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The Universal Periodic Review and the Ban on Intersex Genital Mutilation in an African Context

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Abstract: The Universal Periodic Review (UPR) assesses the human rights records of all 193 UN Member States against the benchmark of the Universal Declaration of Human Rights and its core human rights treaties. To date, more than 100,000 recommendations have been provided to states under review (SUR) from peer Member States. Less than 1% address the rights of intersex persons. Western countries issue most of these cases, followed by the Latin American and Caribbean countries. African and Asian countries formulate a negligible number. This asymmetric data might mistakenly support the assumption that Western countries care more about the rights of intersex persons than non-Western countries. However, the recent groundbreaking Resolution on the Promotion and Protection of the Rights of Intersex Persons in Africa calls upon its states' parties to stop nonconsensual genital normalisation practices on intersex persons and considers these practices as mutilation. Intersex genital mutilation (IGM) stands as a profound human rights infringement experienced by intersex individuals, who undergo medical interventions often performed on their healthy bodies. The primary objective of such interventions is to enforce conformity to prevailing medical and sociocultural norms pertaining to binary genders. I argue that Member States formulating recommendations advocating for the ban on IGM should consider contextualised factors, especially with regards to "informed consent". This approach aims to enhance the persuasiveness of recommendations and increase the likelihood of their acceptance by SUR. Through the analysis of twenty-nine IGM-related UPR recommendations, this article addresses the effectiveness of the UPR in discussing intersex rights and the ban on IGM, with a focus on Africa.

Keywords: human rights; informed consent; intersex; intersex genital mutilation (IGM); Universal Periodic Review (UPR)

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1. Introduction

This paper seeks to strengthen the effectiveness of efforts to eradicate intersex genital mutilation (IGM) within the Universal Periodic Review (UPR) by advocating for contextualised recommendations. IGM (Bauer et al. 2020, p. 726) is a human rights violation experienced by intersex individuals, many of whom undergo medical surgery often conducted against their will at a young age (UN Office of the High Commissioner for Human Rights 2019, p. 4). The UPR evaluates UN Member States' human rights records against the benchmark of the Universal Declaration of Human Rights (UN General Assembly 1948). While the international human rights framework is increasingly emphasising intersex rights (Zelayandia-Gonzalez 2023, p. 2) and the issue of intersex genital surgery (Jorge et al. 2021, p. 679), the UPR process only generates a few IGM-related recommendations, which are mainly provided by Western countries (Ravesloot 2022, p. 259). These cases share similarities in content and formulation, with most recommendations stressing "informed consent". While their current number is limited, and discussions surrounding IGM are still emerging within the UPR process, they are likely to increase in the future. I argue that current recommendations supporting the prohibition of IGM risk reflecting a predominantly Western perspective, which may prove ineffective in addressing IGM in non-Western contexts. This

is particularly evident in the focus on informed consent which, within a Western framework, requires competent, informed, and voluntary decisions on IGM by parents or the intersex individual (Benson 2005). Such consent might not be obtained in a non-Western context as, for example, in certain African countries where community input may form part of that decision-making, due to the sociocultural environment that values collective interests over individual rights (Akpa-Inyang and Chima 2021, p. 15). To advance this argument, this article conducts a content analysis of twenty-nine recommendations related to IGM sourced from the Universal Human Rights Index (UN Office of the High Commissioner for Human Rights 2023). These recommendations, however, do not explicitly use the term IGM.[1] The article assesses the suitability of these recommendations with the doctrine of informed consent as outlined by Benson (2005, p. 36), particularly in non-Western contexts. It uses the African context as a case study to address the question: are UPR recommendations effective in ensuring competent, informed, and deliberate decisions about IGM?

The widely cited estimate of 1.7% for the prevalence of intersex individuals[2] originating from Faust-Sterling's seminal work (Fausto-Sterling 2000), raises more questions about its accuracy than about its origin. Calculated based on "a wide variety of populations" (Garland and Travis 2023, p. 4), it is unclear whether African populations are included. Moreover, the dearth of African research on the subject (Ellaithi et al. 2011, p. 267) further compounds the issue, highlighting a significant gap in our understanding of intersexuality beyond Western contexts. Likewise, most scholars denouncing the atrocities of IGM discuss intersexuality predominantly in Western countries. Critical scientific literature is growing in the West but remains sparse in Africa, where the literature is primarily situated in the clinical (medical) field on intersex issues. However, change is imminent, given the recent groundbreaking Resolution of the Human Rights Council (UN Human Rights Council 2024), and the landmark Resolution on the Promotion and Protection of the Rights of Intersex Persons in Africa (African Commission on Human and Peoples' Rights 2023). Both resolutions support banning harmful practices and stress informed consent, although in different terms. While utilising the term IGM deliberately and aligning with perspectives from critical analyses (Monro et al. 2021) opposing IGM, this article makes a dual contribution. Firstly, it enriches the UPR as a dialogue platform and bolsters its effectiveness by advocating for intersex rights through adequate recommendations to ban IGM. Secondly, while further exploring the use of the concept of informed consent, it offers new insights into a significantly under-researched domain: the rights of intersex individuals in Africa and how the concept of informed consent does not travel universally.

Defining informed consent in the African context is challenging because it stems from the Western liberal tradition (Akpa-Inyang and Chima 2021, p. 8). In African societies, community existence is fundamental, favouring collective rights over individualistic ideals prevalent in the West (Akpa-Inyang and Chima 2021, p. 2). Simply replicating existing UPR recommendations without questioning their effectiveness when addressed to non-Western countries risks undermining meaningful dialogue on the ban on IGM. If UPR recommendations disregard the community in seeking informed consent, efforts to ban IGM might be less effective. Decision-making processes on IGM that do not contextualise informed consent might even cause experiences of epistemic violence (Dotson 2011, p. 242), and more specifically testimonial smothering (Dotson 2011, p. 244), from the intersex person, silencing their own voice in favour of conforming with the community's decision.[3] Even when the community does not enforce a decision on the intersex person, there is the risk that the intersex person anticipates the group's desires, to the detriment of their own wishes. Therefore, while Western models may not fit directly, adaptation is necessary and possible for the African context, without dismissing the importance of informed consent (Akpa-Inyang and Chima 2021, p. 15).

