed in an awake patient – but requires the capacity to have a transvaginal, transcervical procedure thus only suitable for women who are sexually active. It could also be performed under general anaesthetic.

- iv) endometrial ablation – which attempts to destroy the uterine lining, predominantly for the purpose of reducing or achieving no menstrual loss. It does not render a woman infertile, and is often performed in association with a tubal ligation. A pregnancy occurring in a woman following an endometrial ablation carries very high risks of serious complications to both the fetus (with restricted growth) and to the woman (with placental adherence directly to the uterus and thus significantly increasing the risk of serious life threatening bleeding)

- v) removal of both ovaries. This is not a technique that is used to achieve sterilization, although can occur in the context of removing ovaries when there is cancer, or where the ovaries have been removed for other nonmalignant pathological conditions.

- vi) In males – vasectomy. This is also in theory reversible, although requires microsurgery and is not always successful.

Menstrual management techniques are offered to young women whose menses and the associated hormonal changes impact on their quality of life. They are offered treatments to improve their quality of life.

Thus young women with painful periods (with or without intellectual or physical disabilities), young women with heavy periods (with or without intellectual or physical disabilities), young women with cyclic seizures, migraines, headaches, anaphylaxis, exacerbations of asthma, significant mood changes, midcycle pain (regardless of whether they do or do not have an intellectual or physical disability) will be offered care that may prevent the changing hormone levels and menstruation. The aim is to improve the quality of life, to ensure that young women can attend school and participate in activities without cyclic symptoms or menstruation where it had previously had a negative impact. The nature of the problem (pain, menstrual heaviness, cyclic symptoms) is driven by the individual, their needs and the impact on *their* quality of life. The competitive swimmer may find her relatively light periods a significant problem when she is training for national competitions. The young woman with an intellectual disability who may be wheelchair bound may find her light but long periods very distressing as they stop her attending her once weekly swimming activities which provide her with valuable social time and physical activity (for muscle and bone health). Both equally deserve to have their problem dealt with respectfully.

Menstrual symptoms can often be controlled with simple measures such as pain killers – in particular, non steroidal medications (eg nurofen, ponstan or naprogesic); the menstrual loss may be reduced with the use of tranexamic acid – a medication taken on the days of heavy menstrual loss; or the oral contraceptive pill (OCP) – which will usually make periods lighter and less painful. (It is worth noting that the oral contraceptive pill reduces the lifetime risk for ovarian cancer by 50–80%, reduces the risk for endometrial cancer by 50%, reduces the risk for ovarian cysts, reduces the risk of developing fibroids, reduces the risk of developing endometriosis. It is obviously contraceptive. Data regarding breast cancer is conflicting. If there is an increased risk it is extremely small (estimated to be 0.5 excess cases and 1.5 excess cases per 10 000 women aged 16–19, and 20–24 respectively up to 10 years after discontinuation of the OCP)[6]. However breast care guidelines for teenagers have not recommended avoiding the OCP [7]. The OCP may be a cofactor in development of an

uncommon type of glandular cervical cancer –cancer of the neck of the womb. However the OCP is not a cause of the cancer: the causative agent of cervical cancer is human papillomavirus, HPV.

Sometimes simple measures for menstrual symptoms are not adequate to control the symptoms. For some problems that occur specifically with the changes in hormone levels, using the oral contraceptive pill cyclically ie still having periods, means that hormonal changes are still occurring and the problem, for example seizures associated with menstruation, will still be persisting.

In these cases, the option of suppressing menstruation is undertaken. Again these approaches are used in young women with and without disabilities – and are completely reversible. (Having a period every month is not a ‘necessary’ or natural part of womans life. Pregnant women don’t bleed for 9 months, with their ovaries doing very little work at all in this time. Breast feeding women can have no periods for 1–2 years, and again the ovaries and the uterus are doing very little at all in this time. In the past women who had 10 or 12 children and breastfed them all, would have had less than 50 periods in their lifetime, so it cannot be argued to that having periods all the time is ‘natural’ .)

Menstrual suppression can be achieved in several ways.

- a) using the oral contraceptive pill continuously
- b) depot medroxy progesterone acetate – 3 monthly injection
- c) levonorgestrel intrauterine system (Mirena IUS) – intrauterine system that releases hormone, lasts 5 years, reduces menstrual loss by 95% by 6 month, 98% by 12 months. It is contraceptive.

