

# Recognising the Identity and Rights of Transgender, Transsexual and Intersex People in Western Australia

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WA Gender Project Position Paper

**WA Gender Project Inc.**  
**PO BOX 408**  
**MOUNT LAWLEY WA 6929**

web: [www.wagenderproject.org](http://www.wagenderproject.org)

e-mail: [info@wagenderproject.org](mailto:info@wagenderproject.org)

## Executive Summary

It is commonly assumed that sex is a straightforward matter, and is determined by our chromosomes. However, in recent decades medical research has revealed that sex is far more complex than originally thought. For example, it is possible to possess a “male” chromosome pattern of 46,XY but carry an alteration in the gene necessary to make the body respond to testosterone. Individuals with the complete form of this condition are born with female genitals and almost always identify as women. In reality, sex is a complex relationship of genetic, hormonal, morphological, biochemical, and anatomical differences that impact the physiology of the body and the sexual differentiation of the brain.

Whilst sex is a simple matter for the majority of people, there are a small, but significant number of individuals whose sex or gender cannot be classified so easily. The terms *intersex*, *transsexual*, and *transgender* are commonly used to describe such people. In this report, the term *intersex* is used to refer to people with reproductive systems or sexual characteristics that are neither exclusively male nor female; *transsexual* is used to refer to those people who feel they belong to the opposite sex to the one assigned at birth; and *transgender* is used to describe those people whose behaviour or style of dress is inconsistent with social expectations of the sex assigned to them at birth, but are not transsexual or intersex. This would include feminine men, masculine women, and people who cross-dress or present androgynously. Transsexualism and intersex conditions are distinct from sexual orientation, and transsexual, transgender, and intersex people show the same range of sexual attractions as the general populace.

The problems facing transgender, transsexual and intersex (TTI) people are thought to transcend those of lesbian, gay and bisexual individuals, and they are considered to be at an increased risk for harassment and violence. Recent Australian research found that TTI people experience significantly higher rates of discrimination, harassment and vilification than both their heterosexual and same-sex attracted non-TTI peers, and that 84 percent of TTI Australians have experienced at least one form of discrimination or abuse in settings such as education, employment, medical treatment, police/law enforcement, parenting, and the provision of goods and services. Present anti-discrimination provisions do not adequately cover these individuals. For example, transsexual people who have not undergone an approved surgical procedure are excluded. Comprehensive protection from discrimination and vilification is urgently needed.

Many of the problems experienced by transsexual people stem from the inability to obtain appropriate identifying documents, such as a passport and birth certificate. The birth certificate is a crucial document, and as a basic document of general identification, it must often be produced to obtain employment, insurance, travel documents, and proof of age. Presently, transsexual people who have not obtained a corrected birth certificate can be denied Medicare rebates for necessary medical care (for example, mammograms for transsexual women, and testosterone therapy for transsexual men), and are issued with passports that do not reflect their identity and appearance. Travel is difficult and in some cases impossible when identifying documents are inconsistent with appearance. It is therefore of great importance to transsexual and intersex people that the birth certificate can be corrected.

At present, all states and territories have provisions that enable intersex people to correct their birth certificates, and allow transsexual people to change theirs once certain surgical procedures have been undertaken. However, with the exception of Victoria, no state or territory allows intersex people who identify as intersex rather than male or female, to change their birth certificate to reflect their indeterminate sex. In addition, all jurisdictions require specific surgeries to have taken place before the transsexual individual can change their birth certificate. The requirement for surgery is problematic as there are many reasons why transsexual people may not undergo a qualifying surgical procedure. These include the high cost of surgery, medical contraindications and risks, deciding to prioritise surgeries that do not qualify, choosing to wait for improved surgical techniques, and personal reasons.

A recent study of transsexual people in Western Australia found that less than one third had undergone a qualifying surgical procedure. The most common reasons for not undergoing surgery included the inability to afford surgery and the lack of services available locally. In the study, 23% of transsexual men, and 58% of transsexual women reported that their gross annual income was less than \$30,000. Given that the cost of surgery currently required for transsexual women to obtain a corrected birth certificate ranges from \$25,000 - \$30,000, the present system is clearly inequitable.

The requirement for surgical intervention before legal recognition of sex is afforded has been criticised by a number of individuals and bodies, including the Chief Justice of the Family Court of Australia, Anti-Discrimination Board of NSW, New Zealand Human Rights Commission, European Court of Human Rights, and the authors of the Yogyakarta Principles, which clarify the existing state of international human rights law in relation to gender identity and sexual orientation.

A consequence of being unable to correct the birth certificate is that transsexual people are compelled to disclose highly sensitive data on their health whenever they are requested to show this document. Transsexualism is a recognised medical condition, and the compulsion to disclose this information contravenes the right to privacy. The European Court of Human Rights recently found that the government of the United Kingdom breached this right by refusing to issue corrected birth certificates to transsexual people. The Court gave a strong indication to the UK government and all other agencies that they are under a positive obligation to treat transsexual people, in all areas of their lives, with respect and dignity, and to accord them equal rights and status with all other citizens. Legislation now enables transsexual people to obtain legal recognition of their sex, for all purposes, after they have undergone transition which does not necessarily include genital surgery. Similar systems are operating in other European countries, such as Spain and Finland, and others are expected to follow. WA Gender Project submit that a similar system should operate in Western Australia. Transsexual people who have been receiving hormonal therapy or have undergone surgeries that are not currently recognised under the Act will have clear physical attributes of the sex with which they identify, and their commitment should not be overlooked.

The medical care presently available to transsexual and intersex people in Western Australia is limited. Primary quality of care issues for intersex people include a lack of consent for childhood surgeries, lack of counselling and support for intersex individuals and their families, lack of knowledgeable health professionals, and a lack of information regarding alternative treatments. Quality of care issues for transsexual people include a lack of trained medical professionals and local services. The costs associated with transition include regular visits to doctors, (including specialists such as endocrinologists), life-long hormonal therapy, bone density scanning, speech therapy and electrolysis (for transsexual women), and possible surgical intervention. Many of these costs are excluded from both the public health system and private insurance, and transsexual people face excessive out-of-pocket expenses.

Transsexual and intersex people should be able to access comprehensive medical care through the public health system, as they would for any other health problem. WA Gender Project submit that a full, multi-disciplinary centre of excellence should be established in Western Australia, similar to the Monash Gender Dysphoria Clinic, operating at the Monash Medical Centre in Victoria. Such a centre should comprise a team of professionals from the disciplines of psychiatry, psychology, endocrinology, social work, speech therapy, gynaecology, and plastic surgery. The centre would serve the needs of both transsexual and intersex people, and the parents of intersex children.

