International Journal of Law in Context (2026), **22**, 235–255
doi:10.1017/S1744552326100391

ARTICLE

Intersex human rights: a double-edged sword

Mireia Garces de Marcilla

School of Law and Social Justice, University of Liverpool, Liverpool, UK
Email: m.garces@liverpool.ac.uk

(Received 13 March 2025; revised 22 January 2026; accepted 22 January 2026; first published online 20 February 2026)

Abstract
This article brings critical human rights scholarship into the intersex sphere to unearth the potential limitations of the growing deployment of human rights to improve the health care experiences of intersex people. It traces the changing tactics of intersex activist groups and identifies three tendencies – reformism, coerciveness and juridification – that may be brought by the intersex movement and international agencies embracing human rights as the vernacular. This article argues that the dominance of the human rights approach, while allowing the intersex struggle to gain legitimacy, visibility and recognition, risks fuelling a depoliticised framework of remedicalisation and increased penality. It deflects attention from the endeavour of interrogating the social and cultural foundations rendering intersex variances a deviant form of embodiment.

Keywords: human rights; intersex activism; legal change; coerciveness; remedicalisation; juridification

1. Introduction

Human rights have become the hegemonic paradigm to conceptualise and address injustices.[1] The focus of this article is on one of the latest 'frontiers' of human rights: the intersex struggle. Over the past fifteen years, the performance of unnecessary, invasive and non-consensual interventions on children with intersex variations has become recognised as a human rights violation by a growing number of non-governmental organisations (Amnesty International 2017; Human Rights Watch 2017) and international authorities (Council of Europe 2023; EU Agency for Fundamental Rights 2015; IACHR 2023; UN Committee Against Torture 2011; World Health Organization 2014).[2] International bodies (see e.g. Deputy Secretary General, Council of Europe 2023), intersex advocacy (Howe *et al.* 2017) and academics (Carpenter 2016; Ghattas 2018; Pikramenou 2019) alike have celebrated the increasing inclusion of intersex concerns within the human rights agenda. This article shows how this trend, while well intentioned and often presented as a success story, may have problematic implications.

As Ratna Kapur (2018, pp. 37–38) cautions, although human rights are framed as an unequivocally positive achievement, they are not 'naturally benevolent'; their mobilisation might not lead to 'necessarily progressive or liberating' outcomes, and their application might not contribute to attaining a 'better space and a better time inhabited by freedom'. In a similar vein,

[1]This hegemony, however, might be in decline, as it can be seen from the blossoming critical accounts of the role of human rights in ongoing conflicts; see, Krever *et al.* 2024.

[2]Sections 3 and 4 further analyse how several UN treaty bodies have framed these surgeries as human rights abuses.

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Ben Golder (2014, p. 78), investigating 'the contemporary occupation of the political by human rights', asks:

> 'What happens when we frame our political demands in the particular and putatively "post-political" idioms of human rights? What other languages and other avenues for the pursuit of social justice or for resistance to the ravages of global capitalism become silenced and displaced when we speak human rights talk (or are spoken by it)?'

This article transposes these questions to the context of intersex politics. It investigates what is gained and lost by 'naming intersex childhood surgeries as human rights abuses' (Bauer *et al.* 2020, p. 724) and calls into question the praise of intersex human rights as a progressive accomplishment of recognition, visibility and change. In doing so, it puts into conversation intersex and critical human rights scholarship, shedding light on the potential limitations of advancing intersex demands through human rights. With some notable exceptions (Ammaturo 2016; Rubin 2015), the growing dominance of intersex human rights has received little reflection. Scholars within the intersex space (Bauer *et al.* 2020; Carpenter 2022; Garland and Slokenberga 2019; Mestre 2022; Pikramenou 2019; Zelayandia-Gonzalez 2023) have mostly welcomed the human rights turn. Notwithstanding several accounts criticising the 'compliance gap', implementation challenges and lack of effectiveness of this framework (Garland *et al.* 2022; Garland and Slokenberga 2019; Pikramenou 2019, p. 217; Zelayandia-Gonzalez 2023), these do not address the political and tactical implications of intersex politics embracing human rights as the vernacular. Similarly, while approaches exploring the paradoxes and weaknesses of human rights have blossomed in recent years (Brown 2004; Kapur 2018; Kennedy 2001; Madhok 2021; Moyn 2018), critical human rights scholarship has not paid much attention to the use of human rights to denounce medically sanctioned practices in the West.

This article bridges this gap and argues that the (re)formulation of intersex activist demands through human rights is a double-edged sword. On the one hand, intersex human rights validate the experiences of intersex people, making their suffering visible by bringing it to the public and legal sphere, with the intersex movement finally gaining the recognition it has long been fighting for and being able to engage with the core legal tool in liberal democracies to advance their claims. On the other hand, intersex human rights may narrow the political imagination of the intersex movement. Specifically, this article identifies three tendencies of the intersex human rights turn that are not conducive to more liberating and emancipatory outcomes: reformism, coerciveness and juridification. The core argument is that the dominant human rights approach adopted by activists and international agencies to condemn early surgeries risks fuelling a depoliticised framework of remedicalisation and increased penalisation, deflecting attention from the endeavour of interrogating the social and cultural foundations that target intersex variances as a deviant form of embodiment.

This article reflects on 'why, how and with what effect' the turn to human rights influences and potentially transforms conversations about intersex justice (Tapia 2022, p. xv). Most accounts tracing the history of the intersex movement focus on the tensions between activist groups and the medical profession (Davis 2015; Hegarty 2000; Rubin 2017). In contrast, this article analyses the implications of this relationship for how the former have come to embrace *law* as part of their strategy. The challenges brought by the human rights turn within the intersex sphere are embedded in wider trends of penal expansion, legal co-optation and institutional compliance. Nevertheless, these have not been explored in a way that is attuned to the nuances and tensions of the intersex movement, whose heterogeneity has often been misread or oversimplified under the umbrella of 'queer' or LGBTIQ activism (Travis and Garland 2021). Acknowledging the mixed and sometimes opposite views within intersex activism, this article unpacks the promises and potential pitfalls of advancing intersex well-being through human rights.

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Section 1 starts in 1993, the year in which the first intersex-based organisation was created, mapping its transition from a 'rebellious' to a 'reformist' collective. It claims that intersex activism's absorption of the human rights discourse was not inevitable but, as with the development of other social movements (Lobel 2007; Tapia 2022), it is the result of a particular history of intersex groups negotiating with institutional frameworks. The following sections explore how human rights have played a crucial role in the solidification of reformism. Section 2 examines how human rights pervade calls for improving or enhancing (rather than questioning or disrupting) the medicalisation of intersex embodiment. Although this framework enables activist demands to gain traction, it also contributes to the individualisation of intersex health care, framing calls for medical change as a matter of improving medical and ethical standards rather than interrogating how medical knowledge is generated and sustained. Section 3 focuses on the popular tendency of outlawing early normalising interventions. It argues that intersex human rights end up justifying expanding the power of the criminal law, a coercive move that individuates the harms generated by structural biases instead of prompting deep social transformation. This section takes further issue with intersex demands becoming embedded within the legal discourse, suggesting that juridifying the intersex cause might conflate legal with social change.

