

INTERSEX PEOPLE IN AOTEAROA NEW ZEALAND: THE CHALLENGES FOR LAW AND SOCIAL POLICY

PART I: CRITIQUING GENDER NORMALISING SURGERY

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In this first of two articles dealing with the current issues facing intersex people in Aotearoa New Zealand, the author focuses on what is seen by community activists as their most pressing concern: ongoing genital normalising surgery on intersex infants. The resolution of this issue sits at the interface of criminal law, medical law and family law, and requires nuanced and careful engagement with competing norms of social policy. The article defines "intersex", as compared to "trans", and considers how infant surgery is currently (under)regulated in spite of local and international calls for reform. The author argues that it is time serious consideration is given to legislative regulation of surgery on intersex infants, following overseas initiatives, including the recent enactment in the Republic of Malta.

I INTRODUCTION

I studied family law under Bill's careful stewardship in 1987. My memories of that class involved the challenges of having to remember the case names of many matrimonial property cases (as they then were) and puzzling, along with the rest of the class, over the scope of the various pieces of legislation. What about couples who could not marry? What is the real value of non-monetary contributions to a relationship? Who are the best parents for a child?

Twenty-eight years on from worrying (at least up until the end of the examination) about the difficult law and policy conundrums Bill posed for us in lectures, I wonder what issues the current

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family law students find the most challenging. Although many of the hard lines we discussed have been blurred or erased, the increased visibility of the LGBTI (lesbian, gay, bisexual, trans and intersex) communities have required careful thinking about the role of law in the lived experiences of those who are mainly invisible in the statute books. It was not until 1995 that a process existed to allow someone to change the sex recorded on their birth certificate. That same year the first international meeting of intersex adults took place in California, although for many years before then children whose sex could not be determined at birth were initially recorded by the Registrar-General as sex "indeterminate". Today, the term "intersex" is still not used in any New Zealand legislation, nor is "transgender". The phrase "gender identity"¹ makes an appearance in the Sentencing Act 2002 and more recently in an amendment to the Marriage Act 1955, but tellingly not in the Human Rights Act 1993.

I know family law students are familiar with this terminology, and at least some of the hard questions, through co-supervising with Bill undergraduate students whose interest has been piqued by his class discussions, and by reading the work of his Honours course participants. However, the scope of family law is so vast, and the issues so complex, that it is no surprise that the current concerns of the LGBTI communities cannot be fully explored in the space of 36 hours of lectures. That Bill is able to cover the essential substantive material, while also inspiring his students to continue to question the law outside of the classroom is a testament to his pedagogical talents. It also demonstrates the significance of Bill's teaching: the only reference to "intersex" in the New Zealand Family Law Journal is in a piece supervised by him.²

As a criminal lawyer, my foray into family law matters occurs due to the intersections between criminal and family law as a result of the regulation of gender and sexuality. This in turn requires me to engage with human rights jurisprudence and some aspects of international law. This writing is often a welcome break from reading about sexual violence (my ongoing research interest) and affords me the delightful opportunity to work alongside non-lawyers, whose thoughtfulness, energy and activism (usually unpaid) inspires me, in the same way Bill does, to use my privileged and fortunate position as a legal academic to support community endeavours for change.

This piece, the first of two articles, is part of my commitment to that work. I set out what I perceive to be the current social and legal issues for members of the intersex community requiring governmental response – through either policy development or law reform. I begin in this Part by outlining what I mean by "intersex" and the tensions in the international communities about the use of the word. I then discuss the differences and shared experiences of the trans and intersex communities.

1 Gender identity can be defined as a person's internal or deeply felt sense of being male or female, or something other. A person's gender identity may or may not correspond with their sex.

2 Emma Geard "Sex reassignment treatment for minors in New Zealand – the ability of minors or their guardians to consent" (2011) 7 NZJFL 12.

In 2001 I was privileged to meet intersex activist Mani Bruce Mitchell. Mani is now the Executive Director of the Intersex Trust Aotearoa New Zealand (ITANZ), which was established in 1998. As a consequence of talking and working with Mani, I published an article that developed the link between criminal law and the medical treatment of intersex infants. In this article I argued that gender normalising surgery on intersex infants is a form of genital mutilation and may well already be criminal under s 204A of the Crimes Act 1961.³ However, this is not the approach taken in New Zealand, where there is ongoing genital surgery performed on intersex infants, even in the absence of pressing medical need.

Given the social and psychological effect of early surgery and the consequential assignment of gender (which may not conform to the child's own identification) it is unsurprising that ending surgery on intersex infants is considered to be the most pressing issue for many intersex adults. This was clearly identified during the Human Rights Commission's Transgender Inquiry, and the follow up round-table discussions with members of the intersex communities – conversations which I outline in Part III of this article. In the final Part, I consider in more detail the current local and international debates on the issue, including the recent legislation in the Republic of Malta, and conclude that regulatory reform remains a pressing need in New Zealand.

The other matters requiring attention, which were first publicly discussed in New Zealand following the Human Rights Commission's work in 2007 – including access to health care, legal recognition of gender identity and the implications of a binary sex classification – will be discussed in the second instalment of this work.

II TERMINOLOGY

A Intersex: Medical Conditions and Their Consequences

There is considerable debate about who should be considered "intersex", given that millions of people worldwide do not follow the typical sexual differentiation path and have sex indicators that are not all clearly male or female. Some people are of the view that the term intersex should only apply to those with ambiguous genitalia or unclear gender identity. Others consider that intersex people are (only) those who have chromosomal or phenotype (secondary sexual features such as breasts or facial hair) discordance. As discussed further below, people with medical conditions who fall into either of these groups may not want to identify as intersex at all.

