InterAction
for Health and
Human Rights

InterAction for Health and Human Rights

Submission on the Review of the Anti-Discrimination Act 1977 (NSW) Consultation Paper

12 August 2025

1 Contents

2 This submission

Thank you for the opportunity to make a submission on reform of the Anti-Discrimination Act 1977 (NSW). We welcome the opportunity to provide feedback on issues raised in the Commission's Consultation Paper, in the hope of securing the first ever protections for people with innate variations of sex characteristics from discrimination in New South Wales.

InterAction for Health and Human Rights is a national charity. We provide psychosocial and peer support services, and engage in training, information and education, and policy work. Our name is new, introduced on the merger of Intersex Peer Support Australia into Intersex Human Rights Australia. Legally we remain registered as Intersex Human Rights Australia, a Public Benevolent Institution.

Our submission has been drafted by Dr Morgan Carpenter, our Executive Director. It has been reviewed by the board and staff.

Please contact us at info@interaction.org.au in case of any queries or follow-up. We are happy for this submission to be published in full.

3 Innate variations of sex characteristics

The purpose of this section is to provide sufficient understanding to enable consideration of the impact of laws, 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[1] 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/X0 (TS), Triple-X syndrome (XXX).

Below we detail the characteristics and experiences of people with several distinct innate variations of sex characteristics due, in some cases, to their higher frequency, and in one case due to the existence of relevant Family Court decisions.[2]

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[1] Tiffany Jones et al, *Intersex: Stories and Statistics from Australia* (Open Book Publishers, 2016) <https://researchers.mq.edu.au/en/publications/intersex-stories-and-statistics-from-australia>.

[2] *Re Carla* [2016] FamCA 7

3.1 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.[3] 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 ('CAIS') will never 'virilise' ('masculinise') if their gonads are retained or if they take testosterone replacement therapy. Women and girls with partial AIS (PAIS) 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[4]. Following sterilisation, individuals require hormone replacement to maintain bone health, libido and general health. Recent peer-reviewed clinical journals have established that rates of gonadal tumours in people with partial AIS are also so low that they do not justify early prophylactic sterilisations.[5]

People with AIS report assumptions behind medical intervention that include the idea that women and girls with AIS 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, values 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, the Australasian Paediatric Endocrine Group stated:

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[3] Kerry Warren, 'Hormones, Experimental Surgery & Heartbreak: What It Means To Be Intersex', *Whimn* (online, 8 November 2017) <http://www.whimn.com.au/talk/think/hormones-experimental-surgery-heartbreak-what-it-means-to-be-intersex/news-story/358596586943a2d7a0f738f56f633239>.

[4] J Pleskacova et al, 'Tumor Risk in Disorders of Sex Development' (2010) 4(4–5) *Sexual Development* 259.

[5] Michele A O'Connell et al, 'Establishing a Molecular Genetic Diagnosis in Children with Differences of Sex Development: A Clinical Approach' [2021] *Hormone Research in Paediatrics* 1 ('Establishing a Molecular Genetic Diagnosis in Children with Differences of Sex Development').

> *a trend toward consideration of less genital and gonadal surgery in infants assigned female, or delaying surgery. It is important to note that current practice has changed significantly from the past'*[6]

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.[7] We have no evidence that such protocols are being taken up in New South Wales or the rest of Australia.

In 2019, a clinical team in Brisbane published a review of cases managed by the Paediatric and Adolescent Gynaecology Service where, likely following age of diagnosis, 'In CAIS, bilateral gonadectomies were most often done at infancy'; all individuals with PAIS were also subjected to gonadectomies.[8] Practices in New South Wales are not so clearly documented in published reports. In the absence of local published documentation, we take the position that these practices are as plausibly practiced and prevalent in New South Wales as Queensland.

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.[9]

Historically, some women with complete AIS were excluded from competitive sport following chromosomal tests. Some women with partial AIS remain excluded. Women in such situations often have no prior knowledge of their variation, and have suffered humiliation, loss of career and, in at least one documented case, home and relationship.[10]

Chromosomal testing was abandoned as an unjust method of determining sex before the end of the twentieth century[11] before being reintroduced by World Athletics in recent years. That reintroduction of testing affects women with partial AIS and some other variations such as 17-beta hydroxysteroid dehydrogenase 3 deficiency, and 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

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[6] Australasian Paediatric Endocrine Group et al, *Submission of the Australasian Paediatric Endocrine Group to the Senate Inquiry into the Involuntary or Coerced Sterilization of People with Disabilities in Australia: Regarding the Management of Children with Disorders of Sex Development* (Submission, 27 June 2013) <http://www.aph.gov.au/DocumentStore.ashx?id=aafe43f3-c6a2-4525-ad16-15e4210ee0ac&subId=16191>.

