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Submission on amended exposure drafts of Religious Discrimination Bills

Intersex Human Rights Australia (IHRA)

Endorsed by Intersex Peer Support Australia (IPSA)



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2 About this submission

This Report is submitted by [Intersex Human Rights Australia](#) ('IHRA'), a national charitable organisation run by and for people born with intersex variations, formerly known as Organisation Intersex International (OII) Australia. We promote the health and human rights of people born with intersex variations, including rights to bodily autonomy and self-determination. Our goals are to help create a society where intersex bodies are not stigmatised, and where our rights as people are recognised.

We build community, evidence, capacity, and provide education and information resources. Our co-executive directors and other directors engage in work promoting consistent legislative and regulatory reform, reform to clinical practices, improvements to data collection and research. We also work to grow the intersex movement and the available pool of advocates and peer support workers, and address stigma, misconceptions and discrimination. Our work is conducted in line with a 2017 community-designed platform, the Darlington Statement, which sets out priorities for the intersex movement in our region (AIS Support Group Australia et al. 2017).

Since December 2016 we have been funded by foreign philanthropy to contract two part-time co-executive directors to engage in policy development and systemic advocacy work. In addition, welcome funding by the Victorian government currently supports a one-year administrator contract position. Our resourcing is inadequate to meet the demands we face.

IHRA works in partnership with [Intersex Peer Support Australia](#) (IPSA), also known as the AIS Support Group Australia, an intersex-led peer support organisation for people with all intersex variations, including Androgen Insensitivity Syndrome ("AIS"). This submission has been endorsed by Intersex Peer Support Australia. We note that IPSA is also inadequately resourced.

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3 Discussion

Intersex variations are a natural part of human biological diversity. Intersex people are heterogeneous, but share in common risks of shame, stigmatisation and discrimination because we were born with sex characteristics that do not fit medical or social norms for female or male bodies. All intersex variations are biological and many have established genetic causes.

Current medical and legal approaches towards intersex people are disjointed and impose contradictory demands. The effects of current clinical and legal frameworks are that intersex bodies remain surgically and hormonally 'normalised' by medicine, while society and the law 'other' intersex identities. That is, medicine constructs intersex bodies as either female or male, while law and society construct intersex identities as neither female nor male (Carpenter 2018a, 2018b).

Individuals whose intersex variation is more evident to strangers are more likely to bear the brunt of social discrimination (Jones 2017). Ideas that associate bodies with particular identities attitudes reinforcing gender conformity, and such attitudes promote early forced and coercive medical interventions. Current medical practices in Australia violate human rights through forced and coercive medical interventions (Human Rights Committee 2017; Committee on the Elimination of Discrimination against Women 2018; Committee on the Rights of Persons with Disabilities 2019).

Historical documents show that Christian religious (canon) law has long recognised the rights of intersex people, including the right to marry, and the ability of intersex men to witness a testament and be ordained (for example, in Medieval texts by Gratian and Huggucio; see also Finlay 1980). Similar provisions exist in Islam (Uddin 2017; Gesink 2018). Different treatment of men and women by religious institutions on grounds of sex means that religions can be expected to treat people born with intersex variations differently on the basis of sex, hence only intersex men have been ordained according to canon law (Gratian 12th century).

Many religious institutions are neglecting ancient teachings, and many policy-makers and LGBT institutions are only considering the meaning of intersex people to them within a modern LGBT context. Increasing polarisation on issues of sexual orientation and gender identity creates new risks to intersex people arising from a conflation of LGBT and intersex issues.

Some religious bodies have decried the construction of third sex categories (for example, Congregation for Catholic Education 2019); yet the *Darlington Statement (AIS Support Group Australia et al. 2017)*, a regional community consensus platform, describes the construction of intersex as a third sex as harmful, and the consignment of intersex people to such categories appears to have its origins in an ahistorical Family Court of Australia decision (1979) that cited marriage norms in Christendom.

These contradictions and inconsistencies are evident in recent legislative debates on marriage (for example, see Smith 2017a; Fawcett and Paterson 2017a) and abortion

(Tudehope 2019a, 2019b), and illustrate assertions that policy-making is disjointed (Carpenter 2018a, 2018b).

Varying attitudes and beliefs evidenced in religious, judicial and legislative debates on the existence and meaning of intersex people risk being grounded not in fact but in misconceptions, stigma and disgust, often based on physical appearance. These contradictions in religious viewpoints, many of them uninformed, and resulting possibilities for collateral impacts create significant uncertainty and potential harms for people with intersex variations in relation to the current legislative proposals.

4 Specific areas of concern with the exposure drafts

The proposed legislation appears likely to have significant adverse impacts on people with intersex variations, particularly in healthcare settings, for example, in accessing scans, treatment and medication necessary for health and wellbeing.

The proposals regard some adverse health impacts as justifiable, facilitate the refusal of some treatment, and increase risks of coercion particularly for vulnerable infants, children and adolescents.

The proposals also impose a requirement that stigmatised populations accept unsolicited comment in a context where words used by medical providers already cause harm and avoidance of healthcare by intersex people and our families (Johnson et al. 2017).

Alternative providers are not available. Knowledgeable healthcare for people with intersex variations is scarce. Some territories and states rely on providers in other jurisdictions for many key services (Gallagher 2014; Cook 2019).

IHRA takes the view that no-one should experience discrimination in accessing services, and in particular in accessing health services. Overall, as with the previous iteration of the exposure draft legislation, the legislative proposals fails to balance the competing rights of different interests. The provisions relating to healthcare are likely to have significant adverse consequences for the health and wellbeing of people with intersex variations and our families.

4.1 Statements of belief may be intrusive or coercive in medical settings

As with clause 41 the previous exposure draft, clause 42 of the new exposure draft of the *Religious Discrimination Bill* seeks to exempt certain ‘statements of belief’ from all Commonwealth, State and Territory anti-discrimination protections including protections in the *Disability Discrimination Act*, the *Sex Discrimination Act*, the *Fair Work Act*, section 17(1) of Tasmania’s *Anti-Discrimination Act*, and any other law that may become prescribed by regulation. We note, in relation to the *Fair Work Act*, that current legislation provides no protection on grounds of intersex status.¹

The revised definition of a statement of belief in clause 5 appears likely to expose intersex people, disabled people, women, lesbian, gay, bisexual, transgender (LGBT) people, single parents, people in *de facto* relationships, divorced people and other groups, to statements that would otherwise be considered discriminatory, as long as they are said to be motivated

¹ The gap in the *Fair Work Act* in relation to protections for intersex people should be rectified. We recommend an amendment to this Act and the *Sex Discrimination Act* by inserting provisions on “sex characteristics” in place of “intersex status”. The attribute of sex characteristics has become an international standard in the period since the *Sex Discrimination Act* was amended, and has numerous benefits, including universal application (AIS Support Group Australia et al. 2017; Yogyakarta Principles 2017).

in good faith by religious (or non-religious) belief. They express what George Brandis described as a ‘right to be a bigot’ (Griffiths 2014).

Paragraph 549 of the explanatory memorandum states that a statement of belief is permissible while ‘refusal to provide medical services may constitute discrimination’.

The comment in paragraph 549 of the explanatory memorandum suggests that clinicians are protected if they suggest that intersex characteristics (like other stigmatised physical characteristics) are a ‘product of the fall’ or a ‘punishment for sin’, or that adolescents must abide by parental or clinical authority. Religious clinicians may also coerce children and adolescents into unnecessary medical intervention because of a religiously-motivated belief in paternal or parental authority or particular gender stereotypes, or even a religiously-motivated belief in clinical authority. For example, a 2019 statement by a Catholic institution has overturned more than a millennium of historical canon law approaches towards intersex people and stated that:

in cases where a person’s sex is not clearly defined, it is medical professionals who can make a therapeutic intervention. In such situations, parents cannot make an arbitrary choice on the issue, let alone society (Congregation for Catholic Education 2019) (for more on the source statement, see section 5.3.3.6).

Just because an individual holds a belief does not make it credible, or reasonable to make unsolicited comments in any circumstances. This imposes a particular burden on vulnerable, stigmatised, marginalised and poorly understood groups – including parents of infants and young children – to accept intrusive and unsolicited debate about our lives, including intrusive and unsolicited debate that is itself grounded in misconceptions and stigma.

While statements that are considered malicious, or likely to harass, threaten or ‘seriously’ intimidate will not be protected, the line between permissible and such statements is unclear. The distinction between a statement in good faith and a coercive statement is unclear. These are issues already faced by intersex people, people with other kinds of physical difference or disability, and by LGBT people.

Further, the proposals appear likely to intrude on scientific debate, enabling individuals to frame creationism and pseudoscience as arguments warranting ‘balanced debate’.

These provisions override all other Commonwealth, State and Territory laws, making the proposed bill a radical departure from existing legislation on discrimination.

4.2 Health practitioner conscientious objections

The revised exposure draft makes some welcome changes to clauses on health practitioners. In particular, the breadth of professions enumerated in the earlier exposure draft – including podiatry, optometry and medical radiation – gave us cause for concern that the intention is to facilitate discrimination against particular populations, and not to facilitate conscientious objection in relation to particular medical procedures. The narrower

list of professions appears now to be tighter, and more closely aligned with State and Territory provisions on conscientious objection.

4.3 Uncertainty in defining ‘particular kinds of health service’

The following statement in note 2 to section 8(6) clarifies that particular kinds of health services may not be denied to particular people or groups of people:

this provision does not have the effect of allowing a health practitioner to decline to provide a particular kind of health service, or health services generally, to particular people or groups of people. For example, refusal to prescribe contraception to single women may constitute discrimination under the Sex Discrimination Act 1984.

