

Introduction

A widely accepted definition of intersex was published by the United Nations Free & Equal campaign in 2015:

Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.

Intersex is an umbrella term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at birth while in others, they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all.¹

Sexual orientation and gender identity (SOGI) issues have frequently been represented as relating to intersex people, but action on SOGI issues appears to have nowhere led to the protection of intersex people from the particular forms of violence and discrimination that we face, notably violence in medical settings and stigmatisation due to our physical characteristics.

A small number of countries have acted specifically to protect intersex people from violence or discrimination, and the outcomes of those actions have yet to be fully understood. Amongst those countries, in 2013 the Australian federal government enacted an attribute of “intersex status” in anti-discrimination law.

This paper presents some Australian demographic data and my thoughts on attributes and linkages between intersex and LGBT issues, and on the effectiveness of legal protections, using Australian and some other examples. Rather than separate out the demographic material and the analysis into multiple documents that meet the page length requirement, I have kept the materials together in the hope that this transgression will be forgiven.

This post-submission version of the document has some grammatical errors fixed.

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Demographic data

Intersex people are very diverse, as shown in an Australian 2015 survey of 272 people born with atypical sex characteristics, based upon an online survey distributed through print and online media,

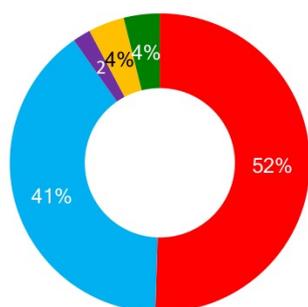
¹ United Nations, Office of the High Commissioner for Human Rights. Free & Equal Campaign Fact Sheet: Intersex [Internet]. 2015 [cited 2015 Sep 5]. Available from: https://unfe.org/system/unfe-65-Intersex_Factsheet_ENGLISH.pdf

and human rights and medicalised settings.² Methodologically, I have to note that the study has been questioned, primarily by some clinicians, for its ability to capture material on a medicalised population outside a clinical setting. This critique thus questions all surveys of intersex persons conducted outside clinical settings.

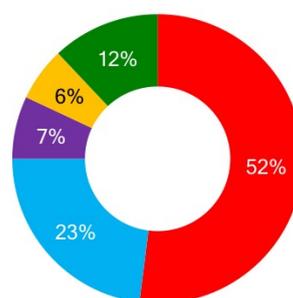
Intersex people have a variety of legal sex assignments, and gender identities; many with identities that coincide with legal sex assignment at birth, and others with identities that differ from that assignment. Australia has had increasingly accessible third sex/gender classifications since 2002, and close to 20% of respondents born with atypical sex characteristics use them (as do a proportion of non-intersex people).

Sex assignments and gender identities

Reported sex at birth



Sex now



Complexities of asking about birth assignment:

“I was christened male, but reassigned female at day 5, and then realigned back to my male self at age 29.”

Note: multiple choices possible

In public discourse, and much academic and legal discourse, biological sex and birth sex assignment are taken to mean the same thing, and efforts to include intersex are often reduced to the creation of a third sex classification that, it is presumed, will recognise our existence, and prevent human rights violations. The former does not reflect our diversity and the latter is a form of magical thinking.³ This approach also represents an explicit marking, or othering, of intersex persons as separate, warranting different treatment.

The evidence from countries where third classifications are legally recognised does not support that thinking, it instead causes policy disconnects that are discussed later in this paper. Further, assumptions that intersex people comprise a third sex are complicated by the reality of the diversity of initial birth assignments of intersex people. It is likely that most intersex people are attached to those birth assignments, while many other intersex people have chosen (and in some cases fought) for the right to choose other binary, non-binary and multiple sex classifications.

Assumptions that intersex people should be a third sex fail to take account of the many different ages where discovery of an intersex trait occurs. For example, should the already-assigned sex of an adolescent be removed from them if a chromosomal variation is discovered? Should women athletes, born and raised as women but found to have an intersex trait, be regarded as no longer women, and reassigned? The costs of disclosure itself, and of excluding women with intersex traits

² Jones T, Hart B, Carpenter M, Ansara G, Leonard W, Lucke J. *Intersex: Stories and Statistics from Australia*. Cambridge, UK: Open Book Publishers; 2016.

³ See, for example, Morgan Carpenter. *Miraculous thinking*. 22 December 2016. Available from: <https://oii.org.au/31093/miraculous-thinking/>

from sport, are known to include humiliation, suicide attempts, and the loss of career, family, housing and self-esteem.⁴ These can also occur with other situations involving late (and not so late) discovery.

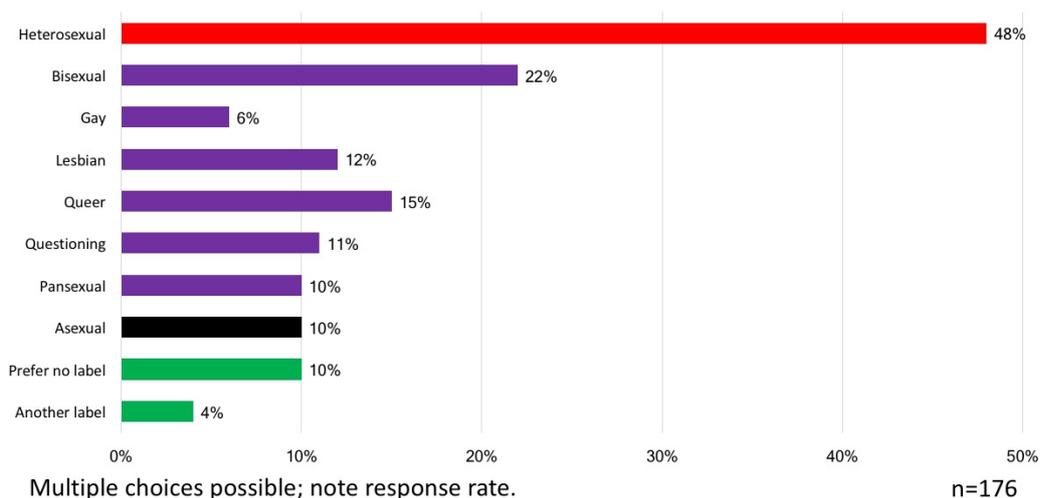
Such attitudes seem based to some extent on an idea that intersex women and intersex men are imposters, not real women or real men, and this is actually implicit or explicit in much of the law.

