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Submission on reform of anti-discrimination law in Western Australia

Intersex Human Rights Australia (IHRA)



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2 Introduction

Thank you for publishing the discussion paper on reform of anti-discrimination law in Western Australia. We are pleased to submit this response.

This submission by Intersex Human Rights Australia (IHRA) has been written by Morgan Carpenter, M.Bioeth (Sydney), M.InfTech (UTS), executive director of IHRA. It has been supported through review and feedback by our board of directors, and it also builds on discussions with community members, legal practitioners and other stakeholders regarding proposed reforms in Western Australia.

Intersex Human Rights Australia is a national charitable organisation run by and for people born with intersex variations, formerly known as Organisation Intersex International (OII) Australia. We registered as a not-for-profit company in 2010 and became a charity in 2012. Since December 2016 we have been funded by foreign philanthropy to employ two part-time staff to engage in policy development and systemic advocacy work.

We promote the health and human rights of people with innate variations of sex characteristics, 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).

We are willing to discuss our analysis, questions, and recommendations, if the Commission would find this helpful. This submission may be published.

3 About intersex

Intersex Human Rights Australia refers to intersex people in this document in line with definitions used by the UN Office of the High Commissioner for Human Rights, for example, in a 2019 Background Note on Human Rights Violations against Intersex People:

Intersex is an umbrella term used to describe a wide range of innate bodily variations in sex characteristics. Intersex people are born with sex characteristics that do not fit typical definitions for male or female bodies, including sexual anatomy, reproductive organs, hormonal patterns, and/or chromosome patterns (Office of the High Commissioner for Human Rights 2019)

Many forms of intersex exist; the word intersex is an umbrella term for a heterogeneous population. We use a variety of terms, including ‘innate variations of sex characteristics’, intersex, intersex variations, and specific diagnostic terms. Since 2006, clinicians frequently use a stigmatising label, ‘Disorders of Sex Development’ or ‘DSD’, to refer to intersex variations (Carpenter 2018a).

At least 30 or 40 different variations are known to science; most are genetically determined. Intersex variations can be determined prenatally (Davis 2013), at birth, during puberty, when trying to conceive a child, or at other times.

Intersex variations can include differences in the number of sex chromosomes, different tissue responses to sex hormones, or a different hormone balance. Examples include androgen insensitivity syndrome, gonadal dysgenesis, micropenis, sex chromosome variations, and congenital adrenal hyperplasia with XX or mosaic sex chromosomes.

Because our bodies are perceived as different, we can experience stigmatisation, discrimination and harmful practices, including medical interventions intended to make our bodies more typically female or male.

3.1 Misconceptions

Misconceptions frequently associate particular gender identities or sex classifications with particular intersex traits. Misconceptions also wrongly situate intersex as a gender identity or a sex classification. Intersex people may grow up to express an LGBT identity (that is, to be same sex attracted or gender diverse) or they may grow up to identify in other ways (for example, heterosexual and/or identify with sex assigned at birth/cisgender). It is highly inappropriate to frame intersex traits in relation to ‘gender history’, as appears to be the case in materials published by the Law Reform Commission (Law Reform Commission of Western Australia 2021b, 2021a). Intersex traits are innate, and individuals live with them – and the consequences of the ways they are treated – throughout all of life.

The words that individuals use to describe themselves typically respond to what we have been taught by parents and clinicians, to our poor experiences of education about human

biological diversity, and to our experiences of misconceptions. Misconceptions can include beliefs – evident in materials prepared by the Law Reform Commission – that presume that people with intersex variations have a ‘gender history’, necessarily identify as non-binary or other than as female or male, or the troubling idea that protections against discrimination targeting people with intersex variations can be addressed through an expansion ‘beyond the currently defined gender reassigned persons (for example, persons identifying as another sex)’ (Law Reform Commission of Western Australia 2021a).

We strongly encourage respect for our diversity as a population, including respect for sexes observed or assigned at birth on the basis of sex characteristics observed at birth, respect for the diversity of our identities, and for the nomenclature that individuals use. People with intersex variations are at risk of stigmatisation, discrimination and other human rights violations irrespective of the words we use and our agency to express any identity. Along with a history of silence, secrecy, and shaming, these issues create significant health and wellbeing risks for our community.

3.2 Some examples of innate variations of sex characteristics

The purpose of this section is to provide sufficient understanding to enable consideration of the impact of policies, policy proposals, and practices affecting people with innate variations of sex characteristics.