However, the nature of a ‘particular kind of health service’ is unclear. Many intersex people require hormone replacement, or hormone treatment. In some cases, such treatment is necessary due to sterilisation without personal informed consent. In other cases, treatment is necessary due to innate characteristics. Lack of treatment can result in osteopenia, osteoporosis, depression and other consequences. In some cases, the medication required is also used for contraceptive purposes by some women. Such treatments may be misunderstood or declined despite their very different rationales and consequences.

Some people with intersex variations, such as women with androgen insensitivity may never ‘virilise’ or ‘masculinise’ with testosterone treatment, and many women with this trait seek testosterone treatment because their bodies naturally produced testosterone before sterilisation. Gender stereotypes play a role in determining such sterilisations (Carpenter 2018a; Kelly and Smith 2017; B. J. Richards and Wisdom 2019), and gender stereotypes play a role in how service providers respond to requests for treatment. Healthcare providers may choose to make a referral or not based on their values, and not the need or values of service users.

These explanations create legal uncertainty about whether or not refusal to provide services is or is not discrimination.

4.4 Adverse health impacts are never justifiable

Subclause 8(7) states that ‘unjustifiable adverse impact’ on ‘the health any person who would otherwise be provided with the health service by the health practitioner’ is not permitted. This presupposes that some adverse health impacts are justifiable.

Personal religious values or views must never be privileged over patient health. No adverse health impacts are justifiable.

4.5 Non-disclosure, and unsolicited disclosures

A 2016 global clinical statement on the health of people with intersex variations identifies many concerns with clinical treatment, including the identification of serious human rights concerns associated with routine treatment, a lack of evidence in support of common surgical and hormonal interventions, lack of clinical consensus regarding timing or even evaluation of outcomes, and concerns with negative experiences. It states, for example:

The practice of withholding medical history details, along with the possibility of negative medical experiences, likely contributes to patients with DSDs frequently being 'lost to follow-up.' (Lee et al. 2016, 170)

The global clinical paper, and a recent statement by the New Zealand Office of the Privacy Commissioner (2018), identify how non-disclosure of medical information is already an issue for many intersex people, and it is accompanied by adverse consequences, limiting individuals' ability to make meaningful choices about their health and wellbeing. Disclosure of affirmative peer and family support groups is already limited. We fear that increasing polarisation on social issues, particularly relating to sex, gender and sexuality, may result in more clinicians with particular religious or ideological beliefs choosing to withhold medical histories, diagnoses and other information.

A 2017 clinical study found that language-related negative emotional experiences of healthcare led to people with intersex variations and their parents changing or ceasing healthcare – and in particular the disordering of intersex variations:

When asked, "How often have you had a negative emotional experience at a medical visit as a result of words used to describe your/your child's condition?", 69% (137/ 198) reported this occurring least once, and 45% (90/198) reported negative emotional experiences as a result of terminology sometimes, frequently, or always... Most (82%, 113/137) who reported negative emotional experiences also reported changing their care as a result of the experience (e.g., 23% stopped going for specialist care, and 14% went to a different hospital for all care). (Johnson et al. 2017).

It is within this context that the exposure draft legislation proposes that unsolicited value statements or beliefs by service providers are acceptable, and impose particular burdens on stigmatised and poorly understood minority populations. In our view, such statements and unsolicited impositions may add to existing known harms. Like existing concerns about clinical attitudes and nomenclature regarding intersex people, such statements may have significant adverse consequences for mental health and for future access to medical services. They are also discriminatory in that they only apply to some service users and not others.

4.6 Alternative service providers are not available

Medical statements promote 'multidisciplinary teams' for the provision of services to infants, children and adolescents with intersex variations and our families (Hughes et al.

2006; Lee et al. 2016). There is no public evidence available on referral rates to such teams, nor the proportion of infants, children and adolescents who are referred. Nor is there detailed evidence about the practices of such teams, although we have been able to identify a range of practices, beliefs and opinions within their institutions (see the summary at Carpenter 2019a).

Multidisciplinary teams are, in and of themselves, no guarantee of healthcare that respects the human rights of intersex people (Liao, Wood, and Creighton 2015; Lohman and Lohman 2018; Consortium on the Management of Disorders of Sex Development et al. 2006). In particular, they may be led by surgeons who favour early surgeries that are recognised as harmful practices (Committee on the Elimination of Discrimination against Women 2018; Committee on the Rights of the Child 2019; Intersex Human Rights Australia 2018; Lohman and Lohman 2018). Recent clinical research has proposed that such teams are more properly described as ‘multi-professional services’ as they do not provide integrated care, and clinicians have called for their reworking ‘to enable team members to hold themselves jointly accountable for the welfare of children and adults’ (Liao and Roen 2019, 12).

Nevertheless, few such services exist. Some States and Territories, for example, Western Australia (Cook 2019) and the Australian Capital Territory (Gallagher 2014), rely on providers in other jurisdictions. Alternative services are not available. Given human rights concerns with early medical interventions, this tension between centralisation and lack of alternative affirmative providers is already a major concern to intersex organisations in Australia. This lack of alternatives creates additional concerns with the impacts of dispositions, beliefs and opinions held by key staff in the few services that exist.

4.7 Differential treatment is not acceptable

Many individuals with intersex variations require treatment, scans and examinations that are atypical for people with their sex markers or appearance. For example, some men with intersex variations may need periodic breast screening, and some women with intersex variations may need prostate screening. Some individuals may need both of these, or other types of screening and treatment. Transgender individuals may also require similar screening and treatments. We note that some medical professionals confuse intersex people with transgender people and, as with every demographic, some people are both intersex and transgender. It is our view that medical professionals should not be able to decline medically-indicated treatment, based on informed consent, to either population.² We note that our position is consistent with a report of the UN Special Rapporteur on freedom of religion and belief (Shaheed 2018, paras 39–40), which stated:

39. The Special Rapporteur also notes with concern the increasing trend by some States, groups and individuals, to invoke “religious liberty” concerns in order to justify differential treatment against particular individuals or groups,

² We examine related issues and human rights implications of medical interventions on people with intersex variations in Appendix 5.2.1 and Intersex Human Rights Australia 2018. A consistent framework to respect the right of all individuals to bodily integrity in relation to medical interventions to modify sex characteristics can be found in the Yogyakarta Principles 2017.

including women and members of the lesbian, gay, bisexual, transgender and intersex community. This trend is most often seen within the context of conscientious objection, including of government officials, regarding the provision of certain goods or services to members of the public.

40. ... It should be noted, however, that the jurisprudence of the Human Rights Committee and the regional human rights courts uphold that it is not permissible for individuals or groups to invoke “religious liberty” to perpetuate discrimination against groups in vulnerable situations, including lesbian, gay, bisexual, transgender and intersex persons, when it comes to the provision of goods or services in the public sphere.

UN Treaty Bodies including the Committee on the Elimination of Discrimination against Women (2018, para. 26) and the Committee on the Rights of Persons with Disabilities (2019, para. 34) have recommended that Australia provide redress to intersex persons who have undergone forced procedures without their informed consent. It would be perverse to expose such individuals to discrimination a result of their medical needs.

4.8 General religious exception

We welcome the provision that subsection 11 ‘does not permit conduct that is otherwise unlawful under any other law of the Commonwealth, including the *Sex Discrimination Act 1984*’.

Nevertheless, provisions regarding religious doctrines, tenets, beliefs and teachings raise profound concerns about shifts and changes in religious doctrines and beliefs that are of significant concern to us. The provisions are overly broad and untethered to persistent actual or evidenced beliefs and tenets.

There is strong historical evidence supporting the full inclusion of intersex people in heterosexual Christian marriage, and the ordination of intersex men. The available evidence shows that Islam and Judaism have long had places for intersex people. Those institutions have taken positions acknowledging the existence of people with intersex variations, and positions that, while not supporting self-determination, are not otherwise stigmatising or discriminatory. Some smaller Christian churches have adopted a belief in ‘the fall’ from Eden, and position all kinds of visible physical difference (including intersex variations) as evidence of that fall (see, for example, Price 2015).

The views of many religious institutions have pivoted as they have taken novel positions on LGBT rights issues. A range of current positions have displaced traditional positions as a consequence. Despite this, the Senate in a 2013 report on proposed legislation that added ‘intersex status’ to anti-discrimination law found no evidence of religious bodies intending to discriminate against intersex people for being intersex (Legal and Constitutional Affairs Legislation Committee, Senate 2013). Similarly, the 2018 religious freedoms inquiry report positioned intersex alongside race, sex and disability, and not with sexual orientation and gender identity (Ruddock et al. 2018).

Positions on intersex that frame intersex within novel theological frameworks on LGBT people are rife with contradictions, evidencing what seems to be an interest in the situation of intersex people only as collateral in debates on the rights of LGBT people. For example, the Congregation for Catholic Education proposed that decision-making in relation to unnamed intersex bodies be placed solely within the domain of medicine while disparaging the word intersex itself, and associating it with third sex/gender categories.

In contrast, 2019 discussions in relation to the decriminalisation of abortion in NSW saw Christian members of the legislative council proposed to add intersex as a third sex category in amendments seeking to prohibit sex selective abortion performed by medical professionals (Tudehope 2019a, 2019b). Indeed, terminations are well documented in relation to some intersex traits, notably of sex chromosome variations (Carpenter and Organisation Intersex International Australia 2014). The same contradiction can be seen in some amendments and debate on the 2017 marriage law (for example, Fawcett and Paterson 2017b; Hastie 2017).

In such a context, the risk is that any possible teaching or belief may appear justifiable, no matter how recent, ahistorical or atypical, and no matter how much it may rely on misconceptions or stigma.

4.9 A Bill of Rights

IHRA recommends enactment of a Bill of Rights in Australia, to more fully enact the *International Covenant on Civil and Political Rights*, and other UN Treaties ratified by the Commonwealth.