[7] Erica M Weidler et al, 'A Management Protocol for Gonad Preservation in Patients with Androgen Insensitivity Syndrome' (2019) 32(6) *Journal of Pediatric and Adolescent Gynecology* 605.

[8] T Adikari et al, 'Presentations and Outcomes of Patients with Disorders of Sexual Development (DSD) in a Tertiary Paediatric and Adolescent Gynaecology (PAG) Service' (at the RANZCOG Annual Scientific Meeting 2019, Melbourne, 2019) <https://ranzcogasm.com.au/wp-content/uploads/2019/10/243.pdf>.

[9] For example, see Faye Kirkland, 'Intersex Patients "Routinely Lied to by Doctors"', *BBC News* (online, 22 May 2017) <http://www.bbc.com/news/health-39979186>.

[10] Maria José Martínez-Patiño, 'Personal Account A Woman Tried and Tested' [2005] *The Lancet* 366.

[11] Simpson J et al, 'Gender Verification in the Olympics' (2000) 284(12) *JAMA* 1568.

as a ‘causal connection between high testosterone levels and enhanced athletic performance among elite female athletes’.[12]

3.2 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.[13]

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.[14] Research to date has, however, found that a diverse range of potential factors including genetics and environmental factors, may be responsible for sexual attraction.[15] 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 [sic] in 46,XX girls and women with 21OHD deficiency.*[16]

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*

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[12] Jeré Longman, ‘Scientists Correct Study That Limited Some Female Runners’, *The New York Times* (online, 18 August 2021) <https://www.nytimes.com/2021/08/18/sports/olympics/intersex-athletes-olympics.html>; BMJ Publishing Group Ltd and British Association of Sport and Exercise Medicine, ‘Correction: Serum Androgen Levels and Their Relation to Performance in Track and Field: Mass Spectrometry Results from 2127 Observations in Male and Female Elite Athletes’ (2021) 55(17) *British Journal of Sports Medicine* e7 (‘Correction’).

[13] Department of Health, *Newborn Bloodspot Screening Condition Assessment Summary Congenital Adrenal Hyperplasia (CAH)* (2020) <https://www.health.gov.au/sites/default/files/documents/2020/02/newborn-bloodspot-screening-condition-assessment-summary-congenital-adrenal-hyperplasia_0.pdf>.

[14] HFL Meyer-Bahlburg, ‘Will Prenatal Hormone Treatment Prevent Homosexuality?’ (1990) 1(4) *Journal of Child and Adolescent Psychopharmacology* 279.

[15] Christopher Richards, ‘Do Your Genes Control Who You’re Attracted to?’ in Genetic Support Network of Victoria (ed), *Connections* (Genetic Support Network of Victoria, 2017) 6 <https://www.gsnv.org.au/media/288183/summer_2017-2018_hr_no_bleed.pdf>.

[16] Saroj Nimkarn and Maria I New, ‘Congenital Adrenal Hyperplasia Due to 21-Hydroxylase Deficiency’ (2010) 1192(1) *Annals of the New York Academy of Sciences* 5.

> *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.*[17]

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.[18] However, their current status in New South Wales and elsewhere Australia is undocumented.

These rationales for treatment have proven controversial.[19] 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*[20] *(our emphasis)*

The New South Wales government publishes no information on practices in New South Wales hospitals. In the absence of concrete local information, we take the position that these practices are as plausibly practiced and prevalent in New South Wales as Victoria.

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, evading questions about medical necessity and the pre-empting of personal consent.[21] Most research, as in Victoria, occurs with clinicians studying the outcomes they are interested in, on their own patients, i.e.

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[17] Ibid.

[18] Senate of Australia Community Affairs References Committee, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013) <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Sec_Report/index>.

[19] Alice Dreger, Ellen K Feder and Anne Tamar-Mattis, 'Prenatal Dexamethasone for Congenital Adrenal Hyperplasia: An Ethics Canary in the Modern Medical Mine' (2012) 9(3) *Journal of Bioethical Inquiry* 277 ('Prenatal Dexamethasone for Congenital Adrenal Hyperplasia').

[20] Safer Care Victoria, 'Congenital Adrenal Hyperplasia (CAH) in Neonates' (17 February 2021) <https://www.safercare.vic.gov.au/clinical-guidance/neonatal/congenital-adrenal-hyperplasia-cah-in-neonates>.