Information regarding reproductive health issues for young women with disabilities is mixed. As clinicians we are aware of seeing young women attending schools (including some special schools) where the issue of menses, menstrual care, and reproductive health issues are not taught. But this also applies to the education for young women without disabilities. There would not appear to be minimal standards of what should be taught across all school.

Onset of puberty and menstruation in a young woman with intellectual disability may pose additional stressors on the young woman and therefore her parents, siblings and carers. It is important that such families have access to timely education to prepare for future challenges. Education and support may reduce fear, and is one of the most important components of care. However accessing reliable information regarding menstrual management issues and contraception for young women with disabilities and their families and carers is challenging. General practitioners are not necessarily well informed of options, or are unaware of options or resources. Families expect their local doctor and their paediatrician to be able to advise them, but a recent study (unpublished undertaken at RCH) revealed that many general practitioners and paediatricians had very limited knowledge and were uncomfortable giving advice. (A number of paediatricians felt that a hysterectomy was the first line option for menstrual management when given a case scenario – this is despite RCH gynaecologists efforts to educate paediatricians regarding menstrual management issues for over10 years. However the RCH gynaecology department has limited funding to be able to access resources or develop resources for patients, their families and other practitioners. The education efforts that have been put in place for paediatricians are largely after hours and self-funded).

Family Planning services previously provided a nurse whose specific job title was as an educational resource person for young women with disabilities and to provide education within the school setting for some special schools, but it is less clear that this is still happening.

Adult gynaecology services in public hospitals do not have dedicated services for women with disabilities. They usually provide services without continuity of care, meaning that women often see a different doctor each visit. Most adult gynaecologists have not had a lot of practical clinical exposure to young women with disabilities. The issues regarding level of skills, other medical problems, communication with the young woman or with the carers who themselves may not be fully aware of all the relevant health issues, are all challenges for the clinician. Waiting times in the public outpatient clinics can be lengthy and for young women with disabilities this can be very challenging to be in a strange, potentially busy and impersonal environment. On one occasion, an adult patient with an intellectual disability was referred to one of the RCH gynaecologists in an adult hospital for a second opinion regarding management. As there was no dedicated service in the adult hospital, the patient had to wait in a busy reproductive clinic where other patients were being seen for hormonal conditions and fertility issues.

(b) The prevalence of these sterilisation practices and how they are recorded across different state and territory jurisdictions

It is worth noting that sterilizing procedures, in particular tubal ligation and hysterectomies require admission to hospital and are procedures undertaken in the operating theatre usually under a general anaesthetic. The one sterilizing procedure

that can be performed in women as an outpatient procedure utilizes a hysteroscopic approach (through the vagina, then cervix and from within the uterine cavity), the tubal openings are blocked with devices (Essure). This can usually only be done on women who have had children, who will tolerate this often potentially uncomfortable procedure.

The Royal Australian and New Zealand College of Obstetrics and Gynaecology has undertaken considerable educational efforts to ensure that gynaecologists are aware of the law with regards to sterilizing procedures in minors and people with intellectual disabilities. One way of guaranteeing this knowledge is to include it as an exam question in the final exams for the doctors completing their obstetrics and gynaecology training – and this has occurred regularly over the last 17–18 years. (On the other hand, it is not so clear that other clinicians – primarily those who undertake vasectomies are as well informed of the legislation.)

From a gynaecologists perspective, as well as a hospital perspective, it is not worth the risk to undertake an illegal procedure (the medicare schedules book reminds clinicians of this in the coding section). Hospitals would risk losing their accreditation and clinicians would risk loss of their medical registration. It is most unlikely that either the hospitals or clinicians would be prepared to do this for the sake of performing one operation on one individual. Although there are stories of mothers being 'admitted', but their disabled daughter undergoing the operative procedure, it seems challenging to imagine how this could happen today. The number of times the name, and date of birth of any individual are checked prior to reaching the operating theatre, by numerous different nursing staff, would require far too many people to be part of this deception. (This process is part of the hospital accreditation process and thus present in all hospitals around Australia). The other story – of young women having appendicectomies, but at the same time having either a hysterectomy or a tubal ligation performed, would also require quite a number of people in the operating theatre to be involved in the deception. Specific instruments are required to undertake a hysterectomy (different to those required for an appendicectomy). If the procedure was being done laparoscopically, the operating video screens would reveal the actual procedure to other staff in the operating theatre. Today the nursing staff are no longer quiet subservient members of the operating team.

