Intersex Genital Mutilation
Human Rights Violations Of Children
With Variations Of Reproductive Anatomy

NGO Report (for LOIPR)
to the 6th to 7th Report of Bulgaria on the
Convention on the Rights of the Child (CRC)
Executive Summary

All typical forms of Intersex Genital Mutilation are still practised in Bulgaria, facilitated and paid for by the State party via the public health system. Parents and children are misinformed, kept in the dark, sworn to secrecy, kept isolated and denied appropriate support. Despite repeated calls by intersex persons, NGOs and human rights agencies to protect intersex children, Bulgaria fails to act.

Bulgaria is thus in breach of its obligations under CRC to (a) take effective legislative, administrative, judicial or other measures to prevent harmful practices on intersex children causing severe mental and physical pain and suffering of the persons concerned, and (b) ensure access to redress and justice, including fair and adequate compensation and as full as possible rehabilitation for victims, as stipulated in CRC art. 24 para. 3 in conjunction with the CRC-CEDAW Joint general comment No. 18/31 “on harmful practices”.

This Committee has consistently recognised IGM practices to constitute a harmful practice under the Convention in Concluding Observations.

In total, UN treaty bodies CRC, CEDAW, CAT, CCPR and CRPD have so far issued 50 Concluding Observations recognising IGM as a serious violation of non-derogable human rights, typically obliging State parties to enact legislation to (a) end the practice and (b) ensure redress and compensation, plus (c) access to free counselling. Also, the UN Special Rapporteurs on Torture (SRT) and on Health (SRH), the UN High Commissioner for Human Rights (UNHCHR), the World Health Organisation (WHO), the Inter-American Commission on Human Rights (IACHR), the African Commission on Human and Peoples’ Rights (ACHPR) and the Council of Europe (COE) recognise IGM as a serious violation of non-derogable human rights.

Intersex people are born with Variations of Reproductive Anatomy, including atypical genitals, atypical sex hormone producing organs, atypical response to sex hormones, atypical genetic make-up, atypical secondary sex markers. While intersex people may face several problems, in the “developed world” the most pressing are the ongoing Intersex Genital Mutilations, which present a distinct and unique issue constituting significant human rights violations.

IGM practices include non-consensual, medically unnecessary, irreversible, cosmetic genital surgeries, and/or other harmful medical procedures that would not be considered for “normal” children, without evidence of benefit for the children concerned. Typical forms of IGM include “masculinising” and “feminising”, “corrective” genital surgery, sterilising procedures, imposition of hormones, forced genital exams, vaginal dilations, medical display, involuntary human experimentation and denial of needed health care.

IGM practices cause known lifelong severe physical and mental pain and suffering, including loss or impairment of sexual sensation, painful scarring, painful intercourse, incontinence, urethral strictures, impairment or loss of reproductive capabilities, lifelong dependency of artificial hormones, significantly elevated rates of self-harming behaviour and suicidal tendencies, lifelong mental suffering and trauma, increased sexual anxieties, and less sexual activity.

For more than 25 years, intersex people have denounced IGM as harmful and traumatising, as western genital mutilation, as child sexual abuse and torture, and called for remedies.

This NGO Report has been compiled by StopIGM.org / Zwischengeschlecht.org, an international intersex NGO. It contains Suggested Questions (see p. 14).
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on the Convention on the Rights of the Child (CRC)  

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A. Introduction

1. Bulgaria: Intersex, IGM and Human Rights

IGM practices are known to cause severe, lifelong physical and psychological pain and suffering, and have been repeatedly recognised by multiple UN treaty bodies including CRC as constituting a harmful practice, violence, and cruel, inhuman or degrading treatment.

Despite that the persistence of IGM practices in Bulgaria is a matter of public record, same as the criticism and appeals by intersex persons, NGOs and human rights agencies, to this day the Bulgarian Government fails to recognise the serious human rights violations and the severe pain and suffering caused by IGM practices, let alone to “take effective legislative, administrative, judicial or other measures” to protect intersex children from harmful practices.

This Thematic NGO Report demonstrates that the current and ongoing harmful medical practices on intersex children in Bulgaria – advocated, facilitated and perpetrated by the state funded University Hospitals, as well as private contractual hospitals, and paid for by the State party via the public health system financed by the compulsory National Health Insurance Fund (NHIF) for employees and self-employed persons, and for children aged 0-18 directly by the State – constitute a serious breach of Bulgaria’s obligations under the Convention.

2. About the Rapporteurs

This NGO report has been prepared by the international intersex NGO StopIGM.org:

- StopIGM.org / Zwischengeschlecht.org is an international intersex human rights NGO based in Switzerland, working to end IGM practices and other human rights violations perpetrated on intersex people, according to its motto, “Human Rights for Hermaphrodites, too!” According to its charter, StopIGM.org works to support persons concerned seeking redress and justice and regularly reports to relevant UN treaty bodies, often in collaboration with local intersex persons and organisations, substantially contributing to the so far 50 Treaty body Concluding Observations recognising IGM as a serious human rights violation.

In 2017 StopIGM.org facilitated an Open Letter by persons concerned, partners, friends and allies with 101 signatories to EU funded IGM clinics, including the Sofia University Hospital and the Varna University Hospital.

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4. https://intersex.shadowreport.org
In addition, the Rapporteurs would like to acknowledge the work of pioneering Bulgarian intersex advocate and IGM survivor Pol Naidenov. And we would like to acknowledge some of the work of Bilitis Resource Center Foundation.