5 Appendices

Background information on intersex people, and on religious lenses on intersex people, can be found below.

5.1 Appendix A: Who are intersex people

There are many misconceptions about intersex people and intersex variations. These have complicated policy development in Australia and they also complicate comprehension of intersex people by religious institutions. In particular, and perhaps because of poor language use and conflation of intersex with LGBT populations, intersex has frequently been imputed to mean a matter of identity rather than a matter of many diverse embodiments. Such imputations defy the experience of many people born with intersex variations, the definition of intersex in the *Sex Discrimination Act 1984*, and internationally widespread definitions of intersex.

Intersex variations are a natural part of human biological diversity. Intersex people are heterogeneous, but share in common risks of stigmatisation and discrimination because we were born with bodies that do not fit medical or social norms for female or male bodies. All intersex variations are biological and many have known genetic origins. A definition by the UN Office of the High Commissioner for Human Rights states:

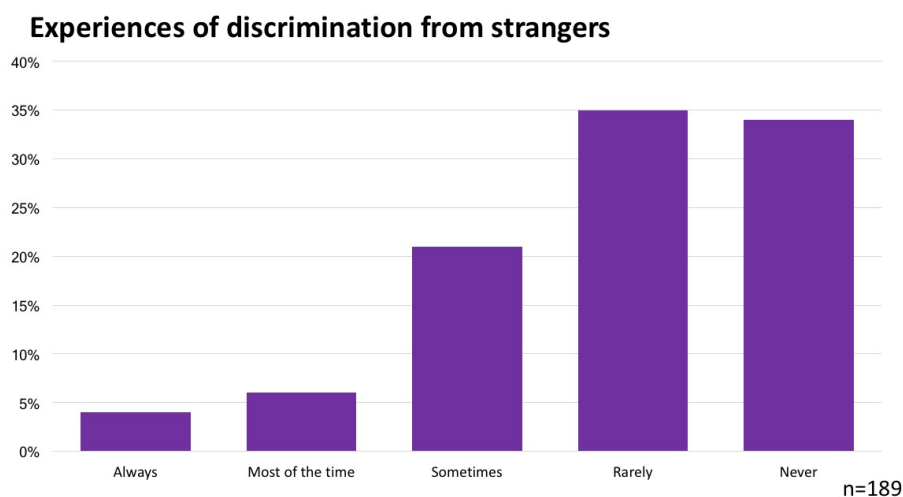
Intersex people are born with physical or biological sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that do not fit the typical definitions for male or female bodies. For some intersex people these traits are apparent at birth, while for others they emerge later in life, often at puberty. (Public statement of UN and regional human rights experts 2016).

This widely-accepted definition of intersex does not specify any sex, gender, sexual orientation or gender identity. Australian and international research shows that intersex people commonly identify with legal sex assigned at birth, while many of us may not. Intersex people may identify or understand ourselves as female or male, or in other ways. Intersex people have a range of sexual orientations.

Many forms of intersex exist; it is an umbrella term, rather than a single entity. At least 40 different variations are known to science (Hiort 2013). Most variations are genetically determined, while many individuals with intersex variations have no clear genetic diagnosis (Hiort 2013). Since 2006, clinicians frequently use a stigmatising label, 'disorders of sex development' or 'DSD', to refer to intersex variations. In line with IHRA policy, the Senate has recommended that such terms not be employed (Community Affairs References Committee, Senate of Australia 2013). An Australian-Aotearoa/New Zealand intersex community consensus statement, the *Darlington Statement*, regards the term DSD as problematic as it frames intersex variations as inherently disordering and in need of 'fixing' (AIS Support Group Australia et al. 2017).

Intersex variations can include differences in the number of sex chromosomes, different physical responses to sex hormones, or a different hormone balance. Some common intersex variations are diagnosed prenatally (Davis 2013). Many persons do not have clear genetic diagnoses. Some individuals have received multiple different diagnoses over time.

A 2015 Australian sociological convenience sample of 272 people born with atypical sex characteristics found that 19% favoured 'X' or non-binary classifications. At the same time, 60% used the term intersex to describe themselves, including people who 'are' intersex and people who 'have' intersex variations or conditions: respondents engaged in code-switching, using different language to describe their sex characteristics in different contexts. 3% used the medical term 'disorders of sex development' to describe their sex characteristics to themselves, while 21% used this term when accessing medical services (Jones 2017).



Data from the same study also suggest that individuals whose intersex variations are more physically evident to strangers are more likely to bear the brunt of social discrimination. Such physical evidence of an intersex variation cannot be assumed to correlate with gender expression or particular gender identities, as they relate to physical characteristics.

For people with intersex variations that are easy to hide or that are not physically evident to strangers, and for heterosexual, non-transgender people born with intersex variations, religious exemptions on grounds of intersex status effectively create a situation of 'don't ask, don't tell'. Where an intersex variation is not evident, an individual is likely to avoid disclosure or medicalise their intersex trait to prevent discrimination.

5.1.1 Some examples of intersex variations

The purpose of this section is to provide sufficient understanding to enable consideration of the impact of policies, policy proposals, and practices affecting people born with intersex variations. Several distinct intersex variations are detailed due, in some cases, to their higher frequency, and in one case due to the existence of relevant recent Family Court decisions.

5.1.1.1 Klinefelter syndrome/47,XXY

People with Klinefelter syndrome are clinically defined as men with an extra X sex chromosome (i.e. XXY sex chromosomes, or 47,XXY). Klinefelter syndrome is associated with small testes, hypogonadism (low sex hormone levels, in this case low levels of testosterone), and also may be associated with cognitive issues such as ADHD, and a range of other health risks (Skakkebaek, Wallentin, and Gravholt 2015). As with other intersex variations, innate characteristics may be stigmatised. Men with Klinefelter syndrome have poorer socioeconomic outcomes (Skakkebaek, Wallentin, and Gravholt 2015). A 2015 clinical review states that 90% of people with Klinefelter syndrome are diagnosed after age 15, and only a quarter of individuals with this variation are ever diagnosed. It is possible that persons with XXY who are not diagnosed may escape some shame, stigma and health risks associated with the variation; alternatively, they may suffer in silence. Not all people with XXY sex chromosomes are male (Röttger et al. 2000) but, due to the current medical paradigm that assumes all people with XXY chromosomes are men, individuals who are not can face additional challenges in accessing appropriate medical care.

5.1.1.2 Androgen insensitivity

Persons with androgen insensitivity syndrome ('AIS') have XY sex chromosomes (typically associated with men), testes (typically intra-abdominal), and a phenotype or physical appearance that may vary. The majority of people with complete AIS appear to identify as women and a high proportion are heterosexual (Warren 2017). People with partial AIS grow up to understand themselves in diverse ways and include many women and girls with a typical female phenotype. Diagnosis may take place at any point during infancy or childhood (for example, if testes are mistaken for herniation) or during puberty (due to lack of menstruation). The nature of AIS means that women with complete AIS will never 'virilise' ('masculinise') if their gonads are retained or if they take testosterone replacement therapy. Women and girls with partial AIS may experience some virilisation if their gonads are retained or if they take testosterone replacement therapy depending on the degree of insensitivity to androgens. Women with 'higher grades' of partial AIS have limited capability for virilisation.

Once diagnosed, women with AIS are frequently subjected to gonadectomies, or sterilisation. Historically, rates of potential gonadal tumour risk have been overstated, particularly in the case of complete AIS. Current papers suggest a low gonadal tumour risk of 0.8% associated with the gonads of people with complete AIS (Pleskacova et al. 2010). Following sterilisation, individuals require hormone replacement to maintain bone health, libido and general health.

Women with complete AIS report assumptions behind medical intervention that include the idea that women should not have testes. These include assumptions that women with complete AIS need oestrogen as post-sterilisation hormone replacement, even though their bodies naturally produced testosterone. People with partial AIS may experience surgeries and other treatments that fail to respect their self-understandings and preferences.

We are aware of clinical claims that prophylactic sterilisations of women with complete AIS no longer take place, including claims that such interventions are ‘in the past’ (for example in Australasian Paediatric Endocrine Group et al. 2013). However we are unable to pinpoint any moment in time that divides that past from the present, and we are unaware of any Australian women with AIS aged under 50 who have not been sterilised.

We are aware of cases where people with AIS have been unaware of their diagnosis, and so unable to manage key aspects of their life, including the consequences of sterilisation (for example, Kirkland 2017).

Historically, some women with complete AIS were excluded from competitive sport following chromosomal tests. Some women with partial AIS are remain excluded. Women in such situations often have no prior knowledge of their intersex variation, and suffered humiliation, loss of career and, in at least one documented case, home and relationship (Martínez-Patiño 2005). Chromosomal testing was abandoned as an unjust method of determining sex before the end of the twentieth century (Simpson J et al. 2000) before being reintroduced by the IAAF in recent years (International Association of Athletics Federations 2019).

5.1.1.3 Congenital adrenal hyperplasia

Children with congenital adrenal hyperplasia (CAH) may necessitate immediate medical attention from birth to manage salt wasting. Children with XX chromosomes (typically associated with women) may also have genitalia that appears atypical.

Atypical genitalia, and higher rates of same sex attraction and gender transition are problematised in persons with CAH and XX sex chromosomes.

A 1990 paper by Heino Mayer-Bahlburg entitled ‘Will prenatal hormone treatment prevent homosexuality?’ highlights ‘an increase in bisexual and homosexual orientation’ in women with CAH attributing this to prenatal androgen exposure (Meyer-Bahlburg 1990). Research to date has, however, found that a diverse range of potential factors including genetics and environmental factors, may be responsible for sexual attraction (C. Richards 2017). According to a 2010 paper by clinicians in New York City:

Without prenatal therapy, masculinization of external genitalia in females is potentially devastating. It carries the risk of wrong sex assignment at birth, difficult reconstructive surgery, and subsequent long-term effects on quality of life. Gender-related behaviors, namely childhood play, peer association, career and leisure time preferences in adolescence and adulthood, maternalism, aggression, and sexual orientation become masculinized in 46,XX girls and women with 21OHD deficiency (Nimkarn and New 2010).