Respondents to a large Australian sociological study of people born with atypical sex characteristics in 2015 (Jones et al. 2016) had more than 35 different variations, including 5-alpha-reductase deficiency, complete and partial androgen insensitivity syndrome (AIS), bladder exstrophy, clitoromegaly, congenital adrenal hyperplasia (CAH), cryptorchidism, De la Chapelle (XX Male) syndrome, epispadias, Fraser syndrome, gonadal dysgenesis, hyperandrogenism, hypospadias, Kallmann syndrome, Klinefelter syndrome/XXY, leydig cell hypoplasia, Mayer-Rokitansky-Küster-Hauser syndrome (MRKH, mullerian agenesis, vaginal agenesis), micropenis, mosaicism involving sex chromosomes, mullerian (duct) aplasia, ovotestes, progestin induced virilisation, Swyer syndrome, Turner’s syndrome/XO (TS), Triple-X syndrome (XXX).

Below we detail the characteristics and experiences of people with several distinct intersex variations due, in some cases, to their higher frequency, and in one case due to the existence of relevant recent Family Court decisions.

3.3 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 be cisgender women and a high proportion are heterosexual (Warren 2017). People with partial AIS grow up to understand themselves in diverse ways, including many women and girls with a largely typical female phenotype, and people who look and understand themselves in different ways.

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. Men and non-binary people with partial AIS may seek virilisation where this is possible. Women and other people with 'higher grades' of partial AIS have limited capability for virilisation.

Once diagnosed, people 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. It was only very recently, in 2019, that a team of clinicians in the United States published a first management protocol for preservation of gonads in individuals with AIS (Weidler et al. 2019).

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 World Athletics in recent years (International Association of Athletics Federations 2019). That reintroduction of testing affects women with partial AIS and some other intersex variations such as 17-beta hydroxysteroid dehydrogenase 3 deficiency, 5-alpha reductase deficiency. This testing is contested, and key evidence supporting testing has been amended to remove

an unsubstantiated claim of what Jeré Longman summarises as a ‘causal connection between high testosterone levels and enhanced athletic performance among elite female athletes’ (Longman 2021; BMJ Publishing Group Ltd and British Association of Sport and Exercise Medicine 2021).

3.4 Congenital adrenal hyperplasia

Children with congenital adrenal hyperplasia (CAH) may necessitate immediate medical attention from birth to manage salt wasting. Salt wasting is potentially fatal and neonatal bloodspot screening is being introduced nationally to identify and treat children at risk (Department of Health 2020).

Children with congenital adrenal hyperplasia and XX chromosomes (typically associated with women) may also have genitalia that appears ‘virilised’ or 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 (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 (Senate of Australia Community Affairs References Committee 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 a resource published by an agency of the Department of Health in Victoria omits consideration of human rights concerns and normalises early elective surgeries, stating:

Most surgical correction [sic] is now delayed until 6 months of age or later. Opinion currently varies between centres as to surgical management options (Victorian Agency for Health Information and Safer Care Victoria 2018)

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).

3.5 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 (Carpenter 2018a; World Health Organization 2020).

The Australasian Paediatric Endocrine Group acknowledges such interventions, even while advising the Senate in 2013 that such 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’ (Cohen-Kettenis 2005). 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 2020), current medical journal articles on this trait (for example, Lee et al. 2016) recommend gonadectomy with female gender assignment, and not on the basis of 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]).

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]) (Family Court of Australia 2016). 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, including in the Criminal Code of Western Australia (Western Australia 2004). The gender stereotyping evident in *Re: Carla (Medical procedure)* demonstrates a moral hypocrisy in such exemptions.

3.6 47,XXY/Klinefelter syndrome

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 (Skakkebak, Wallentin, and Gravholt 2015). As with other intersex variations, innate physical characteristics of people with XXY are socially stigmatised. Men with Klinefelter syndrome have poorer socioeconomic outcomes (Skakkebak, Wallentin, and Gravholt 2015); this 2015 clinical review states that 90% of people with Klinefelter syndrome are diagnosed after age 15, and only a quarter of individuals expected to have this variation are ever diagnosed.

It is possible that persons with XXY who are not diagnosed may potentially escape some stigma associated with the variation; alternatively, they may either suffer in silence, or clinical signs may be skewed towards those evident in people more likely to be diagnosed.

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, women with XXY and people who understand themselves in other ways face additional challenges in accessing appropriate medical care, with their health and social experiences needs largely unreported.

In 2003, reports emerged, originally in the Western Australian newspaper, that Alex MacFarlane, a person with XXY sex chromosomes living in Perth Hills who identified as 'androgynous', received the first 'X' passport (Butler 2003). Alex had received a birth certificate from Victoria stating 'indeterminate – also known as intersex'. This conflation of intersex with a third category of sex is unfortunate in that it fails to acknowledge the diversity of the population of people with intersex variations. It should never be inferred from this development that all people with XXY, or all people with intersex variations, wish to be marked as neither female nor male. Julie Butler, writing for Western Australian, stated 'Not all 47XXY people identify as androgynous. Some perceive themselves as male or female, and many, like Alex, were surgically altered at birth to appear male or female' (Butler 2003).