To leverage UPR recommendations in advocating for the prohibition of IGM in an African context, the next section gives an overview of the literature on IGM and highlights the gaps this article aims to fill. The subsequent section on the materials and methods outlines the research approach. The results section shares findings on the limited and

geographical asymmetric interest of the international community for intersex rights. It then applies the concept of informed consent to the twenty-nine IGM-related UPR recommendations. Next, the discussion section applies these findings to address the question: Are the UPR recommendations effective in ensuring competent, informed, and deliberate decisions about IGM in an African context? Finally, the article concludes by advocating for UPR recommendations that are contextualised and reduce the risks of epistemic violence for African intersex persons.

2. Context

2.1. Intersexuality in Africa

One of the few recent studies on the human rights situation of intersex persons in Africa states that "While countries outside Africa have been progressive when it comes to the rights of intersex persons, progress has been minimal in Africa", with South Africa and Kenya as exceptions and flag bearers in the protection of the rights of intersex persons (Centre for Human Rights 2022, p. 5). Clinical studies on the prevalence of intersexuality in Africa underscore the absence of data (Amolo et al. 2019, p. 1) and records (Ellaithi et al. 2011, p. 267). Ameyaw et al. (2019, p. 638) claim that their study in the Ashanti region of Ghana conducted in 2019 "is to our knowledge the first to provide an estimate of DSD incidence in infants born in sub-Saharan Africa."[4] The lack of reported cases may stem from the limited capabilities of many healthcare systems to diagnose, monitor, and report on instances of intersexuality (Warne and Raza 2008, p. 228). Country-specific factors—including poor healthcare facilities (Gnassingbe et al. 2009, p. 83), the lack of advanced examinations and diagnostic tools to identify the child's sex at hospitals (Warne and Raza 2008, p. 228), inadequately trained health service staff, including midwives (Ameyaw et al. 2019, p. 636), and the traditions of giving birth at home (Ameyaw et al. 2019, p. 638) rather than in a hospital—all create challenges to gather data and lead to an underrepresentation in the reported numbers of intersex infants. Furthermore, while "Many diagnoses have to be made by informed guesswork" (Warne and Raza 2008, p. 228), these diagnoses may occur only later in the life of the intersex child or adult (Gnassingbe et al. 2009, p. 83; Warne and Raza 2008, p. 234). Recent studies estimate the median age for the identification of an intersex person at around 6.5 years, and this identification may even occur during adolescence (Hansen et al. 2022, p. 189). While some studies highlight that "surgeries are a common practice" (Centre for Human Rights 2022, p. 8) in Africa, this delay in the identification of intersexuality supports the suggestion that surgical interventions at an early age are not a standardised medical procedure (Kraus 2013, p. 91).

The literature on the care and future prospects of intersex newborns in Africa is limited, especially from a cross-cultural perspective (Edgerton 1964, p. 1289). Warne and Raza (2008, p. 234), in their clinical analysis of intersexuality across resource-rich and resource-poor countries, acknowledge the diverse perspectives within African societies, in addition to various legal frameworks (Phele 2016, p. 55)[5] and cultural beliefs. They argue that poverty and the quality of social security, medical, and education systems have a greater impact on perceptions of intersexuality than sociocultural factors, such as religion or culture (Warne and Raza 2008, p. 234). Edgerton suggests that societies exhibit diverse responses to intersexuality. In his early anthropological examination of the responses to intersexuality of the Pokot in Kenya, he stresses that they view life in terms of physical sexuality, reproduction, and economic utility. He notes that intersex children were often killed, although in some cases they were allowed to survive (Edgerton 1964, p. 1298). In settings where the killing of intersex newborns persists, Behrens (2020, p. 2) argues that surgical intervention may be justifiable under certain conditions, to respect the best interest of the child and save the child's life. Conversely, it is essential to recognise that expensive medical interventions may not necessarily be the first concern for the parents of an intersex child; at times the child might even die before seeing a doctor (Warne and Raza 2008, p. 231). In rural communities, which are often resource-poor environments, families may first seek affordable alternative treatments or solutions and consult medical providers only as a last

resort (Warne and Raza 2008, p. 230). Moreover, surgery itself is no guarantee of saving a child's life. In Africa, where paediatric surgery is not widely taught (Kraus 2013, p. 91) and only a few paediatricians operate (Gnassingbe et al. 2009, p. 83), surgical intervention on intersex children is no routine practice and "remains a life-threatening situation" (Kraus 2013, p. 91).