As medical experts do not agree on what conditions fit within the definition of intersexuality, and because some conditions are not apparent at birth, it is difficult to cite an accurate number of intersex births. Most experts working in the area agree that between one and two per cent of infants are born with sexual features that vary from the medically defined norms for male and female. One

3 Elisabeth McDonald "Circumcision and the Criminal Law: The Challenge for a Multicultural State" (2004) 21 NZULR 234.

infant in every 1,500–2,000 births is born with genitalia so atypical that specialists are consulted and surgery is considered. It is the surgery on non-consenting intersex infants that is of most concern to activists. Although they acknowledge that in this binary world a sex needs to be determined, this should not mean surgery ought to follow. What if the child is assigned female at birth but identifies later as male – or wishes to identify as neither male nor female? What about the consequences of genital surgery on a person's sexuality later in life? And why is there a desire to make all females or all males look the same? Why can a self-identified girl not be happy with a large clitoris or a self-identified boy with a small penis? And, as Julie Greenberg points out:⁴

The existence of people with an intersex condition whose bodies combine aspects of male and female anatomy provides a perfect rhetorical device for challenging traditional notions of sex, gender, and sexual orientation. Because intersex bodies fail to fall neatly into the traditional male/female binary construct, intersexuality can be used to call into question our basic notions of what it means to be a man or a woman.

What is known is that there are numerous conditions where people have sex variations in their chromosomes, gonads (reproductive sex glands) or hormones, such that they have and may exhibit physically both male and female aspects:⁵

Some intersex conditions involve an inconsistency between a person's internal and external sexual features. For example, some people with an intersex condition may have female appearing genitalia, no internal female organs, and testicles. Other people with an intersex condition may be born with genitalia that do not appear to be clearly male or female. For example, a girl may be born with a larger than average clitoris and no vagina. Similarly, a boy may be born with a small penis and a divided scrotum that resembles a labia.

Some individuals have chromosomes that vary from the typical XX (female) and XY (male). Variations include XXX, XXY, XXXY, XYY and XYYY. Common variations include Klinefelter syndrome (men who have one Y chromosome and two or more X chromosomes) and Turner syndrome (women who have only one X chromosome).⁶

Some people may not have two ovaries or two testicles: some may have a combination of ovarian and testicular tissue or one ovary and one testicle. Those with Swyers syndrome (pure gonadal dysgenesis/development) have XY chromosomes but are missing the sex-determining segment on the Y chromosome, meaning they do not develop fully formed testes. Missing these, an

4 Julie A Greenberg *Intersexuality and the Law: Why Sex Matters* (New York University Press, New York, 2012) at 3.

5 Greenberg, above n 4, at 1–2. See also Ellen K Feder *Making Sense of Intersex: Changing Ethical Perspectives in Biomedicine* (Indiana University Press, Bloomington, 2014) at 19–43.

6 Greenberg, above n 4, at 13.

infant will appear female but will not have ovaries or a uterus.⁷ This condition will not be physically apparent at birth and is often not diagnosed until puberty when lack of menstruation and breast development results in a diagnosis.

The most common hormonal variations are complete androgen insensitivity syndrome (CAIS) and congenital adrenal hyperplasia (CAH). People with CAIS are XY, but their bodies are unable to effectively use the hormones produced in their testicles, so as fetuses they will develop along the female path and form external female genitalia, but no internal reproductive organs.⁸ This condition may also not be diagnosed until puberty. People with CAIS tend to have a female gender identity.⁹

Individuals with the inherited condition CAH have XX chromosomes and ovaries but due to a problem with the production of hormones in the adrenal glands (situated on top of the kidneys), the fetus will then masculinise.¹⁰ The external genitalia will be more similar to male genitals. According to an online patient education website: "This disorder [CAH] can affect the development of sex organs in men."¹¹

It is important to acknowledge that many of those who have an intersex condition do not identify with the term intersex, or even consider that they have a biological condition which impacts on their sexuality or gender identity. The current medical term used is DSD – Disorder of Sexual Development – a term which is eschewed by many members of the intersex communities. The terms "intersex community" or "intersex people" must therefore usually be read to mean those who acknowledge that their experience of their condition has affected them beyond the impact of the medical intervention on their physical body. That is, those who believe that their biological condition has had implications on their sexuality and gender identity, regardless of whether they were "correctly" assigned to the gender they identify with.

In this work, however, I use "intersex" in its widest sense to mean anyone with a congenital condition that means they do not fit clearly into the binary male/female norm and this is consistent with the definition of "intersex status" in the Sex Discrimination Act 1984 (Australia): "the status of having physical, hormonal or genetic features that are: (a) neither wholly female nor wholly male; or (b) a combination of female and male; or (c) neither female nor male."¹²

7 Pak-Lee Chau and Jonathan Herring "Men, Women, People: The Definition of Sex" in Belinda Brooks Gordon and others (eds) *Sexuality Repositioned: Diversity and the Law* (Hart Publishing, Portland, 2004) 187 at 190.

8 At 190.

9 See also *Orchids: My Intersex Adventure* (directed by Phoebe Hart, Hartflicker Moving Pictures, 2010).

10 Greenberg, above n 4, at 15.

11 Kristeen Cherney "Adrenal Glands" (11 June 2013) Healthline <www.healthline.com>.

12 Section 4(1).

So why do I use "intersex" while being aware of the problematisation of the term? I cannot make a better argument than that made by Morgan Holmes in the introduction to the edited collection *Critical Intersex*:¹³

[W]e ... are not yet done with "intersex". ... The implicit imperative in the title ... is that it is too soon to accept the language of *disorder* wholesale and that, in fact, a critical value remains in the use, deployment, recognition and interrogation of "intersex". ... "[I]ntersex" is not one but many sites of contested being, temporally sutured to biomedical, political and social imperatives in play each moment. "Intersex" then, is hailed by specific and competing interests, and is a sign constantly under erasure, whose significance always carries the trace of an agenda from somewhere *else*.

