CIRCULAR 7, 2016: A STEP BACK IN THE FIGHT FOR THE HUMAN RIGHTS OF INTERSEX PEOPLE IN CHILE.

By Laura Inter and Hana Aoi

Special thanks to Dr. Eva Alcántara, who collaborated in the revision of this article.

Laura Inter *is an intersex activist born in the 80s, since 2013 she runs the* Brújula Intersexual *project, which offers support and information to intersex people and their families. Laura was diagnosed with Congenital Adrenal Hyperplasia (CAH), and born with intersex genitalia (also called "ambiguous genitalia"), she was treated outside the public healthcare system and her body was not subjected to surgeries, maintaining her body integrity.*

Hana Aoi *is a Mexican intersex activist born in 1981. She was subjected to three different and totally unnecesary surgeries in her childhood, in which her gonads were removed and a vaginoplasty was performed. Her intersex variation was known as true hermaphroditism. Today the term DSD ovotesticular is more in vogue; Hana disagrees with the use of any of those stigmatizing nomenclatures. This variant occurs when there is ovotesticular tissue in at least one gonad (called ovotestis, pl ovotestes).*

On December 22, 2015, Chile took a step forward when the country's Ministry of Health issued Circular No. 18 of 2015. This circular clearly instructed that harmful and unnecessary medical procedures must stop in intersex infants, children and adolescents, protecting the right to autonomy and bodily integrity of intersex children. However, on August 23, 2016, we learned that the same Ministry of Health revoked this Circular, issuing the Circular No. 7 of 2016. We consider that this new circular is a crude attempt by the Chilean medical institution to continue with the medicalization of Intersex bodies, and an unfortunate setback that officially validates violations of the human rights of intersex people.

BACKGROUND

Circular No. 18 is a document emerged from a series of observations by the Committee on the Rights of the Child (CRC) issued by the UN on October 30 on the same year (CRC observations can be downloaded here). In particular, highlighting the paragraphs 48 and 49, section **E. Violence against children (articles 19, 24 (paragraph 3), 28 (paragraph 2), 34, 37 a) and 39)**, concerning to Harmful practices. In them, the CRC expresses:

"Serious concern about cases of **irreversible and unnecessary surgery from a medical point of view and other treatments applied to intersex children, without their informed consent, that can cause them serious suffering**, and the lack of reparation and compensation mechanisms in such cases. "(Concluding observations on Chile's combined fourth and fifth periodic reports, paragraph. 48, p. 11. The emphasis in bold is ours)

For the above, the CRC recommends, in paragraph 49, to the Chilean State:

"To accelerate the development and implementation of **rights for intersex children-based health care protocol**, which set out the procedures and steps to be followed by the health teams, **so that no person undergoes surgeries or unnecessary medical treatments in infancy or childhood. The right of these children to physical and mental integrity, autonomy and self-determination.** Intersex children and their families should be offered adequate support and counseling, including from people in the same situation; And to ensure effective remedies for victims, including reparations and compensations. "(Ibid., Paragraph. 49, pp. 11-12; emphasis in bold is ours)

CIRCULAR 18, 2015

As a result, Circular No. 18 of 2015 was created. Initially, the will of the Chilean State is favorable, since in one paragraph it states that:

"[...] we are in the process of establishing a protocol to regulate health care for intersex children. This will be prepared by experts from multiple disciplines, with experience in the subject "(Chilean Ministry of Health, Circular No. 18 of 2015)

It is noteworthy that this paragraph speaks to experts from multiple disciplines such as those nominated to develop such a protocol, although it does not specify any involvement of civil society (in particular, intersex groups of activism and peer support). Later on, it instructed on "the formation of a Work Group", made up of medical specialists, along with an Ethics Committee, whose joint sessions allow them to determine the "conduct to be followed". Circular 18 was promising by the specific instruction to stop:

"[...] unnecessary 'normalization' treatments for intersex children, **including irreversible genital surgeries, until they are old enough to decide about their bodies."**

It was encouraging that the same paragraph recognized the need to assign a gender in the birth registration of an intersex baby, stating that no surgery of the type previously described would be tolerated.