Some notes on the scope of the article are required. First, the intersex human rights agenda is concerned with many issues, including education, employment, hate speech, legal gender recognition, sports eligibility and access to justice, among others (Zelayandia-Gonzalez 2023). In October 2025, the Council of Europe adopted a recommendation of the Committee of Ministers aimed at 'ensuring the realisation of fundamental rights and freedoms of intersex persons' (CM/Rec (2025)7, p. 1). Considered 'the most comprehensive framework to date for protecting the human rights of intersex people in Europe' (ILGA Europe 2025), the recommendation reflects the extensive reach of intersex human rights, covering topics such as hate crime (para 12), access to and provision of social care (para 35), the right to seek asylum (para 16) and data collection (para 48). The focus of this article is limited to the invocation of human rights to condemn early normalising surgeries, examining how they are used to push for change within medicine (by revising intersex protocols) and law (by enacting prohibitions on early normalising genital interventions).

Second, intersex activism is not monolithic, and there is much disagreement within groups over the meaning of intersex variances, strategies to follow, alliances to build and goals to achieve. Given the diversity of perspectives, any 'picture' or 'account' of the movement is, as David Rubin (2015, p. 58) acknowledges, 'necessarily partial and open to contestation and revision'. This article is focused on groups that have played an influential (or at least more overt) role in shaping legal or medical change regarding intersex matters. While Section 1 concerns the pioneer intersex group, which originated in the USA, later sections concentrate on European-based groups, since Europe has been fertile ground for criminalising early normalising surgeries. Third, the article aims to analyse what is at stake with the growing pervasiveness of human rights within the intersex movement. Hence, while it hopes to pave the way for further conversations about how to formulate calls to end early surgeries, specific recommendations for what ought to be done lie outside its scope.

Finally, a caveat: in criticising the hegemony of intersex human rights, this article does not suggest that non-consensual genital normalising interventions are not (or should not be) seen as a form of human rights abuse, nor does it claim that the medical management of intersex variations should remain as is. It does not claim that the intersex human rights approach is inherently conservative or self-defeating either, or that it necessarily prevents transformative outcomes and strategies (O'Connell 2018). Rather, this article signals some of the risks that such an approach might entail: its main contention is that adopting human rights as the main tool for advancing critiques about early intersex surgeries may restrict how these can be formulated and 'compromise both the diagnosis and the cure' for bringing about meaningful change for people with intersex variations (Mavronicola 2024, p. 556).

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2. The inception of intersex activism: from contestation to collaboration

Intersex community organisation can be traced back to 1993, when Bo Laurent, known then as Cheryl Chase, founded the Intersex Society of North America (ISNA). Laurent underwent several surgeries as a child but, like many individuals born with intersex variations at the time, only found out about her diagnosis when she was an adult (Hegarty 2000). After managing to retrieve her medical records and having had to come to terms with her experience on her own, she decided to set up ISNA. The group's 'most immediate' goal was to 'create a community' of peer support, with the long-term vision of 'advocat[ing] a treatment protocol … that disrupts conventional understandings of the relationship between bodies and genders' (Chase 1998, p. 203). It initially adopted a strategy of 'collective confrontation' (Davis 2015, p. 39) with members taking to the streets and protesting outside hospitals against the medicalisation of their bodies. Armed with signs with the slogan 'Hermaphrodites with Attitude', activists questioned the authority of medicine 'to police the boundaries of male and female', denouncing the 'violent normalisation' that intersex people fell victim to because of how their bodies defy the gender binary (Chase 1998, p. 189). In these early days of collective organisation, Laurent explicitly talked about intersex politics as a 'queer' issue, contending that early surgical management was fuelled by the fear that intersex children would not be heterosexual. Seeing parallels with the medicalisation of homosexuality, she was sceptical that medicine, on its own, would change or contribute to improving the lives of individuals from either of these collectives unless 'we change public opinion and bring pressure on doctors from the margins' (Hegarty 2000, p. 127).

Perhaps unsurprisingly, the medical profession initially refused to engage with ISNA's demands. The American Academy of Pediatrics (AAP) distributed a press release in 1996 where they were clear that they would not meet with 'any Hermaphrodites with Attitude' picketing its annual meeting (Germon 2009, p. 159). However, doctors gradually began to listen to activists: Laurent was invited to speak to the Paediatric Endocrine Society in 2000 and, that same year, the AAP issued a statement reassessing some of the aspects of intersex case management. These signs of slow yet increasing willingness from the medical profession to pay attention to their demands prompted the ISNA founder to rethink its strategy. Crucially, she renounced her initial position that it was necessary to 'queer' the binary and 'destabilise the heteronormative assumptions that underlie the violence directed at [intersex] bodies' (Chase 2002, p. 138). Instead, she became suspicious of seeing the problems of how the medical profession treats intersex patients as having to do with gendered ideals about embodiment, criticising those who used intersex variances for the 'ludicrous' endeavour of imagining more fluid ideas of gender (Rosario 2006, pp. 94–96). This perspective neglected what really was the core issue for intersex people: how doctors have been performing unnecessary surgery on them as newborns, condemning them to a life of secrecy and shame. Intersex embodiment, she insisted, 'is primarily about stigma and trauma, not gender' (Chase 2003, p. 240). In her own words:

> 'I think that a lot of people in women's studies imagine that the existence of intersex people is a justification for creating a future that is radically different. What I like to remind them is that intersex people have not been subjected to such intense and harmful medicalization for very long … So, radical restructuring is not required in order for us to make the world an easier place for intersex people to live in' (Rosario 2006, pp. 98–99).

Mimicking Laurent's shift, ISNA let go of the commitment to reconceptualise or disrupt gender, taking what they called a 'pragmatic' turn (Germon 2009, p. 160). Their new agenda became centred on 'end[ing] shame, secrecy and unwanted genital surgeries', highlighting that many intersex people 'are perfectly comfortable adopting either male or female gender identity and are not seeking a genderless society or to label themselves as a member of a third gender class' (ISNA n.d.). While recognising that surgeries might be nurtured by the belief that they 'help a child settle

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into a gendered world ... that doesn't mean that the whole system of gender must fall in order for people with intersex conditions to live happy, fulfilling lives' (ISNA n.d.), it means that these surgeries and the shame that surrounds them should stop.

ISNA moved from articulating its criticism of the management of intersex variances through gendered lenses to framing it as an issue of autonomy and medical ethics instead. Its main mission became to persuade the medical profession to shift from a 'concealment-treatment' model to a 'patient-centered' one. Within the latter, destabilising or reinventing gender '[was] not the point; rather, the goal was ensuring that intersex people have 'respect for ... their autonomy and self-determination, truth about their bodies and their lives, and freedom from discrimination' (ISNA, n.d.). ISNA thus changed its rhetoric from 'queering' medicine to ensuring that medical authority is exercised ethically, defending patients' autonomy as paramount. As part of this reformist phase, an era of collaboration with the medical profession began, with the renewed belief that working with, rather than fighting against, doctors could help the organisation 'gain credibility' in its mission to improve the care of intersex individuals (Davis 2015, p. 42). The culmination of this collaborative turn was in 2005, when Laurent attended a meeting with more than fifty international experts on intersex matters, where the so-called Chicago Consensus Statement, currently regarded as the leading international medical guideline of intersex medical management, was developed (Hughes *et al.* 2006).