B Comparison with the Trans Community

In this article, as in *To Be Who I am: Report of the Inquiry into Discrimination Experienced by Transgender People* (the Report of the Transgender Inquiry),¹⁴ I use the term "trans" when necessary to use a generic terms to describe all of the identities already listed. That is, to describe those "who identify their gender in some way in opposition to or outside the gender role which they are meant to fulfil as a result of their sex designation at birth".¹⁵ In New Zealand Aotearoa there is also a cultural context to the use of terminology and identification which needs to be acknowledged.

Pre-colonial Māori communities were "inclusive of whakawahine"¹⁶ (a Māori term describing someone born with a male body who has a female gender identity). More recently takatāpui has been reclaimed as a term to describe gay, lesbian, bisexual and trans Māori.

Today Māori whakawāhine and tangata ira tane (someone born with a female body who has a male gender identity) remain visible within takatāpui communities. A support network for Māori trans people (Tapatoru), based on the traditional concept of whānau or family, now exists. There are many predominantly Pākehā (European) or Tauīwi (non-Māori) networks.¹⁷

New Zealand also has a large Pacific Island population, many of whom acknowledge males who take on traditional female social roles (such as fa'afafine in Samoa and fakaleiti in Tonga). It is therefore not surprising that the people who made submissions to the New Zealand Human Rights

13 Morgan Holmes "Straddling Past, Present and Future" in Morgan Holmes (ed) *Critical Intersex* (Queer Interventions Series, Ashgate Publishing, Surrey, 2009) at 1–2 (emphasis in original).

14 Human Rights Commission *To Be Who I Am/Kia noho au ki tōku anō ao: Report of the Inquiry into Discrimination Experienced by Transgender People* (Wellington, New Zealand, 2008) at 1.

15 Stephen Whittle *Respect and Equality: transsexual and transgender rights* (Cavendish Publishing, London 2002) at xxiii.

16 Human Rights Commission, above n 14, at [2.1].

17 See "Trans people: facts and information: Some trans groups and networks" Human Rights Commission <www.hrc.co.nz>.

Commission's Transgender Inquiry referred to themselves using a range of terms, including transgender, Male-to-Female (MtF) and Female-to-Male (FtM) transsexuals, cross-dressers, queens, intersex, androgynous, genderqueer, takatāpui, fa'afafine,¹⁸ fakaleiti, whakawahine and tangata ira tane.

Members of the intersex communities report many of the same concerns as those who identify as trans, but there are some issues that only affect those born with an intersex condition. Some intersex people may also identify as trans, especially if they are taking hormones or having surgery in response to previous medical interventions.

Intersex people share with members of the trans community all the issues that arise from not fitting gender stereotypes, particularly gender expression. This means intersex people suffer harassment, physical and verbal abuse, sexual violence, and many forms of discrimination based on their gender identity and expression. They may have official documents that do not match their gender identity and are without the financial means to have them altered. They may have limited or no access to health providers with the relevant expertise to advise them on their particular issues. They may have family, employers or co-workers who shun them or treat them disrespectfully or with limited care and understanding of their experiences.

As well as these challenges, intersex people face other difficulties. They may have been denied access to their early medical records, or the records may have been destroyed. They may have had surgery early in their lives that has had ongoing effects on their physical and psychological well-being, including their ability to enjoy sexual intimacy and pleasure. This medical intervention, which may have also involved long-term hormone treatment, may well have been undertaken without proper consent. They may not have been told about their condition until very late in life, if ever. They may therefore have struggled with understanding their emotions and making sense of their body. They may have reacted to the lack of information and support by developing mental health issues.

Those who wish to identify as neither male nor female, like some of the trans community (who may identify as genderqueer, for example), struggle to do so in what is primarily a binary world. Challenges faced by trans men or women, such as access to bathrooms or participation in sports teams or events, are also faced by intersex people. For those who would prefer to identify as "gender indeterminate", however, the usual rules and procedures do not apply. To take a recent example in the criminal context: an officer of what gender should strip search a person of indeterminate

18 See further Povia Junior Ashleigh Feu'u *Ia e Ola Malamalama I lou Fa'asinomaga: A Comparative Study of the fa'afafine of Samoa and the whakawahine of Aotearoa/New Zealand* (Masters Thesis, Victoria University of Wellington, 2013).

gender?¹⁹ It is also an expensive judicial process for an intersex person to change their birth certificate to record their gender as indeterminate, even if that was the original classification at the time of their birth.²⁰

It must be acknowledged, however, that not all in the intersex communities feel closely aligned with the LGBT movement. Julie Greenberg describes this tension:²¹

[Some intersex activists] believe that the primary harm threatening people with an intersex condition is the medical practice of surgically altering infants and cloaking the treatment in shame and secrecy. They recognize that the current medical protocol is based on stereotyped gender assumptions and heteronormativity. ... They believe, however, that [change] ... can best be advanced by focusing on issues emphasized by disability rights advocates, including the right to autonomy and bodily integrity. ... [F]orming alliances with LGBT groups [who can offer the emotional support that a group identity movement can provide] may actually hinder their goal of ending surgeries on infants.