[21] *Insight 2017, Ep 31 - Intersex* (Directed by Insight SBS, November 2017) <https://www.youtube.com/watch?v=tbiSmmCuiYo&list=PLs348akkootwcPaq6GscWFDoLDCzIH4cF&t=0s&index=5>; Morgan Carpenter, 'Fixing Bodies and Shaping Narratives: Epistemic Injustice and the Responses of Medicine and Bioethics to Intersex Human Rights Demands' (2024) 19(1) *Clinical Ethics* 3 ('Fixing Bodies and Shaping Narratives').

subject to confirmation and ascertainment biases. Victorian research has presented information on 'vibration' tests on adolescents and adults, and patient views, in an attempt to justify early interventions, while also reporting separately on adverse urinary issues.[22]

International evidence shows that outcomes are 'not encouraging'.[23] Kalfa and others, for example, have attempted a systematic review but such a review is rendered impossible by a lack of standardised research methods.[24] In their 2024 review in the Journal of Pediatric Urology, the authors state:

> *A large study involving 1040 people from the European multicenter dsd-life study concludes that many people with a range of DSD conditions appear to be dissatisfied with their sex lives, experience a range of sexual problems and are less sexually active than the general population [30]. The results in women with CAH seemed to vary, but in general surgery had a negative effect on sexual function*[25]

Women with CAH, following surgery in early childhood, were also more likely to experience additional problems with urinary continence and vaginal stenosis (a narrowing of the vagina).

Kalfa and co-authors describe surgical outcomes that are 'not encouraging', how nearly 10% of women with CAH have no clitoris due to surgical intervention, and how patient-reported assessments and clinician-reported assessments of outcomes differ:

> *Within the group undergoing feminization surgery, attempts are also being made to consider girls with CAH as a separate group. In a recent study reporting the long-term results of a multicenter European registry study in women with CAH, the results cannot be interpreted as encouraging [35]. One hundred and seventy-four 46, XX individuals were included. A gynecological examination was performed in 84 of whom 9.5% had a missing clitoris, 36.7% had a missing clitoral hood, 22.6% had abnormal large labia and 23.8% had small labia. In 30% of the total study population, sex life was described as poor on the basis of patient-reported outcomes, which contrasts with the positive assessment of outcomes by 97% of clinicians and which emphasizes the need to obtain the patients' perspective...The current analysis of long-term outcomes did not take into account any additional procedures needed later in life after infant surgery. However, we know that up to 50% of patients after pediatric vaginoplasty require additional procedures later in life to allow coitus.*[26]

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[22] Morgan Carpenter, 'From Harmful Practices and Instrumentalisation, towards Legislative Protections and Community-Owned Healthcare Services: The Context and Goals of the Intersex Movement in Australia' (2024) 13(4) *Social Sciences* 191.

[23] Nicolas Kalfa et al, 'Adult Outcomes of Urinary, Sexual Functions and Fertility after Pediatric Management of Differences in Sex Development: Who Should Be Followed and How?' [2024] *Journal of Pediatric Urology* S1477513124000524 ('Adult Outcomes of Urinary, Sexual Functions and Fertility after Pediatric Management of Differences in Sex Development').

[24] Ibid.

[25] Ibid.

[26] Ibid.

In our view, these outcomes are unacceptable. Practices (both historic and current) in NSW are not documented, but we can plausibly expect that they are comparable. Where these interventions occur without personal fully informed consent, the need for such interventions is not indicated or substantiated. 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.*[27]

3.3 17-beta hydroxysteroid dehydrogenase 3 and related traits

Infants with 17-beta hydroxysteroid dehydrogenase 3 (17β-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*[28]

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.[29]

Additionally, according to a review paper, rates of gender change in persons with 17-betahydroxysteroid dehydrogenase 3 deficiency assigned female at birth are '39–64% of cases'.[30] This means that children subjected to feminising genitoplasties may not later come to understand themselves as girls or women.

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[27] Peter A Lee et al, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care' (2016) 85(3) *Hormone Research in Paediatrics* 158 ('Global Disorders of Sex Development Update since 2006').

[28] Morgan Carpenter, 'Intersex Variations, Human Rights, and the International Classification of Diseases' (2018) 20(2) *Health and Human Rights* 205; World Health Organization, '46,XY Disorder of Sex Development Due to 17-Beta-Hydroxysteroid Dehydrogenase 3 Deficiency' in *ICD-11 Foundation* (2022) <https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f887793448>.