As part of this collaborative shift, ISNA expanded its realm of action beyond the medical profession, also resorting to law. Two particular episodes are useful to exemplify this turn. In 1997, ISNA lobbied the US Congress to extend the federal ban on female genital mutilation (FGM) to genital surgeries for intersex variations (Ben-Asher 2006). Its efforts, however, were unsuccessful: Congress did not include intersex surgeries within the federal prohibition, and alliances with anti-FGM US campaigners were not fruitful either (Chase 2002). Rather than giving up, ISNA expanded its focus beyond the USA and, in what could be called the first instance of intersex strategic litigation, submitted an amicus brief to Colombia's Constitutional Court one year later. At the time, this was the only institution in the world to have acknowledged that non-consensual genital normalising interventions constituted a breach of human rights (Corte Constitucional de Colombia, T-477-95). An amicus brief was therefore a promising springboard for ISNA to forge transnational solidarities while establishing itself as an influential collective, gathering ethical and medical experts to denounce the performance of early surgical interventions (ISNA 1998). ISNA achieved its aim. The Court cited the amicus brief in its reasoning, eventually ruling that the eight-year-old girl in this case should not be subjected to surgery, as it was not urgent, its medical necessity was unclear and her right to autonomy should be respected, having reached an age where she had 'sufficient maturity to make decisions about her own body' (Corte Constitucional de Colombia SU337-99, para 76; for further discussion, see Rubio-Marín and Osella 2018). Shortly after, ISNA's tactic of embracing law and human rights began to bear fruit in the USA, when the San Francisco Human Rights Commission became the first US governmental body to 'address medical management of intersex people as a human rights issue' in 2004, which ISNA took as a crucial milestone.

In light of these successes – both in the medical and legal sphere – ISNA decided to cut ties with its rebellious past. The 'Hermaphrodites with Attitude' protests 'had become a negative asset', hindering its ability to work with the medical profession and to 'champion change' (Davis 2015, p. 47). As a result, it closed its doors and created two new organisations, one in charge of advancing medical change by 'fostering collaboration' with doctors (Accord Alliance) and the other one going beyond 'only medical outcomes', focusing on the 'civil and human rights of children born with intersex medical issues' (InterACT: Advocates for Intersex Youth).

Reviewing the first fifteen years of intersex activism exposes the tension between rebellion and compliance within the movement. ISNA eventually chose the latter. Leaving behind the endeavour of deconstructing the heteronormative underpinnings of medicine, it opted for collaborating with the medical profession to improve standards of care while starting a legal project to put a stop to

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early surgeries in the name of human rights. To an important extent, Laurent's and ISNA's suspicion of reading intersex embodiment through the lenses of gender arose from their feelings of being (re)objectified. Some individuals within the LGBTIQ community and feminist scholarship used intersex bodies as an example to imagine new ways of understanding gender, seeing intersex individuals as a 'case-study' for or 'proof' of their political and academic agendas, neglecting their lived experiences of physical suffering and psychological trauma (Dreger and Herndon 2009; Koyama and Weasel 2002). For some alleged allies, intersex people became 'hermaphrodite caryatids' bearing the burden of troubling gender, as though their ambiguous status 'oblige[d] [them] to act as advocate[s] of non-normative agendas' (Rosario 2006, pp. 98–99). However, many intersex activists neither see their life and work as 'doing queer' nor see themselves as part of the LGBTIQ community just because they have an intersex variation (Travis and Garland 2021). Their main issue with the medical profession is not that medical protocols enforce gender norms on them, but that intersex medical management is undertaken with subpar ethical standards, which should be amended by working with the medical profession – and not by contesting gender.

Nevertheless, shedding light on the socially embedded ideals and stereotypes upon which medicine relies is not the same as claiming that intersex is – or should – only be a queer issue; and, most importantly, it does not have to entail homogenising or conflating intersex demands with LGBTIQ claims. Acknowledging that medicine does not operate in a vacuum and that scientific knowledge is produced through and within a context where heterosexuality is the norm can – and should – be done without erasing or instrumentalising intersex experiences. In fact, this is precisely what ISNA did at the beginning, aiming to challenge medical authority over intersex bodies by appealing to the need to oppose assumed correlations between bodies and genders (Chase 1998, p. 203). The fact that some academics or activists co-opted intersex suffering for advancing their own goals does not mean that there is no room for challenging the dichotomously gendered underpinnings of intersex medical management, or that the inquiry should be limited to whether medical knowledge and power are exercised ethically.

This account of ISNA's history, teasing out its conceptual and tactical shifts, contributes to analysing current trends of intersex activism. The following sections move from the USA to Europe, where the intersex movement has blossomed and gained influence in recent years, exploring how prominent intersex organisations have mirrored ISNA's trajectory. Steering away from politicising the medical management of intersex variances, intersex demands have increasingly been framed as a matter of medical ethics and legality, as human rights have been solidified as the main prism to conceptualise and denounce the suffering of intersex people.

3. Intersex human rights and medicine

3.1. Building support through human rights

During and following the years of ISNA's work and transformation, intersex groups have proliferated: more than 150 organisations have been created around the world. These associations are heterogeneous in size and demographics, operating at different levels (local, regional, national or international). Nevertheless, a shared key commonality is their 'strong focus on human rights advocacy' to denounce 'abuses in medical settings' (Lukomnik *et al.* 2024, p. 10). The first time an intersex activist, Mauro Cabral, raised the issue of early normalising surgeries in front of a UN treaty body was in 2004, and a German group's reporting in 2008 led to the first Concluding Observation by the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) mentioning early intersex surgeries (Bauer *et al.* 2020). Following the lead of ISNA's heir organisations, Europe-based groups have been particularly active in turning to legal and political authorities, such as the UN and the CoE, to strive for changing the medical management of intersex variances. Given their organising power and lobbying accomplishments, this section focuses on two European organisations' work toward the institutional recognition that intersex

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medical care must be improved in the name of human rights: Organisation Intersex Europe (OII Europe) and the European International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA Europe).

ILGA Europe (2022a) seeks to 'speak to the realities of LBTI people's lives', and OII Europe's (2023, p. 7) aim is to gather collective strength to ensure the further 'adoption of human rights for intersex people all over Europe'. Pursuing these aims, these organisations have brought together intersex groups on several occasions; the first time in 2013, when the so-called Malta Declaration was elaborated by more than thirty intersex associations, concluding that it is imperative to:

> 'ensure that intersex people have the right to full information and access to their own medical records and history; ensure that all professionals and healthcare providers that have a specific role to play in intersex people's wellbeing are adequately trained to provide quality services ... autonomous non-pathologising psycho-social and peer support be available to intersex people throughout their life (as self-required), as well as to parents and/or care providers.'