It is one thing to be aware of the legislation, and it is another to be aware of all the options for menstrual management and care that are available and that are less restrictive, and less invasive. Thus the case in 2010, re Angela, highlights the fact that the clinicians were aware of the need for seeking appropriate approval prior to undertaking a sterilizing procedure – but on reviewing the available information, it is less clear that all the options had been carefully considered and tried.

As sterilizing procedures have specific medicare codes attached to them, when a medicare claim is made, this coding will be collected by medicare Australia. (see attached Appendix for Australia wide data for the relevant procedures). This reflects the codes of procedures where there is a claim being made for payment – and thus reflects mostly procedures undertaken in private. Procedures undertaken in public hospitals are covered by the state funding provided to the hospital and this funding is not directly linked to the actual procedures performed as the hospitals get block funding. Since the introduction of the Diagnosis Related Groups (DRG) system in Victoria, all hospitals were obliged to provide information regarding admissions with specific coding for specific procedures. Associated coding also provided information on co-morbidities and pathology. Thus it has been possible in Victoria since the early 1990's to get accurate information regarding operative procedures, including age breakdown, associated codes and pathology.

This information enabled a careful review of all sterilizing procedures performed in Victoria in the <20 year old age group, and allowed a comparison of the crude numbers versus corrected numbers of 'sterilising procedure', taking into account potential alternative explanations for these procedures. In particular, there are congenital anomalies of the uterus (a double uterus with 2 "horns") where there is a normal uterine horn present and an abnormal blocked horn which is rudimentary and filling with trapped menstrual secretions. Such an anomaly usually causes significant pain on presentation. Removal of this abnormal horn (with preservation of the normal horn) would be coded as a hysterectomy in an adolescent (as this is the age this problem usually presents), and on crude counting would appear to be a sterilising procedure in a minor. The associated codes of congenital anomaly, obstructed uterine horn, with pathology coding the congenital anomaly, allows appropriate recognition that this is not a sterilising procedure in a minor. Likewise, a hysterectomy in the rare case of a pelvic cancer in a child or adolescent would appear to be a sterilizing procedure in a minor, yet the pathology codes would also identify this as a hysterectomy performed for cancer.

This system of coding, was known as DRG and allowed the analysis of sterilizing procedures in minors in Victoria in the 1990's. (It is now called Victorian Admitted Episodes Dataset.) It would be feasible to undertake this review again – presuming the Department of Health allowed access to the dataset (no identifying information is required to undertake this process). We are not aware which other states have this system of data collection – but the task of sorting the codes is feasible with some knowledge of the relevant conditions. Data on all hospital admissions is collected by the Australian Institute of Health and Welfare (AIHW), but it is unclear to the authors whether this has the associated codes to enable clarification of whether the procedures have been performed in young women with disabilities or whether we can exclude the procedures done for other indications such as congenital uterine anomalies or cancers.

As clinicians with an interest in this area we would be very happy to be involved in the process, if such a review or research was undertaken.

(c) The different legal, regulatory and policy frameworks and practices across the Commonwealth, states and territories, and action to date on the harmonisation of regimes;

There are different requirements in different states and territories. Importantly the structures in Victoria allow notification to Victorian Civil and Administrative Tribunal (VCAT) of all relevant cases going to the Family Law Court. Additionally, VCAT is aware of the clinicians in Victoria with experience and expertise in the care of young women with disabilities, and thus have medical resource people they can use for further opinion. I am not certain that this combination of factors and channels of communication are present in other states. The RCH clinicians have occasionally been contacted for second opinions from Western Australia, Queensland and Tasmania, but the experience from our perspective is often unsatisfactory. There appear to be two reasons for this. One is that the late involvement of expert advice, when the families have been struggling with a significant problem for sometime, means that a solution is required more rapidly. Efforts to assist in menstrual management do not always work immediately. Thus some patience is required to achieve a stable state where menses are not significantly impacting on quality of life in the young woman. The second reason is that the court processes (possibly due to the lack of involvement by the equivalent of VCAT) do not always allow for the appointment of an independent legal support for the young woman with the disability, or the judges involved are unaware of the relevant issues.