In 2013, the Malta declaration by the Third International Intersex Forum demanded, *inter alia*:

- *To register intersex children as females or males, with the awareness that, like all people, they may grow up to identify with a different sex or gender.*
- *To ensure that sex or gender classifications are amendable through a simple administrative procedure at the request of the individuals concerned. All adults and capable minors should be able to choose between female (F), male (M), non-binary or multiple options. In the future, as with race or religion, sex or gender should not be a category on birth certificates or identification documents for anybody.*⁵

People born with atypical sex characteristics also show diversity in our sexual orientations:

Sexual orientations



The rates of asexuality are particularly notable, and may reflect issues relating to body shaming and/or the impacts of medical interventions on capacity for intimacy. In this regard, it is notable that medical interventions are designed to address social stigma and, in part, the impact of stigma on access to (heterosexual) intimate relationships.⁶

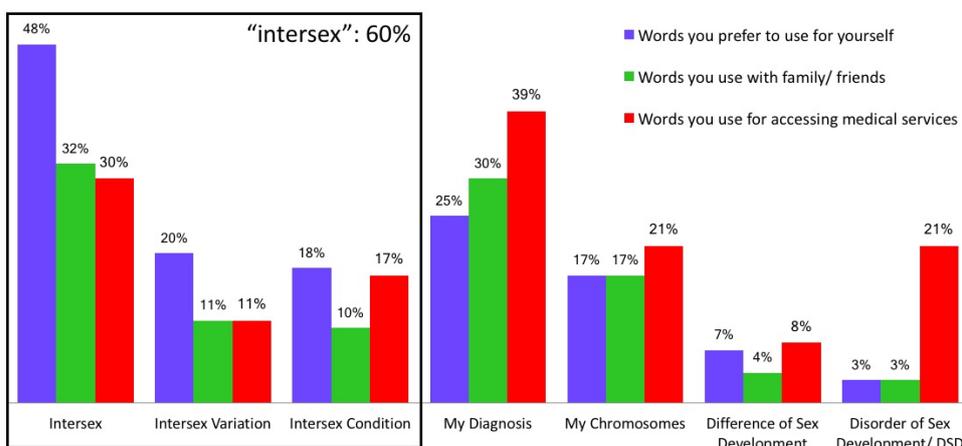
⁴ Martínez-Patiño MJ. Personal Account A woman tried and tested. *The Lancet*. 2005 Dec;366–538. Sengupta R. Why Dutee Chand can change sports. *Live Mint* [Internet]. 2014 Nov 22 [cited 2014 Nov 25]; Available from: <http://www.livemint.com/Leisure/9P3jbOG2G0ppTVB7Xvwj0K/Why-Dutee-Chand-can-change-sports.html>

⁵ Various. Public statement by the third international intersex forum [Internet]. Malta; 2013 Dec [cited 2015 Oct 26]. Available from: <http://intersexday.org/en/third-international-intersex-forum/>

⁶ Cabral M, Carpenter M, editors. *Intersex Issues in the International Classification of Diseases: a revision*. 2014 [cited 2015 Oct 25]. Available from: <http://intersexday.org/wp-content/uploads/2015/10/intersex-issues-in-the-international-classification-of-diseases-cabral-carpenter-2014.pdf> Gillam LH, Hewitt JK, Warne GL. Ethical Principles for the Management of Infants with Disorders of Sex Development. *Hormone Research in Paediatrics*. 2010;74(6):412–8. Available from: <http://www.karger.com/doi/10.1159/000316940>

Overall, these data on sexual orientation and gender identities shows that intersex is a distinct intersectional issue, intersecting with SO and GI, but not intrinsically part of a SOGI framework.

Sex characteristics



Note: multiple choices possible

Overall, 60% of respondents use words including the term intersex. 48% self-describe as intersex, as being intersex. This incidentally might be regarded as self-ascribed identity and it can be compared with 19% of respondents favouring non-binary or third sex classifications. A significant proportion of respondents describe as “having an intersex variation” or “having an intersex condition”. The use of diagnostic labels and sex chromosomes is also common.

As is the case for all stigmatised minority populations (for example, “men who have sex with men”), language choices vary from person to person, and depending on where used. It is particularly notable that only 3% of respondents use the clinical term “disorders of sex development” to describe themselves, while 21% use that term when accessing medical services. This could be regarded as a perceived need to disorder ourselves to obtain appropriate medical care.

In looking at medicalisation, the study researcher found “strong evidence suggesting a pattern of institutionalised shaming and coercive treatment”. Respondents broadly rejected standard medical practices on children with intersex variations:

Parenting debate topic (percentages, n=170)	Strongly Agree	Agree	Neutral/ Unsure	Disagree	Strongly Disagree
Children should have genitals that precisely match the sex they are reared as.	2.9	5.3	16.5	20.0	55.3
Genitals (e.g. clitorises/ penises) that do not fit a size ‘norm’, should be surgically altered in size.	2.4	1.8	8.2	14.7	72.9
Doctors should engage in surgical interventions on intersex kids, without knowing long term outcomes.	1.8	0.6	5.3	12.4	80.0
People should select against having intersex offspring (e.g. using IVF selection techniques).	1.8	2.9	14.7	14.1	66.5
Health providers should be able to apply interventions to my sex characteristics (such as surgeries, sterilisation or hormonal treatments) without my informed consent.	2.4	0.6	5.3	8.8	82.9
Adequate choices and information were given to my parents about my congenital sex variation when it was first diagnosed.	4.7	4.7	22.4	14.1	54.1