[29] Australasian Paediatric Endocrine Group et al (n 7).

[30] Peggy T Cohen-Kettenis, 'Gender Change in 46,XY Persons with 5α-Reductase-2 Deficiency and 17β-Hydroxysteroid Dehydrogenase-3 Deficiency' (2005) 34(4) *Archives of Sexual Behavior* 399.

In 2006, a clinical ‘consensus statement’ described the risk of gonadal tumours associated with 17β-HSD3 to be 28%, a ‘medium’ risk, recommending that clinicians ‘monitor’ gonads.[31] 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’.*[32]

However, risk levels have reduced since with the effect that contemporaneous clinical guidance associates gonadectomy with female sex assignment and not gonadal tumour risks, as stated in material associated with the relevant World Health Organization ICD-11 classification,[33] and 2016 clinical “consensus” statements.[34]

In 2008, in the Family Court case *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226, **a judge approved the sterilisation of a young child with 17β-HSD3. 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:

> *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, a Family Court judge adjudicated the case *Re Carla (Medical procedure)* [2016] FamCA 7. An anonymous government department appeared as a friend of the court. The judge concluded that parents could authorise the sterilisation of a pre-school (5-year old) child with 17β-HSD3, surprisingly claiming that ‘it would be virtually impossible to regularly monitor them for the presence of tumours’ (at [20]). This does not accord with the German experience, or material in a 2006 clinical ‘consensus statement’ that calls on clinicians to ‘monitor’ gonads of people with this trait (Hughes et al. 2006). The judge drew upon affidavits from the child’s multidisciplinary team to describe 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]):

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[31] IA Hughes et al, ‘Consensus Statement on Management of Intersex Disorders’ (2006) 91 *Archives of Disease in Childhood* 554.

[32] Amnesty International, ‘First, Do No Harm: Ensuring the Rights of Children Born Intersex.’ (May 2017) <https://www.amnesty.org/en/latest/campaigns/2017/05/intersex-rights/> (‘First, Do No Harm’).

[33] Carpenter, ‘Intersex Variations, Human Rights, and the International Classification of Diseases’ (n 29); World Health Organization (n 29).

[34] Lee et al (n 28).

> *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****. (our emphasis)*

This statement is quite extraordinary. This was a clitorectomy and labioplasty (at [16]), which may sometimes be termed a 'genitoplasty' or 'vulvoplasty'. 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'.[35] 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, girls with intersex traits are exempt from such protections, including in the Criminal Law of New South Wales, which permits genital surgery if it 'is necessary for the health of the person on whom it is performed and is performed by a medical practitioner' (Crimes Act 1900 (NSW) s45(3)(a)). The gender stereotyping evident in *Re: Carla (Medical procedure)* [2014] FamCA 7 demonstrates a moral hypocrisy in such exemptions. In the absence of concrete local information confirming such practices do not occur in New South Wales, we take the position that these practices are as plausibly practiced in New South Wales as elsewhere in Australia and the world.

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[35] World Health Organization et al (eds), *Eliminating Female Genital Mutilation: An Interagency Statement* (World Health Organization, 2008) ('*Eliminating Female Genital Mutilation*').

The characteristics and health and human rights context for people with 5 alpha reductase deficiency are substantively the same as the context described above for people with 17βHSD3.

3.4 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.[36] As with other innate variations of sex characteristics, the innate physical characteristics of people with XXY are socially stigmatised. Men with Klinefelter syndrome have poorer socioeconomic outcomes;[37] 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 stigma 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[38] 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.[39] Alex had received a birth certificate from Victoria stating ‘indeterminate – also known as intersex’. 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.*[40]

A legal conflation of intersex with a third category of sex (and with ‘indeterminate sex’) evident in the birth certification 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, nor all people with innate variations of sex characteristics, wish to be marked as neither female nor male.

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[36] Anne Skakkebæk, Mikkel Wallentin and Claus H Gravholt, ‘Neuropsychology and Socioeconomic Aspects of Klinefelter Syndrome: New Developments’ (2015) 22(3) *Current Opinion in Endocrinology & Diabetes and Obesity* 209 (‘Neuropsychology and Socioeconomic Aspects of Klinefelter Syndrome’).

[37] Ibid.

[38] S Röttger et al, ‘An SRY-Negative 47,XXY Mother and Daughter’ (2000) 91 *Cytogenetics and Cell Genetics* 204.