4 Intersex people and discrimination

4.1 Discrimination due to sex characteristics

Intersex people need protection from discrimination. Intersex people suffer many distinctive forms of discrimination and violence due to our sex characteristics. The Office of the High Commissioner for Human Rights states:

Intersex people are subjected to human rights violations because of their physical characteristics. Intersex children and adults are often stigmatized and subjected to multiple human rights violations, including violations of their rights to be free from torture and ill-treatment, to health and physical integrity, and to equality and non-discrimination.

Human rights violations include forced and coercive medical interventions; infanticide; restrictions on the exercise of legal capacity and in access to remedies and justice; discrimination in access to education, sport, employment and services. The root causes of human rights violations against intersex people include harmful stereotypes, stigma, taboos, and pathologization (i.e. treating intersex persons as necessarily ill or disordered) (Office of the High Commissioner for Human Rights 2019)

These issues are evident in Australia. A 2015 Australian survey of 272 people born with atypical sex characteristics found many individual and systemic examples of discrimination:

- The researcher found “strong evidence suggesting a pattern of institutionalised shaming and coercive treatment” (Jones et al. 2016).
- 60% had thought about suicide, while 19% had attempted it.
- 41% of the survey population earned less than \$20,000 per year, and 63% earned under \$41,000 per year (Jones et al. 2016).
- 19% of people born with atypical sex characteristics failed to complete secondary school, due to reasons including the impact of medical interventions during puberty, stigmatisation and bullying on grounds of sex characteristics, and unaddressed issues associated with developmental delays (Intersex Human Rights Australia 2016; Carpenter and Zavros-Orr 2019).

The report of UN Office of the High Commissioner for Human Rights notes that:

Some may feel forced into legal sex and gender categories that they do not identify with, including binary (male or female) and third or non-binary categories (Office of the High Commissioner for Human Rights 2019, 4–5)

This lies behind our rejection in the Darlington Statement of associations between intersex variations and exclusion from, or inclusion in, any category of sex as a population (AIS Support Group Australia et al. 2017). We support choice at an individual level where this

does not impact the rights of others to not be forced into particular legal or social categories. Discrimination is also intersectional. For example, the report also states that:

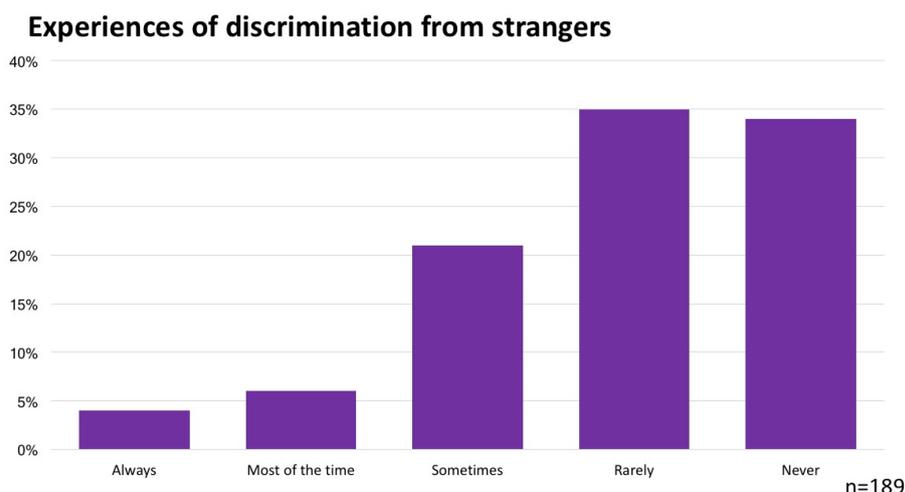
Potential future LGBT identities in intersex children are frequently ignored by clinicians or presented as adverse outcomes, and intersex people who are lesbian, gay, bisexual or transgender may face additional burdens of discrimination (Office of the High Commissioner for Human Rights 2019, 5).

The same is true in relation to experiences of disability, racialisation and other forms of marginalisation. Instances of discrimination in workplaces and schools reported to us include:

- Non-renewal of employment contracts due to perceptions of physical traits
- Lack of access to reasonable accommodations
- Attempts to view genitalia in toilet and other sanitary facilities
- Higher life insurance costs due to genetic test results

In addition, we see issues in workplaces that can, on some occasions, lead to discrimination, such as disrespect for sex registration at birth, and systemic misrepresentation of intersex populations on intake forms and in other data collection.¹

A 2015 Australian sociological convenience sample of 272 people born with atypical sex characteristics found 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. Where an intersex variation is not evident, an individual may avoid disclosure, or medicalise their intersex trait, to prevent risks of discrimination.



