From Re Carla to an emerging ‘Australian model’

How NSW should legislate to protect the bodily integrity of children born with variations of sex characteristics

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SUMMARY

Violations of the right to bodily integrity of children born with variations of sex characteristics are one of the most important human rights issues in Australia today.

This Position Paper begins by analysing Re Carla, in which the Family Court not only authorised a deferrable surgical procedure on a child with an innate variation of sex characteristics, it also abdicated its oversight responsibility in relation to similar procedures in future. This case remains an accurate reflection of the law in NSW today.

The rationale for legislative change is then provided with reference to three seminal reports, by the Senate Community Affairs References Committee in 2013, the Australian Human Rights Commission in 2021, and Equality Australia in 2025.

Lawrie A. (2026) From Re Carla to an emerging ‘Australian model’: How NSW should legislate to protect the bodily integrity of children born with variations of sex characteristics, Justice Ideas Vol 2025(2). Sydney: Law and Justice Foundation of NSW.

ISSN: 2982-3951

This publication was developed as part of the 2025 Law and Justice Foundation of New South Wales Justice Fellowship Program. The project was undertaken with funding and support from the Foundation. The views expressed in this publication are those of the author and do not necessarily reflect the views of the Foundation. The Foundation supports the dissemination of independent research and encourages robust debate to advance access to justice.

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The Position Paper then examines the laws of six European jurisdictions that have adopted regulatory frameworks on this topic, including their strengths and weaknesses, before doing the same in relation to the two domestic laws passed to date:

- The *Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023* (ACT), and
- The *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026* (Vic).

Similarities between the ACT and Victorian schemes help to create an emerging 'Australian model' to the issue of regulating interventions on children with innate variations of sex characteristics, although there are also some key differences, including on extra-territorial application.

The Position Paper concludes by discussing the need for criminalisation of legislative breaches, why guidelines alone are insufficient and the importance of redress for harmful practices, before making three recommendations to the NSW Government for urgent action.

RE CARLA – COURT AUTHORISATION AND ABDICATION

The 2016 Family Court case of 'Re Carla' *(Re Carla (Medical Procedure)* [2016] FamCA 7) perhaps best encapsulates the law's failure to act in the best interests of Australian children born with variations of sex characteristics (often referred to as intersex[1] children).

Not only did the Family Court in this decision authorise violation of the right to bodily integrity of a child with an innate variation of sex characteristics, it then effectively abdicated any further responsibility in exercising oversight of invasive surgeries and other significant medical interventions performed on intersex children into the future.

The facts

The case of Re Carla (a pseudonym) concerned a five-year-old child who had been born with 17 beta hydroxysteroid dehydrogenase 3 deficiency ("17ß-HSD3"), a genetic variation in sex characteristics. This means that, while they were born with XY chromosomes, 'Carla had minimum in-utero exposure to androgens.'[2]

As described by the Australian Human Rights Commission, this meant 'Carla had … external sex characteristics that resembled those associated with girls. Carla had male gonads, but these were located internally in the intra-abdominal cavity.'[3]

In consultation with clinicians, Carla's parents then chose to raise Carla as a girl. Those same clinicians subsequently advised that Carla should, around the age of the case, be subjected to a gonadectomy (the bilateral removal of Carla's male gonads).

1 Intersex people have innate sex characteristics that don't fit medical and social norms for female or male bodies.
2 Re Carla (Medical Procedure) [2016] FamCA 7, at 1.
3 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, p133. [NB Disclosure: the author made a personal submission to this review process.]

Carla's parents agreed with this approach and, following legal advice, sought the Family Court's approval for this procedure, as well as 'such further or other necessary and consequential procedures' that their clinicians recommended.

Serious, life-long consequences

It is obvious that Court approval of this approach would result in a range of serious, life-long consequences for Carla. This includes infertility – a gonadectomy is a sterilising procedure that would deny Carla the ability to have genetic children in future.

This medical imposition would also have a range of flow-on consequences, as noted in the decision:[4]

> *It is then proposed that in the future, as Carla approaches the age of 12, that exogenous oestrogen be administered to her[5] in increasing doses over approximately two years to induce female pubertal development… Carla would then require lifelong oestrogen replacement.*

Other consequences include possible future misalignment between the body that clinicians had chosen for them – effectively determining that they are, and will be in the future, female – and their gender identity, should Carla determine for themselves at or post-adolescence that they are male (and facing significant challenges to undergo gender-affirming surgery at that point because of those earlier interventions).[6]

But even if Carla does identify as female, their rights will still have been violated – as clinicians will have determined for them what their body 'should' look like, while denying their ability to decide what female means to them, including whether to have treatment at all.

A lack of consent

Given these serious, life-long consequences, Carla should have been afforded the opportunity to consent, or not consent, to these procedures, a right to bodily autonomy that endosex[7] people commonly enjoy. At five years old, Carla was too young to understand what was being proposed (falling well short of *Gillick* competency),[8] and therefore too young to consent.

In such circumstances, a reasonable approach would be to defer surgical intervention until a later time when Carla would be in a position to understand the procedure(s), and to consent or not consent.

Indeed, this was explicitly contemplated in the decision:[9]

4 Re Carla (Medical Procedure) [2016] FamCA 7, at 18.
5 The court decision uses she/her pronouns, however elsewhere I will only use gender-neutral language.
6 As well as assuming that they will be a heterosexual female, with a further comment that 'Carla may also require other surgery in the future to enable her vaginal cavity to have adequate capacity for sexual intercourse' (which presupposes a particular kind of sexual intercourse): Re Carla (Medical Procedure) [2016] FamCA 7, at 18.
7 Endosex people have innate sex characteristics that do fit medical and social norms for female or male bodies, that is, it is an antonym for intersex.
8 'Gillick competency' refers to the principles used to assess whether a minor has the required maturity to consent to medical treatment. Originating in a UK decision (Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 (House of Lords)), it is nevertheless influential in Australia jurisprudence.
9 Re Carla (Medical Procedure) [2016] FamCA 7, at 24.

> *Dr C does report that "in theory" male puberty could be suppressed hormonally in Carla to prevent any virilisation until Carla was older and could give informed consent to treatment. However, this would require at least three monthly injections of depot Lucrin intramuscularly, three monthly medical reviews and any female pubertal development would thereby be necessarily delayed until her testes were removed and pubertal suppression could be ceased.*

This reasoning – that frequent injections and medical appointments between the age of five and the onset of puberty, to allow Carla to develop the mental capacity to consent (or not) for themself, was too high of a burden – does not withstand scrutiny given performing the procedure would itself lead to life-long hormone treatments, and likely other ongoing medical interventions.

Rather than pursue deferral, the Court instead gave weight to arguments that it would be preferable to intervene now precisely because it would mean that Carla would be unaware of what was being done to them:[10]

> *The medical evidence recommends that the procedure be performed prior to Carla commencing puberty and supports the position that there is no reason to delay the procedure especially given that 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*** *[emphasis added].*

A lack of 'necessity'

Given the serious, life-long consequences of performing surgery on a five-year-old, and the Court's decision to ignore the legitimate possibility of deferral until such time as Carla could consent for themselves, perhaps the only arguable reason left to permit such an intervention is urgent medical necessity.

The evidence for this necessity would need to be clear, satisfying both limbs – that it was both necessary for the health of the patient, and that it was so urgent it could not wait.

Unfortunately, here too the case for intervention fails. An attempted argument for necessity is found at paragraph 19 of the judgment:[11]

> *Given the positioning of Carla's gonads in the intra-abdominal cavity, if the procedure does not take place and they are not removed, there is a risk of transformation in to germ cell malignancy in the short, medium and long term. Dr C reports that the Consensus Statement for Management of Disorders of Sexual Development[12] puts the risk of germ cell malignancy at 28% for Carla's condition. That is said to be an intermediate level of risk of malignancy. Performing the proposed procedure would remove the risk of tumour development in the testes. This is one of, if not the major reason for undertaking the proposed procedure.*

10 Re Carla (Medical Procedure) [2016] FamCA 7, at 30.
11 Re Carla (Medical Procedure) [2016] FamCA 7, at 19.
12 The term 'disorders of sex development', often abbreviated to DSD, is considered stigmatising to many people with innate variations of sex characteristics, and is avoided in this Position Paper outside of titles, quotes or references.

However, as highlighted by InterAction for Health and Human Rights in their own analysis of this case,[13] 'clinicians in the case cited old data on cancer risks... and the cited data (Hughes et al) actually recommends the action of 'monitoring' gonads, not removing them.'

The Australian Human Rights Commission highlighted similar criticisms of the medical necessity for surgery:[14]

> *One of Carla's treating clinicians cited the 2006 Consensus Statement to describe the risk of malignancy. It was their evidence that the Consensus Statement rated Carla's risk as an 'intermediate level' of risk, cited as 28%, and that surgery was thus recommended. However, this recommendation does not conform to the Consensus Statement, which states that in the case of 17ß-HSD3, the gonads should be monitored, not removed, and that the risk based on an individual assessment of the child may be significantly lower than the quoted rate. Additionally, the version of the Consensus Statement relied upon by the experts in Re Carla was outdated, particularly with regard to data on malignancy rates for children with 17ß-HSD3. More recent research, which was quoted in the 2013 Senate Report and so presumably would have been available to Carla's doctors, placed the risk of cancer for children with 17ß-HSD3 at 17%. Further, diagnostic techniques allow an individualised risk assessment to be carried out, based on observation of specific immunehistochemical markers, rather than assuming that every child with 17ß-HSD3 has a 17% risk of cancer.*

Not only was the risk of cancer lower than claimed, but according to the clinicians' own reference source, surgery was not necessary, or even the medically recommended course of action.

The role of non-medical rationales

In the absence of medical rationales, what then provided the impetus for a push to perform invasive surgery on a five-year-old child?

Based on the decision itself, it is clear that gender stereotypes, as well as societal and especially clinical conceptions of what 'normal' and therefore 'abnormal' male and female bodies look like, played oversized roles.

This includes the gender-related evidence described in paragraph 15 of the decision:[15]

> *In 2014, when Carla was almost four years of age, she was reviewed by Dr S who formed the opinion that Carla had developed a female gender identity and identified as a female and that this was unlikely to change in the future. Dr S formed this opinion based on the following observations:*
>
> *a. Her parents were able to describe a clear, consistent development of a female gender identity;*

13 Carpenter, Morgan, 'Family Court case: Re Carla (Medical Procedure) [2016] FamCA 7', 8 December 2016, available at: https://interaction.org.au/resource/re-carla-family-court/

14 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, pp74-75.

15 Re Carla (Medical Procedure) [2016] FamCA 7, at 15.

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.*

It is apparent that many, if not most of these factors, are dependent on either the parents' descriptions of Carla, or heavily influenced by their decisions (including what clothing and toys they purchased for them, and what interests they encouraged). This is not surprising, based on the evidence described earlier that they had chosen to raise Carla as a girl following clinicians' advice.

What is surprising, however, is that this evidence – about a *three-year-old* at the time of assessment by Dr S – should be employed to justify the sterilisation and life-long medicalisation of a *five-year-old* (by the time of the decision).

After all, even if Carla's gender identity is indeed female, that would not provide a sound rationale for performing gender-affirming surgery at such a young age, that could instead be deferred until much later, with the provision of puberty blockers if the child required more time to attain *Gillick* competence and consent or otherwise to these significant and non-reversible interventions. That option, which is the standard of care for trans and gender diverse children, was denied to Carla as a child born with a variation of sex characteristics.

Court authorised denial of the right to bodily integrity

The case of Re Carla confirms a precedent in authorising invasive surgery on a child who was born with a variation of sex characteristics, causing sterilisation and a range of other serious, life-long consequences (such as the need for hormone treatment from puberty onwards, as well as the potential for a range of other surgeries and interventions).

This authorisation was provided in the absence of consent from the child, and even more importantly in the absence of clear, urgent medical necessity. Instead, the decision reveals the key role that gender stereotypes and expectations played in 'justifying' such surgery on a five-year-old.

The decision of Re Carla remains an accurate summation of the law in any Australian jurisdiction that has not introduced legislation to regulate surgeries and other medical interventions on children with innate variations of sex characteristics.

As we shall see below, as at May 2026, only one territory (the Australian Capital Territory (ACT)) and one State (Victoria) has done so, meaning Re Carla describes the situation in New South Wales and elsewhere.

Court abdication of oversight of similar cases

If that was the extent of the decision in Re Carla, it would be bad enough. But then, at the request of the lawyers representing Carla's parents, the Court went even further.

The Court effectively overturned a previous precedent – in the decision of *Re Lesley,*[16] which had 'almost identical factual circumstances' as the case of Re Carla, and which itself applied the broader principles of the High Court's 1992 decision in *Marion's* case[17] – that required court oversight and approval for similar procedures.

Instead, the Court held that, while it had the inherent power to authorise invasive surgeries that resulted in sterilisation, its approval was not *required*, because:[18]

> *I consider the proposed medical treatment 'therapeutic' as being necessary to appropriately and proportionately treat a genetic bodily malfunction that, untreated, poses real and not insubstantial risks to the child's physical and emotional health.*
>
> *It follows that I do not consider this a case where the decision to authorise the medical procedures that Carla is proposed to be subject to, is one that falls outside the bounds of permissible parental authority as determined by the High Court in Marion's case. As such, I do not consider this to be a case of a decision actually requiring Court sanction.*

In reaching this conclusion, the Court was overly dismissive of McHugh J's observations in *Marion's* case that:

> *If there is any real possibility that, at some future time, the child will acquire the capacity and maturity to choose whether he or she should be sterilised, the carrying out of that procedure cannot be in the best interests of the child unless, of course, protection of the child's health urgently requires that the procedure be carried out during incompetency.*

Instead, the Court in Re Carla determined that, despite the possibility of invasive surgery being deferred until later, not only was it imperative that this surgery 'should be carried out before the onset of pubertal changes in order to ameliorate real and not insubstantial risks to Carla's physical and emotional health',[19] whether this surgery was performed at all was really none of the Court's business.