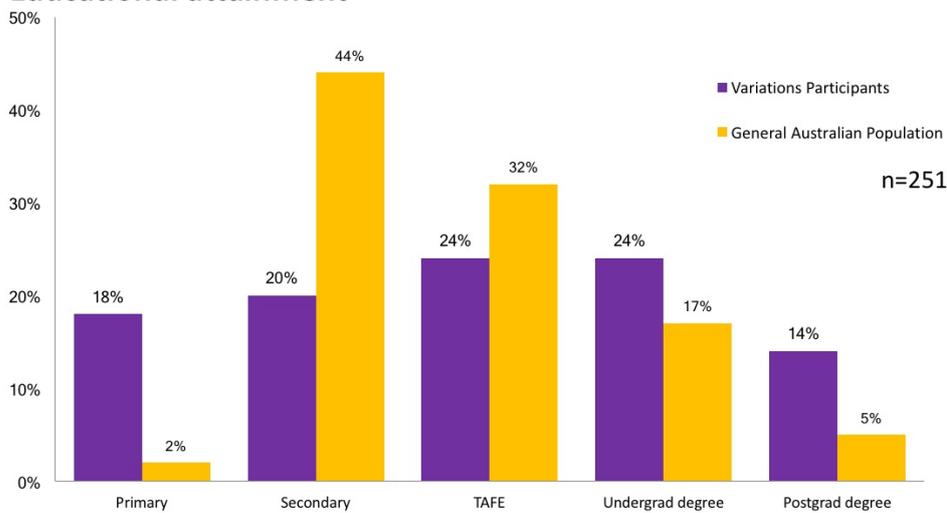
60% of respondents had received treatments on basis of sex characteristics, half at under 18 years of age. The majority experienced at least one negative impact from treatment.

44% of respondents reported institutional pressure to ensure correctly gendered behaviour, and 43% reported this from parents.

60% had thought about suicide, 19% had attempted it (the Australian average is less than 3%).

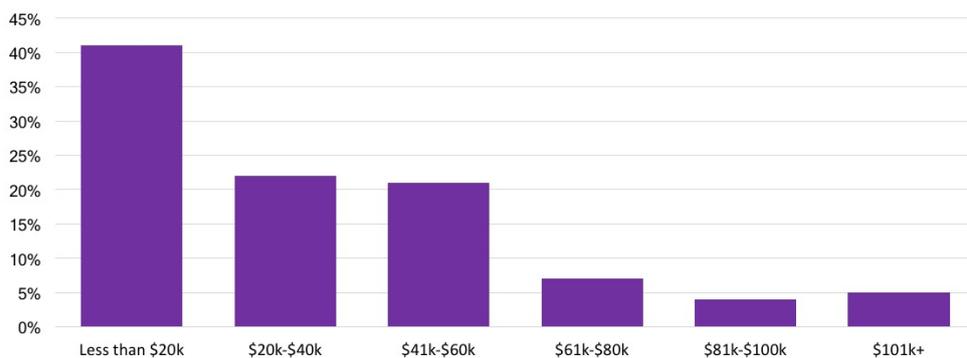
The research also found high levels of poverty, poor mental health (particularly in the years immediately following disclosure of an intersex-related diagnosis), and high rates of early school leaving. The latter is very significant as it appears to relate to the impact of medical so-called “normalising” interventions during puberty, stigmatisation based on physical characteristics and, in some cases, developmental issues that are not effectively supported by schools.⁷

Educational attainment



Some of this is related directly to human rights violations in medical settings, other issues are unrelated or simply reflect the stigmatisation of non-normative physical characteristics and gender performance that are not resolved through medical intervention (such as height, voice, mannerisms, body shape, scarring, penis size).

Income



- 63% earn under \$41,000 per year; 41% earn less than \$20,000
- For comparison, Australian median full time income: \$80,000; all employees average income: \$59,576

⁷ More demographic data can be found at <https://oii.org.au/demographics>

Sex and intersex

A framing of intersex as sex is common. At the same time, many languages do not differentiate between sex and gender, and much discourse on sex has been displaced by discourse on gender, thus intersex was included within a recent National Geographic feature on the “Gender revolution”,⁸ and intersex is frequently framed as a gender (thus misgendering the majority of intersex people).

The term sex itself can relate to biological characteristics, legal classifications, or an act of intercourse. Conflations of these issues can have adverse policy and human rights consequences. On the other hand, if we can ensure that a connection between sex and intersex does not reduce intersex issues to matters of how we should be classified, then inclusion within a framework around “sex” could have positive human rights and policy consequences.

South Africa added intersex to anti-discrimination law within a definition of sex in 2005. The South African definition reads:

‘intersex’ means a congenital sexual differentiation which is atypical, to whatever degree ‘sex’ includes intersex⁹

In September 2015, the High Commissioner for Human Rights grounded the rights of intersex people in a statement about “sex characteristics” that can itself be grounded in recognition of the broader, more generic term “sex”:

Unfortunately, the myth that all human beings belong to one of two distinct and separate sexes is deep-rooted, and it contributes to the stigma, and even taboo, attached to being intersex...

All human beings are born equal in dignity and rights. Those foundational, bedrock principles of universality and equality mean that all of us, without exception, and regardless of our sex characteristics, are equally entitled to the protections of international human rights law.¹⁰

Intersex status

Australia introduced “intersex status” in federal anti-discrimination law in 2013. It was a significant achievement, and the first time an attribute to protect intersex people had been created independently of any other attribute. The Australian 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.¹¹

The choice of “intersex status” rather than inclusion under “sex” or as “sex characteristics” was a matter of what was possible at the time, amid fears that a biological framing of intersex would be

⁸ See, *inter alia*, National Geographic Staff. Our Gender Issue Prompted Many Comments. Here We Respond [Internet]. National Geographic. 2016 [cited 2016 Dec 21]. Available from: <http://www.nationalgeographic.com/magazine/2017/01/gender-issue-reader-comments-faq/>

⁹ Republic of South Africa. Government Gazette: No. 22 of 2005: Judicial Matters Amendment Act, 2005. In: 28391st ed. Cape Town; 2006.

¹⁰ United Nations High Commissioner for Human Rights. Opening remarks by Zeid Ra’ad Al Hussein, United Nations High Commissioner for Human Rights at the Expert meeting on ending human rights violations against intersex persons [Internet]. 2015 [cited 2015 Sep 16]. Available from:

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16431&LangID=E>

¹¹ Australia, Parliament, ComLaw. Sex Discrimination Act 1984. Canberra.