¹ We provide recommendations about good practice at <https://ihra.org.au/forms>

4.2 Genetic discrimination

Some community members have reported to us requirements that they pay loaded insurance premiums for life insurance cover. This is a form of discrimination due to genetic test results.

Tiller and others reported in 2020 on a survey of 174 Australian consumers with genetic traits that predispose them to cancer. They found that ‘both legal (permitted under current regulation) and illegal discrimination is occurring’:

Of those experiencing difficulties, 50% (32/64) had no prior history or symptoms of cancer, and had undertaken risk reduction through surveillance and/or preventative surgery. Seventy-seven percent (49/64) reported difficulties related to life insurance. Follow-up telephone interviews with four respondents further described cases of apparent illegal breaches. All reports of discrimination identified were, to our knowledge, previously unreported in the literature. The number of cases suggests a systemic problem with the Australian life insurance industry. We support calls for government oversight of the inherently conflicted model of industry self-regulation in Australia, and an immediate ban on the use of genetic test results in insurance underwriting. (Tiller et al. 2020, 108)

Rothstein and Brothers note that discrimination on grounds of genetic information ‘discourage people from undergoing potentially beneficial genetic testing’ (Rothstein and Brothers 2020, 2101). Trends towards greater availability of genetic screening, including preconception screening, mean that higher proportions of the population are likely to have identified genetic risks.

Some intersex variations are associated with evidenced high risks of gonadal cancer. Early surgical intervention to remove gonads currently appears to be the norm, even in relation to traits where there is little evidence, or risk levels are not high (Kelly and Smith 2017; Carpenter 2018a). In addition, some individuals have reported unduly high insurance premiums to us even following surgery.

We strongly recommend that ‘genetic discrimination’ be made unlawful, and that regulation ensure that illegal breaches can be effectively eliminated.

5 The law and practices in WA

In this section we raise concerns with legislation in Western Australia that impacts our understanding of discussion and issue papers by the Law Reform Commission, the reforms proposed in these papers, and in particular in consideration of the Commission's view of the meaning of 'gender history' in relation to people with intersex variations.

Section 3 of the Gender Reassignment Act 2000 established a 'gender reassignment board' which grants or refuses 'recognition certificates'. We have reviewed all annual reports by the Gender Reassignment Board currently available online, and we note that all applications are for either 'male to female' or 'female to male' (for example, Gender Reassignment Board of Western Australia 2008). At present, annual reports on applications are available for the period 2008 to 2020.² In these reports, data regarding applications for children are stated only in reports for years between 2008 and 2012 and, in each year, no such applications were reported (Gender Reassignment Board of Western Australia 2008, 2009, 2010, 2011, 2012).

The Gender Reassignment Act 2000 defines 'gender characteristics' and 'reassignment procedures' as follows:

***gender characteristics** means the physical characteristics by virtue of which a person is identified as male or female;*

***reassignment procedure** means a medical or surgical procedure (or a combination of such procedures) to alter the genitals and other gender characteristics of a person, identified by a birth certificate as male or female, so that the person will be identified as a person of the opposite sex and includes, in relation to a child, any such procedure (or combination of procedures) to correct or eliminate ambiguities in the child's gender characteristics; (Western Australia 2000b)*

Section 22 of the Criminal Code Amendment Act 2004 introduced a criminal prohibition of female genital mutilation, and explicitly excluded 'a reassignment procedure within the meaning of the Gender Reassignment Act 2000' from the scope of the prohibition (Western Australia 2004).

These provisions are notable for facilitating surgical interventions on children where their sex characteristics ('gender characteristics') differ from gender stereotypes and other normative ideas for female or male bodies. Such practices are routine in Australian hospitals, following diagnosis of an intersex variation. For example, a letter in May 2019 to our executive director Morgan Carpenter from Roger Cook MLA, in his capacity as Deputy Premier and Minister for Health indicates that:

Children with variations of sex development are offered individualised medical management and care in the public system at Perth Children's Hospital (PCH),

² These annual reports are available at https://grb.justice.wa.gov.au/A/annual_reports.aspx

including surgical care if required, as children with any other complex medical condition or variance would. [...]

Surgery may be indicated for children with variations of sex development for different medical reasons, ranging from reconstructive surgery for variances in development of genitalia, to surgery to minimise high cancer risk in the gonads. (Cook 2019)

It seems to us that parents of children with intersex variations are offered such treatment, as medical interventions on children with intersex variations frequently take place in children's hospitals before individuals are able to personally consent. Indeed, the Family Court case *Re: Carla (Medical procedures)* demonstrates that many such procedures deliberately take place before children are able to understand such procedures (Family Court of Australia 2016; Kelly and Smith 2017; Carpenter 2018b; Office of the High Commissioner for Human Rights 2019). The statement about 'reconstructive surgery for variances in development of genitalia' is of grave concern to us.