In practice, parents now have the legal right to consent to sterilisation of their child, based on the advice of treating clinicians, and with no oversight by the courts. Re Carla therefore demonstrates the courts abdicating even a minimum amount of scrutiny of and accountability for the medical profession.

Indeed, casual references in the decision itself reveal this oversight-free framework was already effectively in place, with no attempt to interrogate that '[s]urgery already performed on Carla has ***enhanced the appearance of her female genitalia***'[20] [emphasis added]. This was

16 Re Lesley (Special Medical Procedure) [2008] FamCA 1226.
17 Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218.
18 Re Carla (Medical Procedure) [2016] FamCA 7, at 52-53.
19 Re Carla (Medical Procedure) [2016] FamCA 7, at 51.
20 Re Carla (Medical Procedure) [2016] FamCA 7, at 2.

apparently a 2014 operation (when Carla was three or four) in which Dr B 'performed a 'clitoral' recession and labioplasty to feminise Carla's external appearance'.[21]

Surgeries on a three- or four-year-old to 'enhance the appearance of genitalia', and feminise their appearance, were not considered sufficiently important to scrutinise, so perhaps it is not surprising that the Court would approve sterilisation with serious life-long consequences.

But just because this outcome is not surprising, does not mean the case of Re Carla is not shocking – and a compelling argument for legal reform on this human rights issue.

INTRODUCTION

This Position Paper started by analysing the case of Re Carla because it describes the current legal situation for children born with variations of sex characteristics in most Australian jurisdictions, including NSW, and highlights the ways in which the law permits serious human rights violations against these children.

It has been prepared as part of a Justice Fellowship, funded by the Law and Justice Foundation NSW, to research this legal problem, and propose appropriate solutions. The specific topic chosen for this research was *'A best practice approach to NSW legislation protecting children born with variations of sex characteristics'*.

Methodology

Preliminary research for this project commenced in November 2025, with the project itself being undertaken in proper between February and May 2026. This research included desktop reviews of:

- international legal approaches to protecting children born with variations of sex characteristics, with a particular focus on Malta, Portugal, Iceland, Germany, Greece and Spain
- the ACT *Variation in Sex Characteristics (Restricted Medical Treatment) Act 2023*, and sub-ordinate legislation
- the Victorian *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026*, and
- relevant case law, including *Re Carla (Medical procedure)* [2016] FamCA 7.

The financial support of the Law and Justice Foundation NSW allowed the author to engage in a research trip to Melbourne in March 2026, to seek the perspectives of key informants on the *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026*. This involved drawing on the expertise of a range of people to clarify relevant issues, and discuss the findings that emerged during the project, and included:

- The Victorian Commissioner for LGBTIQA+ Communities, Joe Ball
- A manager in the Victorian Department of Health program area responsible for developing the legislation
- An adviser to the Victorian Minister for Equality, the Hon Vicki Ward

21 Re Carla (Medical Procedure) [2016] FamCA 7, at 16.

- Leading long-standing Victorian intersex advocate Tony Briffa
- Victorian LGBTIQA+ Taskforce Member, Sean Mulcahy, and
- Executive Director of leading Australian intersex advocacy organisation InterAction for Health and Human Rights, Associate Professor Morgan Carpenter.

Relevantly, the author was appointed to the NSW Department of Health Innate Variations of Sex Characteristics Community Advisory Group in October 2025, attending its first two meetings in November and December 2025.[22] And he met with an adviser to NSW Health Minister, the Hon Ryan Park, and NSW Health Department officials, in March 2026, to discuss the need for legislative reform.[23]

Amendment to Project Scope

The author's membership of the NSW Health Department's Innate Variations of Sex Characteristics Community Advisory Group, and meeting with NSW Health staff, led to a variation in the project's scope.

This was because it became apparent that, in addition to examining what a best practice legislative approach to protecting children born with variations of sex characteristics might look like in NSW, there remains a lack of official agreement that a legislative response to this issue is actually needed.

Therefore, the Position Paper now spends more time making the broader case for legislative intervention to protect intersex children than was initially envisaged, while still seeking to outline what the major features of any legislation should incorporate.

Outline of Position Paper

The remainder of this Position Paper aims to achieve both of these objectives: making the case for legislative intervention; and examining what best practice legislation might look like.

In the following section, it reviews three leading publications in Australia, released between 2013 and 2025, that each confirm human rights violations against children born with variations of sex characteristics are ongoing, with the corresponding need for government intervention.

The Position Paper then looks at international approaches to this problem, including in the countries of Malta, Portugal, Iceland, Germany, Greece and Spain, as well as guidance issued by international human rights institutions.

It then turns to the existing domestic legislative approaches in the ACT (*Variation in Sex Characteristics (Restricted Medical Treatment) Act 2023*) and Victoria (*Health Safeguards for People Born with Variations in Sex Characteristics Act 2026*). This section outlines the major features of each, including key strengths and weaknesses.

Three particular questions arise from this analysis, warranting more detailed discussion:

- Why is criminalisation necessary?

22 No subsequent meetings have been held as at the date of submission for publication (June 2026).
23 Alongside Morgan Carpenter and other lived experience advocates.

- Why aren't guidelines sufficient? and
- What about redress for harmful practices?

The Position Paper then concludes by describing what a best practice legislative scheme in NSW should look like, so that no child experiences the same denial of the right to bodily integrity that Carla did.

VIOLATIONS AGAINST CHILDREN BORN WITH VARIATIONS OF SEX CHARACTERISTICS ARE ONGOING, AND NEED GOVERNMENT ACTION

The case of Re Carla is by no means atypical in how medical practitioners have denied the right to bodily integrity to children born with variations of sex characteristics. Indeed, the facts of that case are not dissimilar to several other cases which have also been considered by Australian courts.[24]

Beyond litigation, however, are the stories of intersex people themselves[25] who report their own mistreatment by medical practitioners engaging in surgeries and other interventions (like hormone treatments) before they were able to consent, and without clear and urgent medical necessity.

These experiences have motivated the intersex community, and its advocacy organisations like InterAction for Health and Human Rights (formerly Intersex Human Rights Australia, and before that Organisation Intersex International Australia), to consistently call for an end to these practices.

This includes through the Darlington Statement, a joint consensus statement by Australia and Aotearoa/New Zealand intersex organisations and advocates, adopted in March 2017.[26]

The Darlington Statement not only asserts '[o]ur rights to ***bodily integrity, physical autonomy and self determination'*** [emphasis in original],[27] but also calls for:[28]

> *the immediate **prohibition as a criminal act** of deferrable medical interventions, including surgical and hormonal interventions, that alter the sex characteristics of infants and children without personal consent. We call for freely-given and fully informed consent by individuals, with individuals and families having mandatory independent access to funded counselling and peer support [emphasis in original].*

However, the intersex community is not alone in drawing attention to the human rights abuses involved in medical interventions on children born with variations of sex characteristics,

24 Cases include: Re Welfare of a Child A (1993) 16 Fam LR 715; Re Sally [2010] FamCA 237; Re Sean and Russell (2010) 44 Fam LR 210; Re Dylan [2014] Fam CA 969; Re Sarah [2014] FamCA 208; and Re Kaitlin [2017] FamCA 83.
25 See for example 'Unspoken: A collection of untold intersex stories', 2017, published on InterAction website: https://interaction.org.au/resource/unspoken-a-collection-of-untold-intersex-stories/
26 Darlington Statement, Joint consensus statement from the intersex community retreat in Darlington, March 2017, text available at: https://darlington.org.au/statement/ [NB Disclosure: the author has affirmed the Darlington Statement via this website.]
27 Ibid, clause 5.
28 Ibid, clause 7.

or in asserting the need for government action to end these violations. Three seminal reports, released in 2013, 2021 and 2025, highlight both points.

The Senate Community Affairs References Committee Report: 'Involuntary or coerced sterilisation of intersex people in Australia', released October 2013[29]

This Senate Committee inquiry was a ground-breaking process, bringing concerns about violations of bodily integrity of intersex children before parliamentarians. Its final report is a historic document in the decades-long push for improved regulation of these practices.

Reflecting on ten years having elapsed since the report was handed down, InterAction noted that: '[a]s we understand it, this was the first parliamentary inquiry into intersex health and human rights anywhere in the world, and it should be celebrated for this',[30] before summarising some of its key findings as follows:[31]

- *The Committee dismissed claims that surgeries on infants and children to ensure social and familial integration are appropriate, and recognised their basis in the stigmatisation of bodily diversity.*
- *It presented a strong analysis of often poorly evidenced claims about cancer risks of gonads. It criticised the intertwining of cancer rationales with psychosocial rationales. That analysis is only reinforced by new evidence that risks associated with partial androgen insensitivity have been exaggerated.*
- *The Committee made recommendations calling for independent oversight of medical interventions on infants and children with intersex variations, to ensure that they conform to established human rights norms.*

In recommending that guidelines be developed to 'ensure treatment is managed by multidisciplinary teams within a human rights framework', the Committee noted that: '[t]he guidelines should favour deferral of normalising treatment until the person can give fully informed consent, and seek to minimise surgical intervention on infants undertaken for primarily psychosocial reasons.'[32]

Some of the evidence considered by the Committee also reinforces the view, discussed in the analysis of Re Carla above, that decision-making on whether to perform surgery or not is often dictated by gender stereotypes, rather than medical necessity:[33]

> *Australian culture currently has strong expectations of 'binary' gender, expecting people to appear 'normal' and to either be male or female. This attitude is evident in the introduction to a chapter in the current medical reference text on intersex, written by Australian medical practitioners:*

29 Senate Community Affairs References Committee, Report: 'Involuntary or coerced sterilisation of intersex people in Australia', October 2013, available at: https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/involuntary_sterilisation/sec_report/index [NB Disclosure: the author made a personal submission to this inquiry.]
30 InterAction, Media Release: 'Ten years since the first Parliamentary inquiry report on intersex health and wellbeing!', 25 October 2023, available at: https://interaction.org.au/40604/ten-years-parliamentary-inquiry/
31 Ibid.
32 Recommendation 3, Senate Community Affairs References Committee, Report: 'Involuntary or coerced sterilisation of intersex people in Australia', October 2013.
33 Senate Community Affairs References Committee, Report: 'Involuntary or coerced sterilisation of intersex people in Australia', October 2013, pp13-14.

> ***"Genital ambiguity in a baby is almost as devastating in the delivery room as a perinatal death."***[34]

> *... Given that some people with genital ambiguity do not require medical treatment in order to be healthy and thrive, the extraordinary statement in this reference text is cause for reflection on the way we consider intersexuality [sic].*[35] *If this sentence reflects the clinical and social environment into which intersex people are born, it is not surprising that both parents and doctors feel great pressure, and wish as quickly as possible to ensure they have a child that is 'normal', and in particular that gender conforms to sex or vice versa.*

Australian Human Rights Commission Report: 'Ensuring health and bodily integrity', released October 2021[36]

Despite the ground-breaking 2013 Senate Report, the following years saw little concrete action to end surgeries and other involuntary medical interventions on children born with variations of sex characteristics in Australia.

No government – at Commonwealth level, or in any of the States and Territories – implemented its recommendations in full in the following eight years, meaning that, perhaps inevitably, these human rights violations continued unabated.

Stepping into this void, the Australian Human Rights Commission (AHRC) undertook its own, even more comprehensive, human rights-based analysis of this situation, and released their 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics' report in October 2021.

The AHRC consulted widely, including with clinicians, the families of people with innate variations of sex characteristics and, appropriately, individuals with innate variations themselves. The Commission reported stories of mistreatment,[37] including noting that they:[38]

> *heard from people who had experienced a range of medical interventions without their consent. These include: surgical interventions intended to "normalise' the appearance of genitalia, such as surgeries to reduce the size of the clitoris (known as clitoridectomy or clitorectomy); other surgeries to modify female genitalia such as reducing the size or modifying the shape of the labia minora (labiaplasty); surgery on external female genitals, generally reducing the size or addressing the asymmetry of the labia minora (vulvoplasty), and surgery on an infant born with smaller than usual male genitalia (micropenis) to create the appearance of a female child by the construction of a vagina (vaginoplasty). The Commission was also told that people have been put on hormone treatment, to facilitate typical male or female sex development.*

34 Quote taken from John M. Huston, 'The neonate with ambiguous genitalia', in John M. Huston, Garry L. Warne and Sonia R. Glover (eds), Disorders of Sex Development: An Integrated Approach to Management, Springer-Verlag, Berlin, 2012, p103.
35 Intersexuality is not generally considered an accepted term to describe people with innate variations of sex characteristics.
36 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021.
37 See Chapter 3, Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021.
38 Ibid, p37.