(d) whether current legal, regulatory and policy frameworks provide adequate:

(i) steps to determine the wishes of a person with a disability,

Clinicians with some experience in working with young women with disabilities are well aware of the need to try and establish the wishes of the young woman herself. This is as a matter of principle, rather than a written policy, with full awareness that the treatment has to be in the best interests of the patient alone. At RCH, the young women with disabilities tend to be in the more severely disabled spectrum with limited capacity for communication and limited self care abilities. Nevertheless efforts are made to try and establish the impact of the menses on the young woman's quality of life, rather than the impact of menses on the family and carers. This may mean assessing absences from school or physical activity important for bone health; measures of distress such as a young person being off their food, sleeping the whole day, verbal and physical cues such as crying and throwing used pads around the house; cyclic behavioural issues such as truancy and potentially getting into trouble with the law; cyclic medical exacerbations such as increased number or severity of seizures, admissions for medical problems; objective measures of heaviness of bleeding such as number of pads or nappies worn, flooding, clots, anaemia, admissions to hospital for low blood count.

(ii) steps to determine an individual's capacity to provide free and informed consent,

Clinicians with some experience in working with young women are well aware of the criteria around Gillick competence as well as the rights of the young woman, and the appropriate documentation required (Gillick v West Norfolk and Wisbech Area Health Authority [1985]). Such guidelines have been provided in writing by medical boards and medical training programs (Medical Board of Victoria, Consent for Treatment and Confidentiality in Young People, Sept 2004). From our perspective, there is no need for a legal framework that reiterates. However further education of practitioners who are less experienced in the field is always an ongoing requirement.

(iii) steps to ensure independent representation in applications for sterilisation procedures where the subject of the application is deemed unable to provide free and informed consent, and

In Victoria, the communication channels between VCAT and the Family Court mean that representation of the interests of the young person with the disability is ensured. It is not clear that this occurs in other states – in particular it would appear that there was not legal representation for the young woman in *re Angela* in Queensland.

(iv) application of a 'best interest test' as it relates to sterilisation and reproductive rights;

The work and thesis undertaken by Dr Sue Brady carefully explores exactly this issue. There is no benefit in reiterating what she has expressed and explained so well[8].

(e) The impacts of sterilisation of people with disabilities;

Sterilising procedures – in particular hysterectomy carries a subsequent risk for bowel adhesions and bowel obstruction with the literature suggesting a 1.36 – 2% rate[9].

For some young women who have sterilising procedures the realization that this has occurred is distressing. I (SG) have seen a young woman who travelled independently to see me from interstate. She had a mild intellectual disability and had

had a hysterectomy performed when she was 14yo. She was very distressed to realize as a 25 year old woman what had been done. I was able to access her medical records and confirm that her abdominal scar combined with an absent cervix on vaginal examination and absent uterus on ultrasound – that there was no doubt that the procedure had been performed. In her case the hysterectomy may have preceded the High Court ruling of 1992 in *re Marion*.

(f) Australia's compliance with its international obligations as they apply to sterilisation of people with disabilities; In the absence of careful analysis of the admissions dataset from the Australian Institute of Health and Welfare (AIHW) it is difficult to know the exact rate of sterilizing procedures. The figure is likely to be quite low when the medicare data is used combined with the earlier study [1] that demonstrated that many procedures coded as potentially sterilizing procedures, when adequately analysed turn out to NOT be sterilizing procedures – but operations performed for congenital anomalies or for malignancies.

It would appear that Australia is probably doing quite well with regards to fulfilling its obligations. There is room for further improvement with improved access to information for the young women and their families and carers, improved availability of clinical resources and improved legal recognition of the special needs of these young women with better communication between the agencies.

(g) the factors that lead to sterilisation procedures being sought by others for people with disabilities, including:

(i) the availability and effectiveness of services and programs to support people with disabilities in managing their reproductive and sexual health needs, and whether there are measures in place to ensure that these are available on a non-discriminatory basis,

Although the Gynaecology department at RCH does provide services to young women with disabilities from all over the state of Victoria and for some young women from interstate, this is far from optimal from families perspectives with the lengthy travel times involved. The development of programs to enable further education of interested practitioners would be useful to increase the number of clinicians with the appropriate expertise .

(ii) the availability and effectiveness of educational resources for medical practitioners, guardians, carers and people with a disability around the consequences of sterilisation, and

(iii) medical practitioners, guardians and carers' knowledge of and access to services and programs to support people with disabilities in managing their reproductive and sexual health needs; and

Re i-iii. We are aware that such resources have been developed by different departments eg Family Planning, Department of Health, Education, and previously by the Centre for Developmental Disability Health Victoria. However these publications go out of date, become unavailable and there is little communication between services. Therefore there is no real understanding of what can potentially be offered. There is an urgent need for resources and better coordination and linkage between sectors. The Dept of Gynaecology at RCH has very limited resources to be able to access educational booklets and DVDs for these young women and their families, and little funding to be able to educate physicians and nurses in the community in a comprehensive way. We would be very happy to participate in a collaborative manner to address such issues in the interests of our patients.