NSW paediatric endocrinologists Vora and Srinivasan state in a 2020 paper that:

Functionality, malignancy prevention and cosmetic appearance are all taken into account when considering surgical procedures. There is currently no consensus in relation to the need for, or optimal timing of, many surgical interventions (Vora and Srinivasan 2020, 420).

In this statement, as is typical in medical literature, the concept of 'functionality' includes reference to gender stereotypes such as the idea that it is 'appropriate' for boys to be able to stand to urinate (Australasian Paediatric Endocrine Group et al. 2013; McLennan 2021). The lack of clinical consensus in relation to timing and necessity of 'many surgical interventions' is typically acknowledged in clinical literature (for example, Lee et al. 2016). This should be understood as an obvious red flag to the Commission, as it is to intersex-led organisations and human rights institutions (Office of the High Commissioner for Human Rights 2019; Carpenter 2018b; Garland and Slokenberga 2018).

It is notable that the Gender Reassignment Act 2000 refers to 'reassignment procedures' in relation to alterations of characteristics of persons 'identified by a birth certificate as male or female', including procedures on children.

This presupposes that children are universally identified as male or female prior to 'reassignment procedures', and this is reflected in clinical practices across Australia. Vora and Srinivasan state:

Sex assignment is a dilemma in a small percentage of patients with DSD and requires an individualised approach taking into consideration prenatal androgen exposure, fertility potential, quality of sexual function, surgical options, gonadal pathology/malignancy risk and potential adult gender identity (Vora and Srinivasan 2020, 418).

The reference to ‘surgical options’ documents human rights abuses in medical settings that have been explicitly condemned in statements to Australia on eliminating harmful practices (Committee on the Rights of the Child 2019; Committee on the Elimination of Discrimination against Women 2018). At the same time, the reference to the rarity of a so-called ‘dilemma’ in assignment also indicates that sex assignment is more often not a dilemma, and also that such ‘dilemmas’ are addressed with sex assignment taking place. It appears that ‘surgical options’ are consequential to sex assignment.

The Gender Reassignment Act 2000 amended the Equal Opportunity Act, inserting a definition of ‘gender history’ that refers to ‘a sex of which the person was not a member at birth’:

35AA. Gender history

(1) For the purposes of this Part, a person has a gender history if the person identifies as a member of the opposite sex by living, or seeking to live, as a member of the opposite sex.

(2) In subsection (1) —

opposite sex means a sex of which the person was not a member at birth.
(Western Australia 2000a)

This appears to us to mean that children with intersex variations who are assigned a sex at birth do not somehow acquire a ‘gender history’ by virtue of having an assigned sex, or by virtue of having undergone harmful practices such as so-called ‘surgical options’ consequential to sex assignment. However, the Commission’s views expressed in the Discussion Paper and an Issues Paper are unclear to us, and references to ‘intersex status’ appear within content referring to ‘gender history’ and ‘gender identity’ (Law Reform Commission of Western Australia 2021b, 2021a). For example, the Commission’s issue paper on gender identity states the following concerns:

That the inclusion of gender identity would require ‘strong balancing provisions’ to safeguard the existing sex-based laws and the fundamental freedoms of people who hold different views on gender. These submissions appear to address the concern that a ground of discrimination based on a more expansive definition of gender history infringe the rights of others to privacy and safety, or, more fundamentally, challenge the traditional conceptions of birth sex status.

The Commission seeks submissions on whether the protections in the Act should be expanded beyond the currently defined gender reassigned persons (for example, persons identifying as another sex)? (Law Reform Commission of Western Australia 2021a)

It is difficult for us to parse the intent of this statement in relation to both cisgender and gender diverse people with innate variations of sex characteristics. It is possible that the Commission is labouring under the misapprehension that intersex is a sex assignment, for example in the reference to ‘persons identifying as another sex’ (Law Reform Commission of Western Australia 2021a), or this may not be the Commission’s intent.