These characteristics, including behavioural ‘masculinisation’ were described as ‘abnormalities’. The paper went on to state:

The rates of gender dysphoria and patient-initiated gender change in this population are higher than the rates ... in the general population... Genital sensitivity impairment and difficulties in sexual function in women who underwent genitoplasty early in life have likewise been reported ... We anticipate that prenatal dexamethasone therapy will reduce the well-documented behavioral masculinization and difficulties related to reconstructive surgeries (Nimkarn and New 2010).

At the time of a 2013 Senate inquiry, this prenatal therapy was available in Australia. The Senate sought to end such interventions due to associated cognitive risks to the children concerned (Community Affairs References Committee, Senate of Australia 2013). However, their current status in Australia is undocumented.

These rationales for treatment have proven controversial (Dreger, Feder, and Tamar-Mattis 2012). Future clinical papers appear to have abandoned disclosure of such rationales – however, the same treatments, including ‘genitoplasties’, persist. This appears to mean that rationales are now simply undisclosed or undocumented.

Despite acknowledgement of impaired sensation and sexual function, and higher than typical rates of gender assignment change, at time of writing the Department of Health and Human Services in Victoria states:

Girls with CAH may need surgery to reduce the size of the clitoris to normal, separate the fused labia and enlarge the vaginal entrance. The technical name for this operation is ‘clitoral recession or reduction and vaginoplasty’. It is done either in one or two stages.

The clitoral reduction or recession is done in the first few months of life. The vaginoplasty is sometimes done at the same time as the clitoral reduction, but may be left until adolescence, before the menstrual periods begin (Department of Health & Human Services 2014).

In November 2017, an SBS Insight program on intersex heard from Professor Sonia Grover of the Royal Children’s Hospital Melbourne, commenting that surgical practices today are better than they used to be, implying certainty about future gender identity, sexual orientation and normative ideas about future preferences for body morphology (Insight SBS 2017).

No disclosure is made about risks to sexual function and sensation, however, reference is made to vaginal scar tissue in the context of pregnancy and vaginal delivery. The need for such interventions is, however, not indicated or substantiated. Evidence of necessity is lacking, and reliable evidence of good outcomes is lacking. Globally, there remains no accepted evidence to support surgical practices. For example, a 2016 clinical update states that:

There is still no consensual attitude regarding indications, timing, procedure and evaluation of outcome of DSD surgery. The levels of evidence of responses

given by the experts are low (B and C), while most are supported by team expertise... Timing, choice of the individual and irreversibility of surgical procedures are sources of concerns. There is no evidence regarding the impact of surgically treated or non-treated DSDs during childhood for the individual, the parents, society or the risk of stigmatization (Lee et al. 2016).

5.1.1.4 17-beta hydroxysteroid dehydrogenase 3

Infants with 17-beta hydroxysteroid dehydrogenase 3 (17 β -HSD3) have XY chromosomes and may have genitals that appear at birth to be somewhere between typically female and typically male. In cases where visible genital variation is evident at birth, the currently proposed World Health Organization *International Classification of Diseases* ICD-11 beta suggests that gender assignment be made based on a doctor's assessment of the technical results of masculinising genitoplasty, and that genital surgeries must occur early. Elimination via selective embryo implantation during IVF is also stated as possible:

If the diagnosis is made at birth, gender assignment must be discussed, depending on the expected results of masculinizing genitoplasty. If female assignment is selected, feminizing genitoplasty and gonadectomy must be performed. Prenatal diagnosis is available for the kindred of affected patients if causal mutations have been characterized (World Health Organization 2018).

The Australasian Paediatric Endocrine Group supports such interventions, even while advising the Senate in 2013 how early interventions are controversial and known to be associated with 'particular concern' regarding post-surgical sexual function and sensation (Australasian Paediatric Endocrine Group et al. 2013).

Additionally, according to a review paper, rates of gender change in persons with 17-beta-hydroxysteroid dehydrogenase 3 deficiency assigned female at birth are '39–64% of cases'. This means that children subjected to feminising genitoplasties may not be girls at all.

In 2006, a clinical 'consensus statement' described the risk of gonadal tumours associated with 17 β -HSD3 to be 28%, a 'medium' risk, recommending that clinicians 'monitor' gonads (Hughes et al. 2006). A more recent clinical review published in 2010 reduced risk levels to 17% (Pleskacova et al. 2010) and a German multidisciplinary team advised Amnesty International in 2017 that, in any case, 'cancer risk even for the high risk groups is not so high. We can monitor with ultrasound and for tumour markers' (Amnesty International 2017). However, like the WHO ICD-11 classification (World Health Organization 2018), current medical journal articles on this trait (for example, Lee et al. 2016) recommend gonadectomy with female gender assignment, and not cancer risks.

In 2008, in the Family Court case *Re Lesley (Special Medical Procedure)*, a judge approved the sterilisation of a young child with 17 β -HSD3 (Family Court of Australia 2009). This was intended to prevent the child's body from virilising at puberty. According to a submission by counsel, the alternative to sterilisation included (at [39]) to:

(a) take no action and allow [Lesley] to virilise and make a determination about her gender later

That is, sterilisation was not predicated on clinical urgency regarding cancer risk, but instead to surgically reinforce a female gender assignment and pre-empt later determination. Risks of gonadal tumour were stated to be 'significant' (at [40]), which differs from current clinical papers focused on sterilisation associated with female gender assignment.

In 2016, in the Family Court case *Re: Carla (Medical procedure)*, a judge approved the sterilisation of a 5-year old child with 17 β -HSD3, surprisingly claiming that 'it would be virtually impossible to regularly monitor them for the presence of tumours' (at [20]) (Carpenter 2017). This does not accord with the German experience. The judge described how (at [30]):

It will be less psychologically traumatic for Carla if it is performed before she is able to understand the nature of the procedure

This indicates a lack of urgency related to tumour potential, in addition to a deliberate constraint on the capacity of 'Carla'. Gender stereotyping appears to form the substantive basis of the decision to sterilise 'Carla', including an assumption of a future female gender identity (at [15]):

- a. Her parents were able to describe a clear, consistent development of a female gender identity;*
- b. Her parents supplied photos and other evidence that demonstrated that Carla identifies as a female;*
- c. She spoke in an age appropriate manner, and described a range of interests/toys and colours, all of which were stereotypically female, for example, having pink curtains, a Barbie bedspread and campervan, necklaces, lip gloss and 'fairy stations';*
- d. She happily wore a floral skirt and shirt with glittery sandals and Minnie Mouse underwear and had her long blond hair tied in braids; and*
- e. Her parents told Dr S that Carla never tries to stand while urinating, never wants to be called by or referred to in the male pronoun, prefers female toys, clothes and activities over male toys, clothes and activities, all of which are typically seen in natal boys and natal girls who identify as boys.*

The judge also expressed, at [18], an assumption of future heterosexuality: 'Carla may also require other surgery in the future to enable her vaginal cavity to have adequate capacity for sexual intercourse'.

The judge also stated, when the child was 3-years of age (at [2]):

Surgery already performed on Carla has enhanced the appearance of her female genitalia.

This was a clitorrectomy and labioplasty,(at [16]) sometimes termed a ‘vulvoplasty’. This statement is quite extraordinary. Australia, in common with many other countries, maintains a legal prohibition on Female Genital Mutilation (FGM). FGM refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for ‘non-medical reasons’ (World Health Organization et al. 2008). In societies where female genital mutilation is a norm, it is recognised to be carried out to, *inter alia*, enable a woman to fully participate in society, prepare for adulthood, and meet cultural standards for female appearance. The World Health Organization and other bodies recognize that medicalization, including as a form of harm reduction, does not justify female genital mutilation. Yet, intersex girls are exempt from such protections. The gender stereotyping evident in *Re: Carla* demonstrates a moral hypocrisy in such exemptions.

5.2 Appendix B: Community priorities

Community priorities are set out in the *Darlington Statement*. This Statement is a community consensus platform developed by Australian and New Zealand intersex organisations and advocates in 2017 (AIS Support Group Australia et al. 2017). It covers a range of priorities in relation to protections for bodily integrity, anti-discrimination law, and sex markers.

5.2.1 Bodily integrity

Community demands include:

- ***prohibition as a criminal act of deferrable medical interventions, including surgical and hormonal interventions, that alter the sex characteristics of infants and children without personal consent***
- ***mandatory independent access to funded counselling and peer support [including integration within multidisciplinary teams in hospitals]***
- ***appropriate human rights- based, lifetime, intersex standards of care with full and meaningful participation by intersex community representatives and human rights institutions***
- ***independent, effective human rights-based oversight mechanism(s) to determine individual cases involving persons born with intersex variations who are unable to consent to treatment, bringing together human rights experts, clinicians and intersex-led community organisations (AIS Support Group Australia et al. 2017)***

None of these demands are currently met. Forced and coercive medical interventions persist. The surgery on ‘Carla’ detailed in the Family Court case *Re: Carla* is not unique.

A 2014 Department of Health Medicare Benefits Schedule Review on ‘vulvoplasties’³ identifies 371 Medicare-funded vulvoplasties for ‘congenital malformations’ during the period 2007/8 to 2011/2; an average of 74.2 per year (Department of Health 2014).

³ Defined in the Review as ‘any surgery performed on the outside female genital structures’

Medicare procedures data published by the Australian Institute of Health and Welfare (AIHW) show an average of 71.5 vulvoplasties per year in children aged under 15 between 2002/3 and 2014/5, with a range from 57 to 95 procedures per year (Australian Institute of Health and Welfare 2017). These data are not associated with diagnostic data or claimed rationales for interventions.