In New Zealand, ITANZ, while cognisant of the political sensitivities, aims to form strategic alliances with other LGBTI groups, as well as with activists in the health and disability areas. As a consequence of increased visibility and education, recent local initiatives have sought to address the concerns of intersex people, either in specific response to their unique experiences, or as part of reforms that are primarily aimed at the trans community. As stated earlier, consideration of those initiatives will primarily be considered in Part II of this work. In this article (Part I), I focus on the pressing issue of genital normalising surgery on intersex infants – an issue also raised with the New Zealand Human Rights Commission in 2006.

III THE REPORT OF THE TRANSGENDER INQUIRY: CURRENT CONCERNS AND ISSUES FOR INTERSEX COMMUNITIES

The New Zealand Human Rights Commission's inquiry into the discrimination experienced by trans people was not originally scoped to include people with intersex conditions.²² However, given the number of submissions made to the inquiry on both shared and different concerns, the Commission dedicated a chapter in the final Report of the Transgender Inquiry to a consideration of intersex people, while acknowledging the need for further engagement with members of this

19 See Katherine Stove "Preserving Human Dignity: An Advocacy for the Consideration of Trans and Intersex People in Accordance with 'Human Rights Values' when Conducting Strip Searches under the Search and Surveillance Act 2012" (LLB(Hons) Dissertation, Victoria University of Wellington, 2013).

20 See J Einfeld, S Gunther and D Shlasko *The State of Trans* and Intersex Organising: A case for increased support for growing but under-funded movements for human rights* (Global Action for Trans Equality and American Jewish World Service, New York, 2013) at 5–6.

21 Greenberg, above n 4, at 5. See further Greenberg, above n 4, ch 9, "Conflicts among Social Justice Movements with Common Concerns".

22 Human Rights Commission, above n 14, at [7.47].

community. The Report was therefore followed up by two roundtable discussions.²³ This article draws on the recommendations and issues raised in both the Report and the roundtable discussions.

Prior to 2007 there was little national or international consideration of the social and legal position of those with intersex conditions. Most visibility and advocacy occurred in the USA with the early work of Cheryl Chase,²⁴ Dr Milton Diamond,²⁵ Julie Greenberg, Alice Dreger²⁶ and others. Locally, Mani Bruce Mitchell, supported by ITANZ, has been very successful in making the issues affecting intersex people more visible, notably most recently through the award-winning documentary *Intersexion*,²⁷ although Mani admits that visibility is only the beginning.

The Human Rights Commission noted that the key difficulties for intersex people were "the lack of recognition that they exist, and the problems that arise when they are assigned a sex which they would not choose for themselves".²⁸ Submitters to the inquiry reported not finding out about their intersex condition for many years, and the limited medical information available to them left them feeling isolated and scared.²⁹ Health professionals consulted during the inquiry confirmed that in New Zealand most infants of indeterminate sex are assigned a sex by medical intervention:³⁰

In most cases the decision to assign a gender to "correct" the child's perceived variation from the norm is taken by the parents and doctors when the child is an infant, followed by repeated genital surgery and ongoing hormonal and psychological treatment, together with socialisation in the assigned gender. *There is a significant risk that this surgical and endocrinological assessment of the children's sex may not be consistent with their adult gender identity or their actual biological sex.*

The main concern raised by submitters was that medical interventions were performed on them as young children, in the absence of their parents having a full understanding of the consequences of the procedures.³¹ This lack of understanding is probably not unsurprising given the "enormity of the

23 "The Inquiry into Discrimination Experienced by Transgender People: Intersex Roundtables" Human Rights Commission <www.hrc.co.nz>.

24 Now known primarily as Bo Laurent, Cheryl set up the now-defunct Intersex Society of North America in 1993.

25 Milton Diamond "Pacific Centre for Sex and Society" (11 April 2015) University of Hawai'i Mānoa <www.hawaii.edu>.

26 Alice Dreger "Is Anatomy Destiny?" (December 2010) TED <www.ted.com>.

27 *Intersexion* (directed by Grant Lahood, Ponsonby Productions, 2012).

28 Human Rights Commission, above n 14, at [7.5].

29 At [7.8]–[7.9].

30 At [7.42] (emphasis added).

31 At [7.14]–[7.15].

distress, the panic so many parents feel when they learn their child has a DSD".³² One submitter noted that female genital mutilation is criminalised, but not surgery on intersex infants.³³ The Commission concluded:³⁴

The overwhelming view of the intersex people who met with the Inquiry was that, except in the case of medical emergencies, intersex children should not be operated on to remove ambiguous reproductive or sexual organs. ... One person suggested that – in cases where it was not possible to delay surgery so a child could participate in the decision-making process, an independent advocate should be available to represent the interests of the child.

As already noted, following the publication of the Report of the Transgender Inquiry, the Human Rights Commission organised and facilitated two roundtable discussions in order to hear further from members of the intersex community, as well as family members with children with intersex medical conditions and specialist health professionals. Participants in the roundtable noted the lack of experienced medical professionals in New Zealand, especially in smaller centres, as well as the lack of education for all those dealing with parents who may, or do, give birth to a child with an intersex condition. The issue of parental consent to early treatment, including surgery, was noted as being fraught, given that a parent may not always have all the relevant information and feel under pressure to make a decision speedily.