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# 1 Introduction

## 1.1 About WA Gender Project

WA Gender Project Inc. (WAGP) is an education and advocacy group for transgender, transsexual and intersex (TTI) people living in Western Australia. We seek to inform governments and the wider community about the needs of people whose sex or gender does not match societal expectations associated with the sex assigned to them at birth. In particular, WAGP aims to:

- advance the human rights of all TTI people - irrespective of medical treatment undertaken - as well as their significant others;
- act as a resource, and provide information and education regarding issues surrounding sex and gender;
- improve access and service provision for TTI people by working with government, individuals, professional bodies and community organisations; and to
- promote positive representation and increased visibility of TTI people, and work toward a society where such individuals, and their significant others, are free from harassment and discrimination.

## 1.2 Who are transgender, transsexual and intersex people?

Children are taught that sex is determined by our chromosomes, but in recent decades medical research has revealed that sex is far more complex than originally thought. For example, it is possible to possess a “male” chromosome pattern of 46,XY but carry an alteration in the gene necessary to make the body respond to testosterone. This condition is called *androgen insensitivity syndrome* and individuals with the complete form of the condition are born with external genitals which are completely female in appearance. Almost all of these individuals feel themselves to be women.

Whilst sex is a straightforward matter for the majority of people, there are a small, but significant number of individuals whose sex cannot be classified so easily. The labels *transgender*, *transsexual* and *intersex* are often used to describe these people and are defined overleaf.

### 1.3 Terms used in this paper

**Sex** is the physiological make-up of a person. It is commonly expressed as a binary and used to divide people into males and females. However, in reality, sex is a “complex relationship of genetic, hormonal, morphological, biochemical, and anatomical differences that impact the physiology of the body and the sexual differentiation of the brain. Although everyone is assigned a sex at birth, approximately 2 percent of the population are intersex and do not fit easily into a dimorphic division of two sexes that are ‘opposite’” (Lev, 2004, p. 398).

Blackless and colleagues (2000, p. 151) note that “the belief that *Homo sapiens* is absolutely dimorphic with the respect to sex chromosome composition, gonadal structure, hormone levels, and the structure of the internal genital duct systems and external genitalia, derives from the platonic ideal that for each sex there is a single, universally correct developmental pathway and outcome”. Reviewing the medical literature from 1955 to 2000, they found that the frequency of deviation from the male or female norm was as high as 2 percent of live births, and “corrective” genital surgery occurred in 1-2 of 1,000 live births.

The number of people whose genetic sex does not match their assigned sex is far greater than most people would realise. Infertility clinics have found that up to 11% of men with fertility problems are discovered to have a 47,XXY chromosome pattern (Okada et al., 1999). During the 1996 Olympic games in Atlanta, eight female athletes were found to have Y chromosome material. As a result, the International Olympic Committee abandoned its policy of genetic sex testing (Genel, 2000).

**Gender** is a term used to refer to the social and cultural construction of what it means to be a man or a woman, including roles, expectations and behaviour. Certain roles and behaviours are assumed to be “natural” to men, and are referred to as *masculine*. Others are assumed to be innate to women and these are described as *feminine*. Although the categories of masculine and feminine are thought to be natural, they are subject to cultural variation and have not remained fixed over time (Butler, 1990; Lev, 2004). As Serano (2007, p. 322-3) explains, “these days it’s common for people to view being thin as a feminine trait. While femininity and thinness have become almost synonymous in contemporary Western culture, women who were more full-figured were considered the feminine ideal in past eras. Similarly, today most of us grow up believing that pink is undoubtedly the most feminine of colors. In the early 1900s, however, it was more common for people to associate pink with boys and blue with girls”.

**Intersex** (previously hermaphrodite) is a term commonly used to describe people with reproductive systems or sexual characteristics that are neither exclusively male nor female. Such variations may not be readily apparent and some intersex people do not discover their intersex state until later in life. For example, some women with complete androgen insensitivity syndrome do not discover their condition until puberty, when they fail to menstruate. Intersex conditions may result from genetic polymorphisms, endocrine disorders, and in utero exposure to hormones and endocrine-disrupting agents.

Until recently, the practice of subjecting infants with ambiguous genitalia to “corrective” surgeries was routine. However, a significant number of affected individuals are subsequently unhappy with the sex of rearing, sometimes with serious consequences for their mental health and well-being (Cohen-Kettenis, 2005; Johannsen, Ripa, Mortensen, & Main, 2006). It is now known that “the process of sexual differentiation is not completed with formation of the external genitalia but that the brain, a substrate of sexual and nonsexual behavior, also undergoes sexual differentiation to match the other characteristics of sex” (Gooren, 2006, p. 593). Sexual differentiation is a complex process and involves more than chromosomes and genitals.

**Transsexual** is a term used to describe a person who feels they belong to the opposite sex to the one assigned at birth. Historically, there has been confusion between homosexuality and transsexualism, with some viewing both as evidence of femininity in males and masculinity in females. However, as Gooren (2006, p. 591) explains, “this approach is flawed and lacks thorough enquiry into the matter, since the two ... are fundamentally different”. Transsexual people seek to be accepted as members of the sex opposite to the one they were assigned at birth, and what is perceived as cross-gender behaviour are “serious attempts to live the life of the desired sex. The desire to become a member of the opposite sex is alien to homosexuals” (Gooren, 2006, p. 591). Transsexualism is also distinct from cross-dressing for sexual thrill or compulsion.

When transsexual people first came to the attention of the medical profession they presented a puzzle, since doctors could find no obvious sexual incongruity. Regrettably, transsexual people were considered mentally ill and attempts were made to cure them through psychotherapy, hormone therapy and various types of aversion therapy including electric shock and hypnosis (Ratnam, Goh, & Tsoi, 1991). These attempts failed, because as transsexual people contend, there is no underlying pathology (Califia, 2003). In their draft guidelines for the treatment of transsexual people, the Royal College of Psychiatrists state: “the experience of this dissonance between the sex appearance, and the personal sense of being male or female, is termed gender dysphoria. **The diagnosis should not be taken as an indication of mental illness.** Instead, the phenomenon is most constructively viewed as a rare but nonetheless valid variation in the human

condition, which is considered unremarkable in some cultures (Royal College of Psychiatrists, 2007, p. 8) [emphasis added].

