

## Intersex Genital Mutilation – IGM: The Fourteen Days of Intersex

By [Gina](http://oiiinternational.com/author/gina/) (<http://oiiinternational.com/author/gina/>) on 25 February 2012.

**ON the Third Day of Intersex we draw your attention to Intersex Genital Mutilation (IGM).**

### What is intersex?

Intersex people are people who, as individuals, have congenital genetic, hormonal and physical features that may be thought to be typical of both male and female at once. That is, we may be thought of as being male with female features, female with male features, or indeed we may have no clearly defined sexual features at all.

### What is Intersex Genital Mutilation (IGM)?

Intersex Genital Mutilation (IGM), like Female Genital Mutilation (FGM), is surgery carried out upon the genitals of newborn babies, infants and children for cultural or religious reasons. Both are forms of infant genital surgery. In the case of IGM, medical needs are also cited as a justification for the surgery but the evidence of actual need is slim at best.

Intersex Genital Mutilation is conducted on newborn babies when their external genitals do not look “normal” enough to pass unambiguously as male or female.

The majority of people born with intersex variations have physical differences that are not externally visible. Things like internal organs, hormones and chromosomes are not readily apparent when a child is born. For most of those children their differences will not become apparent until they reach puberty or the age of reproduction or some chance event like paternity testing reveals their intersex.

For some people our intersex is readily visible at birth, with our genitals especially being obviously different. Registers of birth “defects” held by state health departments reveal that somewhere between 13 and 20 children per one thousand births are children with visible intersex differences. Unfortunately when they are visible our differences are considered defects and our birth is required by law to be recorded as that in a special defects register.

When an Intersex child is born the first question a parent or relative might ask – “Is it a boy or a girl” – is not easily answered. Alarmed parents often have a homophobic response to that uncertainty, believing that differences in genitals somehow means their child is queer or gay. Researchers report that a common response by parents when being told their child is intersex is “Does that mean my baby will be gay?”

### The “cure”

Doctors respond to parental fears and community expectations by offering to “cure” the child of their intersex. That cure takes the form of surgery often followed by more surgery and a lifetime of hormonal reinforcement.

In the past medical practitioners attempted to, wherever possible, make the child more “male-like” thus preserving male privilege in accordance with prevailing values.

These days, medical practitioners are more likely to attempt to make the child more “female-like” because current surgical procedures are far more likely to produce a pleasing long-term outcome when removing tissue and making a vagina than they are when introducing the tissue needed to make a phallus.

The surgery to make an ambiguous child into an “unambiguously female child” is done as quickly as is possible. The theory is that the sooner it is done the more likely the child will heal with minimum scarring and the less likely the child will have any recollection of these invasive practices.

But parents and society are being sold a pup, a deception. Even in newborns scar tissue does not actually grow and scar tissue is insensate. All genital surgery reduces sexual sensation. Babies who have “neo-vaginas” constructed will immediately have to begin vaginal dilation and must continue that for the rest of their lives.

That means that a parent will have to insert a dilator into their baby’s vagina at first on a daily basis and then on a weekly basis until their child is old enough to do it itself. This is the therapeutic sexual penetration of one’s own child. Consider the psychological effects of that.

It gets worse. Because scar tissue does not grow and because of individual physical variations, further regular surgeries are inevitable until the child stops growing at around the age of twenty-two. It is impossible that the child will never know that they are different and that those differences are considered unacceptable.

### **It gets worse**

The notion that somehow medical practitioners are going down a well-worn path is false. There are no long-term studies on the efficacy of the surgeries conducted on intersex children save to say a few that have been done without question show that those of us who have been subjected to surgeries have sex less frequently and do not enjoy it when we do. In fact, it can be excruciatingly painful if not impossible.

To address this situation, professors of medicine such as [Dr Dix Poppas](http://oii.org.au/10103/oped-conspiracy-deceit-alice-dreger-isna-invention-dsd-dix-poppas-cornell-cuts-intersex-babies-clitorises/) (<http://oii.org.au/10103/oped-conspiracy-deceit-alice-dreger-isna-invention-dsd-dix-poppas-cornell-cuts-intersex-babies-clitorises/>) in New York have decided to improve their techniques by testing the sexual reaction of those upon whom they have performed surgery. To see his surgical outcomes, Poppas has subjected children as young as four to sexual stimulation to see if their “resculpted appendage”, now a clitoris, reacts as demanded.

The child has no right of input into this process. These surgeries are done to satisfy parents and to ensure the social sex binary – so precious, so essential, to the segregation of human beings into two distinct categories of sex – is unharmed. That potential crisis is avoided in the case of intersex children by physically reconfiguring nonconforming babies.

### **Did they get it right?**

Doctors can’t tell us that – for two reasons.

There are few long-term follow-up studies of intersex people, especially those over thirty. Those medical studies that do exist either have tiny numbers of participants or exclude huge numbers of specific intersex people such as those with Congenital Adrenal Hyperplasia (CAH), the most common reason for Intersex Genital Mutilation (IGM) and other surgeries.

The second reason is society itself. Our society is one where differences of sex are considered with some revulsion, from the perspective of being monstrosities and from the perspective of deeply entrenched homophobia.

An intersex individual might decide to adopt a low profile in those circumstances, to go along with the notion that they somehow are, in essence, really male or female, hide their differences and try to live a “normal” life. But what would their choices be if society valued their differences as they once did in indigenous, Korean, North American, and Samoan societies? How would we then act and identify?

## What to do?

**First:** do no harm.

**Second:** only act when free prior and fully informed consent can be had from the person being submitted to interventions.

**Third:** when the first item above cannot be ascertained with certainty and the second item can't be done then refer the problem to a court of law where His Honour the judge might call on all kinds of expertise, including intersex people themselves, in deciding a course of action.

The parents or guardians of Australian transsexual children under the age of 16 who wish to undergo life-changing hormonal medical treatment are required to make their case on their child's behalf before the Family Court of Australia. The same should be required of the parents and doctors of intersex children.

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