Due to limited financial resources and technical skills, Western paediatricians occasionally conduct the medical interventions. In her study in West Africa on hypospadias[6] treatment by French medical professionals, Kraus (2013, p. 91) stresses the strong impetus from Western doctors who apply their advanced techniques on intersex persons. Kraus' research highlights how surgeons can impact societal norms and beliefs about what is considered normal or acceptable in terms of ideals of sex, gender, and reproductive heterosexuality. She reports that since the mid-1990s, when the surgical missions became "popular", they have delivered quality surgical care and long-term follow-up for approximatively 160 "patients" per year (Kraus 2013, p. 85). She questions, however, whether patients would have visited the hospital without the French surgeons (Kraus 2013, p. 92). Gnassingbe et al. (2009, p. 83) report that African paediatric surgeons, with or without financial support from non-governmental organisations (NGOs), refer intersex persons to developed countries for treatment. They note that "At times NGOs also collaborate with their western partners to carry out benevolent health expeditions for local treatment of patients suffering from congenital abnormalities, including intersex in Africa." They report on a workshop held in a hospital in Togo in December 2006, which received a total of 107 participants: five French professors of paediatric surgery, sixty-two African paediatric surgeons, and forty African general surgeons (Gnassingbe et al. 2009, pp. 83–84). Intersex persons were invited to be operated on "free of charge" during the workshop, which introduced new (Western) technologies and transferred the accompanying knowledge to treat cases of intersexuality. Only one out of six "patients" did not give their consent and "refused to be feminised". Regarding the other "patients" it is merely assumed that they provided their consent in a competent, informed, and voluntary way, the three preconditions for informed consent, as will be explained below.

This overview of the limited literature on intersexuality and IGM within the African context touches upon the multifaceted dimensions that underpin the challenges faced by African societies in addressing intersexuality. Primarily, these challenges include diverse perspectives toward intersexuality, requiring the need for nuanced knowledge about both socio-economic factors (e.g., poverty, social welfare systems, education) and sociocultural dynamics (e.g., values, beliefs, religion, traditions) that influence a society's approach to intersexuality. Secondly, the literature suggests a critical need to assess the disparities in resources and the availability of medically skilled personnel, since a lack of resources and staff might increase the risk of Western support and practices, including harmful ones. These insights suggest that analysis of UPR recommendations targeting the prohibition of IGM should contextualize these recommendations according to both socio-economic and sociocultural factors, especially when intending to foster competent, informed, and deliberate decision-making on IGM. The subsequent section will delve into the concepts of informed consent, epistemic violence, and, in particular, testimonial smothering, as the latter is a potential negative experience of the intersex person, whereas informed consent is understood from a Western perspective.

2.2. Informed Consent and Epistemic Violence

A significant number of scholars address intersexuality through a human rights and ethical lens and establish a robust human rights-based argument against IGM (e.g., Bauer, Carpenter, Crocetti, Fox, Garland, Ghattas, Horowicz, Slokenberga, Thomson, Travis, and Truffer) (Monro et al. 2021, p. 432). Human rights frequently cited as at risk include: freedom from discrimination; protection from torture and other cruel, harmful or degrading treatment; and the right to health. An additional critical human right is the right to "informed consent". Zucker (1999, p. 2) highlights that some critics advocate for a

suspension of surgery "until the status of previously treated patients are followed-up with greater precision." Beh and Diamond (2000, pp. 3–4) discuss the "doctrine of informed consent", focusing on parents' consent to perform surgery on their intersex child. Conversely, Carpenter (2018, p. 208) identifies the individual right to informed consent as a fundamental human right and defends the physical integrity of intersex children and adults, underscoring that the prohibition of medical interventions excludes essential, life-preserving procedures. Benson (2005, p. 36) scrutinises the rights of intersex persons under the "doctrine of informed consent". She stresses that informed consent should safeguard a patient's right to bodily integrity, self-determination, and the right to decline medical treatment deemed unwanted. Based on the legal concept of informed consent, Benson underscores three preconditions. Firstly, the decision to undergo IGM, or a parent's decision to subject a child to IGM, should be informed, including information about alternative solutions and relying on adequate information; next, this decision should be made (by the parents) in a voluntary way, without coercion; lastly, the decision should be made by the intersex person or the parents in a competent way, demonstrating an understanding of the nature, scope, and likely consequences of the consented action. Beauchamp and Childress (2001, pp. 69–74) stress that competent decisions include acknowledgement of the potential consequences and that "Inquiries about competence focus on whether patients or potential subjects are capable, psychologically or legally, of adequate decision-making." The conundrum, however, is that even when these requirements are completed, there is still a risk that the decision is not taken genuinely, due to the hidden process of testimonial smothering, a form of epistemic violence.

Epistemic violence, originally coined by Gayatri C. Spivak (Brunner 2021, p. 195), is further developed by Kristie Dotson (2011, p. 238), who defines that "Epistemic violence in testimony is a refusal, intentional or unintentional, of an audience to communicatively reciprocate a linguistic exchange owing to pernicious ignorance." In the context of intersex persons, epistemic violence might appear when the audience (medical staff and parents) refuses or avoids communicating with the knower (the intersex person) in a transparent manner. Disengaging from any transparent dialogue occurs intentionally or unintentionally and can be caused by a lack of appropriate knowledge by medical staff and parents regarding knowledge that is owned only by the intersex person. Epistemic violence might also occur when intersex persons are silenced, or unable to express their experiences or personal will, because the medical staff act on harmful biases relating to gender, age, or ethnicity. When doctors lack knowledge or diffuse harmful biases, there is a risk of miscommunication resulting in epistemic violence when the intersex person experiences damaging effects, including IGM.

One specific form of epistemic violence is coined by Dotson (2011, p. 238) as "testimonial smothering". Dotson (2011, p. 244) describes this form of epistemic violence as "the truncating of one's own testimony in order to ensure that the testimony contains only content for which one's audience demonstrates testimonial competence." From the perspective of the intersex person, self-censorship can occur if the person chooses to withhold their thoughts (an authentic decision about the consent), because they believe that their audience may not understand their true decision. In their recent book on intersex embodiment, Garland and Travis (2023, p. 45) share an example of an intersex child who believes that, by holding back, the child's parents will be spared from feeling incapable of understanding the child's authentic wishes: "When you are seven and you realize that your mother especially and also your father are very stressed, everybody is stressed and it has to do with your genitals, and then you consent out of wish to please or to take this stress away. Everybody knows that most children are doing things because they want to be accepted or liked or because they want to please their parents, and the doctors."