[39] Julie Butler, ‘X Marks the Spot for Intersex Alex’, *The West Australian* (Perth, Western Australia, 11 January 2003).

[40] Ibid.

3.5 46,X0/Turner syndrome

Women with Turner syndrome are often diagnosed at puberty, when menstruation fails to occur. In such cases, a preliminary diagnosis based on physical characteristics (such as short stature, webbing of the neck and/or cubitus valgus) will typically be confirmed through diagnostic genetic testing. Diagnosis may occur in utero when genetic testing is undertaken to screen for preferred sex and/or unwanted genetic conditions such as Down syndrome.

Turner syndrome is associated in the literature with significantly increased risk of heart disorders, such as aortic dissection, and has been associated with evidence of reduced life expectancy.[41] Early literature finding significantly increased risks of gonadal cancer have been challenged, and it is now more common for surgical removal to be confined to cases of mosaic Turner women with streak ovaries. Lifetime estrogen therapy is commonly prescribed for Turner women. Turner syndrome women can expect early hearing loss and may suffer the psycho-social side-effects associated with hearing loss.

3.6 Experiences of discrimination

People with innate variations of sex characteristics 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 nondiscrimination.*
>
> *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)*[42]

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'*[43]

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[41] WH Price et al, 'Mortality Ratios, Life Expectancy, and Causes of Death in Patients with Turner's Syndrome' (1986) 40(2) *Journal of Epidemiology and Community Health* 97.

[42] Office of the High Commissioner for Human Rights, *Background Note on Human Rights Violations against Intersex People* (October 2019) <https://www.ohchr.org/en/documents/tools-and-resources/background-note-human-rights-violations-against-intersex-people>.

[43] Jones et al (n 2).

> *• 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*[44]
>
> *• 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*[45]

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*[46]

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.[47] 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*[48]

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.

A 2015 Australian sociological convenience sample of 272 people born with atypical sex characteristics found that individuals whose variations are more physically evident to

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[44] Ibid.

[45] Intersex Human Rights Australia, 'Demographics', *Intersex Human Rights Australia* (28 July 2016) <https://ihra.org.au/demographics/>; Morgan Carpenter and Agli Zavros-Orr, 'Education', *Intersex Human Rights Australia* (7 March 2019) <https://ihra.org.au/education/>.

[46] Office of the High Commissioner for Human Rights (n 43).

[47] AIS Support Group Australia et al (n 1).

[48] Office of the High Commissioner for Human Rights (n 43).

strangers are more likely to bear the brunt of social discrimination.[49] 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 a variation is not evident, an individual may avoid disclosure, or medicalise their intersex trait, to mitigate risks of discrimination.

4 “Indeterminate sex”

The Consultation Paper notes that:

> *the ADA also recognises the existence of persons of "indeterminate sex”. In light of the use of this phrase in the ADA, the High Court concluded that another NSW law “recognises that a person may be other than male or female”.*[50]

The term indeterminate sex is often associated with innate variations of sex characteristics, and a status reflecting exclusion from female and male sex categories.

The Anti-Discrimination Act mentions indeterminate sex in the context of section 38A, discrimination on transgender grounds:

> *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:*
>
> *(a) who identifies as a member of the opposite sex by living, or seeking to live, as a member of the opposite sex, or*
>
> *(b) who has identified as a member of the opposite sex by living as a member of the opposite sex, or*
>
> *(c) who, being of indeterminate sex, identifies as a member of a particular sex by living as a member of that sex,*
>
> *and includes a reference to the person being thought of as a transgender person, whether the person is, or was, in fact a transgender person.*

We have never been able to obtain any clarity about how this is supposed to apply to people with innate variations of sex characteristics, particularly given that we are registered female or male at birth and many (likely most) of us live in line with sex registered at birth.[51] This cohort is not afforded protections, as it is difficult to see how any transgender status might apply.

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[49] Jones et al (n 2).

[50] NSW Law Reform Commission, *Review of the Anti-Discrimination Act 1977 (NSW) Consultation Paper* (May 2025).

[51] Paulo Sampaio Furtado et al, ‘Gender Dysphoria Associated with Disorders of Sex Development’ (2012) 9 *Nature Reviews Urology* 620.