3. Methodology

This thematic NGO report is a localised update to the 2019 CRC Portugal NGO Report (for Session) by the same Rapporteurs. Translations from Bulgarian texts are automatic translations revised by the Rapporteurs.

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7 European Commission (2017), Video: Interview with Pol Naidenov, 
00:02:10: “Usually when parents agree to surgery they have no idea of the consequences of such surgery. Intersex people can live a long and happy life without any surgery.”

8 Monika Pisankaneva, Pol Naidenov (2020), Open Doors National Report: Bulgaria, 
p. 7: “5) there is no legal ban on unnecessary surgery for intersex children which results in body mutilation procedures happening with the consent of the parents; intersex children raised in institutions are often subjects of unnecessary (exp[e]rimental) surge[r]y, and last but not least, the parents of intersex children do not always receive present-day scientific information about the intersex conditions;”

p. 28: “Recommendations. The Bulgarian state should: […] 2) Ban unnecessary corrective surgery for gender reassignment on intersex children, which is accomplished without the consent of the intersex individual.”

9 bilitis.org (2019), Council of Europe Commissioner for Human Rights, Dunja Mijatović, visited Bulgaria, 
“Furthermore, Liliya informed the Commissioner on the developments around a case of an intersex person who has been ‘normalized’ as an infant through series of damaging surgeries in a hospital in Sofia.”

B. IGM in Bulgaria: State-sponsored and pervasive, Gov fails to act

1. Overview: IGM practices in Bulgaria: Pervasive and unchallenged

In Bulgaria, same as in the fellow European Union member states of France (CRC/C/FRA/CO/5, paras 47-48; CAT/C/FRA/CO/7, paras 34-35; CEDAW/C/FRA/CO/7-8, paras 18e-f+19e-f), Denmark (CRC/C/DNK/CO/5, paras 24+12; CAT/C/DNK/CO/6-7, paras 42-43), Italy (CRC/C/ITA/CO/5-6, para 23; CRPD/C/ITA/CO/1, paras 45-46), Germany (CAT/C/DEU/CO/5, para 20; CRPD/C/DEU/CO/1, paras 37-38; CEDAW/C/DEU/CO/7-8, paras 23-24), and in many more State parties,¹¹ there are

- no legal or other protections in place to prevent all IGM practices as stipulated in art. 24(3) and the CRC-CEDAW Joint General Comment No. 18/31,
- no legal measures in place to ensure access to redress and justice for adult IGM survivors,
- no legal measures in place to ensure the accountability of all IGM perpetrators and accessories,
- no measures in place to ensure data collection and monitoring of IGM practices.

Despite that the persistence of IGM practices in Bulgaria is a matter of public record, same as the criticism and appeals by intersex persons, NGOs and human rights agencies (see below, p. 12-13), to this day the Bulgarian Government fails to recognise the serious human rights violations and the severe pain and suffering caused by IGM practices, let alone to “take effective legislative, administrative, judicial or other measures” to protect intersex children from harmful practices.

2. Most Common IGM Forms advocated and perpetrated by Bulgaria

To this day, in Bulgaria all forms of IGM practices remain widespread and ongoing, persistently advocated, prescribed and perpetrated by the state funded University Hospitals, as well as private contractual hospitals, and paid for by the State via the public health system financed by the compulsory National Health Insurance Fund (NHIF) for employees and self-employed persons, and for children aged 0-18 directly by the State.

The best known hospitals practising IGM in Bulgaria are the Sofia University Hospital and the Varna University Hospital “St. Marina”, which are also involved in international IGM networks,¹² namely “DSDnet”,¹³ the IGM-related Main Thematic Group “MTG7: Sex Development & Maturation” of “Endo-ERN”¹⁴ and the “I-DSD/I-CAH Registry”.¹⁵

¹¹ Currently we count 50 UN Treaty body Concluding Observations explicitly condemning IGM practices as a serious violation of non-derogable human rights, see: https://stopigm.org/post/IAD-2016-Soon-20-UN-Reprimands-for-Intersex-Genital-Mutilations
¹³ http://www.dsnet.eu/management-committee.html#Bulgaria
However, the following sections demonstrate that besides the Sofia and Varna University Hospitals also various other public University Hospitals as well as private clinics practice IGM in Bulgaria.

Currently practiced forms of IGM in Bulgaria include:

a) IGM 3 – Sterilising Procedures:

- Castration / “Gonadectomy” / Hysterectomy / Removal of “Discordant Reproductive Structures” / (Secondary) Sterilisation Plus arbitrary imposition of hormones

The Bulgarian Association of Urology (Българско Урологично Дружество) endorses the 2019 Guidelines of the European Association of Urology (EAU), which (see p. 14) include the current ESPU/EAU “Paediatric Urology” Guidelines of the European Society for Paediatric Urology (ESPU) and the European Association of Urology (EAU) which stress:

“Individuals with DSD have an increased risk of developing cancers of the germ cell lineage, malignant germ cell tumours or germ cell cancer in comparison with the general population.”

Further, regarding “whether and when to pursue gonadal or genital surgery”, the Guidelines refer to the “ESPU/SPU standpoint on the surgical management of Disorders of Sex Development (DSD)”, which advocates “gonadectomies”:

“Testes are either brought down in boys or removed if dysgenetic with tumour risk or in complete androgen insensitivity syndrome or 5 alpha reductase deficiency. Testicular prostheses can be inserted at puberty at the patient’s request.”