3. Materials and Methods

Qualitative research was conducted on the data retrieved from the Universal Human Rights Index (UN Office of the High Commissioner for Human Rights 2023). Out

of a total of 101,132 UPR recommendations issued since 2008, 3835 cases related to the group "Lesbian, gay, bisexual and transgender and intersex persons (LGBTI)" were initially selected. These cases formed the basis for an additional selection based on a set of terms related to medical interventions[7], resulting in 216 cases. After removing duplicate recommendations, only 176 distinct UPR recommendations remained. The next step removed UPR recommendations that were not related to IGM. Cases that were excluded involved transsexual persons, legal recognition, the broader right to health and healthcare services, or self-determination of gender identity (mentioned independently). Maintaining a strict focus on IGM enabled comprehensive assessment of recommendations specifically targeting medical interventions for intersex individuals. The ultimate dataset comprised twenty-nine recommendations, involving twelve recommending states and eighteen states under review (SUR). Singular recommendations appeared in 2014 and 2018. In 2019, a notable increase occurred with ten recommendations, succeeded by two cases in 2020, seven in 2021, five in 2022, and three in 2023. This dataset served as the foundation for a content analysis of each recommendation, using the qualitative data analysis application Atlas.ti. I applied the legal concept of informed consent, as outlined by Benson (2005, p. 36), which requires the decision to be made in a competent, informed, and voluntary manner. The UPR recommendations were then further analysed regarding their potential to cause epistemic violence, based on Kristie Dotson's distinction of testimonial smothering as a form of epistemic violence in testimony (Dotson 2011, p. 244).

4. Results

The examination of all twenty-nine UPR recommendations concerning IGM reveals a predominant trend wherein none of the recommendations were issued by African countries. The absence of such recommendations is a crucial element to consider. These missing data underscore the dominant influence of Western countries in the discourse on IGM. Moreover, this absence prompts a critical examination of whose voices are heard and whose experiences are overlooked in discussions about IGM. With the anticipated increase in UPR recommendations on IGM, particularly considering the recent adoption of the two resolutions (UN Human Rights Council 2024; African Commission on Human and Peoples' Rights 2023), there is the potential that existing recommendations influenced by Western perspectives on informed consent may be merely replicated. This replication could occur without the necessary dialogue and without incorporating context-specific recommendations tailored to the diverse realities of African nations and would be less effective in offering protection from IGM.

As the data show in Figure 1, most recommendations were originated by and directed towards Western countries. Six cases were issued by countries from Latin America and the remaining twenty-three cases were formulated by Western countries. Malta[8] and Iceland[9] leading by example, each issued six recommendations. These two countries are among the first to draft legislation on protecting intersex children from nonconsensual medical interventions (Carpenter 2024, p. 14). On the receiving side, the analysis indicates that of the eighteen SUR, half of the recommendations were provided to four countries, namely Austria (four cases), Costa Rica (four cases), Finland (three cases), and Switzerland (three cases), directing the recommendations predominantly towards Western countries. Among the remaining recommendations (fifteen), only two were received by African countries (South Africa and Zimbabwe).

The data further indicate that among the few UPR recommendations that target the ban on IGM, several were identical. This is true for recommendations that advise states to "End harmful practices, including forced and coercive medical interventions, to ensure the bodily integrity of children with intersex variations". Two were issued by Iceland, one addressed to Austria and one to Australia in 2021, and one recommendation was received by South Africa in 2022. An additional identical case was issued by Iceland and addressed to Costa Rica in 2019 and by Malta to Austria in 2021: "Prohibit any practice that modifies a person's sex characteristics without irrefutable medical reasons and the full and informed

consent of the person affected". A third identical recommendation was formulated by Malta and addressed in 2019 to Costa Rica and Slovenia, requiring the states to "Work towards ending protocols that aim to 'normalize' intersex bodies through harmful and medical practices including nonconsensual surgeries". Among the cited identical recommendations, it is noteworthy that only one recommendation was received by an African country (South Africa) and that all were issued by Western countries. These examples reveal the recurring pattern of duplicating existing recommendations and justify the concern that this practice could overlook specific contextual nuances in the future.

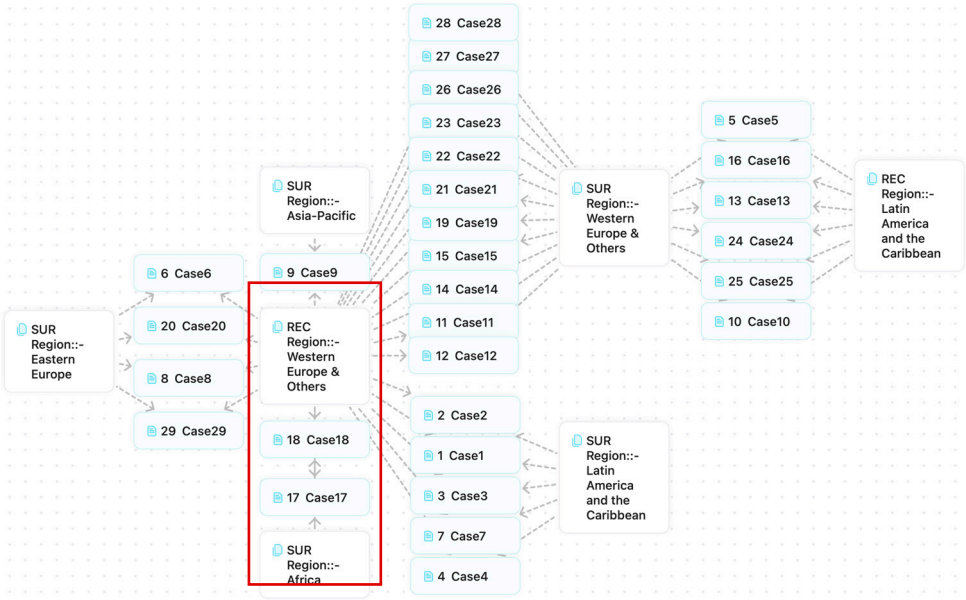


Figure 1. Provenance and destination of IGM-related UPR recommendations. Source: Own analysis using Atlas.ti, December 2023. SUR: state under review, REC: recommending state.