The same AIHW data also show that the numbers of vulvoplasties in the 0-19 year age groups have increased significantly from 101 in 2002/3 to 258 in 2015/5.

The number of masculinising surgeries shows no particular trend over the period from 2002/3 to 2014/5. Of particular note, the Institute reports 200 *repeat* surgeries on persons aged under 20 for 'repair of postoperative urethral fistula' in 2013/4, including 125 such repeat procedures in children aged 1 to 4 years. To be clear, these are follow-up surgeries for iatrogenic conditions, caused by prior medical intervention.

Research published in 2018 shows that there is no evidence of any reduction in the number of surgeries relevant to children born with intersex variations over the period 2002/3 to 2014/5 (Carpenter 2018a).

5.2.1.1 Bodily integrity and international law

The right to security of the person, including freedom from injury to the body and the mind, or bodily and mental integrity are protected by the first substantive right in the *Universal Declaration of Human Rights*, article 3, as well as the *International Covenant on Civil and Political Rights*, article 9, and the *Convention on the Rights of Persons with Disabilities*, article 17 (Committee on Civil and Political Rights 2014, para. 3; United Nations 2006).

States have an obligation to eliminate forced, coercive, and unnecessary medical interventions to modify variations of sex characteristics, and violence against intersex persons. For example, in October 2016, UN agencies and experts, and regional institutions, made the following joint statement:

States must, as a matter of urgency, prohibit medically unnecessary surgery and procedures on intersex children. They must uphold the autonomy of intersex adults and children and their rights to health, to physical and mental integrity, to live free from violence and harmful practices and to be free from torture and ill-treatment. Intersex children and their parents should be provided with support and counselling, including from peers.

Intersex children and adults should be the only ones who decide whether they wish to modify the appearance of their own bodies – in the case of children, when they are old or mature enough to make an informed decision for themselves...

States should investigate human rights violations against intersex people, hold those found guilty of perpetrating such violations accountable and

provide intersex people subjected to abuse with redress and compensation (Public statement of UN and regional human rights experts 2016).

Reflecting developments in international law, the 2017 *Yogyakarta Principles plus 10* on the application of international human rights law in relation to sexual orientation, gender identity, gender expression and sex characteristics state in Principle 32 that:

Everyone has the right to bodily and mental integrity, autonomy and self-determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to be free from torture and cruel, inhuman and degrading treatment or punishment on the basis of sexual orientation, gender identity, gender expression and sex characteristics. No one shall be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person (Yogyakarta Principles 2017).

In 2015, Malta became the first jurisdiction to protect the rights to bodily integrity of intersex and other children. The legislation prohibits non-essential modifications to children's sex characteristics, provides for oversight of decision making on cases where necessity is claimed, and provides for the development of standards of care (Malta 2018).

IHRA made a submission to the UN Human Rights Committee regarding current practices in Australia and our country's obligations under the *International Covenant on Civil and Political Rights*, and the Committee's Concluding Observations in 2017 stated:

25. The Committee is concerned that infants and children born with intersex variations are sometimes subject to irreversible and invasive medical interventions for purposes of gender assignment, which are often based on stereotyped gender roles and are performed before they are able to provide fully informed and free consent (arts. 3, 7, 9, 17, 24 and 26).

26. The State party should give due consideration to the recommendations made by the Senate Standing Committee on Community Affairs in its 2013 inquiry report on involuntary or coerced sterilisation of intersex people, and move to end irreversible medical treatment, especially surgery, of intersex infants and children, who are not yet able to provide fully informed and free consent, unless such procedures constitute an absolute medical necessity (Human Rights Committee 2017).

The cited articles of the *International Covenant on Civil and Political Rights* are on non-discrimination (articles 3 and 24), protection from torture and experimentation (article 7), the right to liberty and security (article 9), privacy (article 17), and equality before the law (article 26). These citations highlight the many ways in which current medical practices violate our human rights. The same *Covenant* underpins international law recognising the right to freedom of belief and religion (article 18). In 2018, the Committee on the Elimination of Discrimination against Women called for Australia to enact specific legal

protections (2018, para. 26). In September this year, the Committee on the Rights of Persons with Disabilities made a similar call (2019, para. 34).

5.2.1.2 Bodily integrity in Australia

In 2013, as part of a broader inquiry on the involuntary or coerced sterilisation of people with disabilities in Australia, the Senate Community Affairs Reference Committee published a report on the involuntary or coerced sterilisation of intersex people in Australia. It called for substantive changes to medical practices to protect the rights of children. Amongst its statements, the cross-party report stated that:

3.107 ... there is no medical consensus around the conduct of normalising surgery...

3.128 ... Normalising appearance goes hand in hand with the stigmatisation of difference... There is frequent reference to 'psychosocial' reasons to conduct normalising surgery. To the extent that this refers to facilitating parental acceptance and bonding, the child's avoidance of harassment or teasing, and the child's body self-image, there is great danger of this being a circular argument that avoids the central issues... Irreversible medical treatment, particularly surgery, should only be performed on people who are unable to give consent if there is a health-related need to undertake that surgery, and that need cannot be as effectively met later, when that person can consent to surgery. (Community Affairs References Committee, Senate of Australia 2013)

The recommendations of the cross-party report have not been implemented in any Australian jurisdiction. In a response to the report, the federal government approvingly cited non-binding and abstract guidelines produced in Victoria (Attorney General's Department 2015b). However, the guidelines appear to be disregarded in that State (Intersex Human Rights Australia 2019).

5.2.2 Anti-discrimination law

Contemporaneously with the Senate inquiry on involuntary or coerced sterilisation, Australia was the first country to introduce standalone protection for intersex people from discrimination in access to services and employment, through welcome cross-party support for amendments to the *Sex Discrimination Act 1984* in 2013. Intersex status is defined in the amended Act:

Intersex status means the status of having physical, hormonal or genetic features that are: (a) neither wholly female nor wholly male; or (b) a combination of female and male; or (c) neither female nor male.

As with the UN definition of intersex, this Australian legal definition refers to *features* or characteristics. It does not specify any legal sex, sexual orientation or gender identity.

According to the explanatory memorandum for the amending bill, the attribute was not intended to create a third sex (House of Representatives and Australia 2013).

Unfortunately, changes to anti-discrimination law in 2013 have, however, been imputed to imply matters of identity (Yoosuf 2015). These misinterpretations have unfortunately been given impetus by poorly-formed federal guidelines on the recognition of sex and gender that simultaneously recognise that intersex people may be female, male or identify otherwise as 'X', and also include the word intersex within a definition of 'X' (Attorney General's Department 2015a). In a positive move to respond to this issue, Australian Standard AS4590 on data interchange now defines 'X' gender as 'non-binary'.

Many submissions to the inquiry may unfortunately reflect these misconceptions, for example, through a framing of issues affecting 'LGBTI' populations or an 'LGBTI community' as issues of sexuality and gender diversity. Perhaps the most challenging effect of such misunderstandings is that they have made intersex more incomprehensible or obscured. We invite the inquiry to carefully examine submissions that extrapolate the characteristics and needs of an intersex population from an exclusive or primary analysis of the characteristics and needs of LGBT people.

Internationally, a different attribute of 'sex characteristics' has been implemented in law by multiple national governments to protect intersex and other people from discrimination and violence (Malta 2018). This attribute has been cited by the Asia Pacific Forum of National Human Rights Institutions (Asia Pacific Forum of National Human Rights Institutions 2016), and a major 2017 supplement to the *Yogyakarta Principles* on the application of international human rights law in relation to sexual orientation, gender identity, gender expression and sex characteristics.⁴ Use of this updated attribute is also supported by the *Darlington Statement* (AIS Support Group Australia et al. 2017) for several reasons, including that it usefully cannot be imputed as a matter of identity rather than embodiment.

The *Darlington Statement* calls for access to reasonable accommodations in education and employment, including 'special needs requirements, workplace adjustments, job access assistance, and provisions for medical leave' (2017, para. 57).

5.2.3 Sex markers

An involuntary consignment of intersex persons in Australia to a *de facto* third or non-binary status has occurred since the annulment of the marriage of a man deemed a 'true hermaphrodite', based on an ahistorical appeal to marriage 'as understood in Christendom', in the 1979 Family Court of Australia case *In the marriage of C and D (falsely called C) (1979) FLC 90-636*. Some individuals (intersex and non-intersex) have freely chosen third or non-binary sex markers since 2002/3 (Butler 2003).

⁴ The *Yogyakarta Principles plus 10* defines 'sex characteristics' as follows: 'UNDERSTANDING "sex characteristics" as each person's physical features relating to sex, including genitalia and other sexual and reproductive anatomy, chromosomes, hormones, and secondary physical features emerging from puberty'

Current federal guidelines (Attorney General's Department 2015a), South Australian regulations (Consumer and Business Services 2017) and ACT regulations (Office of Regulatory Services and Australian Capital Territory Government 2014) position intersex within a third sex/gender category. In response to involuntary association with third sex markers, the *Darlington Statement* declares that:

*8. Regarding **sex/gender classifications**, sex and gender binaries are upheld by structural violence. Additionally, attempts to classify intersex people as a third sex/gender do not respect our diversity or right to self determination. These can inflict wide-ranging harm regardless of whether an intersex person identifies with binary legal sex assigned at birth or not. Undue emphasis on how to classify intersex people rather than how we are treated is also a form of structural violence. (AIS Support Group Australia et al. 2017)*

A persistent harmful framing of intersex as a third sex classification, together with diverse personal preferences while sex classifications remain stated on legal identification documents, led to a declaration that 'The larger goal is not to seek new classifications but to **end legal classification systems** and the hierarchies that lie behind them':

- a. As with race or religion, sex/gender should not be a legal category on birth certificates or identification documents for anybody.*
- b. While sex/gender classifications remain legally required, sex/gender assignments must be regarded as provisional. Given existing social conditions, we do not support the imposition of a third sex classification when births are initially registered.*
- c. Recognising that any child may grow up to identify with a different sex/gender, and that the decision about the sex of rearing of an intersex child may have been incorrect, sex/gender classifications must be legally correctable through a simple administrative procedure at the request of the individual concerned.*
- d. Individuals able to consent should be able to choose between female (F), male (M), non-binary, alternative gender markers, or multiple options. (AIS Support Group Australia et al. 2017)*

In respect of the long-term aspirational goal stated here, we note that Australian governments are increasingly relying on, and sharing, biometric data, and a call to end sex markers on legal identification documents has no consequences for the census and other surveys beyond those caused by the absence of racialised and religious classifications on identification documents.