Also, the “2016 Global Disorders of Sex Development Consensus Statement” refers to the “ESPU/SPU standpoint”, advocates “gonadectomy” – even when admitting “low” cancer risk for CAIS (and despite explicitly acknowledging CRC/C/CHE/CO/2-4):

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18 https://uroweb.org/guideline/paediatric-urology/
19 https://uroweb.org/guideline/paediatric-urology/#3_16_5
20 https://uroweb.org/guideline/paediatric-urology/#3_16_4
23 Ibid., at 180 (fn 111)
Accordingly, a 2018 publication out of the Maternity Clinic of the Sofia University Hospital states:

“In patients with 5-ARD who are raised female, management includes [...] early removal of testicules to prevent masculinisation before puberty, [...] and hormonal therapy at puberty for development of secondary sexual characteristics.”

And a 2018 publication co-authored by doctors of the Department of Paediatrics at the Medical University of Varna associated with the I-DSD Registry regarding “the indications and timing of gonadectomy” within the Registry concludes:

“Data regarding gonadectomy were available in 520 (85%). [...] Gonadectomy was performed in 315 (61%) cases. Females had gonadectomy at a later median age of 14 yrs (0.3, 68) compared to median age of 5 yrs (0.1, 54) in males (P=0.047).”

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The Bulgarian Association of Urology (Българско Урологично Дружество) endorses the 2019 Guidelines of the European Association of Urology (EAU), which (see p. 14) include the current ESPU/EAU “Paediatric Urology” Guidelines of the European Society for Paediatric Urology (ESPU) and the European Association of Urology (EAU). In chapter 3.16 “Disorders of sex development”, despite admitting that “Surgery that alters appearance is not urgent” and that “adverse outcomes have led to recommendations to delay unnecessary [clitoral] surgery to an age when the patient can give informed consent”, the ESPU/EAU Guidelines nonetheless explicitly refuse to postpone non-emergency surgery, but in contrary insist to continue with non-emergency genital surgery (including partial clitoris amputation) on young children based on “social and emotional conditions” and substituted decision-making by “parents and caregivers implicitly act[ing] in the best interest of their children” and making “well-informed decisions [...] on their behalf”, and further explicitly refusing “prohibition regulations” of unnecessary early surgery, referring to the 2018 ESPU Open Letter to the Council of Europe (COE), which further invokes parents’ “social, and cultural considerations” as justifications for early surgery (p. 2).

Accordingly, a 2018 publication out of the Maternity of the Sofia University Hospital states:

“In patients with 5-ARD who are raised female, management includes surgical correction of the external genitalia (vaginal opening, with early separation of the vagina and urethra), [...] clitoral reduction [...]. Sometimes is needed to perform postsurgical dilatation of the vagina.”

And current online publication on “Congenital Adrenal Hyperplasia” by a doctor from the private Medica Hospital in Ruse (contractual hospital to the National Health Insurance Fund (NHIF) with a paediatric surgery department) prescribes:

“Surgical treatment

Surgical treatment is required in some girls. This is usually done around 1 year of age. The type of surgery depends on the degree of masculinisation. The surgeon will reduce the size of the clitoris, preserving the blood vessels and nerve endings. In addition, an opening to the vagina can be made if necessary.”

28 https://uroweb.org/guideline/paediatric-urology/
29 https://uroweb.org/guideline/paediatric-urology/#3_16
30 https://uroweb.org/guideline/paediatric-urology/#3_16_4
31 Ibid.
32 Ibid.
When puberty begins, these girls should be re-examined by a surgeon or gynaecologist. They will assess whether new surgery is needed.

c) IGM 1 – “Masculinising Surgery”: Hypospadias “Repair”

The Bulgarian Association of Urology (Българско Урологично Дружество) endorses the 2019 Guidelines of the European Association of Urology (EAU), which (see p. 14) include the current ESPU/EAU “Paediatric Urology” Guidelines of the European Society for Paediatric Urology (ESPU) and the European Association of Urology (EAU). In chapter 3.5 “Hypospadias”, the ESPU/EAU Guidelines’ section 3.5.5.3 “Age at surgery” nonetheless explicitly promotes, “The age at surgery for primary hypospadias repair is usually 6-18 (24) months.” – despite admitting to the “risk of complications” and “aesthetic[…]” and “cosmetic” justifications.

Accordingly, a 2020 publication out of the University Hospital Stara Zagora of the Trakia University about “redo surgery” due to complications notes:

“The surgical intervention aims to build a new urethra up to the tip of the penis, correcting any possible curvature of the penis (1-2). The correction is surgically, usually when the infant is between 6 and 24 months.”

“Hypospadias causes not only functional problems but also psychological problems for patients and their parents.”

“We reviewed the boys with hypospadias repair of Snodgrass TIP urethroplasty, performed between January 2013 - January 2020 in the Pediatric surgery department of University hospital –Stara Zagora. Cases of proximal hypospadias with severe chordae and those who had undergone previous urethroplasty were excluded. Distal hypospadias in 12 boys aged 8 months to 12 years were included […]”

“Six patients have primary distal hypospadias who have been operated on by four pediatric surgeons needed reoperations, because of the failure of tabularized incised plate urethroplasty […] Two of them had more than one operation in the same area.”

In a 2012 medical news article the corresponding author of above publication elaborates:

“Says Assoc. Prof Dr Krassimira KALINOVA, Pediatric Surgery, University Hospital ‘Prof Dr St. Kirkovich’, Stara Zagora.”