The AHRC spent some time considering the framework for determining whether and in what circumstances interventions should be permitted, stating that:[39]

> *The Commission considers that legal principles, including those derived from and reflect[ing] international human rights law, … mean that medical interventions on children with variations in sex characteristics, where such interventions modify their sex characteristics, should be permissible only if all of the following factors are present:*
>
> - *the medical intervention is required urgently to avoid serious harm*
> - *the risk of harm cannot be mitigated in another less-intrusive way, and intervention cannot be further delayed [and]*
> - *the risk of harm outweighs the significant limitation on human rights that is occasioned by medical intervention without personal consent.*

This approach informed the wide-ranging recommendations of the AHRC, including that:

- *Law and practices concerning medical interventions to modify the sex characteristics of people with variations in sex characteristics should be guided by a human rights framework, based on [five] principles, including:*
  - *Bodily integrity principle*
  - *Children's agency principle*
  - *Precautionary principle*
  - *Medical necessity principle, and*
  - *Independent oversight principle,*[40]
- *New National Guidelines on medical interventions for people born with variations in sex characteristics… should set out what is required to obtain informed consent before performing a medical intervention*[41] *[and]*
- *Medical interventions modifying sex characteristics of children may be conducted without personal consent only in circumstances of medical necessity.*[42]

Of particular relevance for future developments (in both the ACT and Victoria, discussed in more detail below), Recommendation 7 of the AHRC report calls for the creation of independent oversight mechanisms to review and approve or reject medical interventions:

> a. *The Australian Government and state and territory governments should legislate to establish one or more independent panels with responsibility to decide whether to authorise medical interventions modifying sex characteristics of people under the age of 18 years born with variations (Independent panels).*
> b. *Whenever a clinician or clinical treatment team intends to make such a medical intervention, they should be required to apply to an Independent Panel prior to performing the intervention [and]*
> c. *Independent Panels should be constituted by members with expertise that includes relevant clinical expertise, lived experience of being born with variations in sex characteristics, and human rights.*

39 Ibid, p68.
40 Recommendation 1.
41 Recommendation 3.
42 Recommendation 4.

Finally, and pertinent to the discussion later in this Position Paper regarding whether criminalisation is needed, Recommendation 9 provided that:

> *The Australian Government and state and territory governments should legislate to prohibit medical interventions for people born with variations in sex characteristics otherwise than in accordance with Recommendations 7 [and 8]. There should be appropriate criminal penalties for breaching this legislative prohibition.*

Equality Australia's Report: 'The Missing Voice: A thematic analysis and stories of ongoing medical interventions on intersex children in Australia', December 2025[43]

Four years after the AHRC Report, and more than 12 years since the Senate Inquiry, 'The Missing Voice' report – prepared by Equality Australia in collaboration with InterAction for Health and Human Rights – once again confirmed that the rights of children born with variations of sex characteristics continue to be violated in Australia, and that government action is necessary.

Fortunately, in the four years since 'Ensuring Health and Bodily Integrity', an Australian jurisdiction had finally introduced a regulatory framework for medical interventions on intersex children (the ACT's *Variation in Sex Characteristics (Restricted Medical Treatment) Act 2023*, discussed in more detail below). While another jurisdiction had committed to doing likewise, namely Victoria.[44]

But 'The Missing Voice' report's findings remain acutely relevant to those jurisdictions, including New South Wales, that have yet to act. As noted in the foreword:[45]

> *Even with these partial insights [based on Freedom of Information materials], one message is unmistakable: what intersex advocates have said for decades is true.* ***Intersex children born today remain at risk of medical procedures that could be delayed, or avoided entirely, if stronger systems of oversight and support were in place*** *[emphasis in original].*

The main body of the report was based on Freedom of Information (FOI) requests to every major children's hospital in Australia, seeking documents about the medical procedures performed on the sex characteristics of intersex children.

Equality Australia received 248 documents in response to these requests, covering hospitals in Sydney, Brisbane, Melbourne, Adelaide and Hobart, although '[o]nly records from Sydney and Brisbane could be meaningfully analysed.'[46] Importantly, '***[t]hese are not historical accounts but recent cases, spanning 2018 to 2023'*** [emphasis in original].[47]

The findings drawing on those records that could be analysed were disturbing:[48]

43 Equality Australia, 'The Missing Voice: A thematic analysis and stories of ongoing medical interventions on intersex children in Australia', 1 December 2025, available at: https://equalityaustralia.org.au/resources/report-the-missing-voice/

44 With 'The Missing Voice' report a key piece of advocacy ahead of the passage of Victoria's own laws (the Health Safeguards for People Born with Variations in Sex Characteristics Act 2026).

45 Equality Australia, 'The Missing Voice: A thematic analysis and stories of ongoing medical interventions on intersex children in Australia', 1 December 2025, p4.

46 Ibid, p6.

47 Ibid.

48 Ibid, p7.

Of the 83 unique cases that were capable of being analysed across 97 documents from NSW and Queensland, we observed 109 instances of documented non-medical reasons or otherwise unbalanced considerations, namely:

- *Cosmetic preferences for how a child's body should look, prior to the age they can have a say in these decisions.*
- *A desire to 'confirm' or reinforce gender assignments made at birth.*
- *Unbalanced assessment [of] clinical risks, including where monitoring rather than surgery may have been possible, [and]*
- *Responding to parental distress and confusion.*

The fact these rationales continue to be deployed to help justify the violation of bodily integrity of children treated in Sydney is obviously of particular significance given this Position Paper's focus on a possible NSW regulatory approach.

In addition to this FOI data and its analysis, a perhaps even more powerful contribution of 'The Missing Voice' report is the publication of 11 lived experience stories of intersex people outlining their own mistreatment at the hands of medical practitioners. These case studies – from Jade, Stephanie Saal, Mimi Hall, Max, Sarah, Tony Briffa, David, Margie McCumstie, Michelle, Agli, and Eli[49] – provide real-world examples of the types of harms that continue to be inflicted.

Together, the FOI data and analysis, and these testimonies, make a compelling argument for regulation to protect children born with variations of sex characteristics, leading to Recommendation 1 of the Report's call for a legislative response:[50]

State and territory governments should introduce legislation to establish independent oversight frameworks for medical interventions performed on children and adults with innate variations of sex characteristics without the capacity to provide informed consent. Key features should include:

- *An independent oversight panel consisting of individuals with expertise in relevant clinical practice, law and human rights, ethics and lived experience, to review and approve proposed treatment plans, guided by clear assessment and approval criteria.*
- *A prohibition on medical treatment that modifies the sex characteristics of a protected person without their consent, except in an emergency or where an approved treatment plan is in place.*
- *Consistently applied and documented informed consent processes, that ensure intersex people and their families receive accurate, balanced and affirming information, including on access to peer and psychological support.*
- *Mandatory, standardised reporting obligations for hospitals and health services on all relevant medical interventions or other treatment plan decisions (eg deferred procedures).*

49 Ibid, pp28-36.
50 Ibid, p47.

Summary

All three reports, released over the span of a dozen years, provide compelling evidence that human rights violations against children born with variations of sex characteristics in Australia are ongoing, and that urgent government action is required.

But, the problem is not that these two facts are unknown.

The problem is not that intersex people have not spoken out enough about the traumas inflicted upon them, without their consent, or not advocated sufficiently for change.

The problem is not even that decision-makers are unaware of these issues, or the need for them to intervene – they could only be so if they were wilfully ignoring these reports, this data, and those stories.

No. The problem is simply that, in most Australian jurisdictions – including NSW – decision-makers have chosen not to act.

The remainder of this Position Paper turns to considering what such action should look like in the NSW context.

It does so by first examining relevant international examples of Governments prohibiting these interventions, before analysing the legislation passed by the ACT and Victoria in 2023 and 2026 respectively.

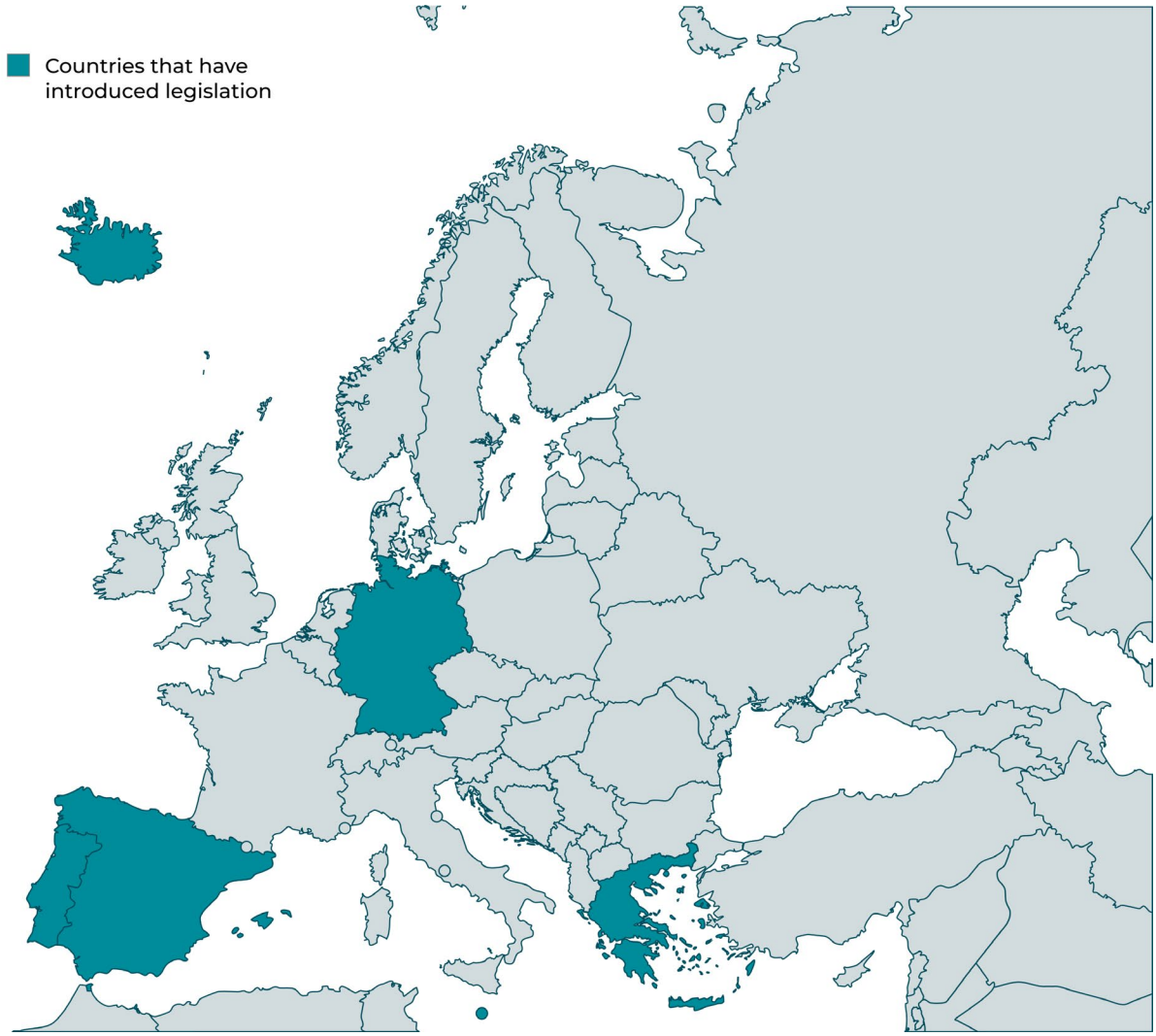
INTERNATIONAL APPROACHES[51]

It is not only jurisdictions within Australia that have been slow to take effective action to prohibit violations of the bodily integrity of children born with variations of sex characteristics. To date, only a small handful of other countries have introduced legislation of this kind, although international momentum is growing.

This section analyses how six countries, all within Europe, have attempted to address this issue, noting some of their key strengths and weaknesses – although this scrutiny is limited to desktop review.

51 [Disclosure: Preliminary research of the approach adopted in the six countries listed was conducted by Adam Hughes, a UNSW Global Student Fellow hosted by the Justice and Equity Centre, during December 2025 and January 2026.]

Figure 1: European countries that have introduced legislation to protect children with innate variations of sex characteristics



Malta, 2015

The first country in the world to introduce legislation to prohibit non-consensual 'normalising' surgeries and other unnecessary and involuntary medical interventions on intersex children was Malta, with the *Gender Identity, Gender Expression and Sex Characteristics Act (2015)*.

Significantly, Article 14(1) provides that:

> *[i]t shall be unlawful for medical practitioners or other professionals to conduct any sex assignment treatment and, or surgical intervention on the sex characteristics of a minor which treatment and, or intervention can be deferred until the person to be treated can provide informed consent:*
>
> *Provided that such sex assignment treatment and, or surgical intervention on the sex characteristics of the minor shall be conducted if the minor gives informed consent through the person exercising parental authority or the tutor of the minor.*

Although the legislation also establishes a carve-out that:

> *[i]n exceptional circumstances treatment may be effected once agreement is reached between the interdisciplinary team and the persons exercising parental authority or tutor of the minor who is still unable to provide consent*[52]

Obviously, this historic legislation carries enormous symbolic importance, lending normative weight to the idea that surgeries and other medical interventions that can be deferred, should be (or legally must be).

However, there have also been significant criticisms of the Maltese legislation, and its implementation, including that the lack of definition of 'exceptional circumstances' leaves open the possibility of deferrable surgeries continuing.[53]

Likewise, the absence of extra-territorial application of the prohibition in Article 14(1) means medical practitioners can, and do, send children to other countries, including the UK, Belgium and Italy,[54] meaning these procedures are merely being outsourced rather than ended.