In recent years, the Committee on the Rights of Persons with Disabilities (2019), Committee on the Elimination of Discrimination against Women (2019), the Committee on the Rights of the Child (2019), the Human Rights Committee (Human Rights Committee 2017), and the Committee on Economic, Social and Cultural Rights (2017) have all made explicit statements condemning unnecessary medical interventions on children with intersex variations. For example, the Committee on the Elimination of Discrimination against Women stated in 2019:

Harmful practices

25. The Committee takes note of the State party's commitment to providing support for women who are victims of forced marriage, regardless of their cooperation with the prosecution authorities. It is concerned, however, about the following:

- (a) The low number of prosecutions of cases of forced marriage;*
- (b) The lack of systematic data collection on the number of women who have been subjected to forced marriage or female genital mutilation;*
- (c) The conduct of medically unnecessary procedures on intersex infants and children before they reach an age when they are able to provide their free, prior and informed consent, as well as inadequate support and counselling for families of intersex children and inadequate remedies for victims;*
- (d) The non-consensual administration of contraceptives to, performance of abortions on and sterilization of women with disabilities.*

26. Recalling the joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2014) on harmful practices, the Committee recommends that the State party ensure adequate protection and support for victims of forced marriage, regardless of their collaboration with the prosecution authorities, and also recommends that the State party:
[...]

(c) Adopt clear legislative provisions that explicitly prohibit the performance of unnecessary surgical or other medical procedures on intersex children before they reach the legal age of consent, implement the recommendations made by the Senate in 2013 on the basis of its inquiry into the involuntary or coerced sterilization of intersex persons, provide adequate counselling and support for the families of intersex children and provide redress to intersex persons having undergone such medical procedures; (Committee on the Elimination of Discrimination against Women 2019)

In two other jurisdictions in Australia, in the ACT and in Victoria, concerns regarding unnecessary, forced and coercive medical interventions have led to public commitments to reforms that will protect the human rights of intersex people in medical settings (Chief Minister, Treasury and Economic Development Directorate 2021a, 2021b; Department of Health 2021). Similarly, the Australian Human Rights Commission will publish a report on these issues on Monday 19 October (Australian Human Rights Commission 2018). IHRA warmly welcomes those developments. However, in Western Australia, inappropriate legal

and conceptual frameworks appear instead to limit comprehension of our population, with adverse consequences for the possibility of reform.

5.1 Questions arising for the Commission

The following questions for the Commission arise from our concerns with WA legislation and the Discussion Paper. These appear to limit the Commission's comprehension of the population, and therefore impact opportunities for reform.

- What is the Commission's view of the meaning and legitimacy of 'reassignment procedures' in relation to children with intersex variations?
- What is the Commission's view regarding when and where a 'gender history' might arise in relation to children with intersex variations who are nevertheless 'identified as male or female' and assigned as such?
- Is it the intention of legislation and the Commission's discussion paper to presume that all people with intersex variations comprise 'dilemmas' of sex assignment? Or that the existence of a 'dilemma' constitutes part of a 'gender history'?
- Is the Commission able to establish whether or not (and if so, how many) children subjected to 'reassignment procedures' on the basis of an intersex variation become 'gender reassigned persons' issued with a 'recognition certificate'?

In any of the above situations, we are perplexed by the possibility that children with intersex variations are presumed to have a 'gender history' or become 'reassigned persons' by virtue of undergoing 'reassignment procedures' that comprise human rights abuses.

- Given that intersex variations are conflated with gender and gender history in the Commission's discussion and issues papers, does the Commission intend a 'more expansive definition of gender history' to include reference to intersex variations?
- Does the Commission intend to refer to intersex people in remarking on persons identifying as another sex? if so, how does the Commission intend such a reference to apply to intersex persons assigned male or female?
- Does the Commission intend that the actual sex observed or assigned at birth of people with intersex variations should be subject to contestation? We support personal decisions in relation to social and legal status, but the contestation of the status of people with intersex variations that is implied by this statement is disturbing to us.

6 Best practice and ‘sex characteristics’

6.1 Intersex status and sex characteristics

Australia introduced “intersex status” in federal anti-discrimination law in 2013. The definition reads:

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.*

Recognition of the diversity of intersex people was and remains important, however, the meaning of “intersex status” is often imputed to mean a fact about legal sex classifications or gender identity that is not supported by either the legal definition of the ground, or the diverse lived reality of intersex lives.

Inclusion of “intersex status” and its definition was a matter of what was possible at the time, amid fears that a biological framing of intersex would be included within a definition of gender identity, accompanied by an authenticity requirement conflicting with a need for protection on grounds of perception (already the case in some jurisdictions).³ No example definition of an alternative like “sex characteristics” was available to a federal government readying itself for an election campaign (Carpenter and Organisation Intersex International Australia 2012).