The Anti-Discrimination NSW takes the current situation to be one where people with innate variations of sex characteristics are not protected, and it has done so since at least 2012.[52]

5 Should intersex people be protected on grounds of sex characteristics or intersex status?

At present, the Commonwealth and South Australia seek to protect people with innate variations of sex characteristics from discrimination on grounds of intersex status, ACT,[53] Victoria,[54] Queensland[55] and Northern Territory[56] have implemented protections on grounds of sex characteristics, and Tasmania offers protections on grounds of "intersex variations of sex characteristics".[57]

Federal protections were introduced in a 2013 amendment to the Sex Discrimination Act.[58] While this was a very positive development at the time, the utility of the protections has unfortunately been limited. The attribute "intersex status" is defined in purely biological terms, and the language is unfortunately based around deficits. The attribute 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.*[59]

Our primary concern is that these actual definitions in the Act have generally been disregarded in widespread framings of intersex as a matter of personal identification; this is associated with ideas that intersex people do not identify as either female or male.

These framings are unhelpful; they fail to respect the heterogeneity of people with innate variations of sex characteristics and the diversity of identities amongst individuals with age and agency to express an identity. These misconceptions have led us to foreground alternative language such as "innate variations of sex characteristics" as this language cannot so easily be reduced to matters of personal identification.

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[52] 'Submission and Speech Received from OII Australia'Letter from Stepan Kerkyasharian and Anti-Discrimination Board of New South Wales, 20 March 2012.

[53] *Justice Legislation Amendment Act 2020 2020*.

[54] *Equal Opportunity Act 2010 No. 16 of 2010 2010*.

[55] *Anti-Discrimination Act 1991 2025*.

[56] Chansey Paech, Anti-Discrimination Amendment Bill 2022 2022.

[57] Parliament of Tasmania, Justice and Related Legislation (Marriage Amendments) Act 2018 2019.

[58] *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013 2013*.

[59] *Sex Discrimination Act 1984 2013* Version of 18 June 2015, with amendments up to Act No. 59, 2015.

In comparison to “intersex status”, “sex characteristics” has additional advantages from our perspective, in addition to being more challenging to reduce to matters of identity:

- No individual would need to associate with the term intersex in order to avail of protections.
- While this is partially dependent on the nature of any complaint, individuals are less likely to need to disclose a diagnosis or otherwise “out” themselves as having an innate variation of sex characteristics.

These issues were evident by 2016, when the South Australian government enacted protections on grounds of intersex status, but our proposal at that time for the Weatherill government to enact protections on grounds of sex characteristics was not successful. All jurisdictions that have amended anti-discrimination legislation since this time to provide new protections for our population have done so under the ground of sex characteristics.

Tasmanian reforms unfortunately refer to “intersex variations of sex characteristics” and fail to define the term intersex, and so are unlikely to provide useful protections.

When he was the federal Minister for Employment and Workplace Relations, the Hon. Tony Burke MP made a commitment to update federal protections from “intersex status” to “sex characteristics”, on 10 November 2022.[60] The debate saw the Albanese first term government vote against a proposal by independents to change the attribute of “intersex status”, as was then proposed in the Fair Work Act, to “sex characteristics”, but Minister Burke concluded with an expression of government support for systemic reform. The debate illustrates an unfortunate conflation of intersex with identity, which reinforces our preference for reform:

> *Mr Wilkie (10:23): [...] These amendments quite simply replace the words 'intersex status' with 'sex characteristics' in the Fair Work Legislation Amendment (Secure Jobs, Better Pay) Bill 2022.*
>
> *[...] these amendments would protect all people with variations of their sex characteristics, not just people who identify as intersex*
>
> *Minister Burke (10:29): [...] My response to these amendments is probably quite different to how I've responded to any of the other amendments in that these amendments are actually seeking to do something that I originally requested during the drafting stage of this bill. The explanation that the member for Clark gave of the process and the interaction with the Sex Discrimination Act was a problem that I was presented with, and the reason why we can't support these amendments in this form.*
>
> *In the first instance, I want to make clear the government makes no argument of principle in any way against any of the two contributions that were just made by*

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[60] ‘BILLS - Fair Work Legislation Amendment (Secure Jobs, Better Pay) Bill 2022 - Consideration in Detail’ <https://www.aph.gov.au/Parliamentary_Business/Hansard/Hansard_Display?bid=chamber/hansardr/26230/&sid=0021>.