Transsexualism is now thought to have a biological basis (Meyer-Bahlburg, 1982; Michel, Mormont, & Legros, 2001), with genetic polymorphisms (Cohen-Kettenis & Gooren, 1999; Henningsson et al., 2005), pre- and perinatal organising effects of hormones (Cohen-Kettenis, van Goozen, Doorn, & Gooren, 1998; Schneider, Pickel, & Stalla, 2006) and exposure to endocrine-disrupting agents (Dörner et al., 2001) suggested to play a role. Transsexual individuals have been shown to have a brain structure consistent with their sex of identification (Kruijver et al., 2000; Zhou, Hofman, Gooren, & Swaab, 1995).

Recently, the right of transsexual people to marry was tested in the Family Court of Australia. Based on the medical evidence tendered, His Honour Justice Chisholm found that transsexualism has a biological basis and that a distinction should not be drawn between the rights of transsexual individuals and those with intersex conditions. He concluded:

*In my view, the expert evidence in this case affirms that brain development is (at least) an important determinant of a person's sense of being a man or a woman*

...

*In my view, the evidence about the experience of transsexuals, and the strength and persistence of their feelings, fits well with the view that "transsexuals have a sexual brain development contrary to their other sex characteristics such as the nature of their chromosomes, gonads, and genitalia"*

...

*I am satisfied that the evidence now is inconsistent with the distinction formerly drawn between biological factors, meaning genitals, chromosomes and gonads, and merely "psychological factors", and on this basis distinguishing between cases of intersex (incongruities among biological factors) and transsexualism (incongruities between biology and psychology)*

...

*In my view the evidence demonstrates (at least on the balance of probabilities), that the characteristics of transsexuals are as much "biological" as those of people now thought of as inter-sex. The difference is essentially that we can readily observe or identify the genitals, chromosomes and gonads, but at present we are unable to detect or precisely identify the equally "biological" characteristics of the brain that are present in transsexuals*

(FamCA 1074, 2001)

The decision was subsequently upheld by the full court of the Family Court of Australia in 2003 (McConvill & Mills, 2003). The biological basis of transsexualism is now accepted as a fact proven to the civil standard under Australian common law.

**Transgender** is a term used to describe people whose expression of gender differs from the social expectations of the sex that they were assigned at birth.

This term is sometimes used as an umbrella term for any person who is perceived to challenge gender norms, such as intersex or transsexual people. However, in this paper, we use this term to describe people whose expression of gender is not consistent with their sex, but are not transsexual or intersex. This would include feminine men, masculine women, and people who cross-dress or present androgynously.

#### **1.4 Issues addressed in this paper**

Transgender, transsexual and intersex people face a number of unique social, medical and legal challenges. Regrettably, TTI people experience high levels of discrimination and harassment, are often unable to obtain appropriate medical care, and face barriers to education, employment, travel, and in other areas of life. For transsexual people, many of these barriers stem from legislation and policy that prevents them from obtaining appropriate identifying documentation. In this paper, we seek to explore some of these problems and present proposals for legislative reform.

## 2 Issues affecting TTI people

### 2.1 Discrimination and harassment

The problems facing transgender, transsexual and intersex people are thought to transcend those of lesbian, gay and bisexual individuals, and they are considered to be at an increased risk for harassment and violence (Levy, Crown, & Reid, 2003). Recent Australian research confirms that TTI people experience significantly higher rates of discrimination, harassment and vilification than both their heterosexual and same-sex attracted non-TTI peers (Pitts, Smith, Mitchell, & Patel, 2006). The Private Lives study, the largest survey of GLBTI<sup>1</sup> people to date, found that:

- personal insults or verbal abuse were experienced by:
  - 74% of transsexual men
  - 70% of transsexual women
  - 64% of intersex men
  - 43% of intersex women
  
- threats of violence or intimidation were experienced by:
  - 29% of transsexual men
  - 47% of transsexual women
  - 27% of intersex men
  - 29% of intersex women
  
- a physical attack of other form of violence was experienced by:
  - 12% of transsexual men
  - 18% of transsexual women
  - 18% of intersex men
  - 29% of intersex women

(Pitts et al., 2006)

A previous study found that found that 84 percent of TTI Australians have experienced at least one form of discrimination or abuse in settings such as education, employment, medical treatment, police/law enforcement, parenting, and the provision of goods and services (McNair, Anderson, & Mitchell, 2001).

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<sup>1</sup> The acronym GLBTI refers to gay, lesbian, bisexual, transgender, transsexual and intersex individuals.

The New Zealand Human Rights Commission recently held an inquiry into the human rights of transgender and transsexual people. Participants reported experiencing discrimination in a wide range of settings, examples of which are given below.

- Several individuals found it difficult to play competitive or social team sport.
- One individual was granted life insurance prior to transitioning<sup>2</sup>, but was subsequently asked to provide medical reports from two endocrinologists and was declined insurance “based on his medical record”.
- A number of individuals highlighted discriminatory health insurance policies that exclude the medical costs associated with transitioning from coverage because they are deemed cosmetic and elective, even when such policies cover pre-existing conditions. One individual noted that coverage was provided to women for mastectomies and to men with breast development (gynaecomastia), but withheld from transsexual men who usually require the same surgeries.
- Some individuals were asked to show their birth certificate to real estate agents in order to check on their tenancy history. Apart from undermining their right to privacy with regard to their transsexual status (and thus medical history), some felt they were treated less favourably once their transsexual status was revealed.
- An individual who had been issued with a corrected birth certificate (with no previous names listed) was concerned he might still be legally required to provide past names for police vetting purposes. This would disclose his transsexual status to future employers.

Such experiences have serious implications for the health and wellbeing of TTI Australians. Discrimination contributes to social labelling and stigmatisation, and increases the likelihood of individuals experiencing psychological distress, social isolation and suicidal ideation (Brown, Perlesz, & Proctor, 2002).

In consideration of the pervasive discrimination experienced by TTI people, WAGP submit that comprehensive protection from discrimination and vilification is urgently needed.

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<sup>2</sup> Transition is the process by which a person changes their body and presentation to match their sense of sex and gender. Transition can include hormonal therapy, surgery, and adjustments to names and style of dress, and is a process that may last for many years.

## 2.2 Difficulty changing identifying documents

The birth certificate is a crucial document. As Walters (1983, p. 73) explains, “the birth certificate is a basic document of general identification, [and] it may have to be produced for obtaining employment, insurance, travel documents and proof of age in other situations. Hence it is of great importance ... that the sex designation on the birth certificate be changed”.