However, this paragraph - the very essence of Circular No. 18, 2015 - loses momentum after the publication of Circular 7. By ignoring the human rights of intersex children, the new Circular represents a regrettable setback for Chile.

CIRCULAR 7, 2016.

Next we analyze each point of the Circular 7 published on 2016 and denounce that the measures indicated there try to pathologize intersexuality once again, by allowing the bodies of intersex babies and children to be intervened irreversibly and unnecessarily. We declare openly that these interventions merely serve **a problem of social distress**; intersex characteristics by themselves **don't imply a health problem.**

FIRST:

> *Since integrating the human rights approach to health, intersex is a term that refers to "all those situations in which an individual's sexed body varies from the cultural*

> *standards for female or male bodies" and is considered that the term intersex would be technically, socially and legally the most appropriate (IACHR, 2013).*
>
> *On the other hand, the medical term used on the basis of the 2006 Chicago Consensus, is Disorders of Sex Development (DSD) in English.*
>
> *When informing the patient or his/her representatives about this condition, especially in the first consultation, appropriate use of language should be considered. If care is not given in a specialist center, the information delivered should be general.*

It mentions that the term "intersex" would be the most appropriate based on a human rights approach, citing the definition of the Inter-American Commission on Human Rights (IACHR); then also quote the controversial term "Disorders of Sex Development" (DSD). This term has a pathological connotation because induces the idea that intersex bodies are a "disorder" and that they don't fit in the social expectation of a human body. The term DSD suggests that an intersex body is not healthy, but pathological, with congenital defects, which need to be "cured" and "corrected."

Let's review the topic from a historical viewpoint. The term DSD was coined after a consensus of a group of medical specialists that took place in Chicago in 2006. Practically since its diffusion, intersex activism groups around the world, dedicated to advocate for the human rights of intersex people of any age, noted that the term DSD represents an "appropriation" of the debate about the true purpose of surgeries in childhood (often described as a form of infant genital mutilation) in the development of the intersex individual. All in Circular No. 7 focuses on the same goal: to convince us that intersexuality is a pathology, which can bring serious problems to the health of the individual and need to be fixed. The underlying thesis of doctors defending these procedures is that a "psychosocial benefit" is provided to this child, who, once he/she becomes adult - and without the memory of the interventions to which he or she was subjected in his/her earliest childhood - will be able to fully adapt to the world. But there is a problem: to this date, this thesis lacks evidence to support it. What does exist is a growing number of voices and stories of intersex adults worldwide who bear witness to the bad and disturbing physical, psychological, and emotional consequences as a direct or indirect consequence of the surgeries and treatments to which they were subjected, and the stigma that leads to the pathologization of intersexuality.

Finally, it's mentioned that care should be taken in order to inform the patient or his/her representatives (i.e. parents or legal guardians) of their condition with a proper language. Since this is a document issued by the Ministry of Health, it is implicit that the recommendation is to use the term DSD since it is the term used in medical language by the vast majority of specialists involved (endocrinologists, urologists, etc.)

SECOND:

> *The recommendation that refers to not performing unnecessary genital surgery, does not refer to pathologies in which there is a clearly defined sex, both genetically*

> *and/or somatically, such as: cryptorchidism, isolated hypospadias, bladder malformations and exstrophies.*

This point mentions some physical conditions that do represent a medical emergency that can result in the death of the person. Intervention may result necessary. However, the case of an intersex variation known as hypospadias is also mentioned. Conveniently, this point fails to mention that in the vast majority of cases of hypospadias there is no health risk for the person, and that the risk is associated with corrective surgeries that cause irreversible damage. Surgical procedures involve multiple and very painful interventions, as we can hear in some testimonies of people who were subjected to them. Some sequel associated with surgical intervention include fistulas, stenosis, urinary tract infections, problems with the healing of manipulated tissues, among others;

THIRD:

> *In cases of people with 46XX DSD with classical congenital adrenal hyperplasia, surgeries such as clitoroplasty, uro-genital sinus surgery, and genitoplasty, should be agreed between the specialist multidisciplinary team and the family, and the opinion of the Ethics Advisory Committee following consultation, when the professionals or the patient consider it necessary. The final decision of the patient and/or the patient's representative must be supported with the signing of a specific informed consent.*

First, it should be clarified that Congenital Adrenal Hyperplasia (CAH) can cause health problems that do require medical treatment, but not in all cases, just in some. Thus, it's necessary to separate these health risks product of CAH - which may require medical treatment – from the variations in the sex characteristics of the person. A baby with karyotype 46 XX and CAH may present what doctors call "ambiguous genitalia" and/or "hypertrophic clitoris", but this characteristics doesn't necessarily represent a health risk.

The surgeries mentioned in this point –for people with 46 XX and CAH, who also were born with "ambiguous genitalia"– are not medically necessary in most cases. What is described as a "clitoroplasty" most commonly becomes a clitorodectomy, an ablation of a clitoris larger than what is interpreted to be "normal" (as arbitrarily established by the medical institution), and under no circumstances this can be considered medically necessary. Genitoplasty or vaginoplasty and the surgery of the uro-genital duct (that is, a conduit where the urethra and vagina joint), in most cases is only performed so that the person can be penetrated by a male penis, and not for medical reasons. We know from many adults with CAH that have an uro-genital duct –that is, they have not been subjected to surgeries, as is the case of one of the authors of this article– , that having this kind of genital variation doesn't necessarily represent a health problem. We still haven't met anyone with an intact body, showing these characteristics, with health problems as a result of the shape of their genitals. In the case that someone had health problems related to their genitalia –called "ambiguous"– it would be advisable to go to the doctor or gynecologist for a treatment aimed solely to restore health (obviously this can happen to anyone, it doesn't matter if such person presents “ambiguous" genitalia or not). It is not possible that this health problem is taken as an excuse to perform vaginoplasty or clitoroplasty to a person who does not request such procedures. We repeat that the intention of the vaginoplasty is that in the future, the created genital form can be penetrated by a penis. It should be noted that from a heteronormative point of view, in these "multidisciplinary and specialized medical teams", it seems to prevail the belief that it is not possible to lead a healthy and satisfying sex life for a person who has a body with "ambiguous genitalia". Such a belief is a lie. We know for sure that many adults with intact bodies lead full and satisfying sex lives. Sexuality can include very vast experiences that are not restricted to heterosexual coitus; that practice can't be generalized as the sole source of pleasure.

Genital surgeries are mainly done to attack a social problem related to experiences of discrimination produced by prejudices against having a different body. However, social problems should NEVER be approached with surgeries and scalpels, but with education and information.

It should be noted that a growing number of doctors and surgeons in the world are showing rejection to these procedures, and are producing contents such as articles or videos available online, where they talk about their opinions and experiences regarding this subject.

FOURTH:

> *Other forms of DSD/intersex, with potential for both sex assignments, should be analyzed in the same way, and the family must be clearly informed of this potentiality. Sex assignment and surgeries in these patients, such as gonadectomy and/or genital surgery, should be done by mutual agreement between parents and the multidisciplinary team; consulting the Ethics Advisory Committee, an entity that will act as a safeguard that all the options have been considered. The possibility should be explained of deferring surgery to an age where the patient may manifest or demonstrate tendencies of a sexual identity.*

Here is one of the main setbacks regarding Circular No. 18. Although the potential of sex assignment is not only an acceptable but expected function of doctors as advisors, the sex assignment should not accompanied by surgical interventions. In the previous point it is stated that gonadectomies (removal of gonads, usually - but not exclusively - testicles in cases of persons with AIS and streak gonads and ovotestes other intersex variations) and/or genital surgeries **should be carried out by agreement between parents and multidisciplinary team**. And although it is indicated that “the possibility should be explained of deferring surgery to an age where the patient may manifest or demonstrate tendencies of a sexual identity.", this point fails in three aspects:

1. It's not specific over when gonadectomies have a health-based justification. There are very specific cases where the malignancy of the cells of the gonads is considerably high but it is necessary to emphasize that the recommendations of gonadectomy are based on studies where the number of cases analyzed is very small and there's not enough long-term outcomes to make an informed decision. The risk of developing cancer in such cases is equivalent to developing prostate or breast cancer in the course of a person's life. It is evident that this risk does not represent enough argument to remove the gonads of a newborn, nor of the same way neither the incidence of cancer of prostate or breast

according to the family antecedents justify the removal of said parts of the body. Therefore, the most appropriate approach in favor of the health and physical integrity of the newborn, is to observe and evaluate periodically his/her development, not to intervene surgically or to carry out radiations and/or irreversible procedures in something that does not represent a real urgency. A gonadectomy sterilizes *ipso facto* the newborn intervened, and condemns him/her to undergo hormone replacement therapy for the rest of his/her life as the only alternative to avoid health problems at an early age (osteopenia and osteoporosis, for example). Such procedures must be carried out when there is a verifiable certainty of their need.

2. Unlike the Second Point, the document analyzed does not indicate in which cases genital surgery results to such an urgent degree that only the multidisciplinary team and the parents have a say in the decision of the interventions. Here there is a worrying ambiguity in legal terms, since the First Point clearly speaks of the "representatives of the patient", leaving room for a loose interpretation, while at this point it is specifically pointed out. This suggests that the wording of the text was thought in a traditionalist and exclusive scenario. Nor is it clear the intervention of the Ethics Committee. It's uncertain how the members of said committee would guarantee the adoption of a role of human-rights advocates of patients. Without prejudice to their age or legal status, an intersex newborn is a subject with full rights.
3. The most regrettable part is the one that speaks about explaining the **possibility** of deferring the surgery until an age in which the patient can **manifest or demonstrate tendencies of a sexual identity**. No human rights recommendation states that surgeries should be deferred based on the awareness of the sexual identity of an intersex person. Not to mention how vague results the concept of "manifesting or demonstrating tendencies of a sexual identity". Does it refer to the set of psychosocial aspects that define the identity of a person based on their sex and gender? Or is it, as it usually is, a poor understanding of the concept of gender identity? Whatever the interpretation of the Ministry is, the reason given can not be taken as a basis for deferring surgeries; Surgeries **must be deferred until the individual can have the voice and capacity to consent or deny such procedures,** in order to preserve their right to self-determination, as quoted by the CRC in their observations to the Chilean State. What the Circular, and therefore the Ministry of Health, loses sight of, is that **the prohibition of surgeries in intersex children is not justified by a topic of gender identity or "sexual identity", but by a human rights issue, namely the right of a patient to physical integrity, the right to bodily autonomy, the right to be fully informed and to have the final decision on the medical procedures intended to perform on his/her body.** On this subject, it is pertinent to recall Principle 18 of the Yogyakarta Principles, "No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed".

Nor does it escape the view that the wording of the text says "**the possibility** of differing". Circular No. 18 did not speak of a "possibility", but was emphatic in the **need** to defer surgeries. It is evident that there are only two cases, mutually excluding:

a. Where surgeries and procedures **have to be performed** because of threats to the health and life of the person.
b. Where surgeries **have no reason to be performed because there is no medical justification**, since there is no threat to the health or survival of the person; In which case it is not as if procedures "can" be deferred: **they must be deferred**.

Finally, an observation: Circular No. 7 does not specify that, **in any scenario, the patient should be entitled to health care and must be guided on options to move forward with his/her decision**. We suppose that this is because the document does not reinforce the patient's will, but the will of their doctors and their legal representatives, even though surgeries are evidently **unnecessary, irreversible and have harmful consequences for the health and well-being of the Individual in the long term**.

FIFTH:

> *When DSD/intersex is suspected in a neonate, it is recommended to defer sex assignment until an evaluation in a Reference Center takes place. Relatives should be informed of the health condition and have it clarified that the patient's reference is for a specialist diagnosis and to make an informed decision, shared between them and the experts. Children and adolescents with suspected DSD/intersex will also be referred for their care to these reference centers.*

This point is fraught with concepts that protect the violations of the human rights of intersex children, and which is directly against not only Circular No. 18, 2015, but also the CRC's own observations.