This featured as a core demand too in the 2014 Statement of Riga, and the 2017 Statement of Vienna, where activists demanded governments 'ensure that medical practitioners ... do not conduct any treatment for the purpose of modifying sex characteristics which can be deferred until the person to be treated can provide full, free and informed consent' (OII Europe 2017). The vocabulary of human rights pervades these Statements, centring the need to protect intersex people's 'rights to health, self-determination, and bodily integrity' (ILGA Europe 2022a).

In order to achieve this, as seen in the Malta Declaration, intersex groups request a moratorium on surgeries, the provision of psychosocial counselling for intersex individuals and their families and establishing 'obligatory training for medical professionals' (see Toolkit elaborated by Ghattas 2019, p. 17). Adopting ISNA's co-operating strategy, they seek to build partnerships with, rather than openly confront, health care professionals to 'review and revise current treatment protocols to bring them in line with current medical best practice and human rights standards' (Ghattas 2019, p. 17). For example, OII Europe's (2023, pp. 18–19) goal is to 'train modules for professionals working in fields relevant to intersex people', with the overarching goal of ensuring 'policy makers, stakeholder, professionals and the general public are better educated on intersex issues from a human rights-based perspective'. In a similar vein, ILGA Europe (2022b) conceives of itself as a 'connector' between 'institutional actors' and 'social movements', building 'strategic partnerships' to 'amplify the voices and issues that are too often side-lined in our societies'.

Several international agencies acknowledge the need for change. Three years after CEDAW first mentioned intersex issues, the Committee Against Torture (CAT 2011) recognised that early surgeries may amount to a human rights violation. It recommended further 'educat[ion] and train[ing] of medical and psychological professionals on the range of sexual, and related biological and physical diversity' (CAT 2011, para 20), and has since insisted on the importance of doing so (CAT 2016a, para 35; CAT 2016b, para 43). Like advocacy groups, the CAT's observations and recommendations usually connect the need to enhance intersex health care with the need to delay these surgeries until individuals are mature enough to provide their own consent. This link is also drawn by the UN Office of the High Commissioner for Human Rights (2016):

> 'Intersex children and adults should be the only ones who decide whether they wish to modify the appearance of their own bodies ... They should have access to support as well as to medical services that respond to their specific health needs and that are based on non-discrimination, informed consent and respect for their fundamental rights.'

Numerous UN treaty bodies have made similar recommendations. The Committee on the Rights of the Child (CRC 2015, para 48) urges the 'develop[ment] and implement[ation of] a rights-based health-care protocol for intersex children', so that 'children and their parents are appropriately

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informed of all options'. The need to ensure that intersex individuals are 'sufficiently mature to make an informed decision' is shared by the World Health Organization (WHO 2014, p. 7), considering that 'health-care professionals should be educated and trained about bodily diversity'. Both the CEDAW (2018a, para 26) and the Committee on the Rights of Persons with Disabilities (CRPD 2022b, para 36) stress the need for 'adequate counselling and support for the families of intersex children' too, with the UN Special Rapporteur on Health (2021, para 21) highlighting that intersex persons have 'specific health needs' which 'must be addressed and differential treatment provided'.

The CoE Parliamentary Assembly (2013, para 7.3; 2017, para 7.1) talks about the importance of 'specific training' as well, together with 'adequate treatment and support' for intersex individuals and their families. The goal is to 'ensure that intersex people have effective access to health care throughout their lives' and 'provide comprehensive and up-to-date training on these matters to all medical, psychological and other professionals concerned'. Similarly, the EU Agency for Fundamental Rights highlights that 'legal and medical professionals should be better aware of the challenges [intersex people face] to ensure that [their] rights are fully respected' (EU Agency for fundamental rights 2015, p. 7), pointing out that treatment should always meet 'human rights standards'.

With the UN, CoE and EU engaging with and echoing activist demands, this seems like a history of success for the intersex movement. Moving from a 'marginal' position of picketing outside hospitals to gain attention from medical professionals (and failing to do so) to having the organisational and lobbying power to influence international authorities, intersex activism has found in human rights a powerful discourse to advance its claims. However, as the next section details, the deployment of human rights might not be conducive to questioning the authority and role of medicine, as ISNA originally intended. Instead, it might channel critiques of intersex medical management as calls to reform specific aspects of medical care, like ISNA in its final days and its successor organisations.

3.2. Reforming or transforming medicine?

ISNA's collaborative tendency of working within (rather than challenging) the medical framework is now solidified. Nevertheless, in its inception, ISNA distrusted the idea of 'good' medicine, insisting on dismantling the medical gaze altogether and interrogating its drive to enforce heteronormativity. OII and ILGA Europe, in contrast, seem to believe that 'good' medicine is possible, seeking to co-operate with medical professionals to achieve better standards of care for intersex people. Their focus is less on exposing the ideological underpinnings of medicine and more on 'regenerating' medicine by amending particular features of medical care, through facilitating more training, interdisciplinary expertise, psychological support and consent safeguards. For instance, ILGA Europe, highlighting the physical and psychological negative health effects of early surgery, recommends, in the name of the right to access health, not only to protect people from being submitted to these interventions without their consent, but also to ensure their access to lifelong treatment and counselling and to include 'human rights-based' intersex issues on the medical curriculum, with tailored training for medical professionals (Ghattas 2019, pp. 24–25).

That said, both groups recognise the power of the gender binary, and OII Europe (2023, p. 6) imagines a world where 'sex is understood as a continuum' and 'diversity is celebrated'. Interestingly, however, in toolkits for policy-makers (see e.g. Ghattas 2019, pp. 27–29), it can be seen how the mission of transforming binary views of gender mostly fades away when it comes to specific criticisms or recommendations about medical care, resurfacing more strongly when proposing non-medical initiatives, including education, antidiscrimination, hate speech and legal gender markers. The fact that calls for more expansive visions of gender emerge more explicitly in other areas rather than medical practice might have unintended problematic effects (Carpenter

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2018; Garland and Travis 2023). For example, the creation of third legal gender markers, if not adequately implemented, as ILGA warns (Ghattas 2019, p. 33), might (re)stigmatise intersex people and inadvertently push for early surgical intervention (Garland and Travis 2023). Indeed, third legal gender markers, conflating intersex embodiment with non-binary identities, misrepresent both intersex and queer realities, since they incorrectly assume that most intersex individuals identify outside the male/female binary, and that those with endosex characteristics adhere to either of these normative categories (for a critical account of how this problem unfolded in the German context, see Garland and Travis 2023). Crucially, opening up new classifications of legal gender beyond the binary does not, in itself, contribute to ending early medical interventions (Carpenter 2018) but might, in fact, fuel the need for their performance, given parental concerns that intersex children would be placed in a third gender category, which might be both outing and stereotyping (Garland and Travis 2023).