Intersex status:

- Is not universal, in that not everyone has an intersex status; this is a characteristic shared with disability status, pregnancy status, trades union membership.
- Has no clear, unambiguous relationship to international law.
- Because of widespread public misconceptions, does not obviously relate to physical sex characteristics.
- For the same reasons, it is often incorrectly imputed or presumed to be (reduced to) an identity classification, or a sex classification.
- May not be used by people with intersex traits who understand themselves using different terms.
- Ensuring that people are protected on grounds of perceived intersex status requires that the definition be generalised in ways that make the attribute more broadly useful to more populations than intended at time of enactment, meaning that protections are not limited to people with actual intersex variations. This means that the name of the attribute does not clearly describe who can avail of the protection.
- Has unfortunately been defined based on a model of deficit, primarily about what intersex people lack and are not.

³ Such as the Equal Opportunities Act 2010 (Victoria).

- Has been orphaned by international developments, notably the widespread adoption of a ground of 'sex characteristics'.
- Is currently adopted in Commonwealth law and South Australian law.

In contrast, sex characteristics:

- Are universal.
- Can be innate (for example, through genetic traits) or be acquired (for example, through life-preserving medical treatment, trauma, or gender affirmation).
- Cannot be so easily imputed to be a matter of identity.
- Operate at a different, finer, degree of granularity to the coarser, broader concept of sex.
- As an attribute is now an international norm, utilised by international institutions and a growing number of jurisdictions in Australia including ACT, Tasmania and Victoria.
- People with innate variations of sex characteristics inherently have combinations of sex characteristics that vary from gender stereotypes.

As a result of these concerns, and because of consensus within the intersex community in Australia and developments in international human rights law, we recommend protection on grounds of sex characteristics and not on grounds of intersex status.

6.2 Darlington Statement

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 (including a call for a prohibition of deferrable medical interventions), standards of care, peer and family support, and sex markers. The Darlington Statement issues direct calls for reforms to anti-discrimination legislation including:

*9. We call for **effective legislative protection** from discrimination and harmful practices on grounds of **sex characteristics**.*

*11. We call for an end to **genetic discrimination**, including in insurance and employment.*

*57. We call for policies in educational institutions and employment to recognise that some people born with intersex variations may benefit from **accommodations and reasonable adjustments**, including special needs requirements, workplace adjustments, job access assistance, and provisions for medical leave. (AIS Support Group Australia et al. 2017)*

In response to involuntary association with third sex markers, and in recognition of the diversity of identities and legal and social status of people with intersex variations, 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 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.

6.3 Yogyakarta Principles plus 10

In November 2017, the Yogyakarta Principles on the application of international human rights law to sexual orientation and gender identity were updated with a Supplement on the application of international human rights law in relation to sexual orientation, gender identity, gender expression and sex characteristics. A definition of ‘sex characteristics’ is provided by that Yogyakarta Principles Supplement:

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 (Yogyakarta Principles 2017)

We expect this definition to continue to be widely adopted in international, national and state law, in the same way that the 2007 Principles have led to the widespread adoption of consistent definitions of 'sexual orientation' and 'gender identity' (O'Flaherty and Fisher 2008; Carpenter 2021).

7 Developments in other Australian jurisdictions

7.1 2018 Religious Freedom Review

In 2018 the *Religious Freedom Review: Report of the Expert Panel* by Philip Ruddock et al. recommended that religious exemptions on grounds of intersex status, race, disability or pregnancy be eliminated:

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. (Ruddock et al. 2018, 5–6)

7.2 Australian Human Rights Commission inquiry

The Australian Human Rights Commission will publish a report on protecting the human rights of people born with variations of sex characteristics in medical settings on Monday 19 October 2021. This follows an inquiry begun in 2018 (Australian Human Rights Commission 2018).

We encourage the Law Reform Commission of Western Australia to take account of the issues raised in this report. In particular, the report will afford an opportunity for the Law Reform Commission to call for further action on these issues. We also hope that the report will afford an opportunity to address inappropriate legal and conceptual frameworks that appear to limit comprehension of our population by Western Australian institutions, in order to provide opportunities for reform.

7.3 Australian Capital Territory

The Commission's issues paper on gender identity asserts that 'Intersex status is also a protected attribute in the ACT, South Australia and Tasmania' (Law Reform Commission of Western Australia 2021a). The Commission appears to have referred to a superseded version of the relevant ACT legislation.

The Discrimination Act 1991 (ACT) was amended by the Justice Legislation Amendment Act 2020 (Minister for Justice, Consumer Affairs and Road Safety 2020) to replace intersex status with a definition of sex characteristics, as follows:

sex characteristics—

(a) means a person’s physical features relating to sex; and (b) includes—

*(i) genitalia and other sexual and reproductive parts of the person’s anatomy;
and*

*(ii) the person’s chromosomes, hormones and secondary physical features
emerging as a result of puberty. (Australian Capital Territory 2020)*

In 2019, the ACT government made a public commitment to end harmful practices in medical settings affecting people with intersex variations (ACT Government 2019). This has been followed by a discussion paper, listening paper and options paper in recent month (Chief Minister, Treasury and Economic Development Directorate 2021a, 2021b; Department of Health 2021).