At present, all states and territories have provisions that enable intersex people to correct their birth certificates, and allow transsexual people to change theirs once certain surgical procedures have been undertaken. However, with the exception of Victoria, no state or territory allows intersex people who identify as intersex rather than male or female, to change their birth certificate to reflect their indeterminate sex. In addition, all jurisdictions require specific surgeries to have taken place before the transsexual individual can change their birth certificate. The requirement for surgery is problematic as there are many reasons why transsexual people may not undergo a qualifying surgical procedure. These include:

- the high cost of surgery;
- medical contraindications and risks;
- deciding to prioritise surgeries that do not qualify;
- choosing to wait for improved surgical techniques; and
- personal reasons.

A recent study of transsexual people in Western Australia found that less than one third had undergone a qualifying surgical procedure (Hyde, 2007). The most common reasons for not undergoing surgery included the inability to afford surgery, and the lack of services available locally. In this study, 23% of transsexual men, and 58% of transsexual women reported that their gross annual income was less than \$30,000. Given that the cost of surgery currently required for transsexual women to obtain a corrected birth certificate ranges from \$25,000 - \$30,000, the present system is clearly inequitable.

Most transsexual people living in Western Australia find themselves unable to change their birth certificate and are frequently forced to show documentation that is inconsistent with their appearance, revealing their transsexual status. Walters (1983) reports that “extreme difficulties are encountered by transsexuals attempting to obtain a passport, borrow money or obtain accommodation. Hence, it is not surprising that some turn to making money as ... prostitutes and resort to addictive drugs when the desire to escape from the reality of a sordid life becomes urgent. When life becomes really desperate, self mutilation or suicide may be the end result for some transsexuals (Walters, 1983, p. 70).

Lack of appropriate documentation has implications for health and well-being at both state and federal levels. Medicare Australia will not update the Medicare record unless a corrected birth certificate is presented. This can prevent individuals from obtaining medical care. For example, transsexual women who have not undergone genital surgery can be denied Medicare rebates for mammograms (McNair & Medland, 2002). This is concerning, given that transsexual women, like all women, are at risk of breast cancer (Ganly & Taylor, 1995; Symmers, 1968). Similarly, transsexual men may have difficulty obtaining appropriate hormonal therapy through the Pharmaceutical Benefits Scheme, as testosterone therapy is only subsidised for those whose legal sex is male.

The Department of Foreign Affairs and Trade will only issue passports that bear the sex shown on the birth certificate. Travel is difficult and in some cases impossible when identifying documents are inconsistent with appearance. This is becoming an increasingly significant problem now that airport security measures have been tightened due to the threat of terrorism. WAGP are aware of several instances where transsexual individuals have experienced difficulty entering other countries, or have been detained by customs officials.

Recently, the Chief Justice of the Family Court of Australia criticised the requirement for surgical intervention, noting that such requirements are a “source of a great deal of distress and embarrassment for the person as well as increasing the risk of being unfairly discriminated against” (*FamCA 297*, 2004, p. 65).

In his judgement, His Honour noted:

*I consider it is a matter of regret that a number of Australian jurisdictions require surgery as a pre-requisite to the alteration of a transsexual person's birth certificate in order for the record to align a person's sex with his/her chosen gender identity. This is of little help to someone who is unable to undertake such surgery. The reasons may differ but for example in the present case, a young person such as Alex, on the evidence, would not be eligible for surgical intervention until at least the age of 18 years. Thus, for the many purposes for which a birth certificate is required (such as an application for a passport), a person such as Alex in those jurisdictions is required to produce a birth certificate that describes him as a female in circumstances where in all other respects he is living his life as a male.*

...

*A requirement of surgery seems to me to be a cruel and unnecessary restriction upon a person's right to be legally recognised in a sex which reflects the chosen gender identity and would appear to have little justification on grounds of principle.*

***I would urge the various State and Territory Legislatures that make surgery a pre-requisite for a change in birth certificates to reconsider their position.***

*A scheme for the change of birth certificates which requires a Magistrate or a Board to make a finding of fact but does not make surgery a pre-requisite is, in my view, more consistent with human rights and therefore preferable in comparison with an administrative scheme wherein the applicant must have had surgery to be eligible for the changed birth certificate.*

(FamCA 297, 2004, p. 65-7) [emphasis added]

Others have also questioned the requirement for surgical intervention. According to Principle 3 of the Yogyakarta Principles<sup>3</sup>, which clarify the existing state of international human rights law with relation to gender identity and sexual orientation, individuals should not be required to undertake surgical intervention as a requirement for legal recognition of sex:

*Everyone has the right to recognition everywhere as a person before the law. Persons of diverse sexual orientations and gender identities shall enjoy legal capacity in all aspects of life. Each person's self-defined sexual orientation and gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom. **No one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity.** No status, such as marriage or parenthood, may be invoked as such to prevent the legal recognition of a person's gender identity. No one shall be subjected to pressure to conceal, suppress or deny their sexual orientation or gender identity.*

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<sup>3</sup> The Yogyakarta Principles were initially drafted by the International Commission of Jurists and the International Service for Human Rights, on behalf of a coalition of human rights organisations. The principles were further developed, discussed and refined by a distinguished group of 29 human rights experts from 25 countries, with diverse backgrounds and expertise relevant to issues of human rights law, at Gadjah Mada University in Yogyakarta, Indonesia from 6 to 9 November 2006.

*STATES SHALL:*

- A Ensure that all persons are accorded legal capacity in civil matters, without discrimination on the basis of sexual orientation or gender identity, and the opportunity to exercise that capacity, including equal rights to conclude contracts, and to administer, own, acquire (including through inheritance), manage, enjoy and dispose of property;
- B Take all necessary legislative, administrative and other measures to fully respect and legally recognise each person’s self-defined gender identity;**
- C Take all necessary legislative, administrative and other measures to ensure that procedures exist whereby all state-issued identity papers which indicate a person’s gender/sex – including birth certificates, passports, electoral records and other documents – reflect the person’s profound self-defined gender identity;**
- D Ensure that such procedures are efficient, fair and non-discriminatory, and respect the dignity and privacy of the person concerned;**
- E Ensure that changes to identity documents will be recognised in all contexts where the identification or disaggregation of persons by gender is required by law or policy;**
- F Undertake targeted programmes to provide social support for all persons experiencing gender transitioning or reassignment.