Reforms to at least end construction of intersex as a third category require change to current federal guidelines on recognition of sex and gender (Attorney General's Department 2015a).

Since early 2015, we have (jointly with a range of other organisations) asked the government to change the definition of X from 'indeterminate/intersex/unspecified' to

‘non-binary’, as a minimum reform of current standards (National LGBTI Health Alliance et al. 2015). IHRA has also made submissions to ACT and SA governments on this matter, prior to establishment of such regulations (Briffa 2013; Carpenter and Organisation Intersex International Australia 2017b).

5.3 Appendix C: Christian teaching and attitudes towards intersex people

Here we present data on some early and some modern Christian attitudes towards intersex persons. We acknowledge that a diverse range of religious beliefs exist within Christian traditions, as with non-Christian traditions. We therefore also acknowledge that some religious institutions seek to make space for people who are same sex attracted and people who are gender diverse and they may also assert inclusivity for intersex people.

5.3.1 Canon law and early common law

Early canon law, apparently based on Roman law, recognised intersex people as ‘hermaphrodites’, a term that has in recent centuries narrowed in meaning to define fertile organisms that possess both female and male reproductive organs. Historic legal definitions, in contrast, recognise a diversity that should be recognised in present-day intersex populations. The 12th century *Decretum Gratiani* states:

Whether an hermaphrodite may witness a testament, depends on which sex prevails (Hermaphroditus an ad testamentum adhiberi possit, qualitas sexus incalescentis ostendit). (Gratian 12th century)

Raming cites the work of the near contemporary Italian canon lawyer Huguccio in *causa* 4, l. 2 and 3, c. 3, 22 *ad v. sexus incalescentis*, which suggests that ordination of intersex men is ‘of course’ possible:

If someone has a beard, and always wishes to act like a man (exercere virilia) and not like a female, and always wishes to keep company with men and not with women, it is a sign that the male sex prevails in him and then he is able to be a witness, where a woman is not allowed, that is, in a will and in final wishes, and then, of course, he is able to be ordained (Raming 2004, 2:113)

Finlay cites Freisen who, in a history of canon marriage law (*‘Geschichte des kanonischen Eherechts’*), quotes from the *Tractatus de matrimonio*:

The question naturally arises, whether a hermaphrodite can contract marriage with a man or a woman. On this matter, the authority of the fathers of the church is emphatic that if the sexual drive of mature years is evident, a hermaphrodite can contract marriage either with a man or a woman according to its indications; consequently, if the hermaphrodite comes closer to the male sex than the female and has the signs of virility, a beard and so forth, he should be understood to be able to contract marriage with a woman (Finlay 1980, 120)

Raming identifies the same perspective on consecration in canonical literature from the 1940s and 1950s:

*Even in modern canonical literature, for instance, the question whether a hermaphrodite can be consecrated is solved in exactly the same fashion used by Huguccio (and thus by Roman law). Cf. Heribert Jone, *Gesetzbuch der lateinischen Kirche*, 2nd ed. (Paderborn, F. Schöningh, 1950-1953), 3 vols., 2:191; A Lanza, "De requista sexus virilis certa determinatione et distinctione ad ordines," in *Apollinaris* 19 (1946):49-66. (Raming 2004, 2:113)*

Coincidentally, Edward Coke held substantively the same position in his *Institutes of the Laws of England*, for example, in relation to inheritance:

Every heire is either a male, a female, or an hermaphrodite, that is both male and female. And an hermaphrodite (which is also called Androgynus) shall be heire, either as male or female, according to that kind of sexe which doth prevaile (Greenberg 1999, 41)

Such examples do not provide a basis for self-determination, but nor are they stigmatising; they indicate that intersex people were able to participate in their societies, including participation in religious practices.

A medicalisation of intersex bodies in the nineteenth and twentieth centuries essentially framed intersex people as a social problem that could be medicalised to prevent the possibility of homosexuality. Elizabeth Reis, for example, states that:

Doctors believed that surgery was warranted in many cases of atypical genitalia, not necessarily for the health, comfort, or pleasure of the patient, but to preclude the undesirable potential for homosexual sex. Even life-long celibacy was preferable to homosexuality. Physicians in the 1880s and 1890s wanted their patients to understand their hermaphroditic conditions as deformities and not as a physical license to commit sexual immorality (Reis 2012, 68).

In addition to the term hermaphrodite, other historical terms applied to some intersex people include 'eunuch' and 'barren woman'.

5.3.2 The Family Court (1979), a break with the past

In Australia, this historical Christian position was overturned in the 1979 Family Court case *In the marriage of C and D (falsely called C)*, inaccurately citing marriage norms in Christendom to consign intersex people to a *de facto* third sex category. In this case, Bell J stated:

The wife's consent to the marriage was not a true consent because she was mistaken as to the identity of the husband at the time of the marriage. She

believed that she was marrying a male whereas in fact she was marrying a combination of both male and female.

Marriage as understood in Christendom is the voluntary union of one man and one woman to the exclusion of all others for life, and since the respondent was a combination of both, a marriage in the true sense could not have taken place and did not exist (Family Court of Australia 1979)

While since repudiated, the case is still cited, as a case of mistaken identity involving someone with *de facto* third sex status, for example in *Tien-Lao & Tien-Lao* [2018] FamCA 953 (21 November 2018):

Although C and D has since been authoritatively repudiated for reasons unrelated to the conclusion reached about the wider meaning of mistaken identity... [54]

even if the broader test adopted by Bell J were to be applied in this instance, it would not afford the parties any advantage. In C and D, at the time of marriage, the husband was found to be a hermaphrodite: neither a male nor a female (at 528). The wife mistakenly believed she was marrying a man, so the marriage was void. [55] (Family Court of Australia 2018)

The analysis in the case was ahistorical, and failed to acknowledge the then available historical record, including that identified by Henry Finlay in a response to the case (Finlay 1980). It preceded the existence of an intersex movement, and continues to call into question the identity and status of people born with intersex variations, even where alternative identities have been unavailable, where they identify with their sex assigned at birth and where they have never understood themselves as anything else. The man in this troubling case was also the subject of a 1966 *Medical Journal of Australia* case, which established that he freely chose surgeries as an adult in line with his sex assigned at birth (early surgeries were not performed when the man was a child) (Fraser, O'Reilly, and Rintoul 1966).

5.3.3 Current positions by Christian institutions

Current Christian approaches often appear unaware of the historical treatment of people with intersex variations in church law. The specific circumstances of intersex people appear to be sometimes unthinkingly subsumed in debates between conservative Christian interests and LGBT interests. Sometimes the existence of intersex people is brought into in a contested, increasingly polarised, debate about concepts of nature, nurture and sin. In the context of marriage, some argue that sexual orientation and gender identity have biological components, that LGBT people are 'born that way', while religious organisations opposing marriage equality have contended that same sex attraction is behavioural and not innate. In this politicised environment, the meaning of intersex people has been reinterpreted through lenses primarily focused on same sex attraction, or transgender people. Such reinterpretations thus carry many risks – particularly for people born with intersex

variations who are not LGBT. Careful regard should be had to the potential impact of these debates on people born with intersex variations – and particularly those who are not LGBT.

Some other religious bodies have framed their analysis around a concept of ‘the fall’ where, in common with other people with physical differences, intersex traits are seen as evidence of a ‘fall’ from Eden.

Religious institutions presently often cite *Matthew 19:12*. The following text comes from a 2017 report by the Sydney Anglican Diocese:

For there are eunuchs who have been so from birth, and there are eunuchs who have been made eunuchs by men, and there are eunuchs who have made themselves eunuchs for the sake of the kingdom of heaven. Let the one who is able to receive this receive it. (Matt 19:12) (Sydney Diocesan Doctrine Commission 2017)

5.3.3.1 Focus on the Family (2015)

Some religious institutions medicalise intersex people, framing us directly or indirectly as tragic, confused and lonely, and as examples of ‘the fall’ from Eden, alongside anyone with (Price 2015) any kind of disability or chronic condition. For example, a 2015 statement by Focus on the Family on transgender people makes a number of comments about intersex people, including:

- That humans live in a ‘fallen’ state that leads to ‘genetic, biological and congenital conditions’ that ‘plague our physical existence’.
- That intersex people do not demonstrate gender fluidity.
- That intersex people ‘often walk confusing, challenging and lonely journeys through life’ (Price 2015).

Focus on the Family stated that Christians should help intersex people to carry a ‘heavy yoke’ ‘and steward their assigned gender’, thus apparently opposing changes from an original sex assignment, but affirming a right to heterosexual marriage (Price 2015).