Within activist toolkits and resolutions by international agencies, human rights language (through the right to health, bodily integrity and autonomy) takes over in the context of reassessing medical practices, putting particular emphasis on i) 'non-medicalised psychosocial expertise' and ii) protecting intersex people's ability to 'make their own choices in regards to their personal lives' (Ghattas 2019, pp. 15–16). These measures, considered capable of putting an end to a cycle of physical harm and psychological trauma, might however operate as what some scholars call an instrument of 'governance' (Lippert and Hamilton 2020). Enshrining intersex human rights has become synonymous with putting in motion 'professional discourses of care' which primarily call for institutional changes (Armstrong 2018, p. 405). However, these developments do not address the foundational causes (Marks 2011) of intersex suffering. While psychological assistance and more robust consent safeguards might potentially displace early surgery as the primary (and only) response to intersex variances (Timmermans *et al.* 2018), having these as central demands might drift away from challenging medicine's drive to enforce the gender binary.

First, seeing counselling as a key mechanism to protect intersex human rights might imply that the ultimate goal is to guarantee the provision of this service, rather than to transform medicine and society so intersex embodiment does not necessarily (and automatically) render one more vulnerable to psychological suffering and in need of psychological support. Hence, although an enhanced role for psychosocial professionals might entail that intersex variances are no longer being perceived as a medical emergency needing an immediate surgical solution, it might become a psychological problem requiring lifelong psychological management, as is already reflected in international medical guidance (Lee *et al.* 2016, p. 176). As Fae Garland and Mitchell Travis (2023, pp. 148–50) highlight, the way in which psychology is incorporated into intersex medical management via the Consensus Statement '[is] not a radical departure from the medical model', but a 'disguised 'co-option' of psychological practices into the medical embodiment model'. The Statement frames psychological support as complementary to surgical interventions, 'in order to promote positive adaptation' (Hughes *et al.* 2006, p. 557), rather than to foster self-acceptance and destigmatisation of intersex variations (Garland and Travis 2023). Of course, this is not to say that intersex individuals do not require psychological care or that this care should not be offered. Rather, the focus on psychosocial care, as it is framed now, continues to nurture a medicalised vision of intersex embodiment. It buttresses the view that intersex people necessitate medical and now also psychological expertise, albeit through the seemingly more progressive language of autonomy, dialogue and openness. To put it in the words of Garland and Travis (2023, p. 151), 'the statement's ostensible commitment to psychological care as essential makes it able to hide its commitment to medical embodiment in plain sight'.

Second, the focal point of guaranteeing 'personal, prior, free and fully informed consent before any surgery is performed' (Ghattas 2019, p. 17) diverts attention away from the context in which decisions about surgery are made. The emphasis on capacity, information and lack of coercion reduces the issue of undergoing these surgeries to a matter of autonomy that can be solved by introducing procedural safeguards, downplaying the power of social norms underpinning having

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one's genitals operated on. The proliferation of the language of 'choice' and 'consent' disguises surgery into a matter of personal preference, obscuring the role that medicine plays in constructing notions of normal and healthy embodiment (Rubin 2015). As Kathryn Paul Morgan (1991, p. 36) argues in relation to cosmetic surgery, what appear to be 'instances of choice' might, in reality, be 'instances of conformity'. Those undergoing 'elective' operations (as intersex interventions seek to become), while seemingly exercising their choice, might, in fact, be trapped by an 'absence of choice', having to navigate 'the norms of beauty ... [and] compulsory heterosexuality with an awareness of the violence that can result from violating these norms' (Morgan 1991, p. 37). Indeed, those undergoing 'elective' interventions might be informed of risks and possible side-effects, and might be provided with 'practical' safeguards, such as cooling-off periods to think about their decision (for a critical appraisal of how informed consent practices might not be up to standard regarding cosmetic surgery, see Latham 2008). Nevertheless, undergoing these types of surgeries might be due to incentives or pressures – what Susan Bordo (1993, p. 166) calls 'the elusive ideal of femininity' in the context of cosmetic surgery – that escape the contours of consent forms and cannot be accounted for in conversations with doctors. In other words, consent, albeit informed and made with full capacity, may not necessarily amount to a 'free choice', and therefore enshrining it as a key guarantor of intersex human rights might replicate a 'paradox' or 'illusion' of choice. Instead of contesting why and how intersex individuals might be driven to opt for surgery, focusing on measures to enhance autonomy 'reformats', rather than challenges, medicalisation, rendering normalising one's genitalia a 'seemingly sensible "choice" for those whose bodies "do not conform to mythical norms"' (Rubin 2015, p. 74).

The days of 'Hermaphrodites with Attitude' are long gone. Rather than rethinking the pervasiveness and ideology of the medical gaze, the human rights agenda is focused on achieving certain milestones to enhance health care. While consent, counselling and training are critical steps for improving the experiences of people with intersex variations, making them the cornerstone of demands and recommendations implies accepting the medical framework, not contesting why intersex embodiment triggers medical attention to begin with. Activist organisations do acknowledge the role that binary visions of gender play in understanding intersex embodiment, although the way in which they formulate their demands is more focused on working *within* the medical framework to improve its standards. Therefore, notwithstanding that human rights provide activist groups with a platform to gain international acknowledgement, they may also fuel the tendency toward reforming, rather than interrogating and ultimately transforming, the authority and role of medicine.

4. Intersex human rights and law

4.1. A human rights violation that must be prohibited

Far from arguing that medical protocols should not change, the previous section contended that reforming intersex care management should not be the end goal per se, but the by-product of medicine becoming more inclusive and less committed to enforcing the gender binary upon what are deemed ambiguous bodies. This present section focuses on the deployment of intersex human rights in pushing for law reform and argues against what has become the second crucial demand from intersex activists to put an end to early normalising surgeries: criminalisation.

As introduced above, criminalisation became part of the intersex activist agenda early on, with ISNA seeking, but failing, to expand the US federal FGM prohibition to cover genital surgeries for intersex variations. Despite being controversial (Ammaturo 2016; Rubin 2015), naming intersex surgeries as 'mutilations' is a conceptual move that has been adopted by an increasing number of intersex organisations since (StopIGM *et al.* 2019). It has been effective insofar as the CRC (2015, para 42–43) recognised that these amount to 'harmful practices'. Originally created to refer to 'traditional' practices in the Global South, particularly FGM (Winter *et al.* 2002), the scope of

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'harmful practices' now includes medical genital normalising interventions, with the WHO (2014) having acknowledged that these are often medically unnecessary and carried out without the individual's consent, causing severe physical and psychological harm. An additional growing number of UN treaty bodies have shown concern about these operations, explaining that they constitute a breach of several human rights, including the right to physical integrity, the right to not be subjected to torture or inhuman and degrading treatment and the right to health, particularly in relation to children (Garland and Slokenberga 2019; Winter Pereira 2022).