The overwhelming view (as voiced publically) of those adults who were subject to non-reversible surgery as infants in order, for example, to "look like a girl", is that such surgery should wait until gender identity is clear – parents should not feel forced into making an early decision as to surgery.³⁵

Even when the surgery results in aesthetically pleasing and sexually functioning genitals, it may be that it is "irreparably incorrect".³⁶ Intersex people may well end up identifying with the gender opposite to their surgically assigned sex. This "gender dysphoria" can be addressed by hormone treatment and surgery, as it is in the case of trans people, but it is significantly more difficult to attempt to replace genitals removed at birth.

32 Feder, above n 5, at 143.

33 Human Rights Commission, above n 14, at [7.16].

34 At [7.14]–[7.15].

35 Hazel Beh and Milton Diamond "An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?" (2000) 7 *Michigan Journal of Gender and Law* 1.

36 Kishka-Kamari Ford "First Do No Harm' – The Fiction of Legal Parental Consent to Genital-Normalising Surgery on Intersexed Infants" (2001) 19 *Yale L & Pol'y Rev* 469 at 484.

By way of contrast, a number of studies into the experience of intersex adults who did not receive surgery, but should have if historical practice had been followed, have found high levels of psychological well-being and low percentages of gender identity disorder. One study involved 20 men with micro-penises, all of whom felt male and were sexually functional. Only six reported being teased about their appearance.³⁷ One such man is Hale Hawbecker, who tells his story in order to convince surgeons, and parents, to delay (or decline) surgery on intersex infants.³⁸

"If not for the two essential Hawbecker characteristics, denial and procrastination," he tells a large audience ... "I would be sitting here a very, very, very angry lesbian. The doctors told my parents I had a very, very small penis. My parents said, 'Do we have to do anything about it now?' And when the doctors hesitated, my parents took me home and wouldn't bring me back." The doctors told the Hawbeckers that their son was deformed and, if not treated surgically, would probably kill himself from shame when he entered adulthood. "I didn't," he says. For a moment, he is visibly uncomfortable and saddened both by what might have happened and by the actual difficulties of his physical condition. "You could look at my genitals and find them pathetic, or" – and he smiles – "you can look at them as my wife and I do and find them ... adorable. But they are mine, they are intact, and I will be grateful for the rest of my life to my parents for their decision to let me be."

The audience ... exhales in relief. They are horrified by the idea that this perfectly nice, perfectly ordinary man might have been mutilated and forced to live as a girl because his penis was so small as to disturb his doctor.

Although most current research comes from other countries, the intersex communities in New Zealand tell similar stories and raise similar issues. Submitters also reported on the difficulty of accessing their medical records, or that medical records were not kept for a sufficiently long time to enable them to look for them when they were eventually told of their condition.³⁹ They were frustrated with the health-funding model that paid for their (unwanted) surgery as a child, but would not provide resources to reverse the procedures.⁴⁰

IV GENITAL SURGERY ON INTERSEX INFANTS: RECENT LOCAL AND INTERNATIONAL ACTIONS

By 2015 global recognition of the different position of intersex people has resulted in the addition of "I" to the acronym used to refer to the communities of people identifying as lesbian, bisexual, gay or trans: hence "LBGTI". There is also an increased use of the term SOGI (sexual

37 PL Chau and Jonathon Herring "Defining, Assigning and Designing Sex" (2002) 16 IJLPF 327 at 336.

38 Amy Bloom *Normal: Transsexual CEOs, Crossdressing Cops and Hermaphrodites with Attitude* (Random House, New York, 2002) at 118.

39 Human Rights Commission, above n 14, at [7.8]–[7.22].

40 At [7.24].

orientation and gender identity) as a way of recognising the fluidity of sexual citizenship and acknowledging the legitimate challenge to the traditionally immutable definitions of gendered bodies.

The internet has made it possible for intersex people around the world to connect and share their experiences and concerns, allowing the harm and pain that has been visited on intersex people due to silence, shame and isolation to be alleviated in some way. International institutions have condemned the treatment of intersex infants. In some jurisdictions, select committees have reported on the need to address the particular needs of intersex people.⁴¹ In the United States, parents have initiated proceedings against the medical professionals who operated on their infant without their informed consent.⁴² In New Zealand, a Member of Parliament referred to the situation of children born with ambiguous gender in the third reading of the amendment to the Marriage Act 1955.⁴³ Much has therefore happened since 2007 to increase the visibility of those born with an intersex condition and to identify issues which need to be addressed in order to both acknowledge the harm caused historically and to prevent harm in the future.

In 2009 the Australian Human Rights Commission considered the issue of surgery on intersex infants from a human rights perspective.⁴⁴ The Commission stated that the "Yogyakarta Principles are persuasive in shaping our understanding of how existing binding human rights obligations relate to people who are sex and gender diverse".⁴⁵ The Yogyakarta Principles were outlined in Indonesia in 2006, and launched in March 2007, as an application of international human rights law in relation to sexual orientation and gender identity.⁴⁶ The Yogyakarta Principles were cited in the Report of the Transgender Inquiry and were a reference point for the Human Rights Conference that was held during the second Asia-Pacific Outgames in Wellington, New Zealand in March 2011.⁴⁷ The Principles confirm that "surgery on infants who are intersex is a human rights issue".⁴⁸ Principle 18B provides that states shall:

41 See for example Community Affairs References Committee of the Senate (Australia) *Involuntary or coerced sterilisation of intersex people in Australia* (25 October 2013).

42 See for example *MC v Amrhein* (4th Cir, no 13-2178, 26 January 2015).

43 Paul Hutchison MP: (17 April 2013) 689 NZPD 9501.

44 Australian Human Rights Commission *Surgery on intersex infants and human rights* (July 2009).

45 At 4.

46 International Commission of Jurists and International Service for Human Rights *The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (March 2007).