The content analysis of the twenty-nine UPR recommendations related to IGM resulted in thirty-nine observations across the entire dataset, as highlighted in Table 1. The findings were categorised into five groups. Group 1 covered recommendations that incorporated all three components (competent, informed, and voluntary). Group 2 related to recommendations including the "competent" and "informed" components. Group 3 highlighted recommendations that stressed the significance of the components "informed" and "voluntary". Finally, group 4 and group 5 referred to recommendations encompassing the components "voluntary" and "competent," respectively. These groups are briefly analysed below.

Table 1. Findings categorised into five groups.

	Group 1 (One Case)	Group 2 (Eight Cases)	Group 3 (One Case)	Group 4 (Eleven Cases)	Group 5 (Seven Cases)
Competent	X	X			X
Informed	X	X	X		
Voluntary	X		X	X	

Source: Own categorisation, December 2023.

Group 1: Only one recommendation covered all three components: competent, informed, and voluntary. Recommendation 147.229 issued by the Russian Federation and addressed to Spain in 2018, reads as follows: "Prohibit *non-consensual* medical interventions performed on intersex people *until the person in question is old enough* to grant their *free* and

informed consent, unless the intervention is absolutely necessary for the development of their vital functions." (italics added).

Group 2: Eight recommendations mentioned the concepts "competent" and "informed". With respect to the component "competent", the cases highlighted that the consent should be "duly" given (one case) or "full" (two cases); that it should ensure (meaningful) participation in decision-making (three cases); and that it should not occur before they are able to give consent (two cases). As for references to the term "informed", the following wording was used: "that children and parents are informed about all options" (one case) and "informed consent" (seven cases).

Group 3: Only one recommendation emphasised the terms "informed" and "voluntary": "138.209 Adopt measures to guarantee the physical integrity and bodily autonomy of intersex people and prohibit unnecessary medical procedures without their *free* and *informed* consent" (italics added). In 2022, this recommendation was issued by Finland and addressed to Mexico.

Group 4: Eleven recommendations solely referred to the component "voluntary", encompassing various descriptions. The terminology mostly used is "non-consensual" (seven mentions), followed by "forced and coercive" (three mentions), and only one mentioned the term "involuntary". The latter was the case for recommendation 111.106 issued by Australia and addressed to Costa Rica in 2019: "Increase efforts to reduce the societal stigma faced by lesbian, gay, bisexual, transgender and intersex people and eradicate *involuntary* surgical procedures to 'normalize' the bodies of intersex people" (italics added).

Group 5: The last category comprised seven cases referencing the term "competent", in one form or another. Four of these forms refer to intersex children or minors and highlight the importance of "the manifestation of their gender identity", the age where they can consent", the "right to self-determination" (two cases), or "participation in decision-making". Another recommendation contains the expression "full consent".

Table 1 below summarises the references to competent, informed, and voluntary consent, organised by group. This summary indicates that most references included the components "competent" (sixteen observations), followed by "informed" (ten observations) and "voluntary" (thirteen observations). Only one recommendation encompasses all three required elements of informed consent.

The next section discusses the significance of these findings and strategies to ensure that informed consent truly represents the individual's intentions and can travel beyond a Western understanding.

5. Discussion

The discussion revolves around the implications of the findings: that only two African countries received recommendations related to IGM, and no African country issued an IGM-related recommendation. With the anticipated proliferation of UPR recommendations on IGM, mainly targeting the concept of informed consent risks replicating the Western ideation that will not succeed in protecting intersex persons from IGM in other contexts. As such, each component of informed consent is examined here, identifying its limitations when applied to a non-Western context, particularly the African context. Throughout this assessment, I will refer to the landmark Resolution on the Promotion and Protection of the Rights of Intersex Persons in Africa (African Commission on Human and Peoples' Rights 2023). I will also articulate the concern regarding the potential risk of self-censorship—a manifestation of epistemic violence labelled as testimonial smothering (Dotson 2011, p. 244). I start by reflecting on the person who gives informed consent.

5.1. Informed Consent

Focusing on the responsibility of the intersex person to provide consent assumes that the subaltern (the intersex person) *can* speak, to use the seminal words of Spivak (1988). When all criteria are fulfilled (competent, informed, and voluntary), the question remains: Whose consent is at stake? The Resolution on the Promotion and Protection of

the Rights of Intersex Persons in Africa may provide guidance. Across the points of the Resolution, the mention of consent encompasses all three components. References to the components "voluntary" and "competent" appear in point 2 of the Resolution: "Stop *non-consensual* genital normalization practices on intersex persons, such as surgical, hormonal and sterilization procedures that alter the sexual characteristics of intersex persons and *ensure respect for their rights to make their own decisions* regarding their bodily integrity, physical autonomy and self-determination" (italics added). While point 2 does not make a reference to the intersex person's age, point 3 focuses on intersex minors and articulates that the consent needs to come from parents: "Ensure that any action concerning an *intersex minor* is carried out *with the permission of the parents* and after medical analysis, taking strict account of the best interests of the child" (italics added). Notwithstanding the reference to the best interest of the child, these two points lack clarity on whether consent should also come from the intersex child. In practice, genital surgery decisions involve parents but may not include the child's direct input (Warne and Raza 2008, p. 234; Swarr 2023, p. 149). Even when the child initially provides voluntary and competent consent, it is possible that, according to point 3, such consent may be overridden by the parents' non-consent. In the recommendation of group 1 (including all three components), the consent explicitly conditions that the intersex person be old enough to grant free and informed consent. This is an essential aspect to consider when formulating effective UPR recommendations on IGM.