The lack of detail around scope of which variations of sex characteristics are included or excluded has also apparently resulted in the continuation of surgeries on children born with one variation – hypospadias – within Malta itself, even with the apparent approval of the Maltese Government.[55]

Indeed, the UN Committee on the Rights of Children, upon reviewing this world-first legislation, found that: [56]

> *[t]he Committee, while welcoming Malta's passing of what was a global first in intersex protection laws, raised concerns that prohibited medical interventions against intersex children were still ongoing, and urged Malta to ensure that such practices do not continue.*

Although one other failing of the Maltese legislation upon its introduction has at least been (partially) addressed. While initially the punishment for medical practitioners for breaching this legislation was a small fine, in 2018 this was amended as follows:[57]

> *Medical practitioners or other professionals in breach of this article shall, on conviction, be liable to the punishment of imprisonment not exceeding five years, or to a fine of not less than five thousand euro, and not more than twenty thousand euro.*

52 Article 14(3), Gender Identity, Gender Expression and Sex Characteristics Act (2015).
53 Markus Bauer and Daniela Truffer, 'Intersex Genital Mutilations: Human Rights Violations of Children with Variations of Reproductive Anatomy – NGO Report to the 3rd to 6th Report of Malta on the Convention of the Rights of the Child (CRC) Report, April 2019, pp10-12.
54 Ibid, p10.
55 Ibid, p8 and p11.
56 Committee on the Rights of the Child, Concluding observations on the combined third to sixth periodic reports of Malta, UN Doc CRC/C/MLT/CO/5-6, 26 June 2019, p8.
57 Article 14(2), Gender Identity, Gender Expression and Sex Characteristics Act (2015).

Portugal, 2018

Portugal introduced their own legislation on this subject with the *Law on Right to Self-Determination of Gender Identity and Gender Expression and to the Protection of Each Person's Sex Characteristics No 38/2018 (2018)*.

This included respective Articles that '[a]ll people have the right to maintain their primary and secondary sex characteristics',[58] and: [59]

> *[e]xcept in situations of proven risk to their health, treatments and surgical, pharmacological or other interventions that imply modifications to the body and sex characteristics of intersex minors should not be carried out until the moment when their gender identity manifests itself.*

Unfortunately, the legislation in Portugal is much more limited than the equivalent approach in Malta. Criticisms include that the scope of the legislation, on important questions of who is protected and what is prohibited, remains unclear, including that the vague term 'proven risk to their health' continues to allow for unnecessary interventions to be performed.[60]

And, while Article 11 provides that '[t]he Director-General of Health must define… a model of intervention in the form of guidelines and standards to be implemented by healthcare professionals', these are not backed by any criminal sanctions. Nor is there any independent oversight mechanism, or protection against children being removed to other States to have medical interventions performed on them without personal consent.[61]

This means – despite the symbolic importance of this legislation – violations of the right to bodily integrity on children born with variations of sex characteristics are likely to be continuing in Portugal.

Iceland, 2019

Iceland joined Malta and Portugal with their own legislation in 2019, namely the *Act on Gender Autonomy (No 80/2019)*. This legislation attempts to impose a general prohibition on medical interventions without personal consent, including through Article 11a:

> *(1) Children born with atypical sex characteristics shall have the right to physical integrity in relation to their sex characteristics and the right to receive the best healthcare available at any given time. In implementing the Act, care shall be taken to respect their right to self-determination regarding personal matters.*
>
> *(2) Permanent changes to the characteristics of a child under the age of 16 born with atypical sex characteristics shall only be made in conformity with the will of the child… However if a child is unable to give its consent due to its young age or is for other reasons unable to express its will, the child's sex characteristics may be changed if*

58 Article 4, Law on Right to Self-Determination of Gender Identity and Gender Expression and Protection of Each Person's Sex Characteristics No 38/2018 (2018). Translated from original using google translate.
59 Article 5, ibid. Translated from original using google translate.
60 Markus Bauer and Daniela Truffer, 'Intersex Genital Mutilations: Human Rights Violations of Children with Variations of Reproductive Anatomy – NGO Report (for Session) of the 5th Periodic Report of Portugal on the International Covenant on Civil and Political Rights (ICCPR) (Report, February 2020).
61 Ibid.

> *so required for health reasons, following a detailed assessment of the need for such changes and of their consequences in the short and long term. Social, psychosocial and appearance-related reasons shall not be regarded as health reasons. Permanent changes pursuant to the first and second sentence include inter alia surgical operations, medication and other irreversible medical interventions.*

There are some key strengths of this framework, including the breadth of the definition of atypical sex characteristics,[62] and the explicit exclusion of interventions made for social, psychosocial or 'aesthetic' reasons.

However, there are also some significant weaknesses, including that it explicitly permits surgical and other medical interventions in relation to some variations of sex characteristics in additional circumstances,[63] that it does not impose any criminal sanctions for breach of its provisions, nor does it apply extra-territorially, once again permitting the removal of children to other jurisdictions to have procedures imposed that would be prohibited domestically.

Another criticism applies with respect of its attempt to create a 'committee of experts on… permanent changes to atypical sex characteristics of children',[64] with this committee being composed of three members:[65]

> *One of the members shall be a paediatrician, appointed by the Directorate of Health; one shall be a psychologist with child psychology as a field of expertise, appointed by the Icelandic Psychological Association; and one shall be a lawyer with special knowledge in the field of children's rights, appointed by the Minister responsible for human rights issues.*

In addition to not including any representatives with lived experience, it has been observed that following the legislation's passage the Committee was not actually established until October 2022, and only included endocrinological and surgical experts, with no psychologist or legal experts as required.[66] As at April 2024, the Committee still had not been convened.[67]

Germany, 2021

The *Act to Protect Children with Variations in Sex Development 2021* introduces a three-tiered approach to non-consensual medical interventions on intersex children where they are incapable of providing their own consent:

1. Interventions 'carried out solely with the intention of aligning the child's physical appearance with that of the male or female sex',[68] are unlawful, with parents unable to consent

62 Article 2, Act on Gender Autonomy (No 80/2019).
63 Article 11(5) allows interventions 'if these entail a surgical operation on account of a short urethra (hypospadias) or medication for micropenis'.
64 Article 9(1).
65 Ibid.
66 Daniela Ataatinoglu and Kari Ragnarsson (2025) 30(4) European Human Rights Law Review 408, pp21-23.
67 Ibid.
68 Article 1631e(1.1) Act to Protect Children with Variations in Sex Development 2021. Translated from original using google translate.

2. Interventions which 'cannot be postponed until the child can make a self-determined decision'[69] and where 'surgical intervention is necessary to avert a danger to the life or health of the child'[70] are lawful, with parents able to consent, and
3. Interventions which cannot be postponed but where there is no immediate necessity to 'avert a danger to the life or health of the child' may still be lawful, where parents apply to the Family Court for approval.[71]

Once again, there are some positive aspects of this scheme, including the explicit prohibition of surgeries for cosmetic or aesthetic reasons, as well as an attempt to ensure independent scrutiny of other, non-vital interventions through the Family Court.

However, Germany's legislation also contains key weaknesses, similar to its European Union counterparts, including the difficulty of enforcement via either the criminal or civil code,[72] and the absence of extra-territorial protections.[73]

The legislation's lack of effectiveness in prohibiting interventions has also been raised by the UN Human Rights Committee:[74]

> *The Committee commends the State party for introducing the Law on the Protection of Children with Variations in Sex Development in 2021. It nevertheless remains concerned by reports that the Law does not specifically restrict all problematic practices, establish criminal liability or effectively address all barriers to access to remedies for victims...*
>
> *Germany should take all steps necessary to ensure that all acts relating to the assignment of a sex to intersex children performed without their free and informed consent are specifically prohibited, except in cases where such interventions are absolutely necessary for medical reasons and the best interests of the child have been duly taken into account.*

Greece, 2022

Greece became the fifth European country to introduce legislation on this topic in 2022, with the *Medically Assisted Reproduction Reform Act (No 4958/2022)*. Its key provision is Article 17(2):

> *An intersex minor who has not completed the fifteenth (15th) year of their age may undergo [medical procedures and treatments, such as surgical or hormonal, for the total or partial change of sex characteristics], only after permission, which is granted with*

69 'Parents may consent to surgical interventions on the internal or external sex characteristics of a child incapable of giving consent with a variation in sex development, which could result in aligning the child's physical appearance with that of the male or female sex and for which the power to consent is not already lacking under paragraph 1, only if the intervention cannot be postponed until the child can make a self-determined decision.' Article 1631e(1.2). Translated from original using google translate.
70 Article 1631e(1.3), translated from original using google translate.
71 Ibid.
72 '[P]ossible penalties via the criminal and civil code but not specific provision that take[s] into account the specific circumstances of the possible victim of such a breach; in addition, as legal experts have pointed out, the presented law may be at risk to causing challenges in applying the criminal and civil code', as per OII Europe, 'A good first step: Germany adopts law banning IGM. But there is still room for improvement', webpage: https://www.oiieurope.org/a-good-first-step-germany-adopts-law-banning-igm/.
73 '[P]rohibited interventions on intersex children, who live in Germany, may still be performed in another country without any repercussions', ibid.
74 UN Human Rights Committee, Concluding observations on the seventh periodic report of Germany, UN Doc CCPR/C/DEU/CO/7, 30 November 2021, [5-6].

the decision of the County Court of the minor's place of residence. The court decides following a non-contentious proceeding and its decision is not subject to appeal. The hearing procedure is conducted behind closed doors. The permission is granted by the court following: a) the opinion of the interdisciplinary committee of Article 18, which is freely evaluated by the court, b) the personal hearing of a representative of the interdisciplinary committee of Article 18 and c) the personal hearing of the minor by the judge…

The permission can only be granted for medical procedures or treatments that cannot be postponed until the minor reaches the age of fifteen (15) and do not cause other future, irreversible or significant complications to the health of the minor. Exceptionally, the permission is not required, when the medical procedure or treatment is necessary to prevent a risk to the life or health of the minor…

There are several key strengths of the Greek framework. This includes the breadth and diversity of the interdisciplinary committee established under Article 18, which includes:

- *A doctor with experience in operations on intersex individuals or any interventions or normalisation of sex characteristics in the field of Disorders of Sex Development (DSD)*[75]
- *A legal expert with expertise in bioethics*
- *A psychologist, preferably with experience in issues of sex characteristics*
- *A social worker with experience in issues of sex characteristics issues, and*
- *A representative of the intersex civil society with similar expertise.*

And especially the sanctions introduced via Article 20(1):

Doctors who perform medical procedures or treatments to minor intersex persons in violation of Article 17, in addition to the foreseen disciplinary and administrative sanctions, are punished with a prison sentence of at least six (6) months and a fine. The repeated performance of the act of the first paragraph constitutes an aggravating circumstance. In any case and regardless of the amount of the imposed penalty, the guilty is mandatorily punished with the additional penalty of Article 65 of the Criminal Code, on the prohibition to practice the profession.

These punishments were particularly welcomed by Organisation Intersex International (OII) Europe upon the law's passage:[76]

'We are also very happy to see that the law provides for sanctions for medical doctors who perform such operations and treatments in breach of the new law, as well as making provisions to ensure that doctors performing such acts will lose their licence to practice,' says Magda Rakita, Co-Chair of OII Europe. 'This is one of its real strengths and makes clear that such interventions are punishable by law.'[77]

75 The terminology Disorders of Sex Development is stigmatising and harmful, and is only included here because it was used in the source material.

76 OII Europe, Media Release: 'Landmark moment as Greek Parliament votes to ban IGM and protect the human rights of intersex minors', 21 July 2022, available at: https://www.oiieurope.org/wp-content/uploads/2022/07/PR_Greece_IGM-Ban_21-07-2021.pdf

77 Although note that, in common with earlier laws, it does not have extra-territorial application.

Given the recently-passed nature of this legislation, there is only limited information about its implementation, so whether its implementation reflects its positive potential remains to be seen.

Spain, 2023

The sixth and final European law examined as part of this section is Spain's *Law for the Real and Effective Equality of Trans People and for the Guarantee of the Rights of LGTBI People No 4/2023*. Article 19(2) provides that:

> *All genital modification practices are prohibited in persons under twelve years of age, except in cases where medical indications require otherwise in order to protect the person's health. In the case of persons between twelve and sixteen years of age, such practices will only be permitted at the request of the minor, provided that, due to their age and maturity, they can give informed consent to the performance of said practices.*

Importantly, the legislation includes criminal penalties for medical practitioners who perform prohibited interventions,[78] although as with previous laws it does not apply extra-territorially.

On the other hand, it does not clearly define nor place limits on what interventions are necessary to 'protect health', leading to the possibility that deferrable surgeries and other interventions will still be performed using this 'loophole'.[79] Nor is there any statutorily created independent oversight mechanism.[80] And, like Greece's law, given it has only been in place for three years, it is premature to assess its effectiveness.

International Human Rights Institutions

While only a small handful of countries have, so far, taken legislative action to protect children born with variations of sex characteristics against involuntary surgeries and other deferrable medical interventions, this momentum is bolstered when taking into account key developments in international human rights fora, at both United Nations level, and within Europe.