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38 https://uroweb.org/guideline/paediatric-urology/
39 https://uroweb.org/guideline/paediatric-urology/#3_5
40 https://uroweb.org/guideline/paediatric-urology/#3_5_5_3
41 http://tru.uni-sz.bg/si/Volume%202018,%20%20Volume%20%20Number%204,%20Series%20Biomedical%20Sciences/10_K_Kalinova(1).pdf
42 Ibid.
“Usually the boy does not complain about anything. The mother is the one who seeks medical help.”

“The treatment is only surgical. […]"

These deformities are surgically corrected before the child is two years old.

He can then urinate normally and have a full sexual life later.”

Above observation that the children themselves have no issue with hypospadias while the parents insist on surgery is also repeated in a 2014 online medical article by a doctor from the Plovdiv University Hospital:45

“Usually the boy does not complain about anything. The mother is the one who is anxious to seek medical help. […] The treatment of hypospadias is only surgical.”

Further, also private hospitals perform “hypospadias repair”, for example the Medical Complex Doverie (contractual hospital to the National Health Insurance Fund (NHIF)) according to its homepage:46

“Doverie Hospital already performs urological operations on children.”

“Also, with the help of prominent doctors, modern equipment is available to help deal with any of the types of diseases in children: […] hypospadias, […].”

“Hypospadias is another type of disease in young children. […] In the specialised ward of Doverie Hospital, the disease can be easily diagnosed and the problem can be removed by surgery.”

“Our team of urologists […] will take care of your child with great attention and concern.”

3. Bulgarian Doctors and Government consciously dismissing Intersex Human Rights

The persistence of IGM practices in Bulgaria is a matter of public record, same as the criticism and appeals by intersex persons, NGOs and human rights agencies.47 48 49 50 51

45 Dr Iliya Bivolarski (2014), “Хипоспадия – лечение и симптоми” (“Hypospadias - treatment and symptoms”), http://zdrave-bg.eu/%D1%85%D0%B8%D0%BF%D0%BE%D1%81%D0%BF%D0%B0%D0%B4%D0%B8%D1%8F/
47 Monika Pisankaneva, Pol Naidenov (2020), Open Doors National Report: Bulgaria, https://bilitis.org/wp-content/uploads/2021/01/OpenDoors-National-Report-Bulgaria-FINAL_EN.pdf p. 7: “5) there is no legal ban on unnecessary surgery for intersex children which results in body mutilation procedures happening with the consent of the parents; intersex children raised in institutions are often subjects of unnecessary (exp[er]imental) sur[ge]ry; and last but not least, the parents of intersex children do not always receive present-day scientific information about the intersex conditions;”
00:02:10: “Usually when parents agree to surgery they have no idea of the consequences of such surgery. Intersex people can live a long and happy life without any surgery.”
“Furthermore, Liliya informed the Commissioner on the developments around a case of an intersex person who has been ‘normalized’ as an infant through series of damaging surgeries in a hospital in Sofia.”
However, **Bulgarian paediatric surgeons** nonetheless continue to **fail to consider any human rights concerns**.

And the **Bulgarian government fails to take practical and legislative measures** to protect intersex children from IGM practices.

### 4. Lack of Independent Data Collection and Monitoring

The **Bulgarian Government fails to collect and disclose disaggregated data** on intersex persons and IGM practices. With **no statistics available** on intersex births, let alone surgeries and costs, and **perpetrators, governments and health departments colluding to keep it that way as long as anyhow possible**, persons concerned as well as civil society **lack possibilities to effectively highlight and monitor** the ongoing mutilations. What’s more, after realising how intersex genital surgeries are increasingly in the focus of public scrutiny and debate, perpetrators of IGM practices respond by suppressing complication rates, as well as refusing to talk to journalists “on record”.

### 5. Obstacles to redress, fair and adequate compensation

Also in **Bulgaria** the **statutes of limitation** prohibit survivors of early childhood IGM practices to call a court, because persons concerned often **do not find out** about their medical history until much later in life, and **severe trauma** caused by IGM practices often prohibits them to act in time once they do. Globaly, no survivor of early surgeries **ever** managed to have their case successfully heard in court. All relevant court cases resulting in damages or settlement (3 in Germany, 1 in the USA) were either about surgery of adults, or initiated by foster parents.

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51 Piet de Bruyn (2017), “Promoting the human rights of and eliminating discrimination against intersex people”, Report to Committee on Equality and Non-Discrimination, CoE Doc. 14404, https://pace.coe.int/pdf/0f0e0beet2be1c94882e907480cf0f0f51f7s9ac3326667a8255f25667a8572ae84828a2fba12/doc.%2014404.pdf

52 Globally, no survivor of early surgeries **ever** managed to have their case successfully heard in court.
C. Suggested Questions for the LOIPR

The Rapporteurs respectfully suggest that in the LOIPR the Committee asks the Bulgarian Government the following questions with respect to the treatment of intersex children:

Harmful practices

Please inform the Committee about the measures taken to:

- Prevent the unnecessary medical or surgical treatment of intersex children, provide families with intersex children with adequate counselling and support, and guarantee access to effective remedies for victims subjected to such treatment during childhood, including the statute of limitations.

