

Intersex human rights, sexual orientation, gender identity, sex characteristics and the Yogyakarta Principles plus 10

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Abstract

The 2006 Yogyakarta Principles apply human rights law in relation to sexual orientation and gender identity. Created outside the UN system, their aim was to promote good practices in protecting the rights of LGBT and intersex people. They were ineffective in protecting the rights of intersex people, including due to an inappropriate framing around ‘sexual orientation’ and ‘gender identity’. In the same year, a group of clinicians published a ‘consensus statement’ reframing intersex traits as ‘disorders of sex development’, entrenching medical authority over intersex bodies. It was not until 2015 that the first country (Malta) sought to enact protections of rights to bodily integrity and physical autonomy and freedom from discrimination, associated with a new attribute of ‘sex characteristics’. In 2017, an update to the Yogyakarta Principles known as the Yogyakarta Principles plus 10 incorporated the new attribute and recognised rights to bodily integrity, truth and legal recognition. These principles have direct relevance to the human rights situation of intersex people. This paper addresses reasons why the earlier Yogyakarta Principles were ineffective and presents the goals of the update process, inviting adoption of a new attribute of sex characteristics and new principles relevant to intersex populations, advocates and policymakers.

Keywords: intersex, disorders of sex development, Yogyakarta Principles, Yogyakarta Principles plus 10, human rights, sexual orientation, gender identity

Introduction

Intersex people have innate sex characteristics that do not fit medical or social norms for female or male bodies (Office of the High Commissioner for Human Rights 2019, 2). The intersex population is extremely diverse, with more than 40 relevant presentations known, including genital, gonadal, hormonal and chromosomal variations. These may be determined prenatally, at birth, at puberty, and at other times, such as when attempting to conceive a child. People with intersex variations use many different terms to describe their bodies and characteristics, often code-switching in response to stigma, context or misconceptions; these terms include intersex, intersex variations or traits, innate 'variations of sex characteristics', 'differences of sex development', individual diagnostic labels and, rarely outside medical settings, the stigmatising term 'disorders of sex development' (Carpenter 2018b, 486).

Because intersex characteristics do not fit medical or social expectations, intersex persons can suffer stigmatisation and discrimination (Office of the High Commissioner for Human Rights 2019, 3). Rights to life, education, sanitation, healthcare, employment and asylum can each be impacted by experiences of stigma, violence and discrimination. Wherever medicine is accessible, people with intersex variations may be subjected to medical interventions to make their bodies more typically female or male without personal informed consent; typically in infancy, childhood or adolescence. Such practices are now recognised as 'harmful practices' (Office of the High Commissioner for Human Rights 2019). The intersex movement has challenged these practices for more than twenty-five years.

The 2006 Yogyakarta Principles (YPs) are a set of norms that sought to apply human rights law in relation to 'sexual orientation' and 'gender identity'. A 2017 update, known as the Yogyakarta Principles plus 10 (YP plus 10), elaborates a new ground of 'sex characteristics' and recognised rights to bodily integrity, truth, and legal recognition.

This paper outlines the goals of the YPs, and their limited impact on people with intersex variations, identifying that this can largely be attributed to inappropriate expectations regarding the framing on sexual orientation and gender identity. The paper also outlines the YP plus 10 update process, and the update's relevance to people with intersex characteristics, advocates and policymakers. The author, an intersex man, is a signatory and a member of the drafting committee for the YP plus 10.

The Yogyakarta Principles

The YPs were described by the Asia Pacific Forum of National Human Rights Institutions (2016, 131) as 'the most authoritative statement' of international human rights law obligations for States 'in promoting and protecting the rights of persons of diverse sexual orientations and gender identities'. Its 29 Principles were developed by human rights experts who met at Gadjah Mada University in Yogyakarta, Indonesia, in 2006.

Necessitated by specific human rights violations affecting sexual and gender minorities, and the absence of an UN process for a convention comparable to those on the rights of the child and of persons with disabilities, the experts set out a comprehensive statement on the application of human rights law. While not binding on States, the principles 'reflect well-established principles of international law' (UN High Commissioner for Refugees 2012, para. 7) and the state of human rights jurisprudence at the time of drafting. While not drafted for adoption by the UN, they have influenced reasoning by UN Treaty Bodies, regional institutions and legal decisions to decriminalise homosexuality, eliminate discrimination and recognise rights to gender recognition (O'Flaherty 2015).