This includes a 2014 multi-agency statement,[81] 2019 background note,[82] 2023 technical note,[83] and 2025 comprehensive report, all led by the UN Office of the High Commissioner for Human Rights.[84] These reports were complemented by the historic 2024 resolution adopted by the UN Human Rights Council which, among other things, saw member states:[85]

78 Article 79, Law for the Real and Effective Equality of Trans People and for the Guarantee of the Rights of LGTBI People No 4/2023.
79 OII Europe, 'An in-depth look: Spain becomes fifth EU country to ban IGM', OII Europe webpage, p2, available at: https://www.oiieurope.org/wp-content/uploads/2024/07/IGMBan-Spain-Analysis.pdf
80 Ibid, p3.
81 OHCHR, UN Women, UNAIDS, UNFPA, UNICEF and WHO, Eliminating forced, coercive and otherwise involuntary sterilisation: An interagency statement (2014).
82 OHCHR, Background Note on Human Rights Violations Against Intersex People (24 October 2019).
83 OHCHR, Technical note for State and other stakeholders on the human rights of intersex people (3 November 2023).
84 OHCHR, Discriminatory laws and policies, acts of violence and harmful practices against intersex persons, UN Doc A/HRC/60/50 (8 August 2025), available at: https://www.ohchr.org/en/documents/thematic-reports/ahrc6050-discriminatory-laws-and-policies-acts-violence-and-harmful
85 Preamble, Human Rights Council, Combatting discrimination, violence and harmful practices against intersex persons, UN Doc A/HRC/55/L.9 (21 March 2024), available at: https://docs.un.org/en/A/HRC/55/L.9

> *Expressing grave concern about the violence and harmful practices that persons with innate variations in sex characteristics, including children, face in all regions of the world, including medically unnecessary or deferrable interventions, which may be irreversible, with respect to sex characteristics, performed without the full, free and informed consent of the person, and in the case of children without complying with the provisions of the Convention on the Rights of the Child.*

The resolution also:[86]

> *Encourages States, in collaboration with relevant international and regional organisations, to enhance efforts to combat discrimination, violence and harmful practices against persons with innate variations in sex characteristics and address their root causes, such as stereotypes, the spread of misconceptions and inaccurate information, stigma and taboo, and to work to realise the enjoyment of the highest attainable standard of physical and mental health for persons with innate variations in sex characteristics.*

Action to end violations of the right to bodily integrity of children born with variations of sex characteristics has also been endorsed by the European Committee of Ministers, through their own historic 2025 recommendation.[87] This included:[88]

> *Recognising the breaches of physical integrity and the related psychological repercussions affecting intersex persons as a result of medical, including surgical, interventions that are not necessary to avert an imminent threat to life or imminent serious damage to physical health, which in many cases concern infants or very young children, and which are carried out without their prior, free and informed consent…*

Before recommending that:[89]

> 3. *Member States should enact legislation that explicitly and specifically prohibits any medical intervention on a person's sex characteristics, including surgical, hormonal and/or mechanical procedures and other treatments, without their prior, free, informed, express and documented consent*
> 4. *Member States should ensure that any intervention on the sex characteristics of children and other persons who, according to the law, do not have the capacity to consent is postponed until they are capable of providing, withholding or withdrawing consent, except:*
>   a. *Where it is necessary to avert an imminent threat to life or imminent serious damage to physical health and where the intervention is strictly confined to the minimum required to address the immediate medical need…*

86 Para 3, ibid.
87 Recommendation CM/Rec(2025)7 of the Committee of Ministers to member States on equal rights for intersex persons, adopted 7 October 2025, available at: https://search.coe.int/cm#{%22CoEIdentifier%22:[%22091259488028b934%22],%22sort%22:[%22CoEValidationDate%20Descending%22]}
88 Preamble, ibid.
89 Part IA. Prohibition of non-consensual interventions or treatments, ibid.

Summary

While only a small number of European nations have so far taken legislative action on this issue, they are part of growing global momentum, backed by supportive statements from both international and European human rights institutions. However, the details of what each country introduces are just as important as the symbolic value of taking action.

In order to be effective at ending violations of the right to bodily integrity of children born with variations of sex characteristics, legislation should be comprehensive – meaning, it should protect all intersex children irrespective of their particular variation(s), rather than leaving some children (for example, those born with hypospadias, as seen in some of the countries discussed), exposed to ongoing mistreatment.

Legislation should also be clear, especially in relation to the circumstances in which surgeries and other interventions will continue to be allowed (for example, providing specific criteria to assess when an intervention is essential to 'protect health', and therefore cannot be deferred).

Successful schemes are also ones that create, in the legislation itself, independent oversight mechanisms to scrutinise and/or approve these decisions. Significantly, these bodies must include a range of perspectives, such as legal, human rights and people with lived experience of being intersex, alongside medical perspectives.

The presence, or absence, of criminal sanctions is a key determinant not only of whether a framework will be effective or not – the lack of penalties makes it more likely unnecessary interventions will continue – but also whether the approach will be accepted by the intersex community, who are primary stakeholders on this topic.

In order to act as a deterrent, these prohibitions must also apply extra-territorially, that is, they must also prevent the removal of children to another jurisdiction so that the unnecessary interventions are simply performed elsewhere.

Each of these factors is discussed in the following section, as it analyses the Acts that have been adopted in the ACT and Victoria, before more detailed discussions of the issues of the need for criminalisation, whether guidelines alone are sufficient, and redress.

AUSTRALIAN APPROACHES

As indicated previously, only two Australian jurisdictions have introduced legislation to regulate surgical and other medical interventions on children born with variations of sex characteristics – the ACT and Victoria. In all other places, including NSW, the law is reflected in cases like Re Carla, which effectively leave these children unprotected.

This section of the Position Paper analyses the laws of the ACT and Victoria, including their key strengths and weaknesses.

Figure 2: Australian jurisdictions that have introduced legislation to protect children with innate variations of sex characteristics, as at June 2026

Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT)

The passage of this legislation in 2023 was a historic moment for the intersex community in Australia, making the ACT the first domestic jurisdiction to regulate this issue. In addition to its symbolic importance, the *Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023* (ACT) established a relatively robust framework (although not without some flaws, see 'weaknesses' below).

This included broad definitions of variation in sex characteristics in section 7,[90] as well as regarding what constitutes a 'restricted medical treatment':[91]

> a. *a surgical or medical procedure or treatment (including the prescription or administration of a drug) that permanently changes the person's sex characteristics,*

90 '[V]ariation in sex characteristics … means a congenital condition that involves atypical sex characteristics' (s7(1)(a)); 'sex characteristics … means a person's chromosomal, gonadal or anatomical sex; and includes – the person's hormones that are related to sex; and the sexual and reproductive parts of the person's anatomy; and the person's secondary physical features emerging as a result of puberty' (ss7(2)), Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT).

91 S8(1), Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT).

or which makes changes to the person's sex characteristics that are only reversible with a further medical procedure or treatment; [or]

b. *a prescribed surgical or medical procedure or treatment (including the prescription or administration of a drug) that temporarily changes the person's sex characteristics.*[92]

The Act then provides that the only way in which restricted medical treatments are permitted[93] to be performed in the ACT is for them to be part of either an approved individual treatment plan (that is, a plan for a specified individual person),[94] or an approved general treatment plan (that is, a plan for a class of persons – in this context, for all people who have a particular variation of sex characteristics).[95]

The Act creates the Restricted Medical Treatment Assessment Board[96] to oversee this framework, including appointing committees to assess applications for both individual and general treatment plans, with the latter including public consultation processes.

The criteria for assessing whether a treatment plan should be approved is also clearly spelled out in section 13(1):[97]

> *An assessment committee may only approve a proposed treatment plan if there is sufficient evidence that-*
>
> a. *the prescribed people to whom the plan applies would be reasonably likely to suffer significant physical or psychological harm (the primary harm) if the proposed treatment or an alternative treatment option were not undertaken; and*
> b. *alternative treatment options have been sufficiently considered; and*
> c. *the proposed treatment is no more restrictive of the ability to make a decision about a prescribed person's sex characteristics in the future than any alternative treatment option.*

Importantly, in relation to children, in assessing harm the committee 'must disregard any evidence that the treatment needs to be undertaken to reduce discrimination or stigmatisation or a perceived risk of discrimination or stigmatisation.'[98]

Strengths

There are several key strengths of the *Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023* (ACT).

The first is the creation of a criminal offence for undertaking restricted medical treatment without approval. Section 28 provides that:

92 Although ss8(2) specifies that 'restricted medical treatment does not include circumcision of the penis.'
93 S10.
94 Including both children, and adults subject to guardianship orders.
95 S11, Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT).
96 Pt 5.
97 S13(1).
98 S14(b). A similar restriction applies in relation to adults who are subject to guardianship orders, although this only applies 'unless the person has communicated a wish to have the proposed treatment or an alternative treatment option undertaken', s15(b).

1. *A person commits an offence if-*
    a. *the person undertakes a restricted medical treatment on a prescribed person;*[99] *and*
    b. *the restricted medical treatment is not undertaken in accordance with an approved treatment plan or any condition applying to the plan.*

Maximum penalty: 200 penalty units, imprisonment for 2 years or both.

This is both clear, and sufficiently serious, to act as a possible deterrent against these practices.

The second key strength is related, with section 28 creating an offence of arranging or authorising unapproved restricted medical treatment:

2. *A person commits an offence if-*
    a. *the person-*
        ii. *takes a prescribed person outside the ACT for the purpose of having restricted medical treatment undertaken on the prescribed person; or*
        iii. *otherwise arranges for restricted medical treatment to be undertaken on the prescribed person; and*
    b. *the person knows that if the restricted medical treatment were undertaken on the prescribed person in the ACT it would be an offence against section 27.*

Maximum penalty: 100 penalty units, imprisonment for 1 year or both.[100]

The earlier analysis of international frameworks demonstrated the importance of ensuring such schemes have extra-territorial application, to help ensure banned procedures are not simply undertaken elsewhere.

This concern is of particular relevance in a small jurisdiction like the ACT, contained within a much larger jurisdiction and given the very real possibility of children being taken across the border for the purpose of deferrable interventions being performed in NSW facilities.

The third key strength is the oversight provided by the Restricted Medical Treatment Assessment Board, and the diversity of its constituent members. Section 31 provides that:

1. *The Minister must appoint to the assessment board-*
    a. *a president; and*
    b. *at least 2 members for each of the following categories:*
        iii. *human rights;*
        iv. *medicine;*
        v. *ethics;*
        vi. *variation in sex characteristics;*
        vii. *provision of psychosocial support.*

The *Variation in Sex Characteristics (Restricted Medical Treatment) Regulation 2023* (ACT) then provides further detail about the meanings of (ii), (iv) and (v), with section 7 clarifying

99 Prescribed person being a child, or person subject to a guardianship order.

100 Sub-section (2) also applies where a decision-maker for a prescribed person – a parent or guardian – 'consents to restricted medical treatment being undertaken on the prescribed person and knows that if the restricted medical treatment were undertaken on the prescribed person in the ACT it would be an offence against section 27.'

that a person appointed to the category 'variation in sex characteristics', must have 'lived experience of a variation in sex characteristics', with two examples provided:[101]

1. *A person with a variation in sex characteristics*
2. *A parent of, or carer for, a person with a variation in sex characteristics.*

Although the primary legislation guarantees that at least one person appointed to the board is 'a person with a variation in sex characteristics.'[102]

As well as the diversity of these categories, the inclusion of human rights, lived experience and psychosocial support categories reduces the risk that the Board will be dominated by medical voices and operate solely as a 'rubber-stamp' to procedures supported by clinicians.

This diversity has been reflected in appointments made to date, with Anna Brown – human rights advocate and CEO of Equality Australia – appointed alongside Morgan Carpenter, Executive Director of InterAction for Health and Human Rights,[103] and Simone-lisa Anderson, Tasmanian representative for Intersex Peer Support Australia[104] (among others).[105]

Weaknesses

There are nevertheless some serious weaknesses with the ACT's legislative approach – first and foremost the fact it does not protect all children born with variations of sex characteristics against intervention.

This is because the definition of variation in sex characteristics in section 7(1) includes the following qualification: 'variation of sex characteristics... does not include a condition prescribed by regulation not to be a variation in sex characteristics.'[106]

With the Regulations then providing that:[107]

> *The following conditions are prescribed:*
>
> *a. Bladder exstrophy;*
> *b. Epispadias;*
> *c. Hypospadias, other than proximal hypospadias with cryptorchidism;*
> *d. Polycystic ovary syndrome;*
> *e. Undescended testes.*

This places children born with these variations outside the primary protections of the Act, meaning surgeries and other interventions without personal consent can continue to be performed without the need for either an individual treatment plan, or general treatment plan, approved by the Restricted Medical Treatment Assessment Board (although there remains a

101 S7, Sex Characteristics (Restricted Medical Treatment) Regulation 2023 (ACT).
102 S31(4), Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT).
103 Although, as per the 2023-24 ACT Health Directorate Annual Report, Carpenter was appointed for his expertise in human rights and ethics, rather than in the category of variation of sex characteristics (p433).
104 Anderson was listed under the category of variation of sex characteristics in the 2023-24 ACT Health Directorate Annual Report, alongside Kristiina Siianowski, President of MRKH Australia (with a possible criticism that none of the lived experience voices are from the ACT itself).
105 Including multiple Board members appointed under the category of medicine.
106 S7(1)(c), Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT).
107 S3, Sex Characteristics (Restricted Medical Treatment) Regulation 2023 (ACT).

requirement for any interventions performed on children with these variations to be reported to the Board).[108]

This exclusion of children with these variations is ethically unjustifiable. If the evidence base for performing surgeries and other interventions in these circumstances is strong, then it would be relatively straight-forward for the Board to approve individual and/or general treatment plans, just as it is expected to do with respect to other variations.

The carve-out of these variations will, however, inevitably lead to less scrutiny of practices being performed on children with these variations, and therefore contribute to the increased risk of interventions being performed in circumstances for which the evidence base is not strong, or in fact strongly contested.