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).¹² At the time, there was also a concern that “sex characteristics” would be interpreted in a way that marginalise intersex people, failing to take account of non-normative characteristics, and no example definition was available to a government readying itself for an election campaign.¹³ Intersex status:

- Is binary, not universal, a feature 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 characteristics.
- For the same reasons, it is often presumed to be (reduced to) an identity classification, or a sex classification.
- Is defined in ways that can be gamed, for example, by redefining what it means to be intersex.
- 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 definition imprecise (this also means that a current *Transgender Persons (Protection of Rights) Bill* in India uses substantively the same definition purportedly to protect transgender people from discrimination).¹⁴
- Has been defined using a model of deficit, primarily about what we lack and are not.

Intersex status has been somewhat helpful as a means of raising the profile of intersex issues. However, intersex has typically been interpreted as a sex or gender identity, and in particular a non-binary gender identity,¹⁵ with our rights a matter of gender recognition, honorifics and toilets.¹⁶

Sex characteristics

In 2015, Malta created an attribute of “sex characteristics”. Without detailed information on the performance of that attribute in the Maltese context, it seems that some disadvantages attached to “intersex status” could be resolved by using an attribute of “sex characteristics”. Maltese law defines “sex characteristics” as:

*“sex characteristics” refers to the chromosomal, gonadal and anatomical features of a person, which include primary characteristics such as reproductive organs and genitalia and/or in chromosomal structures and hormones; and secondary characteristics such as muscle mass, hair distribution, breasts and/or structure.*¹⁷

¹² Such as the Equal Opportunities Act 2010 (Victoria).

¹³ Carpenter M, Organisation Intersex International Australia. Submission on the proposed federal Human Rights and Anti-Discrimination Bill [Internet]. Sydney: Organisation Intersex International Australia; 2012 Dec [cited 2013 Aug 31]. Available from: <http://oii.org.au/21433/submission-human-rights-anti-discrimination/>

¹⁴ Asia & The Pacific Policy Society. India’s new transgender rights bill. 2016 Sep 23 [cited 2017 Feb 11]. Available from: <https://www.policyforum.net/indias-new-transgender-rights-bill/>

¹⁵ Noble M. Apology to South Australian LGBTIQ communities [Internet]. Adelaide; 2016 Dec 7 [cited 2016 Dec 7]. Available from: <https://oii.org.au/31026/south-australian-premier-apology/>

¹⁶ Yoosuf M. Recognition and protection for intersex persons. *Law Institute Journal*, April 2015:52–56. Carpenter M. The human rights of intersex people: addressing harmful practices and rhetoric of change. *Reproductive Health Matters*. 2016;24(47):74–84.

¹⁷ Malta. Gender Identity, Gender Expression and Sex Characteristics Act: Final version [Internet]. 2015 [cited 2015 Apr 15]. Available from: <http://justiceservices.gov.mt/DownloadDocument.aspx?app=lp&itemid=26805&l=1>

The Asia Pacific Forum of NHRIs defines “sex characteristics” as:

*A person’s physical characteristics relating to sex, including genitalia, chromosomes or hormones and also secondary sex characteristics that emerge at puberty.*¹⁸

Sex characteristics:

- Is clearly not the same thing as sex, but is directly related to it, or an extension of “sex”, helping to establish a firm basis for “sex characteristics” in international human rights law.
- Is universal.
- Cannot realistically be framed as a sex classification.
- Does not presume, or cannot be thought to presume a specific identity, behaviour, or understanding of self.
- Is more obviously about physical characteristics, although it might still socially be potentially confused with gender expression.
- Can potentially benefit other intersecting groups, including women and transgender people.

Known issues with the Maltese legislation include no prohibition on jurisdiction shopping (e.g. travelling outside a jurisdiction for surgery), and no action on redress.

Bodily diversity

In Latin America, intersex issues are instead frequently being subsumed under the term ‘bodily diversity’, with the Inter-American Commission on Human Rights also using this term. At present, no country has enacted protections on this ground, and in Chile the term “sex characteristics” may be adopted.

The term “bodily diversity” is also universal, and focused on the body rather than identity, behaviour or performativity (although our behaviours do impact upon our bodies). The term can also be used to protect on grounds of albinism, dwarfism, fat and other situations where particular types of bodies are stigmatised. Its relationships with international law, and with SOGI, are unclear, but “bodily diversity” is a potentially powerful framing that could subsume areas such as physical disability.

Disorders of sex development

The term “disorders of sex development” was formally introduced in the same year as the Yogyakarta Principles, and it has succeeded at reasserting clinical authority over intersex bodies, after a period where this was in contention.¹⁹ Principle 18B of the Yogyakarta Principles stated:

B. Take all necessary legislative, administrative and other measures to ensure that no child’s body is irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with the age and

¹⁸ Asia Pacific Forum of National Human Rights Institutions. Promoting and Protecting Human Rights in relation to Sexual Orientation, Gender Identity and Sex Characteristics [Internet]. Sydney, Australia: Asia Pacific Forum of National Human Rights Institutions; 2016 [cited 2016 Jun 16]. Available from: <http://www.asiapacificforum.net/resources/manual-sogi-and-sex-characteristics/>

¹⁹ Davis G. “DSD is a Perfectly Fine Term”: Reasserting Medical Authority through a Shift in Intersex Terminology. In: McGann P, Hutson DJ, editors. Advances in Medical Sociology. Bingley: Emerald Group Publishing; 2011. p. 155–82. Available from: [http://www.emeraldinsight.com/10.1108/S1057-6290\(2011\)0000012012](http://www.emeraldinsight.com/10.1108/S1057-6290(2011)0000012012)

*maturity of the child and guided by the principle that in all actions concerning children, the best interests of the child shall be a primary consideration.*²⁰

Concepts of “the best interests of the child” and their relationships to stigma and the interests of parents, and of society were unanswered. At the same time, the summary version of a 2006 “Consensus statement on management of intersex disorders” states:

Appearance-altering surgery is not urgent...