(Yogyakarta Principles, 2007, p. 11-12) [emphasis added]

An additional consequence of being unable to correct the birth certificate is that transsexual people are compelled to disclose highly sensitive data on their health whenever they are requested to show this document. Transsexualism is a recognised medical condition (WHO, 2005), and the compulsion to disclose this information contravenes the right to privacy. This was recently recognised by the New Zealand Human Rights Commission, which found that the inability of transsexual people to change their birth certificate results in “inappropriate, unnecessary or unauthorised disclosure of gender related information and undermines the right to privacy and freedom of expression” (NZ Human Rights Commission, 2007, p. 20).

The European Court of Human Rights, in *Goodwin v UK* and *I v UK* (July 2000, under articles 8 & 12) found that the government of the United Kingdom violated the right to privacy by refusing to issue corrected birth certificates to transsexual people. The Court gave a strong indication to the UK government and all other agencies that they are under a positive obligation to treat transsexual people, in all areas of their lives, with respect and dignity, and to accord them equal rights and status with all other citizens. Legislation now enables transsexual people to obtain legal recognition of their sex, for all purposes, after they have undergone transition which does not necessarily include genital surgery (Royal College of Psychiatrists, 2007).

If Australia's obligations under the ICCPR are understood in light of the European jurisprudence, then Australia is obliged to ensure that its authorities legally recognise the self-identified sex of transsexual people. These obligations would extend to all branches of government (executive, legislative and judicial), and at all levels - national, regional and local. As David and Blight (2004) note, "there will be many cases where surgery has little to do with whether a person is socially recognised as a man or a woman. It is consistent with the goal of protecting human dignity to consider the social and cultural factors that go towards recognising a person as a man or a woman and not only what surgery an individual may or may not have had".

### 2.2.1 High cost of surgical procedures

Sex-affirming surgeries are expensive procedures and are not performed in any public hospital in Australia. Genital surgery for transsexual women costs between \$25,000 and \$30,000 when performed in Australia (Haertsch, 2006), or approximately \$20,000 when performed in Thailand (Suporn, 2006). Surgical procedures for transsexual men are also expensive, with chest reconstruction typically costing \$10,000, and hysterectomy costing between \$5,000 and \$10,000. Genital surgeries for transsexual men are prohibitively expensive, with some U.S. surgeons charging between \$50,000 and \$150,000 for phalloplasty (Green, 1994). None of the quoted figures include the costs associated with accommodation and travel.

Unsurprisingly, many individuals struggle to afford these surgeries, particularly young people, the unemployed and those with disabilities. Such financial pressures compound the adverse outcomes associated with discrimination and finding employment when identity documentation is incongruent with physical appearance.

### 2.2.2 Medical contraindications and risks

Sex-affirming surgeries are associated with significant risks. These include herniation, venous thrombosis, urinary and intestinal fistulae, stenosis, prolapse, infection, urinary and intestinal fistulae, incontinence of urine and stool, tissue necrosis, and loss of ability to achieve orgasm (De Cuypere et al., 2005; Jarolím, 2000; Krege, Bex, Lümmer, & Rübber, 2001). Describing the surgical outcome of transsexual women who underwent surgery in Holland, Hage and Karim (1996) report that 18% of individuals lost the ability to orgasm. Similar figures are quoted by other authors (Krege et al., 2001; Lindemalm, Korlin, & Uddenberg, 1986).

Transsexual people who have undergone genital surgery vary in their satisfaction with the results and some come to regret their decision (Olsson & Möller, 2006). Fee and colleagues (2003, p. 900) explain “some web sites contain warnings ‘for those considering MtF [male to-female] SRS,’ warning, for instance, of reduction or loss of sexual feeling and appetite, for both emotional and anatomical reasons. SRS may sever nerves in an area where nerves are essential to sexual arousal and response, although surgical techniques continue to improve”. Some transsexual people consider the potential risks too great, and eschew surgery.

Other individuals are prevented from undertaking surgery due to pre-existing medical conditions. Contraindications for sex-affirming surgeries include: infection with HIV, mental illness, poorly controlled diabetes, hemophilia, severe hypertension and deep vein thrombosis.

### 2.2.3 Many surgical procedures are not recognised

The Western Australian Gender Reassignment Act 2000 requires that a “reassignment procedure” take place before a corrected birth certificate can be issued. This is problematic, because as David and Blight (2004) explain, “there is no single ‘sex-reassignment surgery’. Rather there are a range of procedures available. For example (for male to female): penectomy (removal of penis), orchidectomy (castration), vaginoplasty (creation of vagina), clitoroplasty (creation of clitoris), labioplasty (creation of labia), breast augmentation, scalp advancement and brow position change, orbital rim reduction, cheek augmentation, rhinoplasty, chin and jaw re-sculpting, thyroid cartilage reduction (reduction of adam’s apple), thigh and buttock augmentation. And, (for female to male): bilateral mastectomy, hysterectomy and removal of ovaries, scrotum construction and testicular implants, phalloplasty (creation of penis), metioidaplasty (clitoral release), urethroplasty (extension of urethra) and vaginectomy (removal of vagina)”.

Non-genital surgeries are particularly important to transsexual women, who use them frequently to facilitate acceptance by others in their desired sex (Dixen, Maddever, Van Maasdam, & Edwards, 1984). Becking and colleagues (2007, p. 557) note that whilst genital surgery is the “private domain of a transsexual, other, more visible, body features can impede a successful social acceptance as a member of the opposite gender. In this respect, common maxillofacial procedures can be of benefit for this group of patients”. Such surgeries can be vital to social acceptance for some and should not be viewed as trivial, cosmetic procedures. As the Royal College of Psychiatrists explain, these procedures involve “aggressive cranial surgery and depending on the amount of work undertaken, can take anything from five to twelve hours. Surgery can encompass scalp advancement, brow repositioning, removal of brow bossing on the forehead, re-contouring of the orbital rim, cheek surgery, rhinoplasty, upper lip lift and the re-shaping of the jaw and chin” (Royal College of Psychiatrists, 2007, p. 22). Facial feminisation surgery is an expensive undertaking, with costs ranging from \$20,000 - \$40,000 USD. Given their often critical role in social acceptance, transsexual individuals sometimes choose to have such procedures prior, or in preference to the surgeries currently recognised by the Act.

Transsexual people who have had surgeries that are not currently recognised under the Act, (for example breast implants or facial feminisation surgery for transsexual women, or chest reconstruction for transsexual men), will have clear physical attributes of the sex with which they identify. Their commitment to living as the sex with which they identify should not be overlooked.