The authors aimed to ‘articulate universal rights for all people’ focusing on grounds of sexual orientation and gender identity, irrespective of cultural context or personal identification with identity labels, including LGBT and culturally-specific terms (Quinn 2010, 23). Nevertheless, the 2007 Principles mentioned specific populations – including intersex persons – in the preamble:

historically people have experienced these human rights violations because they are or are perceived to be lesbian, gay or bisexual, because of their consensual sexual conduct with persons of the same gender or because they are or are perceived to be transsexual, transgender or intersex or belong to social groups identified in particular societies by sexual orientation or gender identity (Yogyakarta Principles 2007, 8).

The terms sexual orientation and gender identity were not created by the authors of the principles; they already existed in human rights jurisprudence and in clinical settings. Both terms have had clinical meanings, reflecting a pathologisation of sexual and gender minorities (Meyer-Bahlburg 1990; Money 1994). Like concepts of race, gender, sex and disability, both terms are contested (Gross 2008, 250–51), but the principles provide standardised definitions and applications. Eitelbrick and Trabucco Zerán (2016, 11) comment that the

importance of this cross-cultural and cross-discipline consensus ... on these basic terms cannot be overstated. Agreement as to who is included in the social grouping that is the subject of the law and its application is the necessary first step to actually interpreting and applying the law.

Principle 18, ‘Protection from Medical Abuses’, identifies an aspect of the most intractable human rights violations faced by intersex people. It states:

No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity (Yogyakarta Principles 2007, 23).

And that States are obliged to:

B) Take all necessary legislative, administrative and other measures to ensure that no child’s body is irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with the age and maturity of the child and guided by the principle that in all actions concerning children, the best interests of the child shall be a primary consideration (Yogyakarta Principles 2007, 23).

Intersex people, sexual orientation and gender identity

Intersex people are often included in frameworks concerning sexual orientation and gender identity in ways that presume the applicability or relevance of these concepts – but the UN Office of the High Commissioner for Human Rights definition (2019, 2) of intersex bodies as ones that defy medical norms makes no assumptions about individuals’ sexual orientations or gender identities, nor sex, gender or other attributes. On the one hand, norms associated with sex and gender affect all LGBT and intersex populations, and populations of people with intersex variations overlap with populations of diverse sexual orientation and gender identity. On the other hand, research evidence

shows many intersex people grow up to identify with female or male sex assigned at birth, while some do not, and that many grow to be heterosexual while some do not (Jones 2016, 6; Furtado et al. 2012). Intersex people share no common sexual orientation or gender identity.

Framings of intersex as a sex assignment, or that disregard actual assignments in favour of a position on intersex as a biological sex, fail to account for this diversity of lived, legal and social experiences (Carpenter 2018b). Furthermore, a framing of intersex people as a population identified by sexual orientation or gender identity has had multiple unfortunate consequences. It suggests that intersex persons are definable by sexual orientation or gender identity, despite sharing neither in common.

At an even more fundamental level, explicit statements that populations of diverse sexual orientation and gender identity are defined by their 'emotional, affectational and sexual attraction' and 'internal experience of gender' including chosen 'modification of bodily appearance or function', 'and other expressions of gender' inherently construct an expectation that such individuals are old enough to freely express an identity (Winter 2009, 161). This is not true of infants and children with intersex variations who experience human rights violations because of their innate characteristics but who have no agency to express an identity.

This framing has nevertheless produced expectations that protections on grounds of sexual orientation or gender identity can benefit intersex people and offer protection from the specific human rights violations intersex people face. Yet actions to protect people with agency to express their identities have nowhere protected this population; they have nowhere prevented or eliminated the harmful practices identified in Principle 18 on medical abuses, nor have they addressed specific violations in other settings. To understand why, it is helpful to consider how medicine treats intersex people, now and historically.