But this is contradicted by stated rationales for early cosmetic interventions including:

*beneficial effects of estrogen on infant tissues, avoiding complications from anatomic anomalies, satisfactory outcomes, minimizing family concern and distress, and mitigating the risks of stigmatization and gender-identity confusion of atypical genital appearance.*²¹

The widespread use of “psychosocial” rationales such as parental distress, parental bonding, stigmatization, and also the problematisation of gender identity and (in other clinical ethics papers) marriage prospects²² and sexual orientation²³ highlight the central role of stigma and discrimination in determining “best interests of the child” and clinical practices.

However, there is little to no evidence supporting such practices. In relation to assertions of the necessity of early interventions, the full version of the 2006 clinician statement reads:

*It is generally felt that surgery that is carried out for cosmetic reasons in the first year of life relieves parental distress and improves attachment between the child and the parents. The systematic evidence for this belief is lacking. Long term data on sexual function and quality of life among those assigned female as well as male show great variability. There are no controlled clinical trials of the efficacy of early (less than 12 months of age) versus late surgery (in adolescence and adulthood), or of the efficacy of different techniques.*²⁴

Over the last decade there has been no systematic production of evidence to support existing medical practices. From a 2016 follow-up paper:

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 ...

²⁰ Yogyakarta Principles. The Yogyakarta Principles. Principles on the application of international human rights law in relation to sexual orientation and gender identity. 2007.

²¹ Houk CP, Hughes IA, Ahmed SF, Lee PA, *et al.* Summary of Consensus Statement on Intersex Disorders and Their Management. PEDIATRICS. 2006; 118(2):753–7.

²² Gillam LH, Hewitt JK, Warne GL. Ethical Principles for the Management of Infants with Disorders of Sex Development. Hormone Research in Paediatrics. 2010;74(6):412–8. Available from: <http://www.karger.com/doi/10.1159/000316940>

²³ Meyer-Bahlburg HFL. Will Prenatal Hormone Treatment Prevent Homosexuality? Journal of Child and Adolescent Psychopharmacology. 1990;1(4):279–83. Available from: <http://www.liebertonline.com/doi/abs/10.1089/cap.1990.1.279> Nimkarn S, New MI. Congenital adrenal hyperplasia due to 21-hydroxylase deficiency. Annals of the New York Academy of Sciences. 2010;1192(1):5–11. Available from: <http://onlinelibrary.wiley.com.ezproxy1.library.usyd.edu.au/doi/10.1111/j.1749-6632.2009.05225.x/abstract>

²⁴ Hughes IA, Houk C, Ahmed SF, Lee PA, LWPES/ESPE Consensus Group. Consensus statement on management of intersex disorders. Archives of Disease in Childhood. 2006;91:554–63. Available from: <http://adc.bmj.com/cgi/doi/10.1136/adc.2006.098319>

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...

Physicians working with these families should be aware that the trend in recent years has been for legal and human rights bodies to increasingly emphasize preserving patient autonomy.²⁵

At the same time, the 2016 paper also includes an actual photograph and other images relating to surgical techniques on infant genitals.

In effect, the consensus statements do not provide a consensus about the necessity and evidence for medical interventions on intersex infants, children and adolescents. A consensus statement performs a different role, one of providing a source of justification for the full gamut of existing clinical practices.²⁶ There has been no clinical requirement to produce evidence of surgical necessity and outcomes for essentially cosmetic practices; in fact, the production of such evidence instead provides evidence of human rights violations.²⁷

Many governments cite the Yogyakarta Principles while, at the same time, public institutions cite the “Consensus statement on the management of intersex disorders”.

Policy disjunctions

The term “LGBTI” (including intersex) has entered discourse on human rights issues internationally, and it is now the default term when talking about the Equal Rights Coalition, or when making comments on SOGI issues in relation to the Independent Rapporteur. Many civil society organisations may be using the term “LGBTI” with intent, but states are not. The UN is currently using a more nuanced term, “LGBT and intersex” when including intersex issues.²⁸

Within Australia (and also New Zealand), the term “LGBTI” is typically not used as a formal means of considering what it means to include intersex people and tackling intersex human rights issues. Instead it is a way of expressing locality, a means of distinguishing discourse on LGBT issues within our region from discourse on LGBT+ issues in the UK or LGBTQ issues in the USA.

This reflects a situation where legal and regulatory discussion within Australia about intersex often reflects a lack of considered analysis about the human rights issues facing intersex people, and even the basis on which we possess human rights. Often this is simply extrapolated from references to SOGI. Much legal analysis is unreliable or incoherent as a result.

For example, in the foreword to a new book entitled “*Sex, Gender, Sexuality and the Law*”, Professor Gillian Triggs, president of the Australian Human Rights Commission, frames intersex simultaneously as “sex” and as “other status”. She refers to the book’s subjects as “those who have been marginalised on the basis of their sex, gender, or sexuality” at the same time that “The International Covenant on Civil and Political Rights requires that ... fundamental rights are available to all, equally without distinction including on the basis of “status”, a term interpreted by the Human Rights

²⁵ Lee PA, Nordenström A, Houk CP, Ahmed SF, Auchus R, Baratz A, et al. Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care. *Hormone Research in Paediatrics*. 2016;85(3):158-180

²⁶ Carpenter M. The human rights of intersex people: addressing harmful practices and rhetoric of change. *Reproductive Health Matters*. 2016;24(47):74–84.