#### 2.2.4 Other reasons

Some transsexual people intend to undergo surgical modification of the genitals, but are dissatisfied with present surgical options and choose to wait for improved techniques. For example, the cosmetic result of vaginoplasty is usually good, but current surgical techniques are imperfect. Because the neovagina is not lined with mucosal tissue, transsexual women do not self-lubricate to the degree that natal women do, and dilation of the neovagina must occur regularly to avoid shrinkage and loss of depth. In addition, the skin grafts that are sometimes used can leave the individual with scarring (Lin, Chang, Shen, & Tsai, 2003). However, Italian doctors recently used a patient's own stem cells to grow mucosal tissue to create a vagina in a woman with Mayer-Rokitansky-Küster-Hauser syndrome, a rare condition in which the vagina is absent (Panici et al., 2007). Such advances in technology have the potential to vastly improve functioning for transsexual people.

Statutory definitions of "reassignment procedures" are not consistent nationally. In some states, "any surgical procedure that involves the reproductive organs, that has been carried out for the purpose of assisting the person to be considered a member of the opposite sex, is considered reassignment surgery" (Blight, 2000, p. 1-2). For example, in South Australia, a transsexual man who has undergone chest reconstruction is permitted to correct his birth certificate. The same individual living in Western Australia would also be required to undergo hysterectomy. Some have questioned how this wholly internal surgery will in any way assist them to live as their preferred sex (David & Blight, 2004).

Alternatively, some individuals forgo surgical intervention entirely. Some individuals may consider themselves too old, have religious or cultural reasons or may not feel it necessary - some individuals find that hormonal therapy is sufficient. There is also the issue of individuals who begin the process of transition during childhood. Transsexual children are sometimes prescribed hormonal therapy that halts puberty and prevents the development of secondary sexual characteristics, negating the need for future surgery. For example, a transsexual man who underwent such treatment as a child may not have developed breast tissue, and will not need to undergo surgery to create a male-looking chest.

## **2.3 Difficulty accessing appropriate medical care**

In their position statement on sexual diversity, the Australian Medical Association state that transsexual people are often medically dependent due to the need for ongoing hormonal treatment or possible surgical intervention, and that transsexual people may have unique physical health problems, which may be compounded by experiences of discrimination. They also note the paucity of published research on the intersex population of Australia, and that intersex people may also experience discrimination in health settings, with implications for physical and mental health (AMA, 2002).

### **2.3.1 Issues specific to intersex people**

The birth of an intersex child has historically been considered a “psychosocial emergency”. In a small proportion of live births, “corrective” genital surgeries are performed. Whilst many intersex people who have undergone such surgeries are satisfied with their sex of rearing, others are not. In a recent study of individuals who had undergone such surgeries, Migeon and colleagues (2002) reported that 23% were unhappy with the sex of rearing. Given that genital surgeries can have profound implications for genital sensitivity and functioning even when the sex of rearing is correct, they should not be undertaken lightly. Parents should be able to access specialists who are familiar with the intricacies of the particular condition, along with detailed information on the range of options open to their child.

The primary quality of care issues for intersex people are a lack of consent for childhood surgeries, lack of counselling and support for intersex individuals and their families, lack of knowledgeable health professionals, and a lack of information regarding alternative treatments.

### **2.3.2 Issues specific to transsexual people**

Transition is often an expensive undertaking. Costs include regular visits to doctors, (including specialists such as endocrinologists), life-long hormonal therapy, bone density scanning, speech therapy and electrolysis (for transsexual women), and possible surgical intervention. Many of these costs are excluded from both the public health system and private insurance, and transsexual people face excessive out-of-pocket expenses. Depression is a common outcome for transsexual people who are prevented from accessing appropriate medical care, and some resort to drastic attempts at self-castration (Russell, McGovern, & Harte, 2005). Reporting on one such case, Murphy and colleagues (2001) argue that there is a need to improve the resources available to transsexual people.

Transsexualism is recognised by the World Health Organisation as a bona fide medical condition (WHO, 2005), and transsexual people should be able to access appropriate care as they would for any other health problem. Professor Louis Gooren of the University Hospital of the Vrije Universteit of Amsterdam, a recognised expert on transsexualism and intersex conditions, reports:

*sex reassignment of transsexuals is a medical intervention on a sliding scale. It is not essentially different from procedures in other sex errors of the body. The same interventions including genital surgery are done in other cases of sex errors of the body ... There can be no psychomedical ground not to treat these people respectfully; we must provide them with reassignment treatment which meets their needs*

(Gooren, 1993)

In 1999, the Court of Appeal in the United Kingdom ruled that the National Health Service could not deny treatment to transsexual people (Green, 1999). Recently, the Court of Appeal in Madrid (Katia v IMSALUD, 2004) found that transsexualism should be treated on an equal basis with intersex conditions, and there is no legal basis for not providing treatment (Royal College of Psychiatrists, 2007).

### 3 Proposals for reform

#### 3.1 Protection from discrimination and vilification

The needs of transgender, transsexual and intersex people, whilst similar, do not overlap in all areas. WAGP submit that differing levels of protection are required for the three groups.

- All transgender, transsexual and intersex people should be protected from discrimination in all areas of life, and from harassment and vilification.
  - Transgender people can be protected by enacting legislation that prohibits discrimination and vilification on the basis of dress and appearance (*gender expression*), as recommended in the 1996 Senate Inquiry into Sexuality Discrimination.
  - Transsexual and intersex people can be protected by enacting legislation that prohibits discrimination on the grounds of *sex* or *sexual characteristics*, (where the definitions of the above are broadened to include *transsexualism* and *intersex conditions*), irrespective of medical treatment undertaken or planned.
- Such legislation should also ensure that treating a transsexual or intersex person as a member of the sex previously listed on their birth certificate is considered discrimination, as in the NSW Anti-Discrimination Act 1977.

A person who has been issued with a corrected birth certificate should be treated as their legal sex for all purposes. No exceptions should apply.