> *the member for Clark and the member for Brisbane. In the second instance, the intention to get best-practice language here so that people are properly covered is a commitment that is shared by those who've spoken with the government.*
>
> *Before I knew this amendment was coming—this was during the drafting stages—as soon as I hit this problem of the interaction with the Sex Discrimination Act I raised the issue personally with the Attorney-General, because it was the Attorney-General's Department that had raised it with my department. The intention was made clear to me then, by the Attorney-General, that the government does intend to bring in legislation that will deal with this issue across all relevant legislation at once. Being able to do that avoids any problems with the different parts of legislation not interacting properly.*
>
> *It's a strange one in terms of saying that we won't support the amendments, but it's on the basis that we accept completely the arguments that have been put and want to be able to bring forward government legislation that addresses it consistently across all relevant acts.*[61]

It is our hope that this commitment will be implemented in this new federal term of government. We recommend that New South Wales legislate in line with the majority of other jurisdictions, and a commitment by the federal government.

The most recently enacted protections on grounds of sex characteristics were introduced in Queensland. We recommend implementation in line with the definitions introduced into that State's Anti-Discrimination Act:

> *sex characteristics, of a person, means the person's physical features and development related to the person's sex, and includes—*
>
> *(a) genitalia, gonads and other sexual and reproductive parts of the person's anatomy; and*
>
> *(b) the person's chromosomes, genes and hormones that are related to the person's sex; and*
>
> *(c) the person's secondary physical features emerging as a result of puberty.*[62]

6 Defining direct discrimination

As noted by the Law Reform Commission, introduction of protections on grounds of sex characteristics could cause complications if the comparator test is retained, as everyone has sex characteristics and it may be difficult to identify a suitable comparator.

We acknowledge these concerns, and support changes to the definition of direct discrimination, in line with what we regard as better practice definitions, as in the ACT and Victoria.

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[61] Ibid.

[62] *Anti-Discrimination Act 1991* (n 6).

7 Religious exemptions

The 2018 Expert Panel Report on Religious Freedoms[63] considered religious exemptions on grounds of intersex status and called for their removal in both employment and discrimination against students. The Expert Panel bracketed intersex status with race, disability and pregnancy; it did not bracket intersex status with sexual orientation and gender identity:

> *Recommendation 6 Jurisdictions should abolish any exceptions to anti-discrimination laws that provide for discrimination by religious schools in employment on the basis of race, disability, pregnancy or intersex status. Further, jurisdictions should ensure that any exceptions for religious schools do not permit discrimination against an existing employee solely on the basis that the employee has entered into a marriage.*
>
> *Recommendation 8 Jurisdictions should abolish any exceptions to anti-discrimination laws that provide for discrimination by religious schools with respect to students on the basis of race, disability, pregnancy or intersex status.*[64]

We welcomed these recommendations. In our view, it would be a perverse outcome for religious exemptions to be considered differently for "sex characteristics".

Only South Australia has enacted religious exemptions on grounds of intersex status or sex characteristics. We have brought this anomaly, and the recommendations of the Expert Panel, to the attention of the South Australian government. We expect the Expert Panel report was considered by the South Australian government at the time of publication. No proposals have yet been brought forward to eliminate these exemptions.

8 Sport exemptions

We recommend against introducing any exemptions on grounds of sex characteristics (or intersex status) in sport. No jurisdiction in Australia has introduced such exemptions on grounds of sex characteristics.

Some sporting organisations seek to implement regulations preventing people with particular kinds of innate or acquired sex characteristics from competing in sport. Some women with innate variations of sex characteristics who were registered female at birth have a Y chromosome and may find themselves the subject of some of these regulations. Other women with innate variations of sex characteristics who were registered female at birth are not directly impacted, for example, if they have only X sex chromosomes. (We further note that men irrespective of birth registration are not

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[63] Philip Ruddock et al, *Religious Freedom Review: Report of the Expert Panel* (2018) <https://www.ag.gov.au/rights-and-protections/publications/expert-panel-report-religious-freedom-review>.

[64] Ibid.

subject of any such regulations, and non-binary people are impacted variably depending on birth registration and medical interventions.)

In recent weeks and months, World Athletics has proposed the reintroduction of genetic testing for all women athletes. This was last abandoned ahead of the 2000 Olympics in Sydney, due to its adverse impacts on women registered female at birth.[65] Adverse impacts are well documented on athletes affected by World Athletics regulations since their reintroduction.[66]

Intersex community-controlled organisations and clinical organisations oppose the introduction by World Athletics of genetic screening aimed at excluding many women, registered female at birth, with innate variations of sex characteristics. Both InterAction and the Australia and New Zealand Society for Paediatric Endocrinology and Diabetes (ANZSPED) wrote to World Athletics opposing the introduction of testing for the SRY gene.[67] This follows complementary journal articles addressing the harms of overly narrow constructions of sex in ways that effectively reclassify women registered female at birth out of the female category.[68]