47 Human Rights Commission, above n 14, at [2.14].

48 Australian Human Rights Commission, above n 44, at 4.

Take all necessary legislative, administrative and other measures to ensure that no child's body is irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with the age and maturity of the child and guided by the principle that in all actions concerning children, the best interests of the child shall be a primary consideration.

Research about the current medical practice, and its consequences on the mental and physical health of intersex people and their families is ongoing. In July 2013, Geraldine Christmas completed her PhD at Victoria University. She investigated the clinical management of intersexuality in New Zealand and support for intersex New Zealanders and their families. She concluded:⁴⁹

Support is ... crucial for parents of intersex children. Because we live in a society with ingrained binary sex/gender assumptions, and because intersexuality is not a particularly well-known condition, parents of a newly-diagnosed newborn infant may be understandably bewildered and stressed that the classifications of 'son' or 'daughter' cannot be confirmed immediately.

Support groups are also important for intersex people and their families in terms of providing *legitimate* information. For example, parents of a newborn intersex baby – who may already be stressed – need to be careful when reading easily-accessible information on the internet.

Parents of a newborn intersex baby therefore need to be put in touch with other parents of intersex children, and indeed advocates such as Mani Mitchell ... By contacting support organisations, instead of possibly becoming more stressed by sensationalist accounts on websites, parents can feel supported, comforted and empowered when listening to parents' first hand experiences – and possibly their children's too.

In October 2013 the Community Affairs References Committee of the Australian Senate produced a Report, following a Senate referral, entitled *Involuntary or coerced sterilisation of intersex people in Australia*. The Committee stated that genital normalising surgery on intersex infants still occurs in Australia and cited 2011 international research which found that 78 per cent of practitioners surveyed preferred that the surgery take place before the child is two years old.⁵⁰ The Committee concluded:⁵¹

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

49 Geraldine Christmas "'It's a... does it matter?' Theorising 'boy or girl' binary classifications, intersexuality and medical practice in New Zealand" (2013) 27 *Women's Studies Journal* 25 at 34.

50 Community Affairs References Committee of the Senate, above n 41, at [3.48].

51 At [3.128].

- There is frequent reference to "psychosocial" reasons to conduct normalising surgery. To the extent that this refers to facilitating parental acceptance and bonding, the child's avoidance of harassment or teasing, and the child's body self-image, there is great danger of this being a circular argument that avoids the central issues. Those issues include reducing parental anxiety, and ensuring social awareness and acceptance of diversity such as intersex. Surgery is unlikely to be an appropriate response to these kinds of issues.

The Senate Committee recommended that:⁵²

[A]ll medical treatment of intersex people takes place under guidelines that ensure treatment is managed by multidisciplinary teams within a human rights framework. The 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 primary psychosocial reasons.

Currently, clinical psychologist Denise Steers, based at the Otago University School of Medicine in Wellington, is interviewing three key groups: health professionals (including endocrinologists, paediatricians and surgeons); parents of children born intersex; and, young adults who are intersex. The study will investigate both current practice but also the factors that influence clinical decision making by health professionals and parents when a child is born with an intersex condition. The effects of such decisions will be sought from young people who have to live with the consequences of decisions made by their parents and health professionals. The importance of this type of study has been noted for some time.⁵³

Steers' work is part of a global interest in gathering a full picture of what is actually happening internationally and the effects of medical intervention on all people with intersex conditions. At present in New Zealand, early sex determinations and genital-normalising surgery on intersex infants continues, with surgeons extolling the virtues of early surgery in order to achieve the "best" results. As Geraldine Christmas documented, parents of a newborn are not always best placed to make decisions that will have life-long implications for their child, and far more support and information is required – even about matters that parents may not want to contemplate so early in their child's life. On this point Katrina Roen, another (now New Zealand-based) researcher, makes the following observations:⁵⁴

52 Recommendation three at xiv.

53 See for example Caroline Saunders, Bernie Carter and Lynne Goodacre "Parents need to protect: influences, risks and tensions for parents of prepubertal children born with ambiguous genitalia" (2012) *Journal of Clinical Nursing* 3315 at 3321; and Drew MacKenzie, Annette Huntington and Jean A Gilmour "The experiences of people with an intersex condition: a journal from silence to voice" (2009) *Journal of Clinical Nursing* 1775 at 1781.

54 Katrina Roen "Clinical Intervention and Embodied Subjectivity: Atypically Sexed Children and their Parents" in Morgan Holmes (ed) *Critical Intersex* (Queer Interventions Series, Ashgate Publishing, Surrey, 2009) 15 at 34 (footnotes omitted).

Many clinical texts concerned with early surgical processes lose sight of the temporality of intersex surgery: it is rarely acknowledged that the treatment of an intersex child is about facilitating a life-long relationship with one's body and relationships that involve bodily intimacy with others. ... Where adult sexuality is mentioned, it is usually reduced to very functional and normative criteria, such as the ability of the vagina to house a penis, or whether the patient marries. What is less likely to be mentioned is the experience of the intersex adult in terms of sexually intimate relationships, and their reflections on how their sexual anatomy figures in those relationships and whether or not, from that point of view, the surgery they went through as infants was worthwhile.

Julie Greenberg ends her valuable work, *Intersexuality and the Law*, with the following important message to lawyers in particular:⁵⁵

We should not continue to leave decisions about the treatment of people with an intersex condition solely to medical practitioners. In areas involving sex and gender, science is in its infancy and has engaged in a number of harmful practices based on unsupported theories that later proved to be incorrect.