Indeed, the exclusion of these variations was the primary criticism by InterAction for Health and Human Rights of the Bill upon its introduction:[109]

> *we lost the argument that protections should be available for everyone. This resulted in the government conducting a diagnosis-by-diagnosis analysis to determine inclusion or exclusion from protections. And this means that we expect most forms of hypospadias and all cases of bladder exstrophy to be formally excluded. These exclusions are listed in regulation, which is easier to change (and this impacts traits that might in future be excluded also). We understand the pressures that the government has faced in developing this bill, but we also find this narrow scope of protections distressing, as it means that some children who need protecting will not be protected.*

A second key weakness of the scheme is the limited criteria for determining when surgeries and other restricted medical treatments are allowed because of urgent medical necessity.

The criminal offences in both section 27 (for interventions performed in the ACT) and section 28 (the extra-territorial provision) include carve-outs providing that they do 'not apply to urgent restricted medical treatment'.[110] Urgent restricted medical treatment is then defined in the Act's Dictionary as:

> *restricted medical treatment required to be undertaken urgently to-*
>
> *a. save a prescribed person's life; or*
> *b. prevent serious damage to the person's health; or*
> *c. prevent the person from suffering or continuing to suffer significant pain.*

While in most (although perhaps not all) situations it may be clear whether an intervention was urgently required to save a person's life, it is less clear, and more open to subjective interpretation, what 'serious damage' may mean, and vaguer still what 'significant pain' entails. Unfortunately, the Explanatory Memorandum for the legislation does not provide further clarity on this subject either.[111]

108 S43, Act, s10, Regulations.
109 Morgan Carpenter, 'Bill to end harmful practices in medical settings introduced in the ACT', InterAction website, 21 March 2023, revised 3 April 2023, available at: https://interaction.org.au/40299/act-bill-introduction/
110 S27(3) and s28(5), Act.
111 Explanatory Memorandum, Variation in Sex Characteristics (Restricted Medical Treatment) Act 2023 (ACT), as introduced 22 March 2023.

In an area of medicine where 'traditional' surgeries have been challenged by the voices of survivors of these practices, it would be beneficial to have greater clarity around what constitutes 'serious damage' and 'significant pain', so these are not open to abuse to continue unjustified interventions.

The third and final key weakness of the ACT's legislative approach pertains to how it has been implemented. The legislation was passed by the ACT Legislative Assembly on 8 June 2023, with the Act notified on 23 June 2023. There was then a planned 18-month period prior to it taking effect, on 23 December 2024, to allow for the creation of the Board and time to begin preparation for the submission and consideration of general treatment plans.

However, as noted by the ACT Health Directorate 2023-24 Annual Report, no applications for general treatment plans were received prior to 30 June 2024.[112] The 2024-25 Annual Report shows only two applications for general treatment plans were received by 30 June 2025 – with an application for Turner Syndrome reaching community consultation stage, and another (unspecified) application still undergoing preliminary assessment.[113]

The lack of approved general treatment plans undermines the effectiveness of the scheme, because of the absence of certainty not just for medical practitioners but also for parents and guardians of children born with variations of sex characteristics.

Even on an individual level, there were relatively few applications:[114]

> *Between 1 July 2024 and 30 June 2025, the Board received 8 applications for an [Individual Treatment Plan]. Of the 8 applications, assessment committees assessed and:*
>
> - *approved 4 without conditions*
> - *approved one with conditions*
> - *one was out of scope of the Act.*
>
> *Two applications were under assessment by an assessment committee as at 30 June 2025.*

Although this does still reflect a welcome level of transparency about these practices, with the Annual Report then providing a range of de-identified information relating to the applications, before noting that: '[t]hree of the approved treatments related to ongoing hormone therapy which started before the Act took full effect. One treatment was an orchidopexy, and the remaining treatment was the commencement of hormone therapy.'[115]

There are however, real concerns about a possible lack of transparency in relation to both urgent restricted medical treatments, as well as treatments relating to excluded variations such as hypospadias – while both are meant to be reported to the Board, the Annual Report concludes that '[t]he Board received no reports of reportable treatments in 2024-25.'[116]

112 ACT Health Directorate, Annual Report 2023-24, p434.
113 ACT Health Directorate, Annual Report 2024-25, p398.
114 Ibid, p397.
115 Ibid.
116 Ibid, p398.

It is not clear whether no relevant treatments occurred in the ACT, or whether they have been performed and not reported. If the latter, this represents a failure of public scrutiny.

HEALTH SAFEGUARDS FOR PEOPLE BORN WITH VARIATIONS IN SEX CHARACTERISTICS ACT 2026 (VIC)

Only one other Australian jurisdiction has, so far, joined the ACT in introducing legislation to protect children born with variations of sex characteristics against surgeries and other involuntary treatments without personal consent. Victoria passed their own historic *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026* in February this year.

Perhaps unsurprisingly, its development was heavily informed by the framework already implemented in the ACT, and it shares a number of key features. This includes the creation of a scheme to regulate 'restricted medical treatment', which the Act defines as:[117]

> a. *medical treatment (other than treatment that is prescribed not to be restricted medical treatment) that-*
> i. *permanently changes an applicable person's sex characteristics; or*
> ii. *makes changes to an applicable person's sex characteristics that are reversible only by further medical treatment; or*
> b. *medical treatment that-*
> i. *changes an applicable person's sex characteristics; and*
> ii. *is prescribed to be restricted medical treatment.*

Again, similar to the ACT, such restricted medical treatment cannot be undertaken unless it is as part of either a general treatment plan,[118] or an individual treatment plan.[119]

And, once more, these plans can only be approved by the newly-created Restricted Medical Treatment Oversight Panel[120] (Victoria's equivalent of the ACT's Restricted Medical Treatment Assessment Board).

It could be said then that the ACT and now Victoria laws are creating an emerging 'Australian model' of legislation on this issue. Indeed, at least one other jurisdiction, Tasmania, will potentially introduce its own legislation in the second half of 2026, similarly informed by the laws already passed in its northern counterparts.[121]

Strengths

As with the ACT, one of the key strengths of the Victorian Act is the criminalisation of medical interventions performed without an approved general or individual treatment plan, with section 7 providing:

117 S3, Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 (Vic).
118 Defined as 'a plan for the treatment of a class of protected person using restricted medical treatment', s3.
119 Defined as 'a plan for the treatment of a protected person using restricted medical treatment', s3.
120 Part 5.
121 The author consulted with Tasmanian intersex advocates in November 2025, who have been preparing drafting instructions for their own scheme, drawing on the ACT and Victorian laws, for possible introduction in mid-to-late 2026.

1. *A person commits an offence if-*
    a. *the person provides restricted medical treatment to an applicable person who does not have capacity to give informed consent to the treatment; and*
    b. *the person knows or is reckless as to whether the treatment is restricted medical treatment; and*
    c. *the person-*
        i. *knows the applicable person does not have capacity to give informed consent to the treatment; or*
        ii. *is reckless as to whether the applicable person has capacity to give informed consent to the treatment.*
2. *A person who commits an offence against subsection (1) is liable to 2 years imprisonment or a penalty not exceeding 240 penalty units.*

This offence, including the possibility of imprisonment, recognises the seriousness of the violation of bodily integrity involved in these practices. As Minister for Health, the Hon Mary-Anne Thomas MP observed in her Second Reading Speech: [t]his is an important deterrent to non-compliance, given how devastating and lifelong the consequences can be for people born with variations in sex characteristics.'[122]

A second key strength is that, unlike the ACT, there is no capacity for particular variations in sex characteristics to be prescribed by regulation as not being variations of sex characteristics for the purposes of the scheme.

This means there will not be a similar situation in Victoria like that under the ACT *Sex Characteristics (Restricted Medical Treatment) Regulation 2023* which excludes people with bladder exstrophy, epispadias, hypospadias (other than proximal hypospadias with cryptorchidism), polycystic ovary syndrome or undescended testes from central elements of the ACT primary legislation's coverage.[123]

A third key strength of the Victorian scheme is similar to the ACT's however – and that is the diversity of perspectives included in the Restricted Medical Treatment Oversight Panel. Section 19(3) provides that appointees must be drawn with at least two each[124] having appropriate qualifications from the 'following fields':

a. *lived experience of an innate variation in sex characteristics;*
b. *provision of health care as a registered medical practitioner to persons who have an innate variation in sex characteristics;*
c. *human rights and ethics;*
d. *experience as a current mental health and wellbeing professional;*
e. *health law.*

While the Panel has not been appointed at the time of writing, this diversity of appointees should help to ensure all relevant perspectives are considered in the process of approving general and individual treatment plans.

122 The Hon Mary-Anne Thomas MP, Second Reading Speech, Hansard Victorian Parliament, 3 December 2025.
123 Although note there is still the capacity for particular treatments to be prescribed, as discussed further below under weaknesses.
124 Ss15(3) and 19(3), Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 (Vic).

A fourth key strength of the Victorian Act is found in section 6, which provides that the five principles identified in the Australian Human Rights Commission's 2021 'Ensuring health and bodily integrity' report – bodily integrity, children's agency, precaution, medical necessity, and independent oversight – 'must be considered in interpreting the provisions of this Act'.[125]

This provision should be useful both as the Victorian Department of Health and future Restricted Medical Treatment Oversight Panel work to operationalise the framework, and also in the event that disputes about the legislation's provisions result in litigation.

Weaknesses

As with the ACT, just because the Victorian legislation has several key strengths, does not mean it is free from faults.

First among these is the failure to ensure offences created under the *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026* (Vic) have extra-territorial applicability. In practice, this means it is not an offence to take a child to another jurisdiction to have a procedure performed that would be unlawful were it to be performed in Victoria (or to be otherwise involved in arranging for such interventions to be undertaken).

This is a curious omission. Given the Victorian legislation was informed by and had the benefit of learning from the existing ACT framework – which does have extra-territorial application – a conscious decision was taken to exclude a similar provision in Victoria.

This approach is also inconsistent with the Victorian approach to sexual orientation and gender identity conversion practices, which has extra-territorial application. This is both through the specific offence of 'taking a person from Victoria for a change or suppression practice',[126] and through a more-general provision clarifying the extra-territorial application of the Act where 'there is a real and substantial link between the conduct and Victoria.'[127]

It seems inconsistent that conversion practices – which create long-lasting psychological harm – should be prohibited both within Victoria and where there is a connection to Victoria – but that interventions on children with innate variations of sex characteristics – which can create both long-lasting physical and psychological harms – should not.

The consequences of this omission are not hypothetical. While Victoria is obviously larger than the ACT, and most medical services for children born with variations of sex characteristics would likely be provided in Melbourne, there may be people in border communities like Wodonga who would access services in Albury, and where – at least for the time being – such interventions have still not been prohibited. It would also allow for parents seeking to have such interventions performed on their children to take them to Sydney (or other Australian capitals which have also failed to legislate at this stage).

A second weakness at least somewhat negates one of the strengths listed above. While it is true there will be no regulatory power to exclude particular variations of sex characteristics from the operation of the Act's central protections in their entirety, the definition of restricted

125 S6(1).
126 S12, Change or Suppression (Conversion) Practices Prohibition Act 2021 (Vic).
127 S8, Change or Suppression (Conversion) Practices Prohibition Act 2021 (Vic).

medical treatment nevertheless includes the qualifier 'other than treatment that is prescribed not to be restricted medical treatment.'[128]

This leaves open the possibility future regulations will exclude some practices that relate to particular variations in sex characteristics, and allow these practices to continue without limitation. The real-world impact may ultimately be similar for people with those variations – and means there will need to be close scrutiny of any regulations made under the Act.

A third potential weakness pertains to the criteria for assessing in what circumstances 'urgent' medical treatment is permitted because of necessity and without an approved general or individual treatment plan.

The Act adopts a similar definition to the ACT:[129]

1. *A person does not commit an offence against section 7 if-*
    a. *the person is a registered medical practitioner; and*
    b. *the person believes on reasonable grounds that the restricted medical treatment is urgently necessary-*
        i. *to save the applicable person's life; or*
        ii. *to prevent serious damage to the applicable person's health; or*
        iii. *to relieve significant pain or distress that the person is suffering; or*
        iv. *to prevent the applicable person from suffering significant pain or distress in the future.*

The same criticisms of the ACT's provisions may also apply – that without definitions of what constitutes 'serious damage' to a person's health, or what is meant by 'significant pain or distress', this could open the door to unnecessary and deferrable interventions continuing.

However, two changes from the ACT's approach may lessen this risk. The first is the inclusion in section 8(1)(b) that the registered medical practitioner must 'believe on reasonable grounds' the treatment is urgently necessary. The second is the inclusion of a carve-out to ensure that:[130]

> *pain or distress does not include-*
>
> a. *discrimination, stigmatisation or a perceived risk of discrimination or stigmatisation; or*
> b. *psychological or emotional pain or distress due to discrimination, stigmatisation or a perceived risk of discrimination or stigmatisation.*

These changes may mean there is less likelihood of the 'urgency' exception operating instead as a de facto loophole, although it will need to be monitored once the scheme formally commences.

On that topic, it should be noted that the commencement date proposed for key provisions of the Act – passed in February 2026 – is 1 December 2028.[131]

128 S3, Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 (Vic).
129 S8(1), Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 (Vic).
130 S8(2), Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 (Vic).
131 S2(2), Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 (Vic).