Historical approaches to 'hermaphrodites' in religious law acknowledged diversity amongst intersex people. Christian and Islamic religious laws have stated that hermaphrodites were to be treated as either female or male depending on predominant sex characteristics (Finlay 1980, 120; Sachedina 2009, 192–93). With the development of medical technologies, clinicians established norms for male and female bodies, sought to determine individuals' 'true sex', and align their physical characteristics. Medicine sought to impose social and cultural norms and eliminate the possibility of sin. Elizabeth Reis has described how:

Physicians in the 1880s and 1890s wanted their patients to understand their hermaphroditic conditions as deformities and not as a physical license to commit sexual immorality (Reis 2009, 68).

In the 1950s, John Money and others sought to establish 'thoroughgoing conviction of gender in the hermaphrodite' through surgery and reinforcement of stereotypical gender roles (Hampson, Money and Hampson 1956, 549). This became the standard medical model of forced early surgery to align bodies with 'optimal gender' assignment, accompanied by concealment of information from medicalised subjects.

This model persists today, albeit with rationales that have shifted and become less overt in response to pressure from the intersex movement (Intersex Human Rights Australia 2018). While a nineteenth century statement about sexual immorality is rarely stated overtly by physicians in high-income countries, such statements sometimes persist in other parts of the world (Razzaghy-Azar, Karimi, and Shirazi 2017, 3). In high-income countries, changes in emphasis over recent decades show increasing subtlety but retain comparable underlying beliefs. Clinicians in 1969 imagined intact intersex individuals as 'freaks, misfits, curiosities, rejected by society and condemned to a solitary existence' (Dewhurst and Gordon 1969, vii). In 1983, an Australian newspaper reported a

call to change sex registration of an infant boy with an 'abnormal penis' after surgery to 'give the baby the appearance of a female'; the mother reported that 'as a male, sexual experience would have had to be homosexual' (Canberra Times 1983, 3). A clinical paper in 1990 determined that prenatal interventions to eliminate homosexuality were non-viable, based on studies of people with intersex variations (Meyer-Bahlburg 1990, 279). In 2010, 'ethical principles' identified impaired heterosexual marriage opportunities as a 'psychosocial' rationale for surgery (Gillam, Hewitt, and Warne 2010, 415). The Senate of Australia Community Affairs References Committee (2013, 69) found that the intent behind so-called 'normalising' interventions was 'to deconstruct an intersex physiology and, in turn, construct an identity that conforms with stereotypical male and female gender categories'. Surgeons in recent years have expressed satisfaction in the necessity and cosmetic success of early surgery 'in DSD with a gender issue' identifying the top two aims of such surgery as to 'Restore [sic] functional genital anatomy to allow future penetrative intercourse (as a male or a female)', 'Facilitate future reproduction (as a male or a female) when possible' and also 'Foster development of "individual" and "social identities,"' (Mouriquand et al. 2016, 3–4). These surgeries, explicitly in situations of doubt about future identity, presume individuals' future interests and pre-empt their own choices.

Medical discourse on children with XX (typically female) chromosomes and congenital adrenal hyperplasia (CAH) provides a strong example of many of these developments over time. In 1956, a 6-year old boy with these characteristics was used to illustrate proposals for the 'case management' of 'hermaphroditism' (Hampson, Money, and Hampson 1956). Clinicians have tested post-surgical clitoral sensitivity in children (Yang, Felsen, and Poppas 2007), and act as advisors to medicalised parent groups. Prenatal interventions to eliminate related traits have been justified due to genital 'sensitivity impairment and difficulties in sexual function in women who underwent genitoplasty early in life', 'abnormalities' such as 'behavioural masculinisation', play behaviour and sexual orientation, and 'rates of gender dysphoria ... higher than' the general population (Nimkarn and New 2010, 9) even while such interventions may impact on cognitive development (Dreger, Feder, and Tamar-Mattis 2012). By 2016, the naturalisation and perceived success of 'feminising' interventions led some clinicians to propose that individuals with XX CAH should be considered 'unchallenged females', that many with low 'virilisation' 'achieve normal heterosexual sexual activity and pregnancies', and so CAH should not be classified with other intersex traits (González and Ludwikowski 2016, 3). A 2018 newspaper report frames such interventions as the 'rehabilitation' of 'newly-converted girls' who require 'life-long medicine to maintain their female identity' (Malik 2018). Essentially, these are arguments that take as self-evident the rhetoric that 'successful' medical interventions should and can construct normative female bodies and identities.