Please provide data, disaggregated, on:

- The number of intersex children subjected to irreversible medical or surgical procedures.
Annexe 1 – IGM Practices in Bulgaria as a Violation of CRC

1. The Treatment of Intersex Children in Bulgaria as Harmful Practice and Violence

a) Harmful Practice (art. 24(3) and JGC No. 18) 53

Article 24 para 3 CRC calls on states to abolish harmful “traditional practices prejudicial to the health of children”. While the initial point of reference for the term was the example of Female Genital Mutilation/Cutting (FGM/C), the term consciously wasn’t limited to FGM/C, but meant to include all forms of harmful, violent, and/or invasive traditional or customary practices. 54

This Committee has repeatedly considered IGM as a harmful practice, and the CRC-CEDAW Joint General Comment No. 18/31 on harmful practices as applicable. 55

Also CEDAW has repeatedly considered IGM as a harmful practice, and the CRC-CEDAW Joint General Comment/Recommendation No. 18/31 on harmful practices as applicable. 56

Harmful practices (and inhuman treatment) have been identified by intersex advocates as the most effective, well established and applicable human rights frameworks to eliminate IGM practices and to end the impunity of the perpetrators. 57

The CRC-CEDAW Joint General Comment/Recommendation No. 18/31 “on harmful practices” “call[s] upon States parties to explicitly prohibit by law and adequately sanction or criminalize harmful practices, in accordance with the gravity of the offence and harm caused, provide for means of prevention, protection, recovery, reintegration and redress for victims and combat impunity for harmful practices” (para 13).

Particularly, the Joint General Comment/Recommendation further underlines the need for a “Holistic framework for addressing harmful practices” (paras 31–36), including “legislative, policy and other appropriate measures that must be taken to ensure full compliance with [state parties’] obligations under the Conventions to eliminate harmful practices” (para 2), as well as “Data collection and monitoring” (paras 37–39)

“Legislation and its enforcement” (paras 40–55), particularly:

“adequate civil and/or administrative legislative provisions” (para 55 (d))

55 CRC/C/CHE/CO/2-4, paras 42-43; CRC/C/CHL/CO/4-5, paras 48-49; CRC/C/FRA/CO/5, paras 47-48; CRC/C/IRL/CO/3-4, paras 39-40; CRC/C/NPL/CO/3-5, paras 41-42; CRC/C/GBR/CO/5, paras 46-47; CRC/C/NZL/CO/5, paras 25+15; CRC/C/ZAF/CO/2, paras 39-40+23-24; CRC/C/DNK/CO/5, paras 24+12; CRC/C/ESP/CO/5-6, para 24; CRC/C/ARG/CO/5-6, para 26; CRC/C/ITA/CO/5-6, para 23; CRC/C/BEL/CO/5-6, para 25(b)+26(c); CRC/C/MLT/CO/3-6, paras 28-29; CRC/C/AUS/CO/5-6, paras 25(b)+26(e); CRC/C/PRT/CO/5-6, paras 28(b); CRC/C/AUT/CO/5-6, para 27(a)-b
56 CEDAW/C/FRA/CO/7-8, paras 18e-f+19e-f; CEDAW/C/CHE/CO/4-5, paras 24-25, 38-39; CEDAW/C/NLD/CO/6, paras 21-22, 23-24; CEDAW/C/DEU/CO/7-8, paras 23-24; CEDAW/C/IRL/CO/6-7, paras 24-25; CEDAW/C/CHL/CO/7, paras 22-23, 12(d)-13(d), 14(d)-15(d); CEDAW/C/LUX/CO/6-7, paras 27b-c+28b-c; CEDAW/C/MEX/CO/9, para 21-22; CEDAW/C/NZL/CO/8, paras 23(c)-24(c); CEDAW/C/AUS/CO/8, paras 25(c)-26(c); CEDAW/C/LIE/CO/5, paras 35+36(c); CEDAW/C/NPL/CO/6, paras 18(c)-19(c)
“provisions on regular evaluation and monitoring, including in relation to implementation, enforcement and follow-up” (para 55 (n))

“equal access to justice, including by addressing legal and practical barriers to initiating legal proceedings, such as the limitation period, and that the perpetrators and those who aid or condone such practices are held accountable” (para 55 (o))

“equal access to legal remedies and appropriate reparations in practice” (para 55 (q)).

Last but not least, the Joint General Comment explicitly stipulates: “Where medical professionals or government employees or civil servants are involved or complicit in carrying out harmful practices, their status and responsibility, including to report, should be seen as an aggravating circumstance in the determination of criminal sanctions or administrative sanctions such as loss of a professional licence or termination of contract, which should be preceded by the issuance of warnings. Systematic training for relevant professionals is considered to be an effective preventive measure in this regard.” (para 50)

Conclusion, IGM practices in Bulgaria – as well as the failure of the state party to enact effective legislative, administrative, social and educational measures to eliminate them and to ensure effective access to remedies and redress for IGM survivors – clearly violate Article 24 CRC, as well as the CRC-CEDAW Joint General Comment No. 18/31 on harmful practices.

b) Violence against Children (art. 19 and GC No. 13) 58

Similarly, the Committee has also considered IGM practices as violence against children, and Art. 19 and the General Comment No. 13 also offer strong provisions to combat IGM practices.

2. Required Legislative Provisions to Ensure Protection from IGM Practices, Impunity of the Perpetrators (CRC art. 24(3) and JGC No. 18)

Article 24 para. 3 of the Convention in conjunction with the CRC-CEDAW Joint General Comment/Recommendation No. 18/31 “on harmful practices” (2014) underline state parties’ obligations to “explicitly prohibit by law and adequately sanction or criminalize harmful practices” (JGC 18/31, para 13), as well as to “adopt or amend legislation with a view to effectively addressing and eliminating harmful practices” (JGC 18/31, para 55), and specifically to ensure “that the perpetrators and those who aid or condone such practices are held accountable” (JGC 18/31, para 55 (o)).

