InterAction
for Health and
Human Rights

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Submission on the General Treatment Plan for Testosterone Replacement for Testosterone Deficiency due to Testicular Failure/Insufficiency in Infancy

28 November 2025

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2 This submission

Thank you for the opportunity to make a submission on the General Treatment Plan Application for Testosterone Deficiency due to Testicular Failure/Insufficiency in Infancy.

We warmly welcome the commencement of these public consultation processes for General Treatment Plans, and the opportunity to provide feedback.

InterAction for Health and Human Rights is a national charity and Public Benevolent Institution. Our name is new, introduced on the merger of Intersex Peer Support Australia into Intersex Human Rights Australia. Legally we remain registered as Intersex Human Rights Australia, a Public Benevolent Institution.

We provide psychosocial and peer support services, and engage in training, information and education, and policy work. InterLink is uniquely a professional, peer-run psychosocial support service providing individual and group counselling for people with innate variations of sex characteristics (intersex variations/differences of sex development) and family members delivered by an intersex community-controlled organisation. It is designed and led by Bonnie Hart. The service is now an accredited service provider in accordance with the National Safety and Quality Digital Mental Health (NSQDMH) Standards.

Intersex Peer Support Australia is now a program of InterAction, engaging in peer support and community development work. Kylie Bond leads the delivery of these services. Our policy program is led by Dr Morgan Carpenter. Morgan Carpenter wrote this submission, with input from Kylie Bond and Bonnie Hart, and review by our board and staff teams.

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

2.1 Statement on competing interests

Dr Morgan Carpenter is also a member of the Restricted Medical Treatment Assessment Board and some of its subcommittees. As a small organisation, we have not been able to address any perceived competing interests by allocating the drafting task elsewhere. However, the task of preparing this submission has been approached by focusing on the proposed GTP application itself, the evidence and approach it articulates, and our organisational values.

3 Overview and recommendation

Overall the GTP does not clearly articulate when the treatment is intended to commence and when it is intended to cease.

On balance, we are not opposed to the intention of this GTP in mimicking an endosex male mini-puberty. Although the treatment does irreversibly change a child's sex characteristics, this specific treatment does not appear to reduce choices later in life. To provide a comparison that informs our reasoning on this issue: the pubertal and later life choices of endosex people registered male at birth are not impeded by having undergone a normatively male mini-puberty.

However, we raise concerns about the quality of the evidence, the values expressed in it, and a selective representation of that research. We recommend that these issues be addressed in a version of the GTP suitable for approval.

4 Greater clarity needed regarding who will be covered by the GTP and the treatment timeframe

Currently the GTP omits consideration of children with other IVSCs featuring a 46,XY karyotype, particularly relating to mild and partial forms of androgen insensitivity syndrome. The reasons for this are not clear. We recommend that the inclusion and exclusion criteria be redrafted to attend to this issue.

The age of commencement and completion of the proposed postnatal treatment is not adequately described. The dot points at the top of page 7 of the draft GTP (ACT Health 2025) attend to other aspects of the proposed clinical treatment but omit this information. We do not wish to inadvertently approve long term hormone replacement, nor pubertal induction without personal informed consent.

5 The role of psychosocial, peer support and community-controlled services

The section articulating the need for psychosocial support and the role of the VSC-PSS in the ongoing psychosocial care of young people and families is very helpful and much improved in comparison with the 45,X0 GTP application considered earlier this year.

We also welcome the clear articulation of the complementary role of peer support, community-based services and allied health services. We recommend the naming of

accredited and intersex community-controlled services as providers of psychosocial and peer support.

In section Part 3A (4), on psychological wellbeing (and throughout) we note an assertion of "psychological consequences" on people with "genital and reproductive differences" as a justification for treatment (ACT Health 2025), and note that this is based on a deficit model that assumes psychological distress resulting from stigma or discrimination of having a small penis.

The stigma associated with atypical sex characteristics - including small penis size - are very real, and they are indications of a need for psychosocial support, community connection and work to combat the stigmatisation and demeaning of atypical bodies and cosmetic differences (Carpenter, Rakita, et al. 2023). They are not a rationale for biomedical interventions approved by the Restricted Medical Treatment Assessment Board, in the absence of informed consent from the person undergoing treatment.