### 3.2 Legal recognition of sex

Transsexual people should not be required to undergo surgery before a corrected birth certificate can be issued. In many cases, transsexual people who have not undergone surgery already appear to be the sex with which they identify, and are accepted by others as such. As Serano (2007) explains:

*we actively and compulsively assign genders to all people based on usually just a few visual and audio cues. Recognizing the ubiquitous nature of this phenomenon calls into question most definitions [of sex]. We can argue all we want about what defines a woman or man – whether it's genes, chromosomes, brain structure, genitals, socialization, or the legal sex on a birth certificate or driver's license – but the truth is, **these factors typically play no role whatsoever in how we gender people in everyday circumstances. Typically, we rely primarily on secondary sex characteristics (body shape and size, skin complexion, facial and body hair, voice, breasts, etc.), and to a lesser extent, gender expression and gender roles (the person's dress, mannerisms, etc.).***

(p. 163) [emphasis added]

Subsequent to a decision by the European Court of Human Rights, the government of the United Kingdom enacted legislation in 2004 that “enables trans people to obtain legal recognition of their new gender status, for all purposes, after they have undergone transition which does not necessarily include genital surgery” (Royal College of Psychiatrists, 2007, p. 31). Under this legislation, an individual may obtain a corrected birth certificate if they can satisfy the Gender Recognition Panel, (the body set up to hear and determine applications under the Act), that certain criteria have been met. The applicant must:

- provide reports from two medical practitioners that he or she is transsexual;
- produce affidavit evidence that he or she has lived in the acquired sex throughout the period of two years ending with the date on which the application is made, and that he or she intends to continue to live in acquired sex until death; and
- produce a statutory declaration that he or she is unmarried.

(Sharpe, 2007)

A similar system operates in other European countries, such as Finland and Spain.

### 3.2.1 Proposed criteria

Transsexual people should be able to obtain a corrected birth certificate reflecting their self-identified sex. To ensure that requests for recognition of sex are not made

- lightly;
- with the intention to defraud;
- by individuals who have not undergone medically supervised treatment; or
- by people with mental health problems

it is suggested that the Gender Reassignment Act 2000 is amended to enable alteration of the register of birth to record a change of sex as outlined:

- a) A transsexual person whose birth is registered in the Register can make an application to the Registrar to alter the register of birth to record change of sex.
- b) Where such an application is made, the Registrar must alter the record of a person to reflect the sex with which they identify if he or she is satisfied that the applicant:
  - identifies with a sex other than his/her birth sex; and
  - has lived as the sex with which he or she identifies, being different from his/her birth sex, for a period of not less than 2 years.
- c) The applicant must submit, and the Registrar must consider, supporting documentation comprising:
  - a report from a specialist medical practitioner, confirming that the individual is transsexual;
  - a second report from a non-specialist medical practitioner;
  - a statutory declaration from the applicant, stating that he or she has been living in the sex with which he or she identifies for a period of not less than 2 years;
  - two other pieces of documentation which evidences that he or she has been living as the sex with which he or she identifies for a 2 year period. e.g., change of name certificate, utility or telephone bills, statutory declarations from family, friends, or employer.
- d) A presumption in favour of so altering the record where the person has undergone any sex-affirming surgical procedure.
- e) The Registrar's decision be reviewable in the State Administrative Tribunal.

### 3.2.2 Exception with regard to competitive sport

The Gender Reassignment Act 2000 permits sporting bodies to exclude transsexual people from competitive sport where “the person would have a significant performance advantage as a result of his or her medical history”. It is unclear from the legislative provision precisely how a “significant performance advantage” might be determined. The exception could be used to prohibit all transsexual people from competitive sport, and runs counter to the underlying philosophy of the Act.

The International Olympic Committee, United States Golf Association, and other elite sporting bodies allow transsexual athletes to compete once gonadectomy has been performed (Ljungqvist & Genel, 2005). The present Act creates a situation where transsexual athletes are permitted to compete at the highest levels of sport, yet can be prohibited from training for these events in Western Australia. Whilst the present exception affects both transsexual men and women, it is usually transsexual women who are unjustly accused of unfair competition and excluded from sport.

Although it is sometimes assumed that transsexual women compete at an advantage over non-transsexual women, this is not supported by science. There is a growing body of evidence to show that transsexual women actually compete at a disadvantage to all other female competitors. Corbett (2006, p. 3) writes:

*Transitioned women will lose 30 to 40 percent of overall muscle mass and strength during transition and after transition will have zero testosterone levels. Due to such low levels, transitioned women lose the ability to develop new muscle and have tremendous difficulty sustaining existing muscle no matter the level of output or intensity of training. They also lose the ability to recover quickly during and after exercise. Their bodies lose the ability to burn and lose fat, and even with adequate exercise, weight control becomes a significant concern.*

Whilst some transsexual women may retain features of the sex they were assigned at birth, for example, greater height, Sharpe (2007, p. 40) notes that “differences in factors such as heart size, lung capacity, muscle mass and body fat often traverse, rather than parallel, the division of sex. The precise configuration of these attributes in any particular individual is perhaps more a matter of genetics than sex. If there were a genuine concern to institute a level playing field in the arena of sport it would be necessary to take into account biological and other differences, such as differences of opportunity, among men and women as well as between them and to consider the pertinence of these various differences to a multiplicity of sports”. As the Australian Sports

Commission (ASC) explain, “there is also the related issue of [non-transsexual female] athletes who have genetic advantages for various sports. These include Marfan’s Syndrome which causes women to grow to heights of seven foot (some female basketballers and volleyballers have this syndrome) and congenital adrenal hyperplasia which causes an over-supply of testosterone in women and produces extreme muscularity. If [transsexual women] are prohibited from playing sport because of a presumed genetic advantage, this raises the question of whether people born with genetic advantages for sport should similarly be prohibited from playing” (Australian Sports Commission, 2004, p. 1).

The ASC reject the notion that transsexual people compete unfairly. With regard to transsexual women, they state:

*Within the debate, there are three assumptions:*

- *that anyone exposed to testosterone at puberty will be a good athlete*
- *that all males make better athletes than females*
- *that males will change gender in order to reap rewards in women’s sport which they are unable to obtain by competing in men’s sport.*

*All of these assumptions are false.*

(Australian Sports Commission, 2004)

The ASC recognise the importance of non-discriminatory sporting environments, stating “the issue of safe, respectful sporting environments is so important that the Australian Sports Commission introduced a mandatory requirement for funding to address these issues. The funding criterion requires national sporting organisations to develop, implement and regularly update policies and procedures to promote positive and respectful behaviours and to meet current anti-discrimination and child protection legislative requirements” (Australian Sports Commission, 2004, p. 2)

The ASC policy template for sporting organisations states:

*[SO] is committed to providing an inclusive sporting environment where transgender or transsexual people involved in its activities are able to contribute and participate. [SO] expects everyone who is bound by this policy to treat people who identify as transgender or transsexual fairly and with dignity and respect. This includes acting with sensitivity and*

*respect where a person is undergoing gender transition. We will not tolerate any unlawful discrimination or harassment against a person who identifies as transgender or transsexual or who is thought to be transgender or transsexual*

. . .