Replicating the international consensus with regards to the need to criminalise FGM (WHO 2008), prohibiting 'non-emergency medical interventions performed without full, free and informed consent' has emerged as the main recommendation to protect intersex human rights (UN Office of the High Commissioner 2023). The CAT (2016b, pp. 34–35) and the CRC (2016, para 47) have recommended that states 'take the necessary legislative, administrative and other measures to guarantee respect for the physical integrity of intersex individuals', and 'ensure that no one is subjected to unnecessary medical or surgical treatment during infancy or childhood'. The CRPD (2022b, para 36) and CEDAW (2018b, para 22) have been more specific, urging states to 'adopt clear legislative provisions that explicitly prohibit the performance of unnecessary, invasive and irreversible medical interventions'. Along similar lines, the CoE's Parliamentary Assembly passed a resolution (2017, para 7.1) which, seeking to 'promote the human rights of and eliminating discrimination against intersex people', called on Member States to 'prohibit medically unnecessary sex "normalising" surgery, sterilisation and other treatments practiced on intersex children without their consent'. Likewise, the European Parliament (2019) recognised the 'urgent need to address violations of the human rights of intersex people, calling on the Commission and the Member States to propose legislation to address these issues'.

Intersex activist organisations have welcomed both the labelling of early normalising intersex surgeries as human rights violations and the push for criminalising them (for an overview of reactions within some activist groups, see Zelayandia-Gonzalez 2023, p. 13). OII Europe (2024) celebrates the increasing trend among European countries explicitly banning intersex surgeries, which Malta kickstarted in 2015 and has since been followed by Greece, Germany, Iceland, Portugal and Spain (OII Europe 2024). That is why ILGA Europe (2023) placed these countries higher up in its latest edition of the Rainbow Map and Index, used to 'illustrate the legal and policy situation of LGBTI people in Europe'. Putting a stop to early surgeries by enacting prohibitions was the first point of the community-based Malta Declaration (2013). It featured in the Statement of Riga (2014) and the Vienna Community Statement (2017) as well, which requested governments to 'install legislative protections that ban medical interventions on children with variations of intersex characteristics, on social, psychosocial, cultural or cosmetic grounds'.

The history of campaigning for criminalisation thus appears to also be one of success for intersex activism. After ISNA's initial failure to achieve recognition of intersex surgeries as mutilations and to advance legal change in the USA, the framing of these operations as human rights violations which must be prohibited has been solidified, at least at the international level (Garland *et al.* 2022). As a result, intersex politics are no longer fought in the medical sphere alone but, following ISNA's twofold strategy, the legal arena has become a solid ground to articulate activist claims. Prominent international organisations now see legal change – in the form of expanding the state's punitive powers – as required to protect intersex individuals from human rights abuses. Although calls for legal change expand beyond criminalisation, it occupies a prominent place among activist demands: it is ILGA Europe's first recommendation in their toolkit (Ghattas 2019, p. 15), and it is also OII Europe's (2023, p. 12) first objective for policy change. The next section, however, is critical of this framework of increased penality, warning that it might undermine the collective change required to transform binary views about embodiment, fuelling the need for early operations.

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4.2. Intersex coercive human rights

The language of criminal law dominates conversations about law reform in the intersex context. Not only have surgery bans been enshrined as a crucial method for intersex human rights protection, but the rhetoric of victims' rights has also infiltrated the discussion. For example, the UN High Commissioner for Human Rights (2015) used criminal justice vocabulary when calling for further action to 'address the human rights situation of intersex persons', denouncing the 'impunity for the perpetrators; lack of remedy for victims; and a perpetuating cycle of ignorance and abuse'. A year later, for Intersex Awareness Day, his office issued a press release with a similar tone and called on states to 'hold those found guilty of perpetrating such violations accountable and provide intersex people subjected to abuse with redress and compensation' (United Nations High Commissioner for Human Rights 2016).

This penal turn is not unique to the intersex context and must be inscribed within local, regional and international trends that invoke human rights to justify criminal law increasing its role and scope (Pinto 2020). Criminal prosecution is now seen as legally and politically required to uphold human rights (Mavronicola 2024), with anti-impunity discourse shaping the direction of human rights advocacy, equating human rights protection with criminal justice (Engle 2016). The 'sword' function of human rights is expanding (Tulkens 2011, p. 578), and what can be called coercive human rights (Lavrysen and Mavronicola 2020) have been particularly prominent in relation to questions of sex and gender (Bernstein 2012; Tapia 2022). For example, 'women's rights' have been a catalyst for advocating for more penality. Feminist advocacy has resorted to the discourse of human rights to focus on sexual, psychological and physical violence against women, pressuring states into creating or enforcing criminal laws purported to protect women's bodily integrity and sexuality (Bernstein 2012). Calls for the use of criminal law also occupy a prominent place in trans politics, with hate crimes becoming key in the agenda of advocates for trans equality (Spade 2015). By 'breaking down' women's and trans people's lived subjugation and oppression into particular 'instances' of human rights violations, new offences targeting these particular manifestations of oppression (stalking, sexual harassment, the criminal offence of FGM, hate crimes) have proliferated (Pinto 2020; Spade 2015).

Intersex human rights follow a similar path, nurturing the enactment of criminal prohibitions which tackle particular instances of violence (non-consensual and unnecessary surgeries), but not the broader context that allows for such violence to occur in the first place. The turn to criminal law isolates surgeries from the underlying structural causes of such human rights violations (the dominance of dichotomous views of gendered embodiment), painting a simplistic picture of 'bad' doctors performing surgeries that contravene their Hippocratic duties. 'Individualising' fault misses the complex and multiple ways in which binary visions of embodiment underpin not only medical accounts of what constitutes a healthy body and genitals, but also societal views of normality and beauty (McDougall 2013; Reitsma *et al.* 2011). By seeking criminal accountability from a (limited) number of individuals who perform these interventions, surgery prohibitions seclude these operations from their social and historical context (Dreger 1998; Reis 2009), deflecting collective responsibility (Mavronicola 2024) for the marginalisation of people with intersex variations, framing it as a matter of individual responsibility instead. Seeing intersex surgeries as human rights violations which must be punished not only expands the 'tentacles of the criminal law', but also neither scrutinises nor deconstructs the assumptions about gender, heteronormativity and binarism that are at the root of this violence (Marks 2011).

For these criminal prohibitions to apply in practice, the prosecution would need to prove that modifying someone's sex characteristics before the age of consent is not medically required. One could argue that convincing the court of such lack of medical necessity entails a challenge to binary gendered ideals and assumptions. However, contending that these interventions do not obey a medical aim does not necessarily require deconstructing dominant views about gender. For example, physicians Milton Diamond and Keith Sigmundson (1997, p. 303) famously argued that

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operating on genitals early on to 'mould' intersex children into men or women was not medically indicated. Rather than helping them have a 'healthy psychosexual development', they contended that surgery came with 'an unacceptable psychic price to pay', with lifelong 'traumatising' effects'.[3] Despite their position against immediate surgery, their postulates about gender remained rooted in essentialism and binarism, arguing that chromosomal makeup 'prenatally predisposes' individuals into manhood or womanhood (Diamond and Sigmundson 1997, p. 303). Similarly, the 2016 update of the Consensus Statement discussed above, while it acknowledges that 'timing, choice of the individual and irreversibility of surgical procedures are sources of concerns', continues to see gender identity as binary and dependent on biological factors, considering that 'male or female assignment should be based on physical development, hormonal secretion, the presence/absence of genetic mutation and the response to hormonal therapy' (Lee *et al.* 2016, pp. 169, 176). Therefore, arguing for the lack of necessity of early surgeries does not inherently entail rethinking the effects of gender binarism upon intersex bodies, and criminal prohibitions are not per se conducive to deconstructing binary views about gender, since they may rely on narrow notions of medical benefit, focusing on individual accountability through individual punishment.