So how should we, as Christians, minister to those among us who deal with the unique and often traumatic circumstances associated with intersexuality? Some intersex individuals will marry, and some may never discover their underlying condition. But Jesus' own words, as recorded in Matthew 19, should serve as our guide for those who cannot or don't marry due to intersex issues. (Price 2015)

5.3.3.2 The Nashville Statement (2017)

In August 2017, a group of evangelical pastors in the US signed the *Nashville Statement*, a position statement, primarily focusing on their position towards LGBT people. However, Article 6 comments on intersex people, stating that:

WE AFFIRM that those born with a physical disorder of sex development are created in the image of God and have dignity and worth equal to all other image-bearers. They are acknowledged by our Lord Jesus in his words about “eunuchs who were born that way from their mother's womb.” With all others they are welcome as faithful followers of Jesus Christ and should embrace their biological sex insofar as it may be known.

WE DENY that ambiguities related to a person's biological sex render one incapable of living a fruitful life in joyful obedience to Christ (Coalition for a Biblical Sexuality 2017).

Lianne Simon of Intersex & Faith, Inc., has stated in response that she is ‘troubled that this affirmation appears to require us to give up our bodily integrity and embrace some doctor's guess at what sex God meant us to be’ (Simon 2017a). However, Intersex & Faith contacted more than 100 *Nashville Statement* respondents, and it found that:

- None of the signatories ‘appeared to be in favor of childhood genital surgeries’, with Denny Burk, an architect of the *Nashville Statement*, explicitly opposing them.
- Most respondents felt that they lacked experience and could not properly comment, or felt that individual cases needed to be considered more deeply.
- The largest plurality of respondents suggested that ‘biological sex’ could be reduced to the presence or absence of a Y chromosome, citing an opinion by Denny Burk (Simon 2017b). This is an approach that does not work in cases of AIS, and it has explicitly been rejected as a method of sex determination by sporting authorities.

5.3.3.3 Sydney Anglican Diocesan Doctrine Commission (2017)

A 2017 statement entitled *A Theology Of Gender And Gender Identity*, the Anglican Sydney Diocesan Doctrine Commission makes the following statements:

2.9 Intersex: This is a general term that covers a range of rare ‘disorders of sex development’ (or ‘disorders of sex differentiation’) where there is some biological ambiguity in a person's genitalia or gonads or, more rarely still, in their chromosomes. Except in very rare instances, a person's biological sex can be known from their DNA. Because intersex conditions are medically identifiable deviations from the sexual binary norm they are not regarded as constituting a third sex. Because they are biologically (rather than psychologically) based, some intersex people do not wish to be associated with the LGBTQ movement (Sydney Diocesan Doctrine Commission 2017).

The Commission notes that ‘For this reason, we will use the acronym LGBTQ, rather than LGBTIQ, throughout this report.’ They state:

The biblical account of creation thus indicates that God has created each human being as either male or female. We are given no encouragement to consider male and female as two extremes at either end of a broad continuum, or to consider those with an intersex condition as intended from the beginning as a third sex.

The Commission are, indeed, most concerned with challenging the idea that intersex is a third sex. Referring to Matthew 19:12, the Commission states:

Jesus' first two categories were, no doubt, informed by the Jewish distinction between "eunuchs of the sun"— i.e., those who have been eunuch from birth – and "eunuchs of man"— whether made so by accident or design. The first of these categories, most likely, would have included conditions that today would be regarded as disorders of sex development. However ... Scripture nowhere presents eunuchs as a third sex.

The Commission appears to accept changes to sex classifications in persons who are medicalised as having a disorder of sex development, stating 'that certain intersex conditions may contribute to gender dysphoria in the person with the condition' (Sydney Diocesan Doctrine Commission 2017, footnote 8). Different intersex variations are each associated with different rates of 'gender dysphoria', however, the associated distress is exacerbated by medical interventions. For example, if 'Carla' in *Re: Carla* identifies as male from puberty, in line with a clinical review showing that 39 – 64% of people raised female with 17β-HSD3 are men, then early 'feminising' surgeries will significantly exacerbate distress.

Despite a framing as tragic, these religious arguments are not concerned with the way that intersex people are treated, but are instead more concerned with our meaning for their attitudes towards LGBT people. Further, the approach of the Sydney Diocese unfortunately adds to pressures whereby transgender people may seek recognition of being transgender as a form of intersex in order to gain acceptance and access to genital surgeries (an example of this, expressed as a claim for access to therapeutic genital surgeries that avoids association with mental disorders, is provided by National Foundation for Australian Women and The University of Melbourne 2016).

5.3.3.4 Parliamentary debate on marriage (2017)

A 2015 Australian sociological study found that 12% of respondents who answered a question on marriage and relationships were legally recognised as married in Australia. 1% of respondents were widowed, and 14% were separated or divorced. A further 8% of people had married overseas (6%) or in Australia (2%) but their marriage was not recognised here. These data demonstrate the diversity of the intersex population (Intersex Human Rights Australia 2016).

However, despite attempts to present this diversity (Carpenter and Organisation Intersex International Australia 2017a), reference to the experiences of intersex people were largely absent from parliamentary and civil debates on marriage. The Senate Select Committee inquiry into the Exposure Draft of the Hansard Marriage Amendment (Same-Sex Marriage) Bill did not discuss or comment on the inclusion of intersex people within these exemptions. Nor was there any specific mention or discussion of intersex people in the debate on the *Marriage Amendment (Definition and Religious Freedom) Act 2017* (Cth), except to the

extent that we are supposed to challenge the idea that a marriage is the union of a man and a woman.

The *Marriage Amendment (Definition and Religious Freedoms) Act 2017* replicated exemptions in the *Sex Discrimination Act 1984* discrimination on grounds of 'intersex status' (Smith 2017b), a status which is legally distinct from sex and gender, as intended (House of Representatives and Australia 2013; Carpenter and Organisation Intersex International Australia 2012). However, in his explanatory memorandum, Senator Dean Smith gave the following single example of an intersex person, accompanying an example of a gender diverse person with non-specific gender:

For example, this would include an intersex person who is legally recognised as both male and female and a gender diverse person who is legally recognised as having a non-specific gender (Smith 2017a)

No jurisdiction in Australia legally recognises any intersex person as both female and male. This is therefore a highly unusual choice of example and one that does not reflect the reality for either the intersex population or the individual who identifies in this way.

Amendments proposed during the course of parliamentary debates proposed to broaden exemptions from discrimination laws for marriage celebrants appeared focused on traditional view of the family and marriage, but without awareness of the history of intersex inclusion in Christianity. Andrew Hastie MP, and Senators Fawcett and Paterson, proposed that a 'relevant belief' might include a 'genuine religious or conscientious belief that':

the normative state of gender is binary and can, in the overwhelming majority of cases, be identified at birth (Hastie 2017; Fawcett and Paterson 2017b, 2017c)

This recognises that there are cases where gender cannot be 'identified at birth', suggesting an acknowledgement that intersex people exist, but it provides no guidance on what the authors believe should happen in such instances. Some amendments proposed by the same parliamentarians also stated that marriage celebrants can 'disregard ... intersex status' in the same way that they might 'disregard ... current legal status of ... sex or gender':

in determining whether the other person is a man or a woman, if the authorised celebrant, chaplain or authorised officer reasonably believes and genuinely believes that the current legal status of the other person as a man or a woman is different from the legal status of the other person as a man or a woman at the time of the other person's registration following the other person's birth, the authorised celebrant, chaplain or an authorised officer may disregard the current legal status of the other person's sex or gender, or their gender identity or intersex status (Hastie 2017; Fawcett and Paterson 2017b) (a similar paragraph was proposed in Fawcett and Paterson 2017a).

The implications of this for people with intersex variations are unclear.

It seems likely that those proposing these amendments were poorly informed about the existence of people with intersex variations, church positions, and the biological definition of the legal attribute of 'intersex status'. The proposals also encourage appearance-based determinations; matters of appearance may be entirely unrelated to personal identity.

5.3.3.5 Religious freedoms debate (2018)

The Religious Freedoms review positioned intersex alongside race, disability and pregnancy, and not with sexual orientation and gender identity:

Recommendation 1

Those jurisdictions that retain exceptions or exemptions in their anti-discrimination laws for religious bodies with respect to race, disability, pregnancy or intersex status should review them, having regard to community expectations. ...

Recommendation 6

Jurisdictions should abolish any exceptions to anti-discrimination laws that provide for discrimination by religious schools in employment on the basis of race, disability, pregnancy or intersex status. Further, jurisdictions should ensure that any exceptions for religious schools do not permit discrimination against an existing employee solely on the basis that the employee has entered into a marriage. ...

Recommendation 8

Jurisdictions should abolish any exceptions to anti-discrimination laws that provide for discrimination by religious schools with respect to students on the basis of race, disability, pregnancy or intersex status. ...

1.141 While the Panel accepted that some variation in approaches between jurisdictions was appropriate to reflect the values of different communities, it could see no justification for exceptions in existing law relating to race, disability, pregnancy or intersex status. The Panel is of the view that those jurisdictions retaining exceptions should review them having regard to community expectations. (Ruddock et al. 2018)

Little justification was presented in support of this positioning of intersex status, however, the reasoning can be discerned from the presentation of historical information on religious attitudes towards intersex people, and the following statements by Patrick Parkinson, author of the submission to the religious freedoms inquiry by Freedom for Faith:

The rights and needs of those with intersex conditions do not conflict with religious values. (Freedom for Faith 2018, footnote 15, page 25)

Nevertheless, Parkinson was concerned about instrumentalisation of the existence of intersex people:

The alleged scientific basis for these beliefs [in multiple genders or gender fluidity] rests upon a claim that the prevalence of intersex conditions is a figure that is almost 100 times greater than as understood in conventional medical science. (Freedom for Faith 2018)

5.3.3.6 New Catholic church position (2019)

While the Catholic church historically, and into the mid-20th century is established to have had a place for intersex people, termed hermaphrodites, in Canon law (see section 5.3.1), this position has very recently been overturned with the publication in 2019 of a statement by the Congregation for Catholic Education, entitled ‘*Male and Female He Created Them Towards a Path of Dialogue on the Question of Gender Theory in Education*’.