These examples show a clear affinity between the medicalisation of intersex bodies and the medicalisation of same sex attraction and gender diversity, produced by a shared history of pathologisation rather than shared identity. Medicalisation is, in part, intended to construct people with heterosexual and cisgender identities, with bodies that can fulfil normative heterosexual functions. It is their anticipated possible future identities that justify treatments meted out to infants and children with intersex variations. Medical interventions on children with intersex variations foreclose the possibility of non-normative futures.

Medicalisation has been reinforced by a shift in medical terminology, away from the terms 'intersex' and 'hermaphrodite' and towards 'disorders of sex development' ('DSDs'). Proposed to replace the term hermaphrodite (Dreger et al. 2005), DSDs replaced both terms in clinical settings in a Consensus Statement on Management of Intersex Disorders (Hughes et al. 2006; Houk et al. 2006). Clinicians rapidly adopted the new nomenclature, while a co-opted advocacy organisation, the Intersex Society of North America, aspired for this shift to push clinicians to treat medical issues associated with intersex traits like any other medical issues. The shift instead naturalised the idea

that intersex bodies need ‘fixing’ and reasserted clinical authority over intersex bodies (Davis 2011). It failed to account both for a broader failure of medicine to destigmatise non-normative bodies (Amundson 2000) and the pervasiveness of social and cultural sex and gender norms in clinical thinking. This failure has latterly been acknowledged by a key proponent of the new nomenclature (Dreger 2018, 70).

The 2006 clinical consensus statement asserts that ‘Appearance-altering surgery is not urgent’, but this is compromised by rationales for early interventions including claims of ‘satisfactory outcomes’ for early cosmetic surgeries, ‘minimizing family concern and distress, and mitigating the risks of stigmatization and gender-identity confusion of atypical genital appearance’ (Houk et al. 2006, 755). These claims are unsupported by evidence. For example, the clinician ‘consensus’ reads:

It is generally felt that surgery that is carried out for cosmetic reasons in the first year of life relieves parental distress and improves attachment between the child and the parents. The systematic evidence for this belief is lacking (Hughes et al. 2006, 557).

Over the following decade there was no systematic production of evidence to support those medical practices or beliefs. Lack of evidence persists in a 2016 follow-up paper that also highlights a lack of consensus:

There is still no consensual attitude regarding indications, timing, procedure and evaluation of outcome of DSD surgery. The levels of evidence of responses given by the experts are low [...]

Timing, choice of the individual and irreversibility of surgical procedures are sources of concerns. There is no evidence regarding the impact of surgically treated or non-treated DSDs during childhood for the individual, the parents, society or the risk of stigmatization (Lee et al. 2016, 176).

Clinical secrecy also persists (for example, Office of the Privacy Commissioner 2018), and clinical disclosure of an intersex variation to parents and individuals may frame intersex bodies as necessarily pathological.

Consequently, it is the consensus statement rather than the YPs that has had far greater impact on intersex people in the years since they were introduced. The intentions of the YPs failed to address the reality of medical practices. Protections for people with non-normative *identities* are presumed to benefit intersex people, but they provide no protection for people with non-normative *bodies* (Carpenter 2018b). Thus, governments and institutions may quote the YPs or its concepts in relation to protections for people with diverse identities, and those same institutions may also quote clinical papers while justifying forced and coercive medical practices on children with ‘DSDs’.

In one example, an Australian Capital Territory government minister advised me in April 2014 that the availability of a third sex marker for infants and children would reduce the likelihood that parents would subject intersex children to ‘gender assignment surgery’, while in January 2014 she advised me that children with ‘disorders of sex development’ are treated in line with ‘international consensus statements’, including referral to ‘centres of excellence’ for surgery.¹ The government had no coherent understanding that the same population was impacted by both statements. The intended goal in relation to birth certificates had no impact: no children with ‘DSDs’

¹ Personal communications with the ACT Chief and Health Minister.

have been registered in that third category, and medical practices in relation to children with ‘DSDs’ were left unchanged (Carpenter 2018b, 485–86). In a second example, in 2019 the state government of Victoria in Australia presented intersex demands for reforms to protect intersex people from forced and coercive medical interventions as if those demands were about access to legal gender recognition (AAP 2019).