1. Here is a radically different understanding of the concept of "sex assignment." To assign a sex to a baby for registration purposes is one of the aspects protected by Circular No. 18, 2015, in the sense that, despite the prohibition of irreversible genital surgeries, the allocation of sex should be made according to the "best expectations". Although the Circular fails to suggest the possibility of a change based on the will of the individual itself (we must remember that the Circular is issued by the Ministry of Health, so its scope in the civil aspects ends after the management of birth registration).

   In the interpretation of Circular No. 7 of 2016, it is recommended to defer this assignment, with one reason: to perform the registry assignment based on a surgical intervention **not consented by the minor**, instead of simply evaluating "the best expectations", such as the previous Circular stipulated. This creates a loophole that leaves the newborn unprotected due to something that is again considered, and in a wrong way, a "health condition". With this the Circular takes for granted that **all DSD/intersex diagnoses** (using the same language as the document) represent a "pathology", which is sufficient to justify **any** type of medical procedure, including genital mutilation in children (i.e. **gonadectomies, genitoplaties, and clitorodectomies** – still euphemistically called "clitoroplasties", when the purpose of such procedure is to cut and mold the clitoris to reduce its size to something that has a socially acceptable aspect, without consideration of leaving this part of the body insensitive or with reduced tissue sensitivity)

2. On the other hand, the notion of a "Reference Center" is only a term to formalize and sanction the operation of high specialty centers with intersex clinics that already exist in the infrastructure of the Ministry of Health. The members of these centers are attributed with the title of "experts" simply because of their trajectory that includes mutilations and alterations of bodies of defenseless or poorly informed individuals (when it comes to older children or adolescents). They are, in any case, specialists in what they do, but hardly experts. There is a clear **apathy** in most of these specialists to follow-up their patients' cases whenever they are discharged by pediatrics, which is why they are **completely unaware of the complexities and multidimensional aspects of the life experience of an intersex person**. Not only in the anatomical, metabolic and clinical aspects, but, of course, **in the whole experience of someone who has to live with the consequences of a violation of their physical integrity, autonomy and self-determination**, ranging from physical to psychological. Consequences that none of these "experts" know or seem willing to acknowledge. The lack of evidence of the success they proclaim makes it really questionable to place in them any kind of trust when they assume the cases that are derived to them. **Their evidence does not extend beyond the immediate results**, in which they inform of the satisfaction and relief of the parents with their newborn after the interventions, and of their social integration in function of a shortsighted, purely clinical perspective.

3. The Circular assumes that parental consent (again, the broader term of *legal representatives* is omitted, certainly an attempt to give an emotional charge to what is an official document) is sufficient to proceed with surgical interventions and other procedures for genital normalization (this term means that such procedures seek to make the appearance of the genitals of an intersex person look more like the genitalia typical of a man or a woman, more often the latter, because it is easier to “dig a hole”, which in itself represents a very poor and discriminatory understanding of what constitutes a woman, relying solely on a socially pleasant corporality). While this is a real argument in the very specific caveats where there are health risks that threaten the life of the newborn intersex (where parents or legal guardians have full authority to consent), this **is not the vast majority of the cases,** as has been repeatedly stated (only in the diagnoses of CAH, representing a little more than 60% of the cases of intersex people, the "ambiguous" sex characteristics are not a direct cause of any pathology). But since this whole point includes any form of intersex body as a pathological body, the Circular argues that it is only sufficient that parents or guardians approve for surgeries, when a human rights-based approach would recognize the need to safeguard the right of the newborn, child or adolescent to express their opinion about their own body, and to decide, from being totally and fully informed continuously during their development in childhood about all risks and consequences of such procedures, whether or not you consent to them.