(h) any other related matters.

The consultations involving the reproductive health needs of these young women are always complex and long. At RCH we would regularly take 45-60 minutes with these patients, and even on review visits consultations are likely to be >30 minutes. Yet as apparent by the table below, the medicare schedule payments for different clinicians involved in the same complex patient can be substantially different, with gynaecologists having no access to any more reasonable schedule. Thus gynaecologists in particular when involved in providing this care are poorly reimbursed for their time input. Certainly as gynaecologists the medicare reimbursement for a first consultation (104) and followup consultations (105) are half the rate paid to paediatricians and physicians. Within public hospitals, outpatient services such as our services are often provided within privatised clinics – and hence the payment from medicare does matter. Many of these clinics are not state based funding clinics (ie not Victorian Ambulatory Classification funding system or now the Nationally Consistent Activity Based Funding system)

Table of medicare schedule numbers available for use with complex patients, by specialty of attending doctor (Note patients with disabilities would generally have at least 2 morbidities(eg their disability and a menstrual problem, disability and seizures) thus fulfill the criteria for complex consultations) .

	Gynaecologists	Paediatricians/Physicians	General practitioners
First consultation	104 \$85.55	110 \$150.90	Consultation lasting <20mins \$36.30 Consultation lasting at >20mins \$70.30 Consultation lasting 40+mins \$103.50
Review consultation	105 \$43.00	116 \$75.50	
Long consultation	Not available for gynaecologists		
Complex consultation (x1/year)	Not available for gynaecologists	132 min time 45mins \$263.90 (once/year) 133 min time 20mins \$132.10	Not available for general practitioners

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Appendix

Medicare Australia data on the relevant sterilising codes. Information accessed from the readily available data on the Medicare Australia website

Tubal ligations performed in Australia by State between 1994 - 2012 in young women 0-19year:

(We are making a presumption that tubal ligations would not be performed in girls in this age group for contraception if the young was non-disabled and that it is likely that these young women who have had a tubal to have an intellectual disability)

Item

Item	Calendar	NSW/ACT	VIC/TAS	QLD	SA/NT	WA	Total
35688	Year	Services	Services	Services	Services	Services	Services
Age Range							
0-19	1994	4	2	3	1	2	12
	1995	4	1	4	1	1	11
	1996	4	1	0	1	0	6
	1997	3	1	2	0	1	7
	1998	3	0	-1	1	0	3
	Total	18	5	8	4	4	39
	1999	0	1	0	1	0	2
	2000	0	0	1	0	0	1
	2001	0	0	0	0	1	1
	2002	0	0	0	1	1	2
	2003	0	0	0	0	0	0
	Total	0	1	1	2	2	6
	2004	1	2	0	0	0	3
	2005	0	1	0	0	0	1
	2006	0	0	0	0	0	0
	2007	0	0	0	0	1	1
	2008	0	1	0	0	0	1
	Total	1	4	0	0	1	6
	2009	0	0	0	0	0	0
	2010	0	0	0	0	0	0
	2011	0	0	0	0	0	0
	2012	0	0	0	0	0	0
	Total	0	0	0	0	0	0
Grand total over 19 years	19		10	9	6	7	51

Abdominal hysterectomies in 0-19yo by year and state.

Note - hysterectomies may be performed for other reasons including congenital anomalies and cancers. Numbers may not reflect the number of sterilising procedures. In the next age group (not presented here), some hysterectomies may occur related to complicated obstetrics and life threatening bleeding related to child birth so the number become increasingly inaccurate
Item 35653

Age Range	Calendar Year	NSW/ACT Services	VIC/TAS Services	QLD Services	SA/NT Services	WA Service s	Total Services
0-19	1994	3	3	2	4	0	12
	1995	3	-1	6	0	0	8
	1996	1	1	1	1	1	5
	1997	0	1	0	0	1	2
	1998	1	1	0	0	1	3
	1999	2	0	0	3	0	5
	Total	10	5	9	8	3	35
	2000	-1	1	0	1	0	1
	2001	3	1	1	0	0	5
	2002	0	2	0	0	1	3
	2003	1	1	1	0	0	3
	2004	0	0	1	0	0	1
	2005	1	0	0	0	0	1
	Total	4	5	3	1	1	14
	2006	2	1	0	0	0	3
	2007	0	0	0	0	0	0
	2008	1	0	0	0	0	1
	2009	0	0	0	0	0	0
	2010	1	0	0	0	0	1
	2011	0	0	1	0	0	1
2012	1	0	0	0	0	1	
Total	5	1	1	0	0	6	
Grand total over 19 years	19		11	13	9	4	55