6 Research and evidence issues

The draft GTP makes numerous references to an endosex (non-intersex, see Carpenter, Dalke, et al. 2023) male mini-puberty having an "optimizing effect of the testosterone surgery on male body composition". In our view, the use of the term "optimizing" is unhelpful leading language. A review of the literature also makes evident that other changes are attributed to an endosex male mini-puberty. Becker and Hesse (2020) note, with some fascination:

> "it affects cognitive functions; testosterone has an impact on language organization in the infant brain [...] There are inconsistent findings concerning the impact of minipuberty on sex-specific playing behavior. Minipuberty is an interesting field of research, and further studies in this area will teach us more about this exciting period of human development" (Becker and Hesse 2020).

Peter Hegarty (2023) has identified such research as belonging to a disturbing history of exploitation:

> "Research psychologists have long exploited people with VSC as 'natural experiments' to test nature/nurture theories about sexuality, gender, criminality and cognitive abilities" (Hegarty 2023).

We want more research on the implications of exogenous mini-puberty. However, we recommend that all research on people with innate variations of sex characteristics be community-based and participatory, ideally led by researchers with lived experience, to

ensure a focus on areas of interest and benefit to people with innate variations of sex characteristics.

Returning to Becker and Hesse's mini-review article, we find extensive discussion on behavioural and other aspects of brain development:

> "These studies all suggest that sex hormone concentrations during minipuberty may indeed influence language development up to the age of 5 years. The findings are supported by animal studies which show that postnatally administered sex hormones influence brain development and behavior later in life" (Becker and Hesse 2020).

These statements are uncomfortable in that they give rise to concerns that an exogenous mini-puberty could be associated with gender identity conversion practices, and related normative associations between bodies and identities. Their omission from the GTP gives rise to concerns that research evidence is being selectively quoted.

When discussing alternative treatment options, the draft GTP states that there have been no randomised control trials for delayed versus timely testosterone replacement therapy when earlier the draft GTP states that there are no randomised controlled trials for early childhood testosterone replacement therapy, either. The only reference to a randomised control trial is in relation to people with 47,XXY (Klinefelter syndrome) – a population that is not a part of this GTP's purview. We believe this inconsistency in the use of a 'lack of evidence' creates an unnecessary false dichotomy between the validity of treatment versus no treatment.

7 Application drafting issues

Given the limited evidence base for treatment, and also given a history of interruptions to supply chains and availability of medications, we recommend that treatment with alternative testosterone treatments should be built into the GTP.

In our view, this GTP should provide consideration of a fallback option if testosterone enanthate (brand name "Primoteston Depot") is withdrawn or otherwise not available during the period of time associated with proposed treatment.

8 Citations

ACT Health. 2025. Consultation General Treatment Plan: Testosterone Replacement for Testosterone Deficiency Due to Testicular Failure/Insufficiency in Infancy. https://yoursayconversations.act.gov.au/variation-sex-characteristics-general-treatment-plans.

Becker, Marianne, and Volker Hesse. 2020. ‘Minipuberty: Why Does It Happen?’ Hormone Research in Paediatrics 93 (2): 76–84. https://doi.org/10.1159/000508329.

Carpenter, Morgan, Katharine B Dalke, and Brian D Earp. 2023. ‘Endosex’. Journal of Medical Ethics 2023 (49): 225–26. https://doi.org/10.1136/medethics-2022-108317.

Carpenter, Morgan, Magda Rakita, and Bo Laurent. 2023. ‘Body Shaming Is Unacceptable, Even If Directed at Vile People. An Intersex Critique of “Small Dick Energy”’. Practical Ethics, University of Oxford, January 10. http://blog.practicalethics.ox.ac.uk/2023/01/guest-post-body-shaming-is-unacceptable-even-if-directed-at-vile-people-an-intersex-critique-of-small-dick-energy/.

Hegarty, Peter. 2023. ‘The Psychology of People with Variable Sex Characteristics/Intersex’. Current Opinion in Psychology 49 (February): 101539. https://doi.org/10.1016/j.copsyc.2022.101539.