SIXTH:

> *In patients who present a surgical emergency due to complications derived from their underlying pathology, for example an obstruction or infection of the urogenital sinus, surgical procedures will be carried out to ensure the patient's physical integrity, as guaranteed by the current legal framework, and then be transferred to the relevant reference center.*

Following what was mentioned in the Third Point, it is clear that this point was included to reinforce the idea that these procedures are medically necessary, and therefore, in themselves, intersex bodies represent a pathology. But the statements of this point that say the uro-genital sinus may present obstructions or infections, are not based on clinical studies to adult bodies with these characteristics. Obviously, as already mentioned, anyone, without regard of corporality, may be vulnerable to diseases related to their genitals, but the treatment applied by doctors should only be aimed to ensure a healthy state for the patient, and not to adapt their bodies to the social norms of female or male bodies.

Contrary to what doctors might think, we know cases of many intersex people that were subjected to the surgical procedures mentioned in the Third Point - clitoroplasty, uro-genital sinus surgery and genitoplasty - [as an example, here we can read the testimony of a Chilean person who was born with HSC and "ambiguous genitalia" given to the IACHR in Washington DC], who suffer recurrent urinary and vaginal infections, pain in having sex, scars, sexual insensitivity, chronic pain, among others. Some procedures, such as vaginoplasty, often cause serious health problems; If the vaginal canal is considered to be very short, sometimes intestinal tissue is taken or a roll formed with the skin of the back or thigh in order to lengthen the vaginal canal. Then used of dilators (tubes of metal, glass or plastic of various sizes and thicknesses, generally 7 to 10 sizes) is prescribed in order to allow penetration of the vaginal canal by a penis in the future. We know of cases where these procedures are done to children and mostly to adolescents, without informed consent and without taking into account the sexual orientation the individual may have and which varies from person to person. We even know the case of 5-year old children who were subject to these procedures, where dilations sometimes were performed by doctors, nurses, or even the parents themselves, with all the psychological consequences that a situation as aberrant as this one may have. In addition to physical health consequences, some people report intestinal and digestive problems due to the removal of intestinal tissue to create or to broaden a vagina. These problems are so serious that have put their lives at risk, as can be read in this testimony, which was presented to the Mexico City Human Rights Commission (CDHDF) in Mexico City.

Generally speaking, all the aforementioned surgeries provoke psychological traumas in people subjected to them, because of the long periods of their lives spent in hospitals, because of frequent vaginal examinations since childhood, because of the taking of photographs of their body without their consent or because of being surgically assigned a gender that doesn´t match with their gender identity.

SEVENTH:

> *DSD/intersex patients will be referred for care to specialist centers that have a multidisciplinary team with experience in the integrated [i.e. multidisciplinary] management of people with DSDs. The specialist professional team will ideally consist of a pediatric urologist surgeon, an endocrinologist, a clinical geneticist, a social worker, a psychologist, a psychiatrist, a pediatric radiologist, a pediatric gynecologist and a fertility doctor. On the other hand, the establishment where this specialist attention is carried out must be supported by an Ethics Advisory Committee.*

The multidisciplinary teams mentioned here, generally act together to convince the parents to authorize the aforementioned "treatments", such as surgeries and medically unnecessary hormonal treatments, which, as we have seen in the analysis to the points above, do not aim to achieve optimal health, but to make the person conform to the binary gender norms. That is, **their purpose is to adapt the physical sex characteristics of the person, even at the expense of their health, their well-being and their physical integrity.** These surgeries and treatments are rarely offered as an option to parents, but are presented as necessary. We have found that it is common that doctors lie or retain information to parents – with the excuse of not overwhelming them with "unnecessary" information –in order for them to consent these treatments. From what we have been able to observe in the testimonies of intersex people - both from Latin America and elsewhere in the world - and in our own experience with support groups for parents, we know that on many occasions the role of the psychologist, for example, is to reinforce in an intersex child the gender that was assigned surgically. This can also be seen in an Australian survey to intersex people in 2015, entitled "Intersex: Stories and Statistics from Australia", 44% of the group reported receiving counselling/training/**pressure** from institutional practitioners (doctors**, psychologists,** etc.) on gendered behaviour.

The structure of these multidisciplinary teams neglects the inclusion of peer and parents support groups led by intersex people. It also omits information produced by intersex activists, such as parent guides, and various materials available online, and disregards the testimonies of intersex people and parents, which are also available online. Due to the irreversible nature of the medical procedures mentioned above, we firmly maintain that these resources constitute a better alternative to treat parental distress.