4.3. Legal co-option

The pioneering legal reform in Malta, followed by other European countries in the last few years, has been celebrated for not only 'simply prohibit[ing] medical interventions' but also for 'openly challeng[ing] the disordered narrative of medical embodiment by recognising the social motivations behind medical interventions of intersex infants' (Garland and Travis 2023, p. 113). The Maltese Act (GIGESCA 2015) does not use the pathologising language of Disorders of Sex Development, but talks about 'sex characteristics' and envisions the appointment of an interdisciplinary team for managing intersex cases. In a similar vein, the Spanish statute (Law 4/2023) – the latest prohibition of this kind enacted in Europe to date (OII Europe 2024) – also goes beyond merely restricting the performance of surgeries on intersex children, giving statutory footing to the principles of 'non-pathologisation, autonomy, informed decision and consent, non-discrimination', inter alia, as guides for the provision of intersex health care.

On paper, legal action seems not only focused on coerciveness but also aims for the medical profession to move away from pathologising intersex embodiment. In practice, however, this has not happened. While it is too early to assess the effectiveness of the Spanish legislation, in Malta, ten years on from reform, the Act's envisaged change of medical protocols has not taken place and the 'legal promises of disruption into practice' are unfulfilled (Garland and Travis 2023, p. 123). The key reasons for the 'failure' of the Maltese legislation lie in drafting loopholes and gaps in its implementation (Garland and Travis 2023). Most notably, the Act lacks extra-territorial jurisdiction (Garland and Travis 2023), and the envisioned 'interdisciplinary team' is yet to be appointed (Tabone *et al.* 2024). As a result, medical practice remains unchallenged, with the CRC (2019, paras 28–29) 'remain[ing] concerned' that intersex children continue to be subjected to early surgeries in Malta. Seeing this, the Maltese Act can be argued to be doing the opposite of what it aims to do. It ends up reinforcing 'medical [intersex] embodiment': by suggesting that 'the problematic practice has, in fact, been challenged and ended by law, the effect is to further legitimise that which is able to continue' (Garland and Travis 2023, p. 124).

Beyond the particular obstacles of the Maltese context, it is worth thinking more broadly about the promises but also the limitations of using law to displace early surgeries from the realm of acceptable medical practice. 'Proclaiming' these interventions as human rights violations, and

[3]This article was particularly famous because it was a long-term follow-up on a highly publicised case in the medical literature. It concerned an individual whose penis was accidentally ablated as a child, after which he was reassigned and raised as female. The article exposed that he switched (back) to living as a man during puberty.

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prohibiting them in the name of human rights, might generate the illusion that these operations are part of a problematic past that has been left behind (Crenshaw 1988). Ironically, human rights discourse and legal action, while providing a framework of legitimisation and visibility for the cause, might simultaneously 'accommodate or obscure' the contradictory reality (Crenshaw 1988, p. 1347) that intersex individuals are still being subjected to these surgeries at an early age. Indeed, although these surgeries have been deemed a human rights violation for more than fifteen years, their performance has not ceased, which is mostly because medical guidelines remain non-committal and vague about condemning them. While a growing number of medical professionals (Crouch *et al.* 2008; Minto *et al.* 2003) advocate that these should stop, the 2016 update of the Consensus Statement does not clearly rule them out. It limits itself to acknowledging that this is an area of 'greater complexity' which has come 'under intense scrutiny', and that medical professionals should be 'aware that the trend in recent years has been for legal and human rights bodies to increasingly emphasise preserving patient autonomy' (Lee *et al.* 2016, pp. 176–77). Delegitimisation of early surgeries requires profound rethinking in the clinical world to disentangle intersex embodiment from the narrative of disorder. However, as Laurent warned during ISNA's beginnings, 'doctors will change last, not first' and 'only after we change public opinion' (Hegarty 2000, p. 127). Acknowledging that legal action alone is not enough to alter the clinical approach to intersex variances, some activists insist that the (so far ineffective) legal reform is 'part of a bigger picture' and a 'key mechanism to achieve social change', highlighting the importance of visibility and cultural awareness, as the ultimate goal is to change public opinion (Garland and Travis 2023, p. 125).

Although law and society are porous and do not operate as separate compartments (Lobel 2007), and the relationship between law reform and social movements is multi-faceted (Coglianese 2024), an important risk of conceptualising law as a vehicle for social change (that will, in turn, prompt medical change) is that the former might co-opt the energies and discourse of community organising. Embracing law to guarantee intersex human rights might turn activism into a legal enterprise. Converting intersex demands into human rights claims runs the risk of feeding the mirage that legal change is sufficient to improve the lives of intersex people. Instead of 'engender[ing] radical and lasting social change' (Ammaturo 2016, p. 606), human rights (and legal action designed to uphold them) might trap intersex politics within the 'legal edifice', revamping what should be mandates for societal transformation into calls for law reform (Kapur 2018, p. 100).

To a certain extent, this shift is already in motion, as claims of prominent activist organisations are being absorbed by the attractive force of the legal discourse. Notwithstanding that OII Europe (2023, p. 17) envisions building a society where 'intersex sex characteristics are valued and considered as healthy as male and female sex characteristics' and where 'intersex people are fully accepted and included in our society and culture', the legal and policy missions take up a great deal of their organising efforts. Policy and legal change are the first goals of OII Europe's 2023–27 strategic plan, where prohibitions are considered to be the most effective way to 'stop the violation of the bodily integrity of intersex people and ensure their right to self-determination'. Its goal is to continue to work with the EU and CoE to 'take a firm stand against IGM and other harmful medical practices faced by intersex persons', 'monitor the implementation of existing intersex policy and legislation' and 'continue and expand OII Europe Strategic Litigation Program' (OII Europe 2023, p. 15).