More recently, the Australian scientist who discovered the SRY gene, Andrew Sinclair at MCRI in Melbourne, has written in The Conversation opposing the use of this gene in testing to exclude women with an SRY gene, noting that sex characteristics are more complex than can be determined by a single test.[69]

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[65] Simpson J et al, ‘Gender Verification in the Olympics’ (2000) 284(12) *JAMA* 1568; Louis J Elsas et al, ‘Gender Verification of Female Athletes’ (2000) 2(4) *Genetics in Medicine* 249; Genel M, Simpson J, and de la Chapelle A, ‘The Olympic Games and Athletic Sex Assignment’ [2016] *JAMA*.

[66] Human Rights Watch, *‘They’re Chasing Us Away from Sport’ Human Rights Violations in Sex Testing of Elite Women Athletes* (Human Rights Watch, 2020) <https://www.hrw.org/report/2020/12/04/theyre-chasing-us-away-sport/human-rights-violations-sex-testing-elite-women>.

[67] InterAction for Health and Human Rights, *Submission on Proposed Guidelines for Women with “DSDs” and Gender Diverse Women* (18 February 2025) <https://interaction.org.au/41693/submission-world-athletics-2025/>; Australia and New Zealand Society for Paediatric Endocrinology and Diabetes, *Response to World Athletics Re Sex Differentiation* (2025) <https://media.anzsped.org/2025/03/24155441/o_25_02-World-Athletics-response-re-Sex-differentiation.pdf>.

[68] Katrina Karkazis and Morgan Carpenter, ‘Impossible “Choices”: The Inherent Harms of Regulating Women’s Testosterone in Sport’ (2018) 15(4) *Journal of Bioethical Inquiry* 579; Morgan Carpenter, ‘Caster Semenya’s Life and Achievements Are Cause for Celebration, Respect and Inclusion; Her Exclusion Is Consequential’ (2020) 46(9) *Journal of Medical Ethics* 593; Hilary Bowman-Smart et al, ‘Sex Selection and Non-Invasive Prenatal Testing: A Review of Current Practices, Evidence, and Ethical Issues’ (2020) 40(4) *Prenatal Diagnosis* 398 (‘Sex Selection and Non-Invasive Prenatal Testing’); Morgan Carpenter, ‘Is It Ever OK to Reclassify Someone Out of Their Birth-Observed Sex Without Personal Consent? How Do We Manage Competing Methods of Classifying Sex?’ (2024) 24(11) *The American Journal of Bioethics* 18 (‘Is It Ever OK to Reclassify Someone Out of Their Birth-Observed Sex Without Personal Consent?’).

[69] Andrew Sinclair, ‘World Athletics’ Mandatory Genetic Test for Women Athletes Is Misguided. I Should Know – I Discovered the Relevant Gene in 1990’, *The Conversation* (online, 4 August 2025) <http://theconversation.com/world-athletics-mandatory-genetic-test-for-women-athletes-is-misguided-i-should-know-i-discovered-the-relevant-gene-in-1990-262367>.

Contemporaneously, the European Court of Human Rights has found in favour of South African athlete Caster Semenya.[70] The case began in the Court of Arbitration for Sport (CAS), before heading to a Swiss Federal Supreme Court on appeal. Although the European Court's finding focused on procedural failings, it expressed concern about an unequal relationship between athletes and regulatory bodies in sport, and found that sport regulations considered by CAS have never been adequately assessed for their impact on athlete privacy, nor for their necessity or proportionality.

In our view, women registered female at birth should always be able to play sport and compete in sport as women. To do otherwise is to reclassify them without their consent.

Further, we believe that institutions willing to contemplate the reclassification out of the female category of women in sport will be willing to do this in other spheres of life. This raises profound human rights concerns.

9 Consistency with criminal law

Recent reforms provide for some protections against vilification on grounds of "intersex status". We prefer that this be updated to provide protections on grounds of "sex characteristics", consistent with our recommendations for reform to the ADA.

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[70] International Commission of Jurists, OII Europe, and ILGA-Europe, 'ECtHR Grand Chamber Ruling in Semenya v. Switzerland: Joint Statement of Third-Party Interveners | ICJ', *International Commission of Jurists* (10 July 2025) <https://www.icj.org/ecthr-grand-chamber-ruling-in-semenya-v-switzerland-joint-statement-of-third-party-interveners/> ('ECtHR Grand Chamber Ruling in Semenya v. Switzerland').