EIGHTH:

> *The MINSAL (Ministry of Health) will define the reference centers according to standards that ensure the quality of care.*

As mentioned in the commentary on the fifth point, these reference centers are only high-specialty hospitals with intersex clinics that have operated in the same way for decades, which is a common practice in Latin American countries. It does not innovate at all, but merely formalizes its form of work within the framework of what is specified in this Circular.

NINETH:

> *Considering the rapid changes and the advancing knowledge in these matters, updated technical guidelines will be elaborated and will be reviewed periodically, by a committee of specialists convened at ministerial level, with broad representation of the scientific societies involved in the subject.*

The problem with this paragraph is that it speaks of the elaboration of Technical Guidelines. This can be translated into the development of clinical care protocols that, following the tone of this Circular, are likely to perpetuate the approach that considers intersex variations as a pathology, integrating advances in biomedical research and surgical techniques, and incorporating psychological and social work practice only as reinforcement of the same paradigm that advocates for reinforcing through clinical practice the assignment of a sex at birth.

This approach leaves aside the need to incorporate a new way of thinking about intersex, based on human rights, and centered on the intersex person, regardless of his/her legal status or age. One of the most recurring arguments of those who defend this approach, **highly questioned by human rights activists and intersex people around the world**, is that the current techniques are better than in the past. However, the absence of long-term results to validate these arguments contrasts with the testimonies of intersex adults whose autonomy and physical integrity were violated by medical procedures not consented to by them and suggest the need to objectively question their persistence in medical practice.

TENTH:

> *This instruction establishes in each Health Service a work plan, reaffirming the need to nominate a reference person to lead the management and registration of the cases in the Health Services.*

This point formalizes, through the figure of the "reference person", what is known as "practice of medicine based on eminence", that is, the opinion of a physician with prestige and recognition of their peers is more important than the practice of medicine based on scientific evidence.

Whether the "reference person" figure is imposed merely to perpetuate the same medical approach or that is imposed by the aforementioned lack of results –**a direct consequence of the disengagement of the health services of the intersex patient when he/she is discharged from the Pediatric clinic, not only in the global south but around the world as well**- in no way justifies the blatant ignorance of the human rights of intersex people. In our view, by subscribing to this approach, the Ministry of Health exposes physicians to be subject to legal action in the future, especially as the trend, while still slow, is increasingly inclined to respect the right of an intersex person to decide on his/her body. As an example, can be consulted the article Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, which is a revision of the directives of the 2006 Chicago Consensus update. Rather than radicalizing its position, this document openly admits the necessity to adopt new approaches that are not confined to the clinical and invites to recognize a real practice that involves the recognition of human rights. The Circular 7 of 2016 not only regresses in respect to human rights but also in respect to recommendations of the international medical community itself.

CONCLUSIONS

We believe that the Circular 7 of the Ministry of Health of the Chilean State published in 2016 represents a serious setback in the human rights of intersex people. This circular eliminates any possibility of an approach focused on the well-being of the patient and reuses the same paradigm that addresses variations in sex characteristics as a pathology and as a social emergency that must be resolved through medical intervention.

The Circular 7 thus justifies the practice of procedures ranging from intervention through unnecessary and non-consensual hormonal therapies that have repeatedly resulted in serious consequences to the health of the intersex individuals, to surgeries that can be compared with procedures of forced sterilization and genital mutilation. This is almost always the case in children whose right to decide about their body is taken away, only to relieve parental and social anguish about the physical ambiguity of an intersex body in the face of the social expectation of typically male or female bodies, and responds to phobias related to sexual orientation or gender identity.

We call on the Chilean State (in all its instances, not only the Ministry of Health) to retake the case and approach it from the perspective of respect for human dignity and fundamental human rights, taking into account that Chile is a nation that is assumed as a democratic State that does not forget the darkest episodes of its recent history, and in whose vocation its inhabitants aspire to live their existence at their full, in exercise of all the freedoms and rights to which it has subscribed as a Member State of the United Nations.