Measures to protect people on grounds of sexual orientation and gender identity have a lack of utility to intersex populations that is evident also in concerns regarding representation, misrepresentation and resourcing (Koyama and Weasel 2002; Howe et al. 2017), and extrapolation of data and policy frameworks from LGBT to LGBTI populations without consideration of the specific needs of intersex people (Carpenter 2018b). A framing of sexual orientation and gender identity is inadequate to address issues affecting intersex people but has dangerously been perceived as adequate. It is necessary to move beyond matters of identification, and to consider how bodies are treated.

The YP plus 10 review process

The YPs recognised future need for revision, acknowledging limitations in both international human rights law and understandings of its application (Yogyakarta Principles 2007, 9). With leadership from the International Service for Human Rights² and ARC International,³ the tenth anniversary of the YPs provided an opportunity to address new developments. An open call for submissions launched (Yogyakarta Principles in Action 2017), the Asia Pacific Forum of National Human Rights Institutions and United Nations Development Program (Asia Pacific Forum of National Human Rights Institutions 2017) held a conference in Bangkok to discuss barriers, challenges and new developments, and a drafting committee formed.

The appointed drafting committee members – Mauro Cabral Grinspan, Morgan Carpenter, Julia Ehart, Sheherezade Kara, Arvind Narrain, Pooja Patel, Chris Sidoti and Monica Tabengwa – brought together human rights law, ethics and subject matter expertise. We were charged with synthesising proposals based on consultation responses and jurisprudential developments, supported by a secretariat comprising staff from a small number of human rights, academic and advocacy organisations.

The process offered the potential to fix some flaws in the original Principles as they relate to intersex persons, constrained by the obvious (but also liberating) decision to supplement, and not rewrite, existing Principles.

Draft new Principles and State Obligations were reviewed, discussed, revised and adopted by 33 experts following a meeting of those experts in Geneva in September 2017, convened by the International Service for Human Rights and ARC International. These experts included judges, academics, human rights experts, former parliamentarians, bioethicists, lawyers, and advocates from around the world. The Yogyakarta Principles plus 10 were launched in November 2017.

Overview of YP plus 10 developments

Key developments include the elaboration of two new concepts: ‘sex characteristics’ and ‘gender expression’, alongside nine new Principles on rights to bodily and mental integrity, truth, legal recognition, state protection, freedom from criminalisation, protection from poverty, sanitation, enjoyment of information and communication technologies, and cultural diversity. Outcomes also

² International Service for Human Rights, <https://www.ishr.ch>

³ ARC International, <https://arc-international.net>

included 111 Additional State Obligations, including in relation to equality and non-discrimination, torture, privacy, health, asylum, education, and protection of human rights defenders.

The Principles aimed to be feminist and intersectional, and fully reflect the needs of intersex populations and other populations of diverse sexual orientation, gender identity, gender expression and sex characteristics. Building on jurisprudence and the work of scholars including Crenshaw (1991), the YP plus 10 explicitly recognise the intersectionality of sexual orientation, gender identity, gender expression and sex characteristics, including on grounds of sex, gender, racialisation, religion, belief and disability. The YP plus 10 also recognise that attributes contained within its framework themselves intersect:

recognising that the needs, characteristics and human rights situations of persons and populations of diverse sexual orientations, gender identities, gender expressions and sex characteristics are distinct from each other (Yogyakarta Principles 2017, 7).

Further, the intention was not to eliminate the application of other frameworks on the human rights of intersex people – such as disability and child rights lenses – but instead ensure meaningful and nuanced inclusion when viewed through a broadened lens on the rights of sexual and gender minorities.

The attribute of sex characteristics was identified early as a key development to reflect within the YP plus 10, to address human rights violations based on physical features relating to sex, irrespective of age or agency. It drew upon developments in domestic law in Malta (2015), other European states and institutions (Council of Europe Commissioner for Human Rights 2015, 9), and the work of the Asia Pacific Forum of National Human Rights Institutions (2016). Although implementation is poorly documented (Office of the High Commissioner for Human Rights 2019, 19), Maltese legislation provided the first coherent approach to recognising and protecting rights to bodily integrity, physical autonomy and freedom from discrimination on grounds of sex characteristics (Ni Mhuirthile 2018). This new attribute was defined and also applied to the earlier YPs:

Understanding ‘sex characteristics’ as each person’s physical features relating to sex, including genitalia and other sexual and reproductive anatomy, chromosomes, hormones, and secondary physical features emerging from puberty

[...] recognising that the Yogyakarta Principles apply equally to the ground of sex characteristics (Yogyakarta Principles 2017, 6).