This extended lead-time, which at almost three years is double the 18 months which was the phase-in period for the ACT's legislation, has been deliberately chosen to avoid some of the implementation challenges faced in the ACT (and described above, such as a lack of approved general treatment plans). As the Explanatory Memorandum outlines:[132]

> *This period of up to 3 years is required to allow:*
>
> - *staged implementation of the scheme, including establishing the Panel; and*
> - *preparation and approval of general treatment plans; and*
> - *development of guidance materials; and*
> - *education for health services, practitioners and affected communities.*

This aims to ensure all relevant parties, including both clinicians and the community more broadly 'are adequately prepared for the new scheme before the safeguards, offence and reporting provisions commence.'[133]

As this last quote makes clear however, the obvious downside of choosing an extended commencement period is that criminal prohibitions for performing unnecessary and deferrable surgeries on children born with variations of sex characteristics will not apply until that date either.

CRIMINALISATION, GUIDELINES AND REDRESS

Previous sections examined legislation in six international jurisdictions, before turning to domestic approaches adopted in the ACT and Victoria, including analysis of their key strengths and weaknesses. Taking a step back, there are three issues that warrant particular attention. The first two are related:

- Why is criminalisation necessary? *and*
- Why aren't guidelines sufficient?

The third relates to a feature that has not appeared in either the ACT or Victorian legislation, nor in any of the European schemes introduced to date:

- What about redress for harmful practices?

Why is criminalisation necessary?

One of the key issues in developing a legislative scheme on the issue of medical interventions on children born with variations in sex characteristics is whether it should include a criminal offence for breaching its framework.

On the one hand, many in the intersex community fiercely advocate for criminalisation as an essential part of any effective law (more on that below), while on the other, some clinicians

132 Clause 2, Explanatory Memorandum, Health Safeguards for People Born with Variations in Sex Characteristics Bill 2025 (Vic).
133 Ibid.

push back against criminalisation as entirely inappropriate, with some calling for no legislative oversight at all.

Indeed, previous Australian consultations on this topic – both the aforementioned 2021 Australian Human Rights Commission report,[134] and an Equality Australia 'listening report' on possible legislation in Victoria[135] – received input from clinicians arguing against criminalisation. From the AHRC report:[136]

> *Clinical stakeholders... made forceful objections to legislative prohibition of medical interventions modifying sex characteristics and, in particular the creation of new criminal offences...*
>
> *There was a view that regulation would not be appropriate because medical interventions proposed by clinicians... are aimed at improving the lives of people born with variations in sex characteristics and in accordance with medical ethics... The introduction of prohibitions would, it was said, imply malicious intent on their part.*

Similar concerns were expressed to Equality Australia:[137]

> *Another [clinician] expressed a view that clinicians should be protected from misconduct if they provide treatment they consider to be in the best interests of a patient at the time...*

While

> *Several clinical participants did not support any legislative model at all, including because 'strong regulatory requirements' on surgical practice already adequately protected the autonomy of patients.*

Given the influence clinical stakeholders have in relation to health policy – and that their resistance is one factor explaining why, in the now 13 years since the Senate Committee Inquiry report into these practices, only two Australian jurisdictions have introduced legislation on this topic – it would likely be a more straight-forward process to introduce a scheme that does not include criminal offences.

Why then does criminalisation remain necessary?

The first reason is that these interventions can and have caused serious, long-term harm – as demonstrated not only by the case of Re Carla, but also as detailed in the three leading reports analysed earlier in this Position Paper (the 2013 Senate Committee Inquiry Report, 2021 Australian Human Rights Commission Report, and 2025 Equality Australia Report).

134 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021.
135 Equality Australia, 'A right to be, belong and become': Listening report from our consultations on a proposal for a Victorian intersex oversight panel, August 2021.
136 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, p130.
137 Equality Australia, 'A right to be, belong and become': Listening report from our consultations on a proposal for a Victorian intersex oversight panel, August 2021, p22.

Surely, in circumstances where the right to bodily integrity has been violated – by the performance of unnecessary and deferrable surgeries and other medical interventions, without consent of the patient – causing significant and life-long harm, a criminal response is not only just, but essential.

The second reason is that a criminal offence is needed to act as a deterrent to prevent these practices from occurring in the first place. These penalties must be sufficiently serious to ensure deterrence is real and not hypothetical – in this context, both the ACT and Victoria have chosen a maximum penalty of two years' imprisonment. As we have already seen, the Victorian Health Minister was clear that deterrence was a key objective of these penalties.[138]

Indeed, the importance of criminal offence as deterrence – and especially of a sufficiently serious penalty for its breach – can be seen by Malta's amendments to its own laws after just three years of operation, moving from a small fine to a maximum penalty of five years' imprisonment.[139]

The third reason to introduce a criminal offence is to encourage compliance with the regulatory oversight provided by the Restricted Medical Practices Assessment Board and Restricted Medical Treatment Oversight Panel respectively. That is, to 'operate as an effective means of enforcing the obligation to seek authorisation from independent Panels.'[140]

It should be remembered here that neither the ACT nor Victorian legislation actually prohibit any particular medical procedure – they merely prohibit practices that are not approved under either general or individual treatment plans,[141] with the corollary that any particular procedure that has a sufficient evidence-base will likely be approved by these oversight bodies.

Imposing criminal penalties for undertaking procedures in the absence of an approved plan therefore acts as a positive incentive for medical practitioners to engage with the regulatory framework, in the first instance ensuring there is appropriate independent scrutiny of these practices, and in the second increasing community confidence in this area of medicine.

Community acceptance is also the fourth, and potentially most important, reason to ensure criminal offences are included in regulatory schemes on this issue – and that is because the intersex community considers them to be essential.

The inclusion of a criminal offence was described as a 'red-line' issue by long-standing Victorian intersex advocate Tony Briffa,[142] meaning any legislation that did not include a criminal offence was not worthy of being considered, let alone supported.

InterAction for Health and Human Rights Executive Director Morgan Carpenter backs calls for criminalisation:[143]

> *The international evidence on regulating medical practices on our population shows that absence of effective penalties means absence of compliance. This is the sole*

138 The Hon Mary-Anne Thomas MP, Second Reading Speech, Hansard Victorian Parliament, 3 December 2025.
139 Article 14(2), Gender Identity, Gender Expression and Sex Characteristics Act (2015) (as amended in 2018).
140 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, p131.
141 Or are otherwise considered urgently needed.
142 Interview, conducted online, Friday 27 March 2026.
143 Response to written interview questions, received via email, Friday 22 May 2026.

rationale for effective penalties, and they should include criminal penalties for the worst cases.

It is no coincidence that a call for criminalisation is the first substantive demand of the historic 2017 Darlington Statement from intersex community leaders and advocates:[144]

> *We call for the immediate **prohibition as a criminal act** of deferrable medical interventions, including surgical and hormonal interventions, that alter the sex characteristics of infants and children without personal consent. We call for freely-given and fully informed consent by individuals, with individuals and families having mandatory independent access to funded counselling and peer support [emphasis in original].*

The AHRC's consultation as it prepared its 'Ensuring health and bodily integrity' report also heard loud and clear the demand for a criminal offence from intersex advocates:[145]

> *Stakeholders from peer support and human rights organisations, and people with lived experience of variations in sex characteristics, advocated for the creation of new criminal offences...*
>
> *Some stakeholders called for criminalisation in line with human rights obligations. Existing offences relating to female genital mutilation were taken as a precedent, including in relation to extra-territorial application. Some emphasised that criminalisation was a concern of the highest priority to them...*
>
> *Some stakeholders were adamant that nothing short of criminalisation would be adequate to promote a culture shift, which they considered necessary to de-pathologise people born with variations in sex characteristics and de-medicalise initial responses by means of early intervention.*

For all of these reasons the Australian Human Rights Commission, in considering this issue at length, recommended: '[t]he Australian Government and state and territory governments should legislate to prohibit medical interventions for people born with variations in sex characteristics'[146] and that '[t]here should be criminal penalties for breaching this prohibition.'[147]

While also observing that:[148]

> *While medical interventions without personal consent may be carried out with the best of intentions, this is not a valid argument against the introduction of sanctions designed to protect people's human rights. These medical interventions do cause some people devastating and lifelong harm – and are in conflict with the principle of bodily integrity.*

It is difficult to disagree with either their recommendation or their reasoning – any legislation on this issue must include a criminal offence.

144 Article 7, Darlington Statement, 10 March 2017, available here: https://darlington.org.au/statement/
145 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, p129.
146 Recommendation 9, ibid, p131.
147 Ibid.
148 Ibid, p129.

Why aren't guidelines sufficient?

To some extent, the arguments against the introduction of guidelines as a stand-alone approach to regulating medical interventions on children born with variations of sex characteristics – without accompanying criminal offences – mirror the arguments outlined above in favour of criminalisation. This includes that guidelines alone are an insufficient response to the serious harms caused by violations to the right to bodily integrity, including in many cases lifelong adverse outcomes. Guidelines without associated penalties for their breach also offer an inadequate deterrent to clinicians seeking to continue performing these practices.

Non-binding guidelines fail to provide significant positive incentive for clinicians to seek authorisation from any independent oversight bodies that may be established under them, thereby limiting appropriate scrutiny of these practices as well as undermining community confidence in this area of medicine. Any attempt to address these issues by the introduction of guidelines in the absence of criminal offences would be met by opposition from many parts of the intersex community, who are the very people that should be protected by such a scheme.

These reasons alone should be enough to reject a guidelines-only response – but they are supplemented by the fact that, on this issue at least, they simply don't work.

As summarised by Morgan Carpenter:[149]

> *Guidelines do not provide mandatory rules for clinical practice, they depend on the availability of evidence, and the acceptance of that evidence and norms by clinicians who hold varying attitudes and beliefs about treatment. Evidence remains scarce. Systematic reviews are absent. Randomised control trials are likely to be unethical. Adherence even in relation to 'high-burden' clinical conditions in Australia is found to be poor. These factors provide a poor foundation for guidelines in relation to the clinical treatment of people with innate variations of sex characteristics where the key questions are fundamentally about unethical and human rights considerations.*

Perhaps even more relevantly, the reliance on guidelines is an approach that has been tried, and has failed.

The 2013 Victorian Decision-Making Principles, issued by the Victorian Department of Health, were an attempt to regulate this area of medicine with a 'stated purpose… to help achieve the best possible outcomes for infants, children and adolescents with intersex conditions who are cared for in Victorian hospitals', 'framed as current best practice'.[150]

In addition to the fact that '[s]ome intersex advocates… criticised the 2013 Victorian Decision-Making Principles as still permitting early interventions that are not medically necessary and reject them as inadequate to protect human rights',[151] the AHRC itself stated that '[a]t present, the 2013 Victorian Decision-Making Principles are not consistent with the Commission's

149 Morgan Carpenter, Clinical guidelines: what is the issue?, 14 August 2020, revised 4 February 2025, available online: https://interaction.org.au/resource/guidelines/
150 Ibid, p101.
151 Ibid, p102.

views on when interventions should be able to be authorised, based on the Medical necessity principle.'[152]

The AHRC also noted some community objections to the non-binding nature of the Principles:[153]

> *Intersex advocates stated that the non-binding nature of the existing guidelines meant they could not be considered as an effective framework to ensure human rights compliant interventions occurred. A LGBTI community organisation argued that there is no published, independent evidence to indicate that any of the guidelines affect practice. They attributed this to, among other things, their non-binding nature.*

It is clear then that the 2013 Victorian Departmental attempt at a guidelines-based approach did not end unnecessary and deferrable interventions on children born with variations of sex characteristics, and did not satisfy legitimate community expectations that the right to bodily integrity should be protected.[154]

Ultimately, the Victorian Government agreed with this critical perspective, by passing the *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026* (Vic), which effectively supersedes and replaces the guidelines.

It seems reasonable to view possible introduction of stand-alone guidelines, without accompanying criminal sanctions, in NSW as a similarly doomed-to-fail endeavour – one that would serve primarily as a delay to achieving what is actually needed: a comprehensive legislated framework, including independent oversight and criminal offence(s).

What about redress for harmful practices?

The laws in the ACT and Victoria, and those of the countries analysed earlier, are all forward-looking – seeking to prohibit unnecessary and deferrable medical interventions on children born with variations in sex characteristics now and in the future.

None are retrospective and, at least in relation to the imposition of criminal penalties, that may arguably be legally appropriate (although this Position Paper does not express a formal view about that particular question, especially in relation to egregious practices).

However, this means none of these legislative schemes address the important question of what should be done for people whose rights to bodily integrity were infringed by harmful practices prior to their commencement[155] – in other words, none tackle the subject of redress.

152 Ibid.
153 Ibid, p103.
154 A judgment endorsed by Morgan Carpenter, who observes: 'Guidelines have been tried in Victoria. They have been described by come clinicians outside Victoria as national in scope. They didn't change practice. This is not a surprise. Guidelines need a strong evidence base and clinician buy-in, and these are both lacking. But clinician adherence is lacking even for guidelines on common childhood conditions', Response to written interview questions, received via email, Friday 22 May 2026.
155 As well as those who may be harmed after the introduction of these laws, noting that some harmful practices may continue, especially in the years immediately following commencement.