Accordingly, with regards to IGM practices, and referring to Article 24 para 3 and the CRC-CEDAW Joint General Comment/Recommendation No. 18/31, CRC repeatedly recognised the obligation for State parties to “[e]nsure that the State party’s legislation prohibits all forms of harmful practices [including intersex genital mutilation]”, 59 as well as to “ensure that no-one is subjected to unnecessary medical or surgical treatment during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to children concerned”, 60 and to “[u]ndertake investigation of incidents of surgical and other medical treatment of intersex children without informed consent and adopt legal provisions in order to provide redress to the victims of such treatment, including adequate compensation”. 61

59 CRC/C/ZAF/CO/2, 27 October 2016 paras 39–40
60 CRC/C/CHE/CO/2-4, 26 February 2015, para 43
61 CRC/C/DNK/CO5, 26 October 2017, para 24
3. Obstacles to Redress, Fair and Adequate Compensation, and Rehabilitation (CRC art. 24(3) and JGC No. 18)

Article 24 para. 3 of the Convention in conjunction with the CRC-CEDAW Joint General Comment/Recommendation No. 18/31 “on harmful practices” clearly stipulate the right of victims of IGM practices to “equal access to legal remedies and appropriate reparations” (JGC 18/31, para 55 (q)), and specifically to ensure that “children subjected to harmful practices have equal access to justice, including by addressing legal and practical barriers to initiating legal proceedings, such as the limitation period” (JGC 18/31, para 55 (o)).

However, also in Bulgaria the statutes of limitation prohibit survivors of early childhood IGM practices to call a court, because persons concerned often do not find out about their medical history until much later in life, and severe trauma caused by IGM practices often prohibits them to act in time even once they do. So far there was no case of a victim of IGM practices succeeding in going to a Bulgarian court.

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62 Globally, no survivor of early surgeries ever managed to have their case successfully heard in court. All relevant court cases resulting in damages or settlement (3 in Germany, 1 in the USA) were either about surgery of adults, or initiated by foster parents.
Annexe 2 – Intersex, IGM and Non-Derogable Human Rights

1. Intersex = variations of reproductive anatomy

Intersex persons, in the vernacular also known as hermaphrodites, or medically as persons with “Disorders” or “Differences of Sex Development (DSD)”, are people born with variations of reproductive anatomy, or “atypical” reproductive organs, including atypical genitals, atypical sex hormone producing organs, atypical response to sex hormones, atypical genetic make-up, atypical secondary sex markers. Many intersex forms are usually detected at birth or earlier during prenatal testing, others may only become apparent at puberty or later in life.

While intersex people may face several problems, in the “developed world” the most pressing are the ongoing Intersex Genital Mutilations, which present a distinct and unique issue constituting significant human rights violations, with 1 to 2 in 1000 newborns at risk of being submitted to non-consensual “genital correction surgery”.

For more information and references, see 2014 CRC Switzerland NGO Report, p. 7-12.

2. IGM = Involuntary, unnecessary and harmful interventions

In “developed countries” with universal access to paediatric health care 1 to 2 in 1000 newborns are at risk of being submitted to medical IGM practices, i.e. non-consensual, unnecessary, irreversible, cosmetic genital surgeries, and/or other harmful medical treatments that would not be considered for “normal” children, practiced without evidence of benefit for the children concerned, but justified by societal and cultural norms and beliefs, and often directly financed by the state via the public health system.

In regions without universal access to paediatric health care, there are reports of infanticide of intersex children, of abandonment, of expulsion, of massive bullying preventing the
persons concerned from attending school (recognised by CRC as amounting to a harmful practice), and of murder. 

Governing State bodies, public and private healthcare providers, national and international medical bodies and individual doctors have traditionally been framing and “treating” healthy intersex children as suffering from a form of disability in the medical definition, and in need to be “cured” surgically, often with openly racist, eugenic and suprematist implications. 

Both in “developed” and “developing” countries, harmful stereotypes and prejudice framing intersex as “inferior”, “deformed”, “disordered”, “degenerated” or a “bad omen” remain widespread, and to this day inform the current harmful western medical practice, as well as other practices including infanticide and child abandonment.

Typical forms of medical IGM include “feminising” or “masculinising”, “corrective” genital surgery, sterilising procedures, imposition of hormones (including prenatal “therapy”), forced genital exams, vaginal dilations, medical display, human experimentation, selective (late term) abortions and denial of needed health care.

Medical IGM practices are known to cause lifelong severe physical and mental pain and suffering, including loss or impairment of sexual sensation, poorer sexual function, painful scarring, painful intercourse, incontinence, problems with passing urine (e.g. due to urethral stenosis after surgery), increased sexual anxieties, problems with desire, less sexual activity, dissatisfaction with functional and aesthetic results, lifelong trauma and mental suffering, elevated rates of self-harming behaviour and suicidal tendencies comparable to those among women who have experienced physical or (child) sexual abuse, impairment or loss of reproductive capabilities, lifelong dependency on daily doses of artificial hormones.