No conclusive studies have been conducted to determine whether the current medical treatment protocol, which continues to support surgical alteration of "atypical" appearing genitalia, is beneficial. Given this uncertainty and the critical constitutionally protected rights at stake, legal institutions should take a more active role in ensuring that the rights of people with an intersex condition are protected.

It should therefore come as no surprise that most intersex activists and advocates call for an end to non-essential genital normalising surgeries on intersex infants. However, even the inquiry into "non-essential" is fraught.⁵⁶ This too may be a medical decision, where "essential" includes the cultural desirability of a body and sexuality that matches a normative gender identity. Who should therefore decide if medical intervention is necessary or even desirable for the mental and physical health of the child? The various options proposed, including parental control based on enhanced informed consent procedures, the intervention of the courts or leaving the decision to the child when competent to consent for themselves, are all problematic in various ways. Julie Greenberg therefore suggests a combination of an ethics committee with court approval.⁵⁷ However, moving to that model first requires acknowledgement by the medical profession that the current process requires reform – including acceptance that surgery may not be the best option.

Recent engagement with this issue in both national and international areas has included submissions by local intersex communities during the Universal Periodic Review (UPR). In 2013 Aotearoa New Zealand's Sexual Orientation, Gender Identity and Intersex (SOGII) UPR Coalition

55 At 135.

56 Community Affairs References Committee of the Senate, above n 41, at [3.128].

57 Greenberg, above n 4, at 42.

made a submission to the United Nations' 2014 UPR of New Zealand's human rights record.⁵⁸ ITANZ has also made a submission on New Zealand's draft periodic report on the Convention Against Torture.⁵⁹ Both contributions included the following statements:⁶⁰

If surgery is not medically necessary to perform while the person is an infant (for the child's physical well-being), any irreversible treatment should not occur until the person can give free and fully informed consent. Such surgery has recently been categorised as a violation of children's rights by the International NGO Council on Violence against Children (October 2012) and in February 2013 the Special Rapporteur on torture (including ill-treatment in health care settings) called on all States to repeal any law allowing genital-normalising surgery, when "enforced or administered without the free and informed consent of the person concerned."

We therefore recommend that in New Zealand there should be:

- *statutory prohibition of non-consensual surgical procedures on children aimed solely at correcting genital ambiguity;*
- *facilitation of dialogue between intersex people, relevant government agencies, District Health Boards and medical practitioners in order to best inform policy and medical practice regarding intersex conditions; and*
- *compulsory provision of training in relevant undergraduate and postgraduate courses on appropriate medical responses to intersex conditions.*

These recommendations were restated in September 2013 as part of the New Zealand SOGII⁶¹ response to New Zealand's draft country statement on the Second UPR. Despite this, no mention was made of these specific concerns in the final response by the New Zealand Government. Instead the following statement was made (tabled in June 2014):⁶²

The New Zealand Government is aware that some issues raised by the Human Rights Commission and NGOs in their UPR submissions were not reflected in the interactive dialogue and Working Group recommendations, for example issues around legal abortion and the rights relating to *sexual orientation*,

58 Aotearoa New Zealand's Sexual Orientation, Gender Identity and Intersex (SOGII) UPR Coalition "Submission to the United Nations Universal Periodic Review" (2013).

59 Intersex Trust Aotearoa New Zealand (ITANZ) "Alternate NGO Submission on the sixth periodic report to the United Nations on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment from New Zealand" (13 January 2015) (on file with author).

60 At 3–4, paraphrasing SOGII, above n 58, at 8.

61 Based on the United Nations category of "sexual orientation and gender identity" with the addition of intersex.

62 Ministry of Foreign Affairs and Trade *New Zealand Government Response to the Second Universal Periodic Review* (2014) at [3] (emphasis added).

gender identity and intersex people. We intend to follow up on these issues separately as part of our commitment to ongoing engagement with civil society on the UPR.

Following this statement, there was another opportunity to make a public statement in support of the concerns about surgery on intersex infants. In February 2013, the Special Rapporteur on Torture, Juan E Mendez, in his Report dealing with forms of abuse in health care settings said:⁶³

The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including *forced genital-normalizing surgery*, involuntary sterilization, unethical experimentation, medical display, "reparative therapies" or "conversion therapies", when enforced or administered without the free and informed consent of the person concerned. He also calls upon them to outlaw forced or coerced sterilization in all circumstances and provide special protection to individuals belonging to marginalized groups.

ITANZ was of the view that this statement was a clear direction to the New Zealand Government to review the current laws and practices which impact in these ways on members of trans and intersex communities – in particular: ss 28 and 29 of the Births, Deaths, Marriages and Relationships Recognition Act 1995; s 204A of the Crimes Act 1961; and, the current medical practice of cosmetic genital surgery on intersex infants without the free and fully informed consent of the child or the child's parents. However, when New Zealand's National Preventive Mechanism (NPM) under the Optional Protocol to the Convention Against Torture (OPCAT) released its seventh annual report on 9 December 2014, no mention was made of any of these issues.⁶⁴ ITANZ has therefore recently joined other community groups in voicing its concerns directly to the Secretariat of the Committee against Torture.⁶⁵

ITANZ was also represented by Mani Mitchell at the second International Intersex Forum in Stockholm in December 2012. The demands that were promulgated after that Forum (and the later one in December 2013 in Malta) are consistent with the concerns expressed in New Zealand.⁶⁶

The Forum agreed to affirm the principles of the first International Intersex Forum and extended the demands aiming to end discrimination against intersex people and to ensure the right of bodily integrity and self-determination:

63 Juan E. Méndez *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment A/HRC/22/53* (2013) at [88] (emphasis added). See also the collection of work following this Report: Center For Human Rights and Humanitarian Law *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report* (American University, Washington, 2014).