²⁷ See, for example, the *Re Carla (Medical procedure)* [2016] FamCA 7

²⁸ United Nations. *Living Free and Equal* [Internet]. 2016 [cited 2016 Nov 23]. Available from: <http://www.ohchr.org/Documents/Publications/LivingFreeAndEqual.pdf>

Committee to include sexual orientation, gender identity and intersex.”²⁹ On occasion, an otherwise strong analysis on intersex rights can link the disordering of intersex bodies not to the actual medical construction of physical “disorders of sex development” but instead to “gender identity disorder”.³⁰

Effectively, the intersex human rights movement still faces the same issues today that were evident in 2001, arguably reinforced by resource constraints and a limited willingness of people to expose themselves to public misconceptions and stigma:

*discussions about intersex existence are "stuck" at where it is used to deconstruct sexes, gender roles, compulsory heterosexuality, and even Western science, rather than addressing medical ethics or other issues that directly impact the lives of intersex people. But perhaps this is an inaccurate way to describe the situation: the truth is not that these discussions are "stuck" prematurely, but that they are starting from a wrong place with a wrong set of priorities*³¹

These issues mean that intersex issues are often presented in ways that are not comprehensible or relevant to people born with intersex traits, for example, broadly including those who are heterosexual, comfortable with birth sex assignment and/or taught to use medicalised words.

These issues, not always accidentally, also lead directly to policy disjunctions through a disassociation in public policy between actions on identity and LGBTI issues, on the one hand, and actions relating to the treatment of intersex bodies in medical settings, in the other. This means that legal and government systems are complicit in the medical "normalisation" of intersex bodies at the same time they are complicit in the “othering” of our identities as a population.

In 1979 the Australian Family Court case, “*In the marriage of C and D*” annulled the marriage of a man - C - who was, the judge said, born and raised male, but had chromosomes typically associated with females, a “true hermaphrodite”. He had undergone numerous medical interventions to reinforce his assigned sex. There’s no evidence that he identified as anything other than male (indeed, a political identity as intersex or hermaphrodite was not available to anyone in the 1970s). His marriage was annulled on the basis that he was biologically a combination of man and woman, and so “a marriage in the true sense could not have taken place”.³² He was “normalised” and still inescapably “othered”. The judge in this case, Justice Graham Bell, retired only in 2015.

Since this time, Australian legislation aimed at including intersex people has typically framed intersex people as the other. For example, the *Transgender (Anti-Discrimination and Other Acts Amendment) Act 1996 (NSW)* states:

A reference in this Part to a person being transgender or a transgender person is a reference to a person, whether or not the person is a recognised transgender person: ...

²⁹ Triggs G. Foreword. In Hardy S, Rundle O, Riggs D. *Sex, Gender, Sexuality and the Law: Social and legal issues faced by individuals, couples and families*. 2016. Thomson Reuters.

³⁰ Narrain A. The Right Not To Be Mutilated: Intersex People and The Quest For Justice [Internet]. *Jurist*; 2015 [cited 2015 Oct 28]. Available from: <http://jurist.org/hotline/2015/10/arvind-narrain-intersex-justice.php>

³¹ Koyama E, Weasel L. Teaching Intersex Issues (June 2001 edition) [Internet]. 2001 [cited 2016 Feb 1]. Available from: <http://isna.org/pdf/teaching-intersex-web.pdf> See also Koyama E, Weasel L. From Social Construction to Social Justice: Transforming How We Teach about Intersexuality. *Women’s Studies Quarterly*. 2002;30(3/4):169–78.

Available from: <http://www.jstor.org/stable/40003252>

³² In the marriage of C and D (falsely called C) (1979) FLC 90-636

*(c) who, being of indeterminate sex, identifies as a member of a particular sex by living as a member of that sex,*³³

The construction of someone of indeterminate sex as not male or female (but obliged to “identify” and “live” as such to be protected from discrimination) has an unclear relationship to actual processes of birth registration, legal sex assignment and medical intervention, particularly when becoming a “recognised transgender person” is predicated on a legal reassignment of sex, but such persons are constructed as the “other”, and to be “normalised”.

In 2009, the Australian Human Rights Commission published a paper on intersex people and surgeries, citing Yogyakarta Principle 18B, but also simply describing clinical practices, with limited analysis and no conclusions:

Surgery is performed on infants who are intersex for two reasons:

- *in circumstances where it is a medical emergency or to treat a malfunction or disease (therapeutic surgery), and/or*
- *to make the body appear more male or female.*³⁴

The document has since been used as a source of justification for the use of “psychosocial” rationales for medical intervention.³⁵ A subsequent 2010 Australian clinical paper defining ethical principles was immediately critiqued for its focus on surgeries,³⁶ and it lists psychosocial rationales for medical interventions as including parental distress, family bonding and the child’s future marriage prospects.²²

In 2013, we won inclusion of “intersex status” in law, and also a Senate inquiry report into the involuntary or coerced sterilisation of intersex people in Australia.³⁷ No human rights institution made a relevant submission to that inquiry, and only one single “LGBTI” organisation made a submission. The inquiry made 15 recommendations to change clinical practices and improve oversight, but these have not been implemented.

The Australian Capital Territory government minister told me in 2014 that availability of a third sex marker for infants and children will reduce the likelihood that parents will subject intersex children to “gender assignment surgery” at the same time it told me that children with DSDs are treated in line with a national clinical approach, including being “normally referred to either Melbourne or Sydney” for surgery.³⁸ In doing so, the minister failed also to acknowledge her government’s responsibility for actions carried out by public hospitals.

³³ New South Wales. Transgender (Anti-Discrimination and Other Acts Amendment) Act 1996 No 22 [Internet]. 22 of 1996 1996. Available from: http://www.austlii.edu.au/au/legis/nsw/num_act/taoaaa1996n22541.pdf

³⁴ Australian Human Rights Commission. Surgery on intersex infants and human rights [Internet]. Australian Human Rights Commission; 2009. Available from: <https://www.humanrights.gov.au/surgery-intersex-infants-and-human-rights-2009>

³⁵ Royal Australasian College of Physicians. Sexual and Reproductive Health Care for Young People Position Statement [Internet]. 2015 [cited 2016 Aug 14]. Available from: <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-ps-sexual-and-reproductive-health-care-for-young-people.pdf>

³⁶ Dreger A, Sandberg DE, Feder EK. From Principles to Process in Disorders of Sex Development Care. Hormone Research in Paediatrics. 2010;74(6):419–20. Available from: <http://www.karger.com/doi/10.1159/000316943>

³⁷ Australian Senate, Community Affairs References Committee. Involuntary or coerced sterilisation of intersex people in Australia [Internet]. Canberra; 2013 [cited 2013 Oct 26]. Available from: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Sec_Report/index

³⁸ Personal communications with the ACT Chief/Health Minister in 2014.