This document refers to an unnamed population in paragraph 24 who are to be subjected, without reservation, to medical interventions:

From the point of view of genetics, male cells (which contain XY chromosomes) differ, from the very moment of conception, from female cells (with their XX chromosomes). That said, in cases where a person’s sex is not clearly defined, it is medical professionals who can make a therapeutic intervention. In such situations, parents cannot make an arbitrary choice on the issue, let alone society. Instead, medical science should act with purely therapeutic ends, and intervene in the least invasive fashion, on the basis of objective parameters and with a view to establishing the person’s constitutive identity. (Congregation for Catholic Education 2019)

We discuss this point in the next section, on abortion law reform in NSW and efforts by Minister Damien Tudehope and the Rev Fred Nile to include intersex within amendments aimed at preventing sex selective terminations, as these are known to be provided by many of the same doctors who propose postnatal ‘therapeutic’ interventions.

Paragraph 25 of the Congregation’s statement associates the word intersex with identification, ‘Efforts to go beyond the constitutive male-female sexual difference’, and being transgender.

This ahistorical analysis, including its separation of nomenclature from discussion on embodiment and the surrendering of intersex bodies to clinicians, has been the subject of debate within the intersex movement globally. A joint statement signed by 1043 organisations and individuals (including some Catholic theologians) was submitted to the Congregation on 25 June. Commenting on the document, Morgan Carpenter (co-executive director of Intersex Human Rights Australia) stated:

The Joint Statement demands that the Catholic Church should acknowledge its own history. The existence of people born with variations of sex characteristics has been recognised by the institution since its earliest times. Our existence cannot be associated with any particular contemporary fashion, theory or ideology. (Carpenter 2019c)

Tony Briffa (co-executive director of Intersex Human Rights Australia) stated:

As a Catholic person born with an intersex variation, it is disappointing the Church has taken a position that encourages unnecessary, irreversible, non-consensual and damaging intervention on bodies like mine – all in their need to easily classify people into narrow boxes of what it means to be female or male. God’s diversity does not work in this way. The document will cause harm to children and families. (Carpenter 2019c)

5.3.3.7 New South Wales abortion debate (2019)

On 26 August 2019, Danielle Le Messurier of the Daily Telegraph reported that former spokesman for the Australian Family Association:

Finance Minister Damien Tudehope will move a motion in the upper house stating “termination not be used for sex- selection if the foetus is confirmed or suspected to be a female foetus, a male foetus or an intersex foetus” (Messurier 2019).

An editorial on the same day in the Daily Telegraph stated:

It is one issue to decide on an abortion because a foetus is male or female. What happens, however, if a foetus cannot be easily classified as either? What if the foetus is intersex, or as obstetrician Dr Gregory Jenkins puts it, has “undifferentiated genitalia”? ...

The precise wording of the amendment, soon to be moved in the upper house, requires that “termination not be used for sex selection if the foetus is confirmed or suspected to be a female foetus, a male foetus or an intersex foetus”. (The Daily Telegraph 2019)

On the one hand, the elimination of foetuses with intersex traits is a known phenomenon, and one that significantly reduces the number of live births of infants with some intersex variations such as sex chromosome variations (Carpenter 2019b).

On the other hand, this proposal, put before the NSW Legislative Assembly in amendments c2019-057F and c2019-057H and debated on 18 September 2019 (Tudehope 2019a, 2019b), both frame intersex as a third category that is, to use the words of the Congregation for Catholic Education ‘beyond the constitutive male-female sexual difference’, and it disputes the ability of medicine to make what is framed as ‘a therapeutic intervention’ (Congregation for Catholic Education 2019).

In the same debate, the Reverend the Hon. Fred Nile stated, ‘I support the proposed amendments on behalf of the Christian Democratic Party’. Commenting on the inclusion of ‘an intersex foetus’, he recognised our existence as people with human dignity, but also

referenced the old language of hermaphrodites, offensive clinical language such as ‘physically malformed’, and commented:

The synonyms listed there confirm the definition cited above, namely, a person who is physically malformed such that their external sexual organs have either indeterminate gender or elements of both male and female...

As early as 1919 the condition was recognised as genetic but rare and in following decades through to today the physical genetic basis of this condition has been confirmed by medical science. Intersex people have been born in the past and have lived stigmatised lives. The condition may also have rendered them infertile in some cases. Nevertheless, they are still people and have human dignity. Radical activists may use this unfortunate condition that some people suffer from as an excuse to further undermine the fact that our human species is composed of male and female. But those of us who oppose abortion on moral grounds cannot accept a situation where abortion is allowed for eugenic purposes. (NSW Parliament 2019, 56–58)

It is the construction and use of intersex as a third sex category, and our meaning in relation to LBBT populations, that exercises many Christian commentators. In this regard, we draw attention back to the *Darlington Statement* and its demand for recognition that construction of intersex as a third sex denies our diversity and rights to self-determination.

As with debate on reform of marriage law, this is surprising given the description of intersex as a third sex category in the proposed amendments, and the origins of such constructions in a 1979 Family Court case that annulled the marriage of an intersex man, based on an ahistorical appeal to marriage norms in Christendom.

5.4 Appendix D: Islamic teachings and attitudes

5.4.1 Inheritance

Uddin describes a standard process for the inheritance of intersex people (termed hermaphrodites or ‘khuntha’) in Islamic law. He states that the gender of intersex people is determined, traditionally according to method of urination (2017, 227). In certain cases of ‘difficulty’, termed ‘khuntha mushkil’, different authorities apply different approaches, but generally such an individual was traditionally regarded as male and female and receives a variable lesser inheritance share, based on a model where women receive smaller inheritance shares. Uddin remarks:

There is no conflict upon the inheritance of hermaphrodites in contemporary Muslim world and all jurists are agree upon that hermaphrodites will take share according to sex dominancy. If organs of male are prominent then it would be consider as male and if organs of female are present then it would be consider as female. But there is conflict on inheritance of khuntha mushkil (whose sex is ambiguous) that how much share it would inherit. (Uddin 2017)

5.4.2 Medical interventions

Sachedina states in a 2009 paper that surgery is intended to eliminate the possibility of ‘abnormal sexual behaviour’:

The hermaphrodite possesses physical traits of both sexes; such a person might have ambiguous genitalia or an otherwise amorphous sexual makeup. The common medical justification for such corrective surgery for hermaphroditism was to provide a strict social boundary between two sexes so that those patients whose bodies were not immediately recognizable as male or female could overcome the fears of abnormal sexual behavior. (Sachedina 2009)

Islamic teachings appear to endorse so-called ‘corrective’ surgical interventions:

increased efforts to surgically establish norms for gender identification were treated as corrective surgery and hence accepted as part of the solution to help an individual whose male or female identity was anatomically aberrant. In general, the jurists endorsed corrective surgical procedures to treat both types of hermaphrodites: the nonproblematic hermaphrodites that had an additional or defective private part of the opposite sex, or the problematic hermaphrodites that could not be categorized as a man or a woman (Sachedina 2009)

Some views in Islam support female genital mutilation, labelled as ‘female genital circumcision’. For example, on 10 February 2018, and following the launch of a global social media campaign against FGM, an academic and member of the Islamic Cultural Centre of Ireland called for the legalisation of ‘female circumcision’, stated:

I am not an advocate of female genital mutilation, but of female circumcision. If we see female circumcision in the same way as male circumcision, it might be needed for one person and not another, it has to be determined by a doctor and practiced in a safe, medical environment... It has been described in a horrible way, it's always described as 'barbaric' and we always hear the term mutilation, it is portrayed as a dark skin practice, or something that belongs in the Dark Ages (Armstrong 2018).

It should be noted that female genital cutting is practiced in Australia. A 2013 Australian government framework against FGM prohibits such interventions. However, it permits genital surgeries on intersex people, described as ‘sexual reassignment procedures’ that ‘give a female, or a person whose sex is ambivalent,[sic] the genital appearance of a particular sex’ (Attorney General’s Department 2013).

This policy framework does not discuss issues of necessity or evidence in support of medical interventions, perhaps assuming that medical interventions will be supported by both. Policy-makers responsible for this language may not have intended it to support, *inter alia*, the clitorrectomy and labioplasty in *Re: Carla*. Disclosure of the rationales, including the

gender stereotyping, in *Re: Carla* undermine the moral authority of arguments against FGM based on grounds of culture, appearance or gender roles.

Further, despite this prohibition of FGM, labioplasties and other vulvoplasties, including for aesthetic purposes, are permitted (Spriggs 2016). The Department of Health has investigated a 'marked increase' of 105% in numbers of Medicare-funded vulvoplasties and labioplasties in adolescents and adults between 2003/4 and 2012/13 (Department of Health 2014). Aesthetic rationales for surgery appear in promotional literature on labioplasties produced by Australian plastic surgeons. It is not clear on what basis such practices can be supported when conducted for cosmetic or aesthetic reasons, other than by the informed consent of the recipient. In our view, the Yogyakarta Principles plus 10 offer a clear and universal framework for the protection of the bodily integrity of all children (Yogyakarta Principles 2017).

5.5 Appendix E: Other traditions

We note and acknowledge that a range of other religious traditions and beliefs have places for intersex people, and these have had limited impact on the construction of Australia's laws. We regret that our limited organisational capacity means that we have been unable to do justice to those positions in this submission.

We specifically note that some non-Western traditions may have had particular roles and places for some intersex and non-intersex people that do not mirror the norms identified in traditional Christian and Islamic teaching (Holmes 2004).

IHRA is also aware of multiple refugees with intersex variations who have fled regions and countries due to the social stigmatisation of their bodies.

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