UN Treaty bodies and other human rights experts have consistently recognised IGM practices as a serious violation of non-derogable human rights, namely as a harmful practice and inhuman treatment falling under the absolute prohibition of torture. UN Treaty bodies have so far issued 50 Concluding Observations condemning IGM practices accordingly.

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69 For example in Nepal (CRC/C/NPL/CO/3-5, paras 41–42), based on local testimonies, see: 


72 In the WHO “World Atlas of Birth Defects (2nd Edition)”, many intersex diagnoses are listed, including “indeterminate sex” and “hypospadias”: 

73 “The Racist Roots of Intersex Genital Mutilations” 


75 See “IGM Practices – Non-Consensual, Unnecessary Medical Interventions”, ibid., p. 38–47


77 [https://stopigm.org/post/TAD-2016-Soon-20-UN-Reprimands-for-Intersex-Genital-Mutilations](https://stopigm.org/post/TAD-2016-Soon-20-UN-Reprimands-for-Intersex-Genital-Mutilations)
3. Intersex is NOT THE SAME as LGBT or Transgender

Unfortunately, there are also other, often interrelated harmful misconceptions and stereotypes about intersex still prevailing in public, notably if intersex is counterfactually described as being the same as or a subset of LGBT or SOGI, e.g. if intersex is misrepresented as a sexual orientation (like gay or lesbian), and/or as a gender identity, as a subset of transgender, as the same as transsexuality, or as a form of sexual orientation.

The underlying reasons for such harmful misrepresentations include lack of awareness, third party groups instrumentalising intersex as a means to an end for their own agenda, and State parties trying to deflect from criticism of involuntary intersex treatments.

Intersex persons and their organisations have spoken out clearly against instrumentalising or misrepresenting intersex issues, maintaining that IGM practices present a distinct and unique issue constituting significant human rights violations, which are different from those faced by the LGBT community, and thus need to be adequately addressed in a separate section as specific intersex issues.

Also, human rights experts are increasingly warning of the harmful conflation of intersex and LGBT.

Regrettably, these harmful misrepresentations seem to be on the rise also at the UN, for example in recent UN press releases and Summary records misrepresenting IGM as “sex alignment surgeries” (i.e. voluntary procedures on transsexual or transgender persons), IGM survivors as “transsexual children”, and intersex NGOs as “a group of lesbians, gays, bisexuals, transgender and intersex victims of discrimination”, and again IGM survivors as “transgender children”, “transsexual children who underwent difficult treatments and surgeries”, and IGM as a form of “discrimination against transgender and intersex children” and as “sex assignment surgery” while referring to “access to gender reassignment-related treatments”.

Particularly State parties are constantly misrepresenting intersex and IGM as sexual orientation or gender identity issues in an attempt to deflect from criticism of the serious human rights violations resulting from IGM practices, instead referring to e.g. “gender reassignment surgery” (i.e. voluntary procedures on transsexual or transgender persons) and “gender assignment surgery for children”, “a special provision on sexual orientation and gender identity”.

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81 For example ACHPR Commissioner Lawrence Murugu Mute, see https://stopigm.org/post/ACHPR-African-Commissioner-warns-Stop-conflating-intersex-and-LGBT
86 CAT/C/DNK/QPR/8, para 32
“gender identity”, “civil registry” and “sexual reassignment surgery”.

What’s more, LGBT organisations (including “LGBTI” organisations without actual intersex representation or advocacy) are using the ubiquitous misrepresentation of intersex = LGBT to misappropriate intersex funding, thus depriving actual intersex organisations (which mostly have no significant funding, if any) of much needed resources and public representation.

4. IGM is NOT a “Discrimination” Issue

An interrelated diversionary tactic is the increasing misrepresentation by State parties of IGM as “discrimination issue” instead of a serious violation of non-derogable human rights, namely inhuman treatment and a harmful practice, often in combination with the misrepresentation of intersex human rights defenders as “fringe elements”, and their legitimate demands and criticism of such downgrading and trivialising of IGM as “extreme views”.

5. IGM is NOT a “Health” Issue

An interrelated, alarming new trend is the increasing misrepresentation of IGM as “health-care issue” instead of a serious violation of non-derogable human rights, and the promotion of “self-regulation” of IGM by the current perpetrators – instead of effective measures to finally end the practice (as repeatedly stipulated also by this Committee).

Even worse, Health Ministries construe UN Concluding observations falling short of explicitly recommending legislation to criminalise or adequately sanction IGM as an excuse for “self-regulation” promoting state-sponsored IGM practices to continue with impunity.

88 CCPR120 Switzerland,
https://stopigm.org/post/Pinkwashing-of-Intersex-Genital-Mutilations-at-the-UN-CCPR120
92 For example in Scotland (UK), LGBT organisations have so far collected at least £ 135,000. – public intersex funding, while actual intersex organisations received ZERO public funding, see 2017 CRPD UK NGO Report, p. 14, https://intersex.shadowreport.org/public/2017-CRPD-UK-NGO-Coalition-Intersex-IGM.pdf
96 For example CEDAW Italy (2017), see https://stopigm.org/post/Major-Setback-for-Intersex-Human-Rights-at-the-UN
97 For example CEDAW Austria (2019): CEDAW/C/AUT/CO/9, paras 34(h), 35(h)
98 For example Ministry of Health Chile (2016), see https://stopigm.org/post/Circular-7-step-back-for-intersex-human-rights-in-Chile
Annexe 3 – “IGM in Medical Textbooks: Current Practice”

IGM 1 – “Masculinising Surgery”: “Hypospadias Repair”

“Hypospadias,” i.e. when the urethral opening is not on the tip of the penis, but somewhere on the underside between the tip and the scrotum, is arguably the most prevalent diagnosis for cosmetic genital surgeries. Procedures include dissection of the penis to “relocate” the urinary meatus. Very high complication rates, as well as repeated “redo procedures” — “5.8 operations (mean) along their lives … and still most of them are not satisfied with results!”