*[SO] recognises that the exclusion of transgender or transsexual people from participation in sporting events has significant implications for their health, well-being and involvement in community life. In general [SO] will facilitate transgender or transsexual persons participating in our sport of the sex with which they identify*

(Australian Sports Commission, 2004, p. 9-10)

The process of transition undertaken by transsexual people is a complex and long-term process based on genuine medical need. It must be remembered that transsexual people do not undertake transition lightly, or to gain a competitive advantage in sport (DCMS, 2005).

WAGP submit that the present exception should be modified so that it is consistent with established sporting guidelines. Transsexual individuals who have undergone gonadectomy (and whose hormonal profile is thus congruent with their identified sex) should not be prohibited from competitive sport.

### **3.2.3 Exception with regard to marriage**

Transsexual people show the same range of sexual attractions as the general populace, and some transsexual people enter into marriages prior to transitioning. However, the Gender Reassignment Board will reject an application for a corrected birth certificate where the applicant is married. This policy forces many married transsexual people to dissolve loving, committed relationships. In the *Re Kevin* case, His Honour Justice Chisholm specifically considered such situations, and concluded:

*the marriage would I think still be valid: its validity would be determined as at the date of the marriage, and I would not think it would become invalid by reason of the reassignment*

(FamCA 1074, 2001)

The issue of whether a person is a man or woman for the purpose of marriage is thus decided at the time of marriage. The sex of either party after the date of the marriage is not relevant to the validity of the marriage, and the requirement that transsexual people be unmarried before they can be issued with a corrected birth certificate should be removed.

### **3.3 Provision of appropriate medical care**

Transsexual and intersex people should be able to access comprehensive medical care through the public health system. WAGP submit that a full, multi-disciplinary centre of excellence should be established in Western Australia, similar to the Monash Gender Dysphoria Clinic, operating at the Monash Medical Centre in Victoria (Damodaran & Kennedy, 2000).

Such a centre should comprise a team of professionals from the disciplines of psychiatry, psychology, endocrinology, social work, speech therapy, gynaecology, and plastic surgery. The centre would serve the needs of both transsexual and intersex people, and the parents of intersex children.

## 4 Commonly cited objections to reform

### 4.1 Use of public toilets, changing rooms and other facilities

It is sometimes argued that if transsexual people are permitted to change their birth certificate and other documentation without first undergoing surgery, their use of public changing rooms, toilets and other such facilities could make others feel uncomfortable. For example, some women may object to the idea of transsexual women who have not undergone genital surgery using female toilets. However, this kind of thinking is incredibly naive, as transsexual people are already using the facilities appropriate to their identity. In most cases, other people sharing these facilities are completely unaware, because as Serano (2007) explains, “we make assumptions every day about other people’s genders without ever seeing their birth certificates, their chromosomes, their genitals, their reproductive systems, their childhood socialization, or their legal sex” (Serano, 2007, p. 13).

Although some people think that transsexual people (particularly transsexual women) pose a risk to others if they are allowed to use facilities appropriate to their identity and appearance, this is not the case. Rather, it is transsexual people who are exposed to risk if they are prohibited from using facilities consistent with their self-identified sex. Writing on the experiences of transsexual patients in hospital emergency departments, Shaffer (2005) reports that “a feminine-appearing 24-year-old patient with severe asthma was placed with three other women in an ED room until it was discovered, during the physical examination, that she had a penis. She was a preoperative transsexual who was taking female hormones. She was immediately moved to a male room, where the other patients called her ‘babycakes’ and ‘sweetie’. She was ridiculed by some of the staff, who referred to her as ‘pervert’ and ‘freak’” (Shaffer, 2005, p. 406) . Such experiences are not uncommon amongst transsexual people.

## 4.2 Reversion to previous sex

It is sometimes argued that transsexual people may change back and forth between sexes if surgery were not a prerequisite for changing the birth certificate. This trivialises the reality of transsexualism and is demeaning to transsexual people. Commenting on the NSW Transgender (Anti-Discrimination and Other Acts Amendment) Bill, the Honourable Elisabeth Kirkby MLC, noted that the “serious and severe psychological, physical and emotional effects of a decision to alter one's gender is never undertaken lightly. In addition to the internal pain and agonising that often occurs, [transsexual people] ... will probably experience some, if not all, the systemic discrimination, abuse and violence that is directed towards their community” (NSW Legislative Council Hansard, 4 June 1996, p. 2371).

It is possible that after a period of living in their chosen sex, some individuals may subsequently decide to revert to the sex assigned at birth. However, the present requirement for surgery does not guarantee this won't occur. Although uncommon, some individuals regret having undertaken surgery and revert to their previous sex (Kuiper & Cohen-Kettenis, 1998; Olsson & Möller, 2006). Overseas experience shows that a system that does not require surgery to have taken place is viable. For example, the systems operating in Finland and the United Kingdom have been operating without incident.

### 4.3 Fertility and reproduction

Some argue that a surgical procedure resulting in sterility should be a requirement for legal recognition of sex. This is presumably to avoid the situation in which a transsexual woman becomes a father, or a transsexual man becomes a mother. However, a requirement for sterilisation is unworkable, discriminatory and in many cases unnecessary.

Female hormone therapy has been shown to adversely affect fertility in XY individuals (Handelsman, Wishart, & Conway, 2000; Thiagaraj et al., 1987; Venizelos & Paradinas, 1988), and most transsexual women will become infertile after a few years of treatment. Testosterone treatment in transsexual men has been shown to induce changes similar to polycystic ovarian syndrome (Baba et al., 2007; Levy et al., 2003) and impairs fertility. As a result, physicians often recommend that patients store ova or semen prior to beginning therapy.

Like non-transsexual people, transsexual people have the same range of sexual attractions and orientations as the general populace (Denny, 1999). For example, some transsexual women identify as lesbian or bisexual, and are attracted to women. Some of these individuals may wish to have children with their partners, and if they have stored semen they are in the unique situation of being able to use their own germ cells to do so, via artificial insemination or IVF. Some transsexual people transition later in life, and may have children from a previous relationship. It is clear that a requirement for sterility does not prevent the situations described previously, and would violate the right to found a family, embodied in the United Nations Declaration of Human Rights.

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