5.2. Consent Given in a Competent Manner

The various references to consent given in a competent way, as highlighted for group 2 (competent and informed) and group 5 (competent), allow for the mitigation of some of the risks mentioned above. While the interpretations of "duly" given and "full" consent are subject to debate, a more precise approach to guaranteeing consent given in a competent way is by emphasising the subject's meaningful participation in decision-making processes about IGM. However, since practices for gender assignment vary across cultures (Edgerton 1964, p. 1298), sociocultural factors can compromise the right to meaningfully participate in decision-making. In Kenya, among the Pokot, the gender of a child is shared with the community from the moment of birth (Edgerton 1964, p. 1294). Conversely, in Ghana, parents have more time before the child's gender is revealed publicly (Ameyaw et al. 2019, p. 638). Overall, parents tend to reveal the gender of the child soon after birth. When parents decide to subject their child to IGM, they may infringe upon the child's rights, especially since newborns cannot meaningfully participate in such decisions (Monro et al. 2021, pp. 435–36). Recommendation 39.294, from Malta to Switzerland in 2023, suggests a way to ensure a child's meaningful participation in decision-making: "Consider explicitly prohibiting non-emergency, invasive and irreversible surgery or treatments with harmful effects on infants and children with variations in sex characteristics and ensure that these surgeries or treatments are postponed until the children can meaningfully participate in decision-making and give their informed consent" (italics added). References to the child's right to self-determination and gender identity, as in the recommendations 138.210 (Iceland to Finland in 2022)[10] and 111.107 (Portugal to Costa Rica in 2019)[11], provide another model to increase a child's meaningful participation in the decision to undergo IGM.

To mitigate the risk that the child's rights are violated during decision-making about medical interventions, the optimal measure is to delay this decision until the child can provide competent consent (Centre for Human Rights 2022, pp. 12–13). In a Kenyan study from 2019, intersex persons share their wish to postpone surgery until puberty, which allows them to review medical test results and interpret their dominant sex characteristics before consenting to any medical or surgical intervention (Amolo et al. 2019, p. 7). To ensure that the intersex child can participate meaningfully in decision-making, there needs to be an agreement on when a child is mature enough. While a child's age of maturity varies across cultures, there is still the risk that the family can overrule any individual decision regardless the child's age, maturity, or ability to decide. To counter this risk,

additional reference to the protection of bodily integrity, autonomy, and self-determination are valuable, as in the recommendation 156.158, issued by Malta and addressed to Sweden in 2020: "Protect children's rights to *bodily integrity*, *autonomy* and *self-determination* by ensuring, by legislation or otherwise, that non-vital surgical or other medical procedures on intersex infants are not performed before they are able to provide their *informed consent*" (italics added). As such, there is a supplementary safeguard defending the child's own wishes while protecting the child against those of the wider community.

5.3. Consent Given in an Informed Way

The requirement to provide sufficient adequate information to the parents or to the intersex person frequently appears in the recommendations categorised under groups 2 (informed and voluntary) and 3 (voluntary). As highlighted above, achieving consent in Africa is often a collective process (Akpa-Inyang and Chima 2021, p. 15), i.e., a consensus among different parties who all need information about the treatments, possible outcomes, and alternatives. Occasionally, key stakeholders, such as the family and community leaders, postpone naming the child and assigning its gender until they have sufficient information to discuss how to ensure the infant's acceptance within the family and community (Ameyaw et al. 2019, p. 638). This raises a critical question: Who shares this information? The new Resolution provides insights and underscores this information's significance in two ways. First, point 7 stresses the importance of capacity building for healthcare personnel to deliver necessary and sufficient information to parents and children, especially with regard to prenatal counselling and support services, while "respecting the autonomy, psychological integrity and sexual characteristics of the intersex person". Second, point 9 (African Commission on Human and Peoples' Rights 2023) highlights the need to "Ensure intersex people's right to full information, including access to their own medical records and history". There is a shared concern that more skilled medical staff (Hansen et al. 2022, p. 191) and training centres are needed in Africa (Ameyaw et al. 2019, p. 638) to share adequate information.

More important, however, is the question of who produces this information. The competence of African doctors is doubted by Gnassingbe et al. (2009, p. 83) who note that, because there are only four paediatric surgeons per African country, intersex children "are treated most of the time by urologists, who are not competent in this regard". As illustrated in the articles of Kraus (2013, p. 85) and Gnassingbe et al. (2009, p. 83) knowledge and information from the Global North may be used. Enabling informed consent through the transfer of knowledge from the Global North to the Global South may be questionable in a context where local medical staff lack the technical know-how for appropriate medical interventions and knowledge about the consequences of IGM. This assertion holds even more validity in situations of knowledge sharing, as illustrated by the clinical workshop in Togo (Gnassingbe et al. 2009), where capacity building and training included IGM. Bridging knowledge gaps by using advanced technologies from the Global North, explained by Western (French) professors to African medics, focuses on optimising the surgical interventions. Such "surgical safaris" (Kraus 2013, p. 85) pose a problem, stressing the power relation between Western paediatrics (pioneering) and African medics (passive receivers of knowledge), creating an enabling environment for epistemic violence, and more specifically testimonial smothering experienced by African doctors and intersex persons.