The term sex characteristics was adopted in the YP plus 10 in preference to ‘intersex status’, ‘sex’, and ‘bodily diversity’. Intersex status was enacted in Australian anti-discrimination law in 2013 (Carpenter 2018b). In contrast to sex characteristics, the term is not universally applicable (not everyone has an intersex status), has frequently been inadvertently imputed to mean a sex classification or gender identity, and has been defined in relation to deficits (in relation to characteristics that intersex people lack). Use of the attribute sex to refer to intersex persons suffers some of the same deficits, including risks of reduction to issues of social or legal classification that reflect widespread assumptions that persons born with non-normative bodies should have non-normative identities (Carpenter 2018b). Sex and sex characteristics are related to each other in that sex is typically assigned based on observed sex characteristics at birth. Bodily diversity derives from work by the Inter-American Commission on Human Rights (2015). It is universal and has broad scope, offering a powerful way of addressing discrimination on grounds of sex characteristics,

albinism, dwarfism, physical disability and size, but has not been adopted by any national jurisdiction.

The YP plus 10 also add new Principles of importance to people with innate variations of sex characteristics. These include Principles on the Right to Bodily and Mental Integrity, the Right to Truth, and the Right to Legal Recognition. A range of Additional State Obligations relating to genetic technologies, sport, reasonable accommodations, asylum and data disaggregation are also relevant.

The Right to Bodily and Mental Integrity

This Principle, numbered 32, addresses forced and coercive medical interventions, making a clear statement about the necessity of either emergency or free, prior and informed consent for interventions to modify sex characteristics:

Everyone has the right to bodily and mental integrity, autonomy and self-determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to be free from torture and cruel, inhuman and degrading treatment or punishment on the basis of sexual orientation, gender identity, gender expression and sex characteristics. No one shall be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person (Yogyakarta Principles 2017, 10).

Underpinning the principle are rights to liberty and security recognised in the Universal Declaration of Human Rights (United Nations 1948, Article 3) and International Covenant on Civil and Political Rights (United Nations 1966, Articles 7 and 9), and elaborated by the UN Committee on Civil and Political Rights:

Article 9 recognizes and protects both liberty of person and security of person. In the Universal Declaration of Human Rights, article 3 proclaims that everyone has the right to life, liberty and security of person. That is the first substantive right protected by the Universal Declaration, which indicates the profound importance of article 9 of the Covenant both for individuals and for society as a whole... Security of person concerns freedom from injury to the body and the mind, or bodily and mental integrity... (Committee on Civil and Political Rights 2014, paras 2–3).

Principle 32 is accompanied by a series of State Obligations to:

- A) Guarantee and protect the rights of everyone, including all children, to bodily and mental integrity, autonomy and self-determination;
- B) Ensure that legislation protects everyone, including all children, from all forms of forced, coercive or otherwise involuntary modification of their sex characteristics;
- C) Take measures to address stigma, discrimination and stereotypes based on sex and gender, and combat the use of such stereotypes, as well as marriage prospects and other social, religious and cultural rationales, to justify modifications to sex characteristics, including of children;
- D) Bearing in mind the child's right to life, non-discrimination, the best interests of the child, and respect for the child's views, ensure that children are fully consulted and informed regarding any modifications to their sex characteristics necessary to avoid or

remedy proven, serious physical harm, and ensure that any such modifications are consented to by the child concerned in a manner consistent with the child's evolving capacity;

E) Ensure that the concept of the best interest of the child is not manipulated to justify practices that conflict with the child's right to bodily integrity;

F) Provide adequate, independent counselling and support to victims of violations, their families and communities, to enable victims to exercise and affirm rights to bodily and mental integrity, autonomy and self-determination (Yogyakarta Principles 2017, 10).