Published in 2016, the Australian state health department of Victoria describes online how it:

*values and celebrates diversity... including... sexualities, gender identities and intersex variations. It ... is committed to removing discrimination from Victorian laws, services and society...*³⁹

at the same time that it states online, in a publication dated 2015:

*Ambiguous genitalia... can be a source of great distress for parents, delivery room and nursery staff... Corrective surgery is usually undertaken within the first year of life*⁴⁰

Last year, in January 2016, the Australian Family Court case of “*Re Carla (Medical procedure)*” saw a 5-year old child with an intersex trait, 17 β -hydroxysteroid dehydrogenase deficiency (17 β -HSD-3), described as having a “sexual development disorder”.⁴¹ The judge permitted parents to authorise the child’s sterilisation, on the basis of a potential risk of gonadal cancer, even though clinical documentation supports monitoring and not removal of gonads. “No reason to delay” was stated:

there are physical and psychological risks associated with such a delay and particularly given that it will be less psychologically traumatic for Carla if it is performed before she is able to understand the nature of the procedure.

The judge relied extensively on gender stereotyping to make that decision:

- 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 noted that two years previously, likely aged 3, the child had a clitorrectomy and labiaplasty:

Surgery already performed on Carla has enhanced the appearance of her female genitalia. In 2014, Carla underwent two operations. In March that year, Dr B, performed a ‘clitoral’ recession and labiaplasty to feminise Carla’s external appearance.

³⁹ Department of Health and Human Services. Rainbow eQuality [Internet]. 2016 [cited 2016 Jun 9]. Available from: <https://www2.health.vic.gov.au/about/populations/lgbti-health/rainbow-equality>

⁴⁰ Department of Health and Human Services. Ambiguous genitalia in neonates [Internet]. 2015 [cited 2016 May 18]. Available from: <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/neonatal-e-handbook/congenital-abnormalities/ambiguous-genitalia>

⁴¹ Re: Carla (Medical procedure) [2016] FamCA 7 (20 January 2016). Carpenter M. The Family Court case Re: Carla (Medical procedure) [2016] FamCA 7 [Internet]. OII Australia - Intersex Australia. 2016 [cited 2016 Dec 7]. Available from: <https://oii.org.au/31036/re-carla-family-court/>

No Court oversight was considered necessary for those surgeries, nor did the Court comment on the necessity for oversight, the Court described as therapeutic interventions “for the chief purpose of preventing, removing or ameliorating a cosmetic deformity”, despite the framing of early surgeries as an enhancement”. No recognition was made of a conflict of interest inherent in a parental and clinician investment in the success of those early cosmetic surgeries. The Court also noted future surgery that might be required to prepare the child’s body for (heterosexual) intercourse:

Carla may also require other surgery in the future to enable her vaginal cavity to have adequate capacity for sexual intercourse.

Not only is there no evidence of the necessity of such medical interventions, but the risks of clitorectomies are the same as those of FGM (clitorectomies are a form of FGM), including established risks of loss of sexual function and sensation, and incontinence.²⁶ There is also a strong chance that Carla may not be a girl:

Gender role changes were reported in 56–63% of cases with 5 α -RD-2 and 39–64% of cases with 17 β -HSD-3 who were raised as girls. The changes were usually made in adolescence and early adulthood. In these two syndromes, the degree of external genital masculinization at birth does not seem to be related to gender role changes in a systematic way...⁴²

The term intersex was not mentioned in either cited Family Court case; it was studiously avoided in “*Re Carla*”. The case appears to show that anti-discrimination legislation does not protect children from human rights violations based on sex and gender norms. An anonymous government department acted as a friend to the Court. No human rights institution in Australia was able to comprehend and proactively draw a relationship between the content of the case, and human rights violations against intersex people, and human rights protections for intersex people.

In recent years, multiple human rights institutions have described how these harmful practices have profound negative effects and fail to meet human rights norms.⁴³ Specific legislation prohibiting abuses in medical settings may be the only means of preventing such abuses. We currently have insufficient information on the situation in Malta, but it remains best practice.

Recent research in Germany has shown how infant genital mutilation has been used as a rationale for the creation of a de facto third sex classification for some infants and children, while there has been no reduction in the number of feminising or masculinising surgeries in the period 2005 to 2014.⁴⁴ The model unfortunately is likely to encourage medical interventions in parental attempts to

⁴² Cohen-Kettenis PT. Gender Change in 46,XY Persons with 5 α -Reductase-2 Deficiency and 17 β -Hydroxysteroid Dehydrogenase-3 Deficiency. *Archives of Sexual Behavior*. 2005;34(4):399–410. Available from: <http://link.springer.com/10.1007/s10508-005-4339-4>. See also Hewitt JK, Warne GL. Management of disorders of sex development. *Pediatric Health*. 2009;3(1):51–65.

⁴³ Office of the High Commissioner for Human Rights. Intersex Awareness Day – Wednesday 26 October. End violence and harmful medical practices on intersex children and adults, UN and regional experts urge [Internet]. Office of the High Commissioner for Human Rights; 2016 [cited 2016 Oct 24]. Available from: <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20739&LangID=E>

⁴⁴ Klöppel U. Zur Aktualität kosmetischer Operationen „uneindeutiger“ Genitalien im Kindesalter. *Gender Bulletin*. 2016;(42). Available from: <https://www.gender.hu-berlin.de/de/publikationen/gender-bulletins/texte-42/kloepfel-2016-zur-aktualitaet-kosmetischer-genitaloperationen> and OII Germany. OII Germany: CEDAW Shadow Report. With reference to the combined Seventh and Eighth Periodic Report from the Federal Republic of Germany on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) [Internet]. 2017 [cited 2017 Feb 7]. Available from: http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/DEU/INT_CEDAW_NGO_DEU_26315_E.pdf

avoid disclosure, stigma and uncertainty.⁴⁵ The legislation is not based upon self-determination and offers no direct means of addressing the core issue.