7.4 South Australia

Prior to legislative reforms in 2016, IHRA had advised the South Australian Law Reform Commission and government to enact protections on ground of sex characteristics and not the enacted attribute of intersex status. We repeated this recommendation in relation to reform of religious exemptions in 2020.

As noted in the discussion paper, South Australia implemented an exemption in section 34(3) of the Equal Opportunity Act 1984 relation to religious freedoms in school settings on the ground of intersex status (South Australia 2018). South Australia is the only jurisdiction to have implemented such a provision in relation to the grounds of sex characteristics or intersex status. In 2018 the *Religious Freedom Review: Report of the Expert Panel* by Philip Ruddock et al. recommended that religious exemptions on grounds of intersex status, race, disability or pregnancy be eliminated (Ruddock et al. 2018).

7.5 Tasmania

The Commission’s issues paper on gender identity asserts that ‘Intersex status is also a protected attribute in the ACT, South Australia and Tasmania’ (Law Reform Commission of Western Australia 2021a). The Commission appears to have referred to a superseded version of the relevant Tasmanian legislation.

The Anti-Discrimination Act 1998 was amended by the Justice and Related Legislation (Marriage and Gender Amendments) Act 2019 to replace intersex status with a definition of sex characteristics as follows, and protections on grounds of ‘intersex variations of sex characteristics’:

sex characteristics means a person’s physical, hormonal or genetic features relating to sex, including genitalia and other sexual and reproductive anatomy, chromosomes, genes, hormones, and secondary sex characteristics; (Tasmania 2019)

7.6 Victoria

The Commission's issues paper on gender identity asserts that 'NSW, Queensland and Victorian provisions include 'indeterminate sex' in their definition of gender identity'. However, the situation in Victoria has changed with enactment by that State government of reforms that received assent on 16 February 2021 and that are awaiting commencement.

The attribute of "sex characteristics" was added to the Equal Opportunity Act 2010 in the Change or Suppression (Conversion) Practices Prohibition Act 2021 (Victoria 2020) as follows:

***sex characteristics** means a person's physical features relating to sex, including—*
(a) genitalia and other sexual and reproductive parts of the person's anatomy;
and
(b) the person's chromosomes, genes, hormones, and secondary physical features that emerge as a result of puberty; (Victoria 2020)

The same Act updated the definitions of sexual orientation and gender identity. No exemptions applicable to 'sex characteristics' were added to the Act at that time.

The Equal Opportunity Act 2010 was first enacted with the attribute of 'physical features', defined as follows:

***'physical features** means a person's height, weight, size or other bodily characteristics' (Victoria 2010)*

This attribute has appeared more likely than a reference to 'indeterminate sex' to provide some protections from discrimination for people with intersex variations. However, the newly enacted reforms to the Equal Opportunity Act 2010 (Vic) to add the ground of sex characteristics provide protections that meet community expectations and conform to international best practice.

In 2021, the Victorian Minister for Health and Equality made a public commitment to regulate medical practices on people with intersex variations (Department of Health 2021). IHRA and Equality Australia have been contracted to further these goals, with IHRA also contracted to develop resources for individuals, parents and families, and the wider community.

8 Recommendations

8.1 Sex characteristics

In line with best practice developments in international human rights law, the Yogyakarta Principles plus 10, the Darlington Statement, and developments in ACT, Tasmania and Victoria, we recommend that the Western Australia government reform anti-discrimination law by prohibiting discrimination on the ground of 'sex characteristics', as follows:

sex characteristics means a person's physical features relating to sex, and includes:

- (a) the person's genitalia and other sexual and reproductive parts of the person's anatomy; and*
- (b) the person's chromosomes; and*
- (c) the person's hormones; and*
- (d) secondary features emerging as a result of puberty.*

In line with developments in ACT and Victoria, and the report of the religious freedoms review panel, no exemptions should be enacted.

8.2 Genetic discrimination

In line with best practice international developments and recommendations for Australian jurisdictions, we recommend that the Western Australian government prohibit genetic discrimination in insurance and employment.

8.3 Protections from harmful practices in medical settings

In line with evolving best practice as described in public commitments and action in the Australian Capital Territory and Victoria, and in line with the recommendations of UN Treaty Bodies to Australia, we recommend that the Western Australian government enact separate protections from harmful practices in medical settings for people with innate variations of sex characteristics.

8.4 A Human Rights Act

IHRA supports proposals to enact human rights legislation in Australian jurisdictions, as implemented in the ACT, Queensland and Victoria. We strongly recommend that the Western Australian government build on existing proposals to reform equal opportunity law by taking this further step.

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