64 Human Rights Commission *Monitoring Places of Detention: Annual report of activities under the Optional Protocol to the Convention Against Torture (OPCAT)* (Auckland, 2014).

65 Submission on file with the author.

66 ILGA Europe "The Second International Intersex Forum concluded" (press release, 12 December 2012).

1. To put an end to mutilating and "normalising" practices such as genital surgeries, psychological and other medical treatments, including infanticide and selective abortion (on the grounds of intersex).
2. To ensure that the personal, free, prior, and fully informed consent of the intersex individual is a compulsory requirement in all medical practices and protocols.
3. Creating and facilitating supportive, safe and celebratory environments for intersex people, their families and surroundings.
4. In view of ensuring the bodily integrity and health of the intersex child, psycho-social support and non-pathologising peer support be provided to parents and/or care providers and the child's immediate family instead of surgical or other medical treatment unless such interventions are life-saving.
5. The provision of all human rights and citizenship rights to intersex people.
6. The provision of access to one's own medical records and any documentation, and the affirmation of the intersex person's right to truth.
7. The acknowledgement and redress of the suffering and injustice caused in the past.

Lack of action through country review mechanisms is not unfamiliar regarding these issues, and some academics outline the potential risks of engaging with international human rights processes and mechanisms.⁶⁷ In the meantime, ITANZ (with financial assistance from community funders such as the JR McKenzie Trust) continues to support Mani Mitchell in her work. Mani offers lectures, seminars and education programmes at tertiary institutions, government departments, schools and NGOs (such as Women's Refuge and Rape Crisis). This includes speaking to law and psychology classes at Victoria University and medical students,⁶⁸ nurses and midwives at Auckland and Massey Universities respectively.

International support for local initiatives came unexpectedly in April 2015 from another small island country – The Republic of Malta, a member state of the Commonwealth of Nations. On 14 April the Gender Identity, Gender Expression and Sex Characteristics Act⁶⁹ came into force, which notably provides, in art 14(1):

⁶⁷ Jena McGill "SOGI – So What? Sexual Orientation, Gender Identity and Human Rights Discourse at the United Nations" (2014) 3 *Canadian Journal of Human Rights* 1; and Tom Dreyfus "The 'Half-Invention' of Gender Identity in International Human Rights Law: From CEDAW to the Yogyakarta Principles" (2012) 37 *AFLJ* 33.

⁶⁸ As part of an elective course entitled: "That's a bit queer: Diversity of sex, gender and sexuality and medicine".

⁶⁹ Chapter 540 of the Maltese Code.

It 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.

Although this "ban" was welcomed enthusiastically by intersex communities around the world,⁷⁰ Article 14 still allows for parental consent to surgery with agreement of an interdisciplinary team, who must give paramount consideration to the best interests of the child (see art 4(5)(b)). Article 14(2) does state that "medical intervention which is driven by social factors without the consent of the minor, will be in violation of this Act" (such a violation potentially resulting in a criminal conviction and a maximum fine of 1,000 Euros: art 11(3)). It will be important to see how "social factors" is interpreted; the width of this term being the key to the effectiveness of the legislation. However, there is no doubt that this enactment has provided another argument in favour of regulation for activists and communities in other countries to refer to.

V CONCLUSION

Since the first public consideration of the issue of surgical and medical interventions on intersex infants in 2007 (as part of the New Zealand Human Rights Commission transgender inquiry process), the concerns of the local and global intersex communities have been far more visible. One of the consequences of this visibility has been consideration of genital normalising surgery as a breach of human rights, both domestically and internationally. Close by, an Australian Senate Committee has recommended regulation of the common practice of surgery, noting that there is an absence of information suggesting that this form of intervention is necessary or helpful. To date, however, none of the Committee's recommendations have been implemented.

Surgery on intersex infants is still usual practice in Aotearoa New Zealand, despite the argument that such surgery breaches s 204A of the Crimes Act 1961 and falls within the prohibition on torture in health care settings. The current medical model relies on parental consent to proceed – although activists query whether parents can truly be said to be giving full and informed consent in the absence of a multi-disciplinary team (including an intersex adult advocate) assisting them to make a decision. The establishment of such a team has recently occurred in Malta, as part of art 14 of the Gender Identity, Gender Expression and Sex Characteristics Act 2015, which also criminalises medical intervention "which is driven by social factors without the consent of the minor".

This recent reform serves as a reminder that there has not been a uniform or universal response to the issue of surgery on intersex infants. In fact, in many countries, such as New Zealand, there has been overwhelming silence on the issue except within SOGII communities. There is no doubt, however, that a willingness of law and policy makers to engage with the debate is overdue and essential for change to occur – even if it is only to develop protocols which should be followed

70 See for example Organisation Intersex International Europe "OII-Europe applauds Malta's Gender Identity, Gender Expression and Sex Characteristics Act" (press release, 4 May 2015).

when an intersex child is born. In the meantime, those involved in education and raising public awareness, such as Mani Mitchell and ITANZ, can only continue to talk about the importance of acknowledging the potential harm of such surgeries and the need for a more nuanced approach to managing the range of normal sex variations.

Atypical sex anatomy is not some exceptional difference, but an ordinary matter of our humanity. Like most human matters, it is not clean, or tidy, or easy, but it is a vital measure of the embodied vulnerability we are obligated to protect. Acknowledging the value of our imperfections lays the groundwork for the ongoing reflection that is the condition of our flourishing.⁷¹

⁷¹ Feder, above n 5, at 210.