State Obligations D and E tackle concerns that Principle 18 on medical abuses failed to address violations against children with no agency that appealed to children's best interests, for example, to justify the sterilisation of children before they can understand a procedure, on the basis of gender stereotypes (Carpenter 2018a, 210). Statements by the Committee on the Rights of the Child underpin these: General Comment 14 (Committee on the Rights of the Child 2013, para. 34) identifies concerns that the concept of the child's best interests can and has been manipulated, while General Comment 13 (Committee on the Rights of the Child 2011, para. 54) on freedom from all forms of violence states that the concept of best interests of the child 'cannot be used to justify practices ... which conflict with the child's ... right to physical integrity'. Concluding observations by the same committee underpin guarantees, access to support and redress (for example, Committee on the Rights of the Child 2016, para. 25).

The Right to Truth

Principle 37 addresses the right to full and complete information about human rights violations, including disclosure of medical histories to individuals and of systemic violations to communities, and a right to reparation not subject to statutes of limitations. It states:

Every victim of a human rights violation on the basis of sexual orientation, gender identity, gender expression or sex characteristics has the right to know the truth about the facts, circumstances and reasons why the violation occurred. The right to truth includes effective, independent and impartial investigation to establish the facts, and includes all forms of reparation recognised by international law. The right to truth is not subject to statute of limitations and its application must bear in mind its dual nature as an individual right and the right of the society at large to know the truth about past events (Yogyakarta Principles 2017, 14).

State Obligations in relation to the right to truth include:

A) Adopt legal provisions to provide redress to victims of violations on the basis of sexual orientation, gender identity, gender expression and sex characteristics, including public apology, expungement of relevant criminal convictions and records, rehabilitation and recovery services, adequate compensation and guarantees of non-recurrence;

B) Ensure, in cases of violations of the right to mental and bodily integrity, effective access to remedies, redress, reparation and, where appropriate, psychological support and restorative treatments;

C) Protect individuals' right to know the truth about their medical histories, including through full access to accurate medical records;

D) Adopt and fully implement procedures to establish the truth concerning violations based on sexual orientation, gender identity, gender expression and sex characteristics;
E) Establish a truth-seeking mechanism and process in regard to human rights violations based on sexual orientation, gender identity, gender expression and sex characteristics;
F) Ensure that, in addition to individual victims and their families, communities and society at large can realise the right to the truth about systemic human rights violations based on sexual orientation, gender identity, gender expression and sex characteristics, while respecting and protecting the right to privacy of individuals (Yogyakarta Principles 2017, 14–15).

The right to truth has been elaborated in particular in South Africa, Latin America and the Balkans to combat impunity in response to systemic human rights violations, and concealment of evidence about them (World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance 2001, para. 98). Diane Orentlicher (2005) elaborated principles to combat impunity adopted by the Economic and Social Council, including the ‘inalienable right to know the truth about past events’, the ‘duty to preserve memory’, the ‘imprescriptible right to know the truth about the circumstances in which violations took place’, and guarantees to give effect to these rights. Concluding Observations by the Committee on the Elimination of Discrimination Against Women have elaborated the importance of ‘specific measures aimed at providing all victims of forced sterilizations with assistance to access their medical records’ (2015, para. 37(b)). Recognising difficulties in pursuing actions in relation to concealed human rights violations, Principle 37 incorporates the elimination of statutes of limitations, a measure increasingly adopted in response to child abuse (for example, Pakula 2015).

The Right to Legal Recognition

Legal identification documents typically identify people by their sex or gender. Both intersex and endosex (non-intersex) people may seek legal recognition of a gender identity that differs from their sex assigned at birth but attempts to single out intersex people for a distinct and specific legal status fail to respect the diversity of the intersex population. Principle 31 states:

Everyone has the right to legal recognition without reference to, or requiring assignment or disclosure of, sex, gender, sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to obtain identity documents, including birth certificates, regardless of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to change gendered information in such documents while gendered information is included in them (Yogyakarta Principles 2017, 9).

The Principle is underpinned by the International Covenant on Civil and Political Rights (United Nations 1966, Articles 16 and 24) and the Convention on the Rights of the Child (United Nations 1989, Article 7). Articles 16 and 24 of the Covenant read:

Everyone shall have the right to recognition everywhere as a person before the law.

1. Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.

2. Every child shall be registered immediately after birth and shall have a name.

These articles enumerate attributes including race, sex and religion, and call for registration of children with a name, but do not require legal classification according to any biological or other inherited characteristics. This principle also reflects a German Constitutional Court recommendation allowing for mandatory recording of sex/gender to be waived (Federal Constitutional Court 2017, 51–52; Oll Europe et al. 2017).

State Obligations in relation to the right to legal recognition include provision for documents after ending registration of sex or gender, with interim obligations that recognise that this development can be regarded as a long-term aspiration:

A) Ensure that official identity documents only include personal information that is relevant, reasonable and necessary as required by the law for a legitimate purpose, and thereby end the registration of the sex and gender of the person in identity documents such as birth certificates, identification cards, passports and driver licences, and as part of their legal personality...

C) While sex or gender continues to be registered: ... Make available a multiplicity of gender marker options (Yogyakarta Principles 2017, 9).

The Australian – Aotearoa/New Zealand Darlington Statement explicitly links an end to registration of sex/gender to an end to ‘the hierarchies that lie behind’ such classifications (AIS Support Group Australia et al. 2017, para. 8).

Principle 31 does not impact data collection or affirmative action on grounds of sex, gender, sex characteristics or other enumerated attributes any more than it impacts them on grounds of other attributes rarely or historically registered in identification documents, such as racialisation or religion.

Additional recommendations

A State Obligation (numbered 2L-M) on non-discrimination in relation to prenatal selection calls for an end to prenatal interventions and genetic selection that discriminate on grounds of sex characteristics, sex, sexual orientation, gender, gender identity and expression. It reflects statements on the role of sex selection in discriminating against women (Toebe 2008). The obligation also anticipates the impending feasibility of modifications to human genetic material (Nuffield Council on Bioethics 2018). The State Obligation does not call for prohibition of such technologies, because the principles reflect existing norms in international human rights law. At the same time, obligations protecting rights to abortion and post-abortion care (numbered 33B and 17P) match the best available international jurisprudence.

A new State Obligation (numbered 2G) to provide reasonable accommodations recognises that some intersex and other people may need support in education, employment and other contexts, whether due to innate or acquired health issues related to their sex characteristics. It is underpinned by Articles 2 and 5 of the Convention on the Rights of Persons with Disabilities (United Nations 2006).

On discrimination in sport (Obligations numbered 2I-K; Additional R), the YP plus 10 call for States to ensure that all individuals can participate in sport without discrimination on grounds of sex characteristics and other attributes, and ensure participation ‘in line with the gender with which they identify, subject only to reasonable, proportionate and non-arbitrary requirements’. This draws

on a report by the UN Special Rapporteur on the right to health (2016, paras 55–61), who is also a signatory of the principles.

State Obligation numbers 10D-E recognises that forced modifications of sex characteristics may amount to torture. Obligations numbered 16J and 17S call on States to ensure inclusion of ‘comprehensive, affirmative and accurate material on sexual, biological, physical and psychological diversity’ in education, drawing on work on inclusive education by UNESCO (2015). Drawing on work on data collection on LGBTI populations by the United Nations Development Program (2016) and World Bank (2016), State Obligation number 19I calls for collection and disaggregation of data.

Conclusions

Reflecting accepted norms and principles in human rights law, the Yogyakarta Principles are a necessary elaboration of principles to address the specific human rights violations faced by sexual and gender minorities. However, actions addressing human rights violations on the basis of sexual orientation and gender identity have failed to protect intersex people from discrimination or harmful practices. Protections for people with non-normative identities provide no protection for people with non-normative bodies.

Carefully drawing upon developments in human rights jurisprudence, the Yogyakarta Principles plus 10 update meaningfully addresses the specific human rights violations faced by people with innate variations of sex characteristics. It does so by elaborating an appropriate new attribute - sex characteristics - and by directly addressing harmful practices in medical settings and other specific violations. In doing so, the update invites better and more nuanced recognition of intersex human rights issues by people utilising a sexual orientation and gender identity framework, broadening that framework beyond matters of self-identification to sexual orientation, gender identity, gender expression and sex characteristics.

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