Nonetheless, clinicians recommend these surgeries without medical need explicitly “for psychological and aesthetic reasons.” Most hospitals advise early surgeries, usually “between 12 and 24 months of age.” While survivors criticise a.o. impairment or total loss of sexual sensation and painful scars, doctors still fail to provide evidence of benefit for the recipients of the surgeries.

- Elbakry (BJUI 88: 590-595, 2001): 42% complications
  - 5 breakdowns (7%)
  - 17 fistulae (23%)
  - Urethral strictures (9%)
  - Urethral diverticulae (4%)

- Asopa / Duckett tube
  - 3.7% (El-Kasaby J Urol 136: 643-644, 1986)
  - 69% (Parsons BJU 25: 186-188, 1984)
  - 15% (Duckett - 1986)
Hypospadias - Procedures for cripple hypospadias

- No standardized procedures
- Personal experience of the surgeon
- Importance of a uro-endocrine approach of complex cases to increase the healing abilities of the penile tissues

Official Diagnosis “Hypospadias Cripple”
= made a “cripple” by repeat cosmetic surgeries

Treatment of isolated fistulae

- Rectangular skin incision around the fistula orifice, often lateral
- Dissection and excision of the fistula tract
- Urethral suture
- Multilayer cover with well-vascularized tissue (tunica vaginalis, dartos, dorsal subcutaneous flap ...)
- Problem: coronal fistula +++: Prefer redo urethroplasty
- Suprapubic diversion ?
  Elbakry

Bad cosmetic result
infection
IGM 2 – “Feminising Surgery”: “Clitoral Reduction”, “Vaginoplasty”
Partial amputation of clitoris, often in combination with surgically widening the vagina followed by painful dilation. “46,XX Congenital Adrenal Hyperplasia (CAH)” is arguably the second most prevalent diagnosis for cosmetic genital surgeries, and the most common for this type (further diagnoses include “46,XY Partial Androgen Insufficiency Syndrome (PAIS)” and “46,XY Leydig Cell Hypoplasia”).

Despite numerous findings of impairment and loss of sexual sensation caused by these cosmetic surgeries, and lacking evidence for benefit for survivors, current guidelines nonetheless advise surgeries “in the first 2 years of life”, most commonly “between 6 and 12 months,” and only 10.5% of surgeons recommend letting the persons concerned decide themselves later.
Caption 8b: “Material shortage” [of skin] while reconstructing the prepuceum clitoridis and the inner labia.

IGM 3 – Sterilising Surgery: Castration / “Gonadectomy” / Hysterectomy

Removal of healthy testicles, ovaries, or ovotestes, and other potentially fertile reproductive organs. “46,XY Complete Androgen Insufficiency Syndrome (CAIS)” is arguably the 3rd most common diagnosis for cosmetic genital surgeries, other diagnoses include “46,XY Partial Androgen Insufficiency Syndrome (PAIS)”, male-assigned persons with “46,XX Congenital Adrenal Hyperplasia (CAH)”, and other male assigned persons, who have their healthy ovaries and/or uteruses removed.

Castrations usually take place under the pretext of an allegedly blanket high risk of cancer, despite that an actual high risk which would justify immediate removal is only present in specific cases (see table below), and the admitted true reason is “better manageability.” Contrary to doctors claims, it is known that the gonads by themselves are usually healthy and “effective” hormone-producing organs, often with “complete spermatogenesis [...] suitable for cryopreservation.”

 Nonetheless, clinicians still continue to recommend and perform early gonadectomies – despite all the known negative effects of castration, including depression, obesity, serious metabolic and circulatory troubles, osteoporosis, reduction of cognitive abilities, loss of libido. Plus a resulting lifelong dependency on artificial hormones (with adequate hormones often not covered by health insurance, but to be paid by the survivors out of their own purse).

Fig. 91.6 An inguinal approach for gonadectomy in a CAIS patient with two palpable gonads

Table 1. Prevalence of type II GCT in various forms of DSD

<table>
<thead>
<tr>
<th>Risk</th>
<th>Type of DSD</th>
<th>Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>GD in general</td>
<td>12*</td>
</tr>
<tr>
<td></td>
<td>46,XY GD</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Frasier syndrome</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Denys-Drash syndrome</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>45,X/46,XY GD</td>
<td>15-40</td>
</tr>
<tr>
<td>Intermediate</td>
<td>PAIS</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>17β-hydroxysteroid dehydrogenase deficiency</td>
<td>17</td>
</tr>
<tr>
<td>Low</td>
<td>CAIS</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td>Ovotesticular DSD</td>
<td>2.6</td>
</tr>
<tr>
<td>Unknown</td>
<td>5α-reductase deficiency</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Leydig cell hypoplasia</td>
<td>?</td>
</tr>
</tbody>
</table>

GD = Gonadal dysgenesis; PAIS = partial androgen insensitivity syndrome; CAIS = complete androgen insensitivity syndrome.
* Might reach more than 30%, if gonadectomy has not been performed.


“Bad results” / “Gonadectomy, Feminising Genitoplasty”