Laparoscopic hysterectomies by age 0-19 and by state

Laparoscopic hysterectomies did not have a specific code prior to 1997. This procedure may be used for removal of a rudimentary horn (ie congenital anomaly) and this the numbers may not represent sterilising procedures

Medicare code

35750

		NSW/ACT	VIC/TAS	QLD	SA/NT	WA	Total
		Services	Services	Services	Services	Services	services
Age Range	Calendar Year						
0-19	1997	0	0	0	0	1	1
	1998	0	0	0	0	1	1
	Total	0	0	0	0	2	2
	1999	0	0	0	1	0	1
	2000	0	0	0	0	0	0
	2001	0	1	0	0	0	1
	2002	0	0	0	0	0	0
	2003	0	0	0	0	0	0
	Total	0	1	0	1	0	2
	2004	0	0	0	0	0	0
	2005	0	0	0	0	0	0
	2006	0	0	0	0	0	0
	2007	0	1	0	0	0	1
	2008	0	0	0	0	0	0
	Total	0	1	0	0	0	1
	2009	2	0	0	1	0	3
2010	0	0	0	0	0	0	
2011	1	0	0	0	0	1	
2012	0	0	0	0	0	0	
Total	3	0	0	1	0	4	
Grand total for 16yrs	3	2	0	2	2	9	

Vasectomies in Boys 5-14 years.

There is an uncommon medical condition in boys that is managed with vasectomy – thus these cases may represent legitimate procedures and may be unilateral procedures, thus not sterilising.

	NSW	Vic	Qld	SA	WA	Tas	ACT	NT	Total
1994	1	0	0	0	0	0	0	1	2
1995	0	0	1	0	0	0	0	0	1
1996	0	1	2	0	0	0	0	0	3
1997	1	0	0	0	0	0	1	0	2
1998	0	0	3	0	0	0	0	0	3
1999	0	1	0	0	0	0	0	0	1
2000	0	0	2	0	0	0	0	0	2
2001	0	0	0	0	0	0	0	0	0
2002	0	0	0	0	0	0	0	0	0
2003	0	0	0	0	0	0	0	0	0
2004	0	0	0	0	0	0	0	0	0
2005	0	0	0	0	0	0	0	0	0
2006	0	0	0	0	0	0	0	0	0
2007	0	0	0	0	0	0	0	0	0
2008	0	0	0	0	0	0	0	0	0
2009	0	0	0	0	0	0	0	0	0
2010	0	0	0	0	0	0	0	0	0
2011	0	0	0	0	0	0	0	0	0
2012	0	0	0	0	0	0	0	0	0
Total	0	1	2	0	0	0	0	0	3

Vasectomies in males aged 15-24 years.

These procedures may not be being performed in young men with disabilities, but it would be relatively uncommon for a sterilising procedure to be performed in a male of this age. Some of these procedures may for medical reasons and may be unilateral – ie not sterilising

	NSW	Vic	Qld	SA	WA	Tas	ACT	NT	Total
1994	21	8	68	6	21	5	5	1	135
1996	11	7	68	4	10	2	4	1	107
1997	16	10	45	2	14	7	4	1	99
1998	12	11	65	1	10	5	2	0	106
1999	14	9	46	2	8	3	3	1	86
2000	13	9	37	1	9	0	8	2	79
2001	11	9	39	3	9	5	1	0	77
2002	9	4	31	1	4	1	2	0	52
2003	9	10	22	1	0	0	2	0	44
2004	9	5	23	0	4	0	3	0	44
2005	7	7	22	0	4	1	0	1	42
2006	9	5	25	0	9	3	0	0	51
2007	10	6	20	2	5	0	4	0	47
2008	6	5	23	1	8	1	0	0	44
2009	13	1	21	1	3	0	2	0	41
2010	8	3	21	3	7	0	2	0	44
2011	4	7	15	0	1	0	2	0	29
2012	9	4	22	0	8	0	1	0	44
Total	191	120	613	28	134	33	45	7	1171