Testimonial smothering may arise when Western specialists, collaborating with African medics, disregard, underestimate, or overlook the insights and expertise of African doctors, whether unintentionally or intentionally due to discriminatory biases. This may have negative consequences for the African doctors who, consequently, silence their own voices and disengage from the communication, allowing potential IGM to go unaddressed. Conversely, while interacting with Western paediatrics, African doctors may refrain from explaining features of African society, anticipating that such aspects are difficult to understand for doctors who are not familiar with a country's duties and traditions. This may result in flawed conversations about options and alternatives for medical interventions

or surgery on intersex persons. In this scenario, the intersex individual may become a casualty of power dynamics, potentially abandoned to the care of a foreign doctor who lacks understanding of the local context, and more specifically of the interests and needs of the intersex individual. Moreover, medical interventions from foreign paediatricians may increase the knowledge gap between the doctor and the intersex person, depriving the patient or the patient's parents of a valid interlocutor. Intersex persons may find it more challenging to grasp information from someone who is unfamiliar with the intersex person's culture. Even more critical is the expectation that the intersex person—who may live in poverty and lack basic education and literacy skills—understands the meaning of the proposed medical intervention and can anticipate the consequences. This potential knowledge gap exacerbates existing unequal power relations between the intersex person and the medics, potentially creating conditions for testimonial smothering experienced by the intersex person, who might keep silent to conceal a lack of understanding of the options and consequences of medical interventions or surgery. Finally, the emphasis on medical interventions and surgery as the response to intersexuality excludes alternative solutions from the conversation between the intersex person and foreign medical staff.

Only one of the ten IGM-related recommendations referring to informed consent specifically mentions that alternative solutions must be provided. This is the case for Recommendation 57.162, provided by Chile to Ireland in 2021: "Develop a health-care protocol for intersex children, based on human rights, that ensures that children and parents are *informed about all options* and that children participate in decision-making, thus avoiding subjecting intersex children to irreversible interventions and medically unnecessary surgical procedures" (italics added). All the other cases simply mention informed consent, leaving the risks of testimonial smothering unaddressed. To mitigate these risks, I argue that UPR recommendations should stress the need for comprehensive and adequate information, including references to alternative solutions, when advocating for the prohibition of IGM. Furthermore, these recommendations should require such information to be provided by medical professionals who are trained and familiar with the specific context of the intersex individual.

5.4. Consent Given on a Voluntary Basis

Nonconsensual medical interventions occur in Africa (African Commission on Human and Peoples' Rights 2023). In her study in South Africa, Baird (2021, p. 373) finds that "These surgeries are performed without the consent of the child and at times without the consent of the parent/s and/or guardians, often resulting in life-long medical complications and mental trauma." In the fight against IGM, the Resolution (African Commission on Human and Peoples' Rights 2023) warns "that non-consensual and unnecessary surgical and other genital normalization procedures performed on intersex persons, in a medical or other setting, may cause them lifelong physical and psychological suffering, permanent sterility, incontinence, and loss of sexual pleasure". Point 2 of the Resolution (African Commission on Human and Peoples' Rights 2023) calls for a ban on nonconsensual IGM, where "State Parties to the African Charter have the obligation to recognize the rights, duties and freedoms guaranteed by the African Charter by adopting legislative or other measures to implement them". There are two layers at stake here for the intersex person in cases where their consent is requested before surgery: their duties towards their parents, and their duties those towards the community.[12] Both layers may result in testimonial smothering: children obeying their parents' will, and parents feeling pressured to conform to the sociocultural context and the will of the community. According to Warne and Raza (2008), traditional values and beliefs may hold significant influence across diverse cultures. While emphasising the scientific and technical complexity of intersexuality and arguing that local communities may struggle to grasp this complexity, decisions on medical interventions may become entangled with myths, misconceptions, and taboos, directing involved parties to faith healers, shrines, and sources of magic (Warne and Raza 2008, p. 230). Such an environment can disrupt communications among the community, parents, and the intersex

person, who may silence their voice in favour of the will of the family and community. This, however, does not mean that the community will opt for any medical intervention. Nevertheless, there is a lack of clarity around the alternative solutions pursued and their potential to harm the intersex individual.

The salient role of the parents, family, and local communities has been stressed in most of the cited studies. In resource-poor environments, various aspects impact decisions regarding IGM, both for parents of intersex children and for intersex adults. These include lack of funds to finance medical interventions (Amolo et al. 2019, p. 7), the parents' preference for a boy (Hansen et al. 2022, p. 190), sociocultural pressure, and fear of discrimination (Warne and Raza 2008, p. 231). However, is parental consent for their intersex child to undergo a medical intervention, such as IGM, genuinely voluntary, when consent is given to comply with the prevailing sociocultural norms? Parents might constrain their choice and obey the expectations of the community, which overrules any "free" parental consent or consent from the intersex child. One might question how much free will remains for the intersex person in an African context to decide on their own bodily integrity.

None of the UPR recommendations claiming voluntary consent, as in group 3 (informed and voluntary) and 4 (voluntary), confront this risk. References to nonconsensual, forced, and coercive or involuntary consent are insufficient in an African context. For example, UPR recommendation 122.102, provided by New Zealand to Chili in 2019, does not specify who should give this consent: "Consider putting an end to non-consensual medical procedures which affect intersex persons". UPR recommendations should explicitly mention that the consent should come from the intersex person. Nevertheless, even when the intersex person consents, there is no guarantee that this consent truly reflects the preferences of the intersex person. To avoid testimonial smothering, UPR recommendations should refer to competent, informed, and voluntary consent given by the intersex person, while also recommending accompanying measures to raise awareness and build capacities. These measures should target the intersex persons, parents, families, and communities to create conditions for the intersex person to be able to make an authentic decision. This suggestion is backed by the Resolution, in point 11, i.e., "Raise awareness of intersex issues and the rights of intersex persons in society".