Redress is an important objective for the intersex community. It forms one of the primary asks of the 2017 Darlington Statement, via article 10:[156]

> *We call on governments and institutions to **acknowledge** and **apologise** for the treatment of people born with variations of sex characteristics, and provide **redress and reparation** for people born with variations of sex characteristics who have experienced involuntary or coercive medical interventions. There must be no time limit on access to redress and reparation [emphasis in original].*

Morgan Carpenter of InterAction for Health and Human Rights reiterated that redress remains on their agenda today:[157]

> *We have been calling for redress since the Darlington Statement in 2017. Redress presupposes an acceptance that harm has happened and it shouldn't happen again, and so it hasn't yet gotten onto the agenda in any jurisdiction. It should contain a public apology, but it should also include compensation and could include supported access to reparative treatment.*

The topic of redress also frequently arises in international and European human rights fora, and was another of the recommendations of the historic 2025 European Committee of Ministers Statement:[158]

> 10. *Member States should provide intersex persons who have been subjected to medical interventions or treatments that violated their rights with effective access to justice, access to effective remedy, adequate redress and reparation and safeguards against repetition of these acts, which may include public apologies, financial compensation and, in accordance with national law, other forms of accountability and restorative justice…*

This is backed by the practical recommendation in Article 11 that:[159] 'Member States should aim to ensure that statutes of limitations allow intersex persons to access redress and reparation at a time when they are able to understand what has happened to them.'[160]

It is perhaps not surprising then that, even where domestic consultations on the subject of possible legislative approaches to this issue have not specifically asked about the subject of redress, intersex community members have placed it on the agenda via their contributions.

156 Darlington Statement, Joint consensus statement from the intersex community retreat in Darlington, March 2017, text available at: https://darlington.org.au/statement/

157 Response to written interview questions, received via email, Friday 22 May 2026.

158 Recommendation CM/Rec(2025)7 of the Committee of Ministers to member States on equal rights for intersex persons, adopted 7 October 2025, available at: https://search.coe.int/cm#{%22CoEIdentifier%22:[%22091259488028b934%22],%22sort%22:[%22CoEValidationDate%20Descending%22]}

159 Ibid.

160 Other international bodies have also called specifically for Australia to consider redress on this issue: 'The Commission also notes the remarks to Australia by the UN Committee on the Rights of Persons with Disabilities (2019) and the UN Committee on the Elimination of Discrimination Against Women (2018) calling for provision of redress', Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, p148.

For example, the Australian Human Rights Commission noted that:[161]

> *In the submissions describing their experiences, some expressed their views on the need for redress for past harms. Other contributors, such as human rights agencies, also expressed their views on what redress they believe is needed to address past harms.*
>
> *Options proposed include:*
>
> - *apology from both governments and institutions*
> - *direct personal responses, such as those offered to survivors of institutional child sexual abuse, where desired*
> - *reparation, redress and life-long financial support for ongoing reparative treatment required by virtue of non-consensual intervention*
> - *life-long access to counselling for individuals and family members, where desired*
> - *no statute of limitations on civil or criminal litigation.*

Although the Commission concluded that, because it had not asked for detailed comments on this issue: '[i]n the absence of comprehensive input across the range of stakeholders, it would be premature for the Commission to express a view on appropriate redress measures'.[162] However, they did express that they are 'sympathetic to an appropriate body exploring this issue, with a view to engaging all relevant stakeholders. The Australian Law Reform Commission might be such a body.'[163]

Similarly, through Equality Australia's 2021 consultation on a proposed Victorian intersex oversight panel, which did not seek to incorporate redress provisions, they nevertheless received clear feedback expressing support for redress. From their 'Listening Report':[164]

> *Acknowledging that the proposed scheme would operate prospectively, several participants raised the need for redress in respect of historical practices. Among the redress measures raised with us were:*
>
> - *an apology or acknowledgement that what was done previously was wrong, a betrayal of trust and a breach of rights;*
> - *the need for simple answers as to what was done to a person, including access to health records or medical procedures that would help provide those answers;*
> - *support for connection and contact with others in a similar position, particularly through funding peer support;*
> - *financial support for psychological care or further medical treatment, including to fund corrective surgeries to reverse the negative effects of past medical procedures;*
> - *clear avenues for compensation.*

In their Final Report, Equality Australia then concluded:[165] 'we would support such redress

161 Australian Human Rights Commission, 'Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics', October 2021, pp147-148.
162 Ibid, p148.
163 Ibid.
164 Equality Australia, 'A right to be, belong and become': Listening report from our consultations on a proposal for a Victorian intersex oversight panel, August 2021, p45.
165 Equality Australia, 'Victorian Intersex Oversight Panel Proposal: Final report and recommendations to the Victorian Government', September 2021, p149.

measures and encourage the Victorian Government to consult with people with innate variations of sex characteristics in this regard.'

There are of course existing precedents for Government-established redress schemes, including those that provide redress for actions by non-government actors (through the National Redress Scheme for people who have experienced institutional child sexual abuse).

In late 2025, the Tasmanian Government also introduced a nation-leading redress scheme for people who have sought expungement for historical LGBTQ+ criminal offences.[166] Where an application for expungement is successful, individuals qualify for payments of up to $75,000.[167]

On the subject of redress then: intersex advocates view it as essential; international human rights bodies have expressed support for it; domestic public consultation processes on the topic have supported it in-principle; and there are domestic precedents on other issues that show it is possible.

The inclusion of redress is also an opportunity for any NSW scheme to demonstrate best practice on the subject of legislative responses to medical interventions on children born with variations of sex characteristics.

It will not be the first, second, or perhaps even third,[168] Australian jurisdiction to prohibit these practices prospectively. While key elements will most likely involve building on the approaches of the ACT and Victoria, and hopefully choosing the best elements of both (see more in Conclusion, below), rather than introducing legislation with radically different features to the emerging 'Australian model'.

However, on redress NSW still has an opportunity to lead the country, by committing to develop a comprehensive redress scheme for harmful practices. This should be created in close consultation with the intersex community, so it genuinely meets their needs, and could incorporate a combination of those features already identified (such as apology, access to medical records, financial support for ongoing reparative treatments, access to counselling for individuals and family members where desired, and compensation).

CONCLUSION

This Position Paper has shown that unnecessary and deferrable medical interventions on children born with variations of sex characteristics are ongoing, with many leading to life-long adverse outcomes. This has been demonstrated through three seminal reports, published between 2013 and 2025, by the Senate Community Affairs Reference Committee, Australian Human Rights Commission and Equality Australia.

166 Such as 'consenting sex between men; men loitering or soliciting sex with other men; [and] a person assigned male at birth in a public place dressed in female clothes between sunset and sunrise', Tasmanian Government, Webpage 'Expungement of Historical Gay Sexual Offences and Cross-dressing Offences', https://www.ehos.tas.gov.au accessed 14 May 2026.

167 'People who were charged with an offence but were not convicted and did not serve jail time will receive $15,000; People who were convicted an did not serve any time in jail or receive any other court sanction will receive $45,000; People who were convicted of offences and served time in jail or had other court sanctions, will receive $75,000', ibid.

168 With possibility of Tasmania introducing legislation later in 2026, discussed at footnote 121.

Unfortunately, the current legal situation in NSW – reflected in the case of Re Carla, discussed in detail at the start of this report – leaves these children without adequate protection, with the Family Court first authorising an unnecessary and deferrable surgery, before abdicating any future oversight role in relation to similar interventions.

There is therefore a compelling argument for the NSW Government to intervene, by introducing legislation to protect children with innate variations of sex characteristics, and to do so as a matter of urgency.

Recommendation 1

The NSW Government should urgently develop legislation to protect children with innate variations of sex characteristics from unnecessary and deferrable medical interventions.

This Position Paper then analysed the schemes adopted by the six European countries that have, to date, passed laws on this topic: Malta, Portugal, Iceland, Germany, Greece and Spain. Each has strengths and weaknesses, and knowledge of their respective frameworks is useful in understanding some of the key features NSW legislation should contain.

However, in terms of concrete examples showing the way forward, it is better to look much closer to home. The ACT's *Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023*, and Victoria's *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026* provide the foundations for an emerging 'Australian model' of regulation in this area.

Both laws share a number of important characteristics, including the criminalisation of procedures that are not conducted in accordance with approved general or individual treatment plans, and the establishment of independent oversight bodies that draw expertise from a range of different areas, including clinical perspectives alongside experts from human rights and ethics, mental health and wellbeing, and lived experience.

Perhaps understandably, the Victorian Act, as the most-recently passed and therefore informed by learnings from the ACT's experience, is the preferrable of the two. This is both because the *Health Safeguards for People Born with Variations in Sex Characteristics Act 2026* (Vic) does not allow for the exclusion of particular variations from the scheme's central protections, but does explicitly include the principles of bodily integrity, children's agency, precaution, medical necessity and independent oversight to inform its interpretation.

However, the Victorian Act is deficient in that, unlike the *Variations in Sex Characteristics (Restricted Medical Treatment) Act 2023* (ACT), it does not create extra-territorial application. This is a serious gap that other jurisdictions, like NSW, should not replicate.

Recommendation 2

This legislation should reflect the emerging 'Australian model' on this issue, using the Victorian Health Safeguards for People Born with Variations in Sex Characteristics Act 2026 as its starting point. However, it should also include extra-territorial application, to prevent children being taken to another jurisdiction for procedures that would be unlawful were they to be performed in NSW.

The implementation of these first two recommendations would ensure NSW effectively matches the existing protections offered under both the ACT's and Victoria's laws.

However, in order to deliver '*A best practice approach to NSW legislation protecting children born with variations of sex characteristics*' (the initial objective of this Fellowship), the NSW Government should also seek to introduce something neither of its domestic counterparts have to date: a scheme offering redress for harmful practices.

This has been a key ask by the intersex community over an extended period of time, including through the community-led 2017 Darlington Statement. And given the serious harms that are experienced by people who have been subjected to these practices, a redress scheme in this area would sit easily alongside existing frameworks such as the National Redress Scheme for survivors of institutional child sexual abuse.

Of course, any redress scheme should be developed in close consultation with the intersex community, to ensure it meets their needs, including consideration of options such as public apology, compensation, and supported access to reparative treatment (where desired).

Recommendation 3

The NSW Government should develop a redress scheme for harmful practices, in consultation with the intersex community.

The author has attempted to use a wide lens to examine the issue of medical interventions without personal consent on children born with variations of sex characteristics, including analysis of both international and domestic legal approaches to this topic.

This has been supplemented by a research trip to Melbourne to discuss the Victorian scheme with a range of stakeholders, as well as engagement with Morgan Carpenter of InterAction for Health and Human Rights.

However, there are some limitations of this approach, including that the analysis of the schemes adopted by six European countries was, by necessity, desktop only. A future research project could potentially seek to engage with both decision-makers and community organisations in these jurisdictions to understand each framework, and how it has operated in practice, more fully.

Another limitation is that both the ACT and Victorian laws are so new – with the former's substantive provisions only commencing 18 months ago, and the latter's not commencing until 1 December 2028. A second future research topic could therefore examine how these laws have been implemented, including whether they have lived up to expectations and, if not, how they should be amended.

A third limitation relates to the scope of the Position Paper itself – and that is its focus on the subject of law reform only. As with almost any justice-related issue, a change to the law, on its own, will never deliver a complete solution.

In this context, while the establishment of a legal framework that prohibits unnecessary and deferrable medical interventions on children with innate variations of sex characteristics is essential, it *must* also be supported through the provision of adequate funding for psychosocial support services for children and their families. And these *must* include intersex-led support services, such as InterLink (a professional psychosocial support service operated by InterAction).

These services are vital to educate and assist parents and guardians as they negotiate any potential distress about having a child different to societal 'expectations', and to navigate the complexities of the health system. But above all they will help intersex children to have happy and healthy futures.

And it is on the subject of the future that this Position Paper will end – what it would mean, and how the intersex community could respond, if the NSW Government ultimately legislates to end these harmful practices.

In the words of Canberran intersex advocate Cody Smith, following introduction of the ACT's Bill:[169]

> *I have always lived with the consequences of decisions that should have never been made for me, and a profound grief that I have been unable to prevent these circumstances from happening to others. I've often described this burden of activism as being like a dripping tap. It's hard to focus on things when all you can hear is a dripping tap, and similarly the trauma of medical violence takes over every conversation about intersex justice. More importantly you can't fix the issues caused by a dripping tap without fixing the tap first. Indeed, how is our community supposed to come together and heal when we all know the harm has never stopped?*
>
> *So when I say these laws provide a profound sense of relief. It is the first time a government in Australia has recognised that all the surgeries, hormones, and decisions taken away from me was wrong and that it can't be allowed to happen to anyone else. More importantly than the personal, our community has been given the opportunity to replace the intersex narrative of violence, trauma, and grief with one of celebration, healing and joy. For the first time we have the chance to thrive on our own terms. Now the conversation has been changed here, it can be changed anywhere. All people living with any variation in sex characteristics, anywhere in Australia, deserves this sense of peace and justice and what it can bring.*

169 Quoted in Morgan Carpenter, 'Bill to end harmful practices in medical settings introduced in the ACT', 21 March 2023 (revised 3 April 2023), available at: https://interaction.org.au/40299/act-bill-introduction/

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ACKNOWLEDGEMENTS

Alastair expresses his sincere gratitude to the Law and Justice Foundation NSW for the Fellowship which allowed him to undertake this project, as well as the ongoing encouragement of his Foundation mentor Sarah Ratcliffe. He also acknowledges the backing of the Justice and Equity Centre, and its CEO Jonathon Hunyor, in giving him the space to draft this Position Paper, and the contribution of UNSW Global Student Fellow Adam Hughes for conducting preliminary analysis of international legislative approaches. Alastair thanks his partner Steve for his constant support. Finally he expresses his admiration and appreciation for long-term intersex advocates Tony Briffa and Morgan Carpenter for their generosity in sharing their immense wisdom on this important topic.

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