Best interests of the child

Multiple different perspectives exist on the “best interests of the child”, normality, and necessary therapeutic treatment. The Yogyakarta Principles simply state:

in all actions concerning children the best interests of the child shall be a primary consideration and a child who is capable of forming personal views has the right to express those views freely, such views being given due weight in accordance with the age and maturity of the child

Given contestation about the best interests of the child, and in particular the role of stigma in determining best interests, this is not adequate.

In 2012, the Swiss National Advisory Commission on Biomedical Ethics recommended deferring all medical interventions that can be deferred “until the person to be treated can decide for him/herself”:

In general, parents make ... decisions on behalf of and in the best interests of their child. In doing so, they have the task of supporting the child in developing its gender identity, while respecting its physical and psychological integrity... There is no guarantee that a decision which is good for the child in its current state will also be best for this person in puberty or adulthood. The Commission recommends that the determination of the child's welfare should be based as far as possible both on the current interests of the child and on the anticipated interests of the future adult.⁴⁶

On the “best interests of the child” in cases of intersex children the Australian Senate stated in 2013:

The evidence suggests that a human rights consistent framework for 'normalising surgery' where it involves irreversible and invasive procedures must necessarily operate from a presumption in favour of maintaining the status quo for as long as possible except where such a presumption would conflict with the child's best interests. A model that confers rights on third parties, through substitute decision making, before it guarantees the rights of the child, is likely to be a disproportionate limitation of the child's right to autonomy/self-determination.

The Senate committee also stated:

Normalising appearance goes hand in hand with the stigmatisation of difference. Care needs to be exercised that medical treatment of intersex is not premised on, and contributing to, the stigma and perceived undesirability of people appearing different from one another.

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. Those issues include reducing parental

⁴⁵ Council of Europe, Commissioner for Human Rights. Human rights and intersex people, Issue Paper [Internet]. 2015 [cited 2015 May 12]. Available from:

[https://wcd.coe.int/ViewDoc.jsp?Ref=CommDH/IssuePaper\(2015\)1&Language=lanEnglish&Ver=original](https://wcd.coe.int/ViewDoc.jsp?Ref=CommDH/IssuePaper(2015)1&Language=lanEnglish&Ver=original)

⁴⁶ Swiss National Advisory Commission on Biomedical Ethics NEK-CNE. On the management of differences of sex development. Ethical issues relating to “intersexuality”. Opinion No. 20/2012. Berne; 2012. (2012). Available from: http://www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/NEK_Intersexualitaet_En.pdf

anxiety, and ensuring social awareness and acceptance of diversity such as intersex. Surgery is unlikely to be an appropriate response to these kinds of issues.

Kirsten Sandberg, rapporteur and former chair of the Committee on the Rights of the Child, states that, a lack of evidence, and well-documented harms, mean that early interventions violate article 3 of the Convention on the Rights of the Child, on the best interests of the child, as well as violating physical integrity and article 19 on protection from all forms of violence. Medical intervention:

constitutes an intervention into the physical integrity of the child, from which the child has a right to be protected unless such intervention is medically necessary. Since it has been established that this treatment is not medically necessary, at least at the early stages of a child's life, the parents have no right to consent to it. ... the matter is so personal and serious that treatment should not be carried out without the child's consent.⁴⁷

Conclusions

In the absence of clarity about the exact form of output or revision created by the YP+10 process, these conclusions offer some thoughts and guidance on how intersex issues can be addressed.

It seems necessary to state that intersex is not a complex issue. Similarly, intersex is not a medical issue, it is an ethical issue. Intersex human rights are primarily about self-determination, and access to the same rights as non-intersex people. There is a careful need to disentangle issues related to stigma from issues relating to physical necessity or personally and freely-given informed consent, in the same way that other populations also need careful attention both to universal human rights and specific forms of stigma, violence and discrimination.

The available data suggests serious issues with discrimination and stigmatisation in areas where populations stigmatised on grounds of SOGI also face discrimination and stigmatisation, such as education, employment, sport, and access to healthcare.

Specific attention also needs to be given to the complicity of legal and medical systems, and to the prohibition of human rights violations in medical settings.

It is necessary for any output or revision to comment thoroughly on the treatment of people because of our bodies. It is also necessary to comment thoroughly on the "best interests of the child". It may also be necessary to define what may be therapeutic or medically necessary.

The use of an attribute of "sex characteristics" can offer a way of protecting intersex people from discrimination in ways not addressed by SOGI, but this would need to be fully integrated throughout. A definition of sex characteristics appropriate to the YP+10 process might be:

Understanding 'sex characteristics' to refer to each person's physical characteristics relating to sex, including genitalia and other reproductive anatomy, chromosomes and hormones, and also secondary physical characteristics emerging from puberty.

Qualifying factors may include:

⁴⁷ Sandberg K. The Rights of LGBTI Children under the Convention on the Rights of the Child. Nordic Journal of Human Rights. 2015;33(4):337–52. Available from: <http://www.tandfonline.com/doi/full/10.1080/18918131.2015.1128701>

Sex characteristics may or may not correspond to any legal classification assigned at birth, and may develop innately or be acquired.

Despite the advantages of “sex characteristics” over alternative means of addressing intersex human rights issues, there remain unresolved issues about the “fit” of a legal attribute relating to intersex or sex characteristics within a framework broadly focused on recognition of identities, behaviours and attractions. When international work on human rights is so polarised, the meaningful addition of intersex issues to a contested framework on SOGI issues *ipso facto* brings opposition to intersex human rights. Of course, this may have already happened due to framings of “LGBTI” as SOGI issues.

To my mind, the distinctiveness of each population within SOGIESC needs to be better recognised, and a more intersectional approach adopted, within as well as external to SOGIESC, in an attempt to both acknowledge and reduce side effects.

Careful attention needs to be given to ensure that intersex inclusion mindfully addresses policy disjunctions, and does not simply reinforce an existing emphasis on identity issues over issues of bodily autonomy. Strong effort is needed to ensure that bodily autonomy issues are effectively addressed and clearly articulated.