6. Conclusions

Based on the content analysis of the twenty-nine IGM-related cases, I argue that advocating for the respect of the universal human right of informed consent is a Western response to IGM that may not completely capture the priorities and requirements in non-Western settings; as such, it will consequently fail to achieve its objective: genuine informed consent. While this analysis is built on only a few cases, it opens up an area of inquiry moving forward, as more IGM-related recommendations will be formulated, particularly with the recent African Union Resolution (African Commission on Human and Peoples' Rights 2023) that explicitly highlights the ban on IGM. Future recommendations should capture the substantial needs of intersex children and adults, and ensure that genuine consent is given in a competent, informed and voluntary way. There is a risk that Western countries will continue to produce the majority of IGM-related UPR recommendations, which may create a perceived political skew and risks undermining the spirit of the UPR process, which is meant to be a dialogue. Additionally, countries with limited interest in the rights of intersex persons may disengage from the dialogue, while concealing human rights violations. Some human rights violations will be addressed, while others remain hidden, which may lead some to conclude that IGM is merely a Western concern. There is an urgent need to foster meaningful dialogue and develop recommendations that are sensitive to the unique sociocultural contexts of African countries, ensuring that the voices and needs of all stakeholders, including those of intersex individuals, are adequately represented and addressed.

In an African context, decisions regarding medical interventions for intersex children frequently exclude the intersex individual from the decision-making process. Decision-

making often requires wide consultation among family members and the community. This collective process reduces the probability that the ultimate decisions about medical interventions and surgery represent the individual wish of the intersex person. This likelihood of obtaining genuine consent requires first that the decision is made in a competent way. This means that the (parents of the) intersex person understand the consequences and participate meaningfully in the decision-making process. A prerequisite for meeting this criterion is to delay decisions about medical interventions until the intersex child is old enough to make their own decisions. This approach rules out IGM for infants unless there is a life-threatening situation. In addition, decisions about medical interventions or surgery on intersex persons require adequate information that allows the intersex individual, or their parents, to understand the treatment and to assess alternative solutions. Capacity building is required for all parties involved, i.e., the medical staff, the parents, the extended family, and the community, to ensure appropriate knowledge sharing and transparent communication. Thirdly, decisions should be made on a voluntary basis. In an African context, however, free decisions about medical interventions or surgery are scarce, due to the importance of sociocultural context. Therefore, any UPR recommendation pursuing the ban on IGM should guarantee that the decision can be made in a competent, informed, and voluntary manner, while also recommending measures to safeguard the intersex person's ability to decide, and to ensure that this decision is respected by parents, families, and communities.

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Notes

1 An analysis of the terms found in IGM-related UPR recommendations (Ravesloot 2022) reveals that "normalising surgery", "gender-normalising surgery", or "medical interventions" are commonly mentioned.

2 Diverse definitions of intersex contribute to varying estimates (Blackless et al. 2000).

3 Both concepts are explained further in the text and build on the work of Kristie Dotson. She defines epistemic violence as "a failure of an audience to communicatively reciprocate, either intentionally or unintentionally, in linguistic exchanges owning to pernicious ignorance" (Dotson 2011, p. 242). Dotson identifies testimonial smothering as "the truncating of one's own testimony in order to insure that the testimony contains only content for which one's audience demonstrates testimonial competence." (Dotson 2011, p. 244).

4 DSD stands for Disorders of Sex Development a medical term used to describe variations of sex characteristics, or intersex. I avoid using this term as it places intersexuality within a medical context. In contrast, intersex "allows for a greater discussion of the social and cultural understandings that are associated with the term, including issues around sex and gender (Garland and Travis 2023, p. 5).

5 Phele (2016, p. 55) in Botswana explores the rights of intersex individuals, particularly concerning official documentation and notices that their rights are often neglected in laws and policies.

6 According to (Cynthia Kraus 2013, p. 86), hypospadias is a variation of sex characteristic "in which the urethral opening is not located on the tip of the glans".

7 Following terms were used: medical, surg (encompassing variations such as surgery, surgeries, or surgical), variation, harm, characteristic, norm (encompassing normalizing, or normalization), reassignment and sterilization.

8 In 2015, Malta (n.d.) adopted The Maltese Gender Identity, Gender Expression and Sex Characteristics Act of 2015. ACT XI of 2015, as amended by Acts XX of 2015 and LVI of 2016 and XIII of 2018. The Act states in Article 14 that "It shall be unlawful

for medical practitioners or other professionals to conduct any sex assignment treatment and, or surgical intervention on the sex characteristics of a minor which treatment and, or intervention can be deferred until the person to be treated can provide informed consent: Provided that such sex assignment treatment and, or surgical intervention on the sex characteristics of the minor shall be conducted if the minor gives informed consent through the person exercising parental authority or the tutor of the minor."

[9] Iceland adopted in 2019 the Act on Gender Autonomy, No. 80/2019 as amended by Act No. 159/2019, No. 152/2020, and No. 154/2020 (Act on Gender Autonomy 2019). The Act states in Article 11 that "Permanent changes on genitals, gonads or other sex characteristics of persons 16 years or older are prohibited without their written consent."

[10] "138.210 Respect intersex children's right to self-determination and ban unnecessary surgeries."

[11] "111.107 Continue its efforts for the protection of the rights of lesbian, gay, bisexual, transgender and intersex persons, namely by recognizing the right of intersex persons to gender identity self-determination and gender expression, inter alia by prohibiting the performance of surgical or pharmacological interventions on children before the manifestation of their gender identity".

[12] The African Charter on Human and Peoples' Rights (ACHPR) precises in its article 27 that the (intersex) individuals are obligated to fulfil responsibilities to both their family and society and to exercise their rights and freedoms according to the prevailing morality and common interest (Organisation of African Union 1981).

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