Several intersex groups themselves admit that a great deal of their energy is devoted to working within the legal framework, preparing reports for international organisations, writing third-party interventions and monitoring state compliance (Zelayandia-Gonzalez 2023, p. 4). Becoming inserted in institutional and legal spaces might leave little time for 'community organising, base building, local advocacy, and [providing] services to intersex people and family members' (Howe *et al.* 2017, p. 17). For example, OII Europe (2023, p. 20) notes the 'lack of supportive mechanisms', 'shrinking spaces' and 'lack of resources' as obstacles that intersex people face, setting out

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as a goal to apply for EU and other sources of funding to strengthen the 'overall operational and organisational capacity of intersex activists'. It also seeks to establish a specific pot for 'rapid response' to help intersex individuals and their families in 'urgent need' (OII Europe 2023, p. 22). The creation of these sources of support was, as seen in the first section, precisely the chief, most immediate goal of intersex activism in its early days. Furthermore, going back to the notion of human rights as instruments of governance introduced above, these 'audit, oversight and accountability' functions awarded to activist groups might contribute to 'hide and preserve' the structural 'conditions of subjugation' for intersex individuals (Spade 2015, p. 15). Reporting and auditing mechanisms, while invoking 'principles of organisational transparency', might render invisible practices that 'escape the tidy contours of surveillance accountability reports' (Molnar and Warren 2020, pp. 14–17). Therefore, while the role undertaken by intersex organisations may be celebrated as a step toward inclusivity and accountability, it might also have the effect of obscuring and entrenching conditions that, given their diffuse nature (Foucault 1972), do not fall under the scope of accountability reports or litigation programmes, albeit they are essential in explaining why intersex characteristics are seen as in need of fixing.

Finally, intersex human rights also present the dangers of what Gerry Simpson (2021, p. 70) calls 'misdescription' and 'over-legibility'. Simpson writes about how the language of rights fails to 'capture certain types of wrongdoing', and ends up doing 'injury to certain kinds of injury'. For example, to speak about the suffering inflicted upon Holocaust victims as, first and foremost, a 'violation' of human rights amounting to a crime seems 'painfully inadequate' to characterise 'the acts perpetrated on [them] and the wrongs suffered by [them]' (Simpson 2021, p. 70). In a similar way, to define chronic pain, irreversible loss of erotic sensibility and psychosexual trauma as breaches of the right to bodily integrity may also fail to grasp the pain experienced by intersex individuals. Juridifying suffering through human rights 'transmutes the unspeakable to the routine', inscribing it in the 'minutiae of legal technique' of proportionality, rationality and necessity (Simpson 2021, pp. 69–70). Crucially, intersex human rights, while making harm resulting from early surgeries intelligible and visible through law, also make such harm legible and comprehensible within the legal universe. Judicialisation of early surgeries entails that such operations are no longer violent enforcements of the gender binary but are now read through legal formulas and tests to determine if a human rights violation has occurred. For example, in *M v France* (2022),[4] the European Court of Human Rights, assessing the potential violation of Article 3 in a case where the applicant had undergone normalising surgeries as a child, asked: have these interventions entailed a 'minimum level of severity'? Has their 'medical necessity been convincingly shown to exist'? Does the imposition of treatment without the patient's informed consent amount to an 'interference with their right to physical integrity'?[5] The incorporation of these surgeries into the legal world as potential breaches of Article 3 entails that they become inscribed in and are talked about through legal language, as it can be seen from OII Europe's press release (2022) on the case: 'the Court has now established the basis for qualifying non-vital interventions on intersex persons without their informed consent as a form of torture, prohibited by Article 3, and this is a very important step forward'. The peril is that the legal discourse might pervade the ways in which we talk about the harm resulting from these operations, turning the condemnation of the suffering they generate into a 'legal argument', with the legitimacy of the cause potentially ending up hinging on the viability of legal claims. As Simpson argues in relation to international law (2021, p. 71), intersex human rights too provide a 'juridical cover' by 'applying law to horror'. They 'over-assimilate' suffering into law and transform the denouncement of the pain of having one's body irreversibly altered into an exercise of legal argumentation. As he wonders (2021, p. 70), 'is this the right language to describe these horrors?'

[4]App no 42821/18 (ECtHR, 26 April 2022).

[5]The Court did not rule on the merits of the case, dismissing it on a procedural basis.

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5. Conclusion

This article aims to initiate a much needed yet so far untrodden discussion about the role and challenges of human rights in the intersex context. Expanding upon existing reflections about the limitations of law in the quest for improving intersex health-care experiences (Garland and Travis 2023), it has made the distinctive contribution of exploring the potential implications of human rights becoming a pervasive framework through which intersex activist groups formulate their demands. Intersex human rights constitute a particular mode of thinking and talking about the intersex experience. No longer seen only through medical lenses, intersex individuals have become potential victims of human rights violations, a conceptual shift that has coincided with, and nurtured discursive and tactical changes within, intersex activism. From picketing in front of medical conferences to sitting down to negotiate with health care professionals and engaging with international authorities, the intersex movement has moved from a 'rebellious' to a 'collaborative' strategy.

This genealogy of intersex activism – tracing its evolving relationship with medicine and law – gestures toward a broader lesson to learn: the importance of examining how critique is re-shaped when institutional collaboration and law reform, through the discourse of human rights, are set as a strategy (Tapia 2022). The landmark collection of essays in *Governance Feminism* (2019, p. xii) asks what happens 'when feminists and feminist ideas find their way into legal institutions'. Reflecting on the success of the intersex movement, this article has uncovered what might occur when the intersex struggle becomes embedded in the human rights agenda, showing how what seems like a positive history of progress, visibility and recognition might also involve reformism, punitiveness and legal co-option.

First, the central goals of improving medical care and introducing consent safeguards, rather than challenging the foundations and legitimacy of the medicalisation of intersex embodiment, risk facilitating and legitimising the medical project of intersex health-care management. Second, the popular trend of triggering the state's punitive powers in the form of prohibiting intersex surgeries before the age of consent does not address the oppressive ideals and structures that other intersex bodies for not conforming to the gender binary. It fuels a carceral solution to a problem that requires social transformation. Third, the legal discourse might absorb activist demands. The condemnation of intersex surgeries now lies more on their being unlawful (a form of human rights abuse, a criminal offence), rather than on their constituting a form of oppression. The pain and suffering these interventions generate might mutate into a legal problem (a violation of UN treaty body resolutions, CoE recommendations or legislative prohibitions) which compels legal action, rather than a social injustice which requires collective reflection.

All in all, this article paves the way for further debate about whether and how human rights can be deployed to facilitate, rather than potentially undercut, calls for structural change to improve intersex well-being. In a context of evolving medical views on intersex embodiment (see e.g. Muschialli *et al.* 2024) and potential further calls for legal reform (UK Government Equalities Office 2019), the question about whether and how we should rethink our commitment to human rights discourse is not a theoretical one. As Garland and Travis (2023, p. 175) point out, although the usefulness of legal frameworks in disrupting othering views of intersex embodiment has been limited thus far, this does not mean that they are 'completely unhelpful in terms of their conceptualisation of intersex embodiment'. It is therefore time to give careful thought to the tactics and tools to dismantle the structural context marginalising those whose bodies are not considered to fit conventional norms.

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Cite this article: Garces de Marcilla M (2026). Intersex human rights: a double-edged sword. *International Journal of Law in Context* **22**, 235–255. https://doi.org/10.1017/S1744552326100391

https://doi.org/10.1017/S1744552326100391 Published online by Cambridge University Press