Critical
Social
Policy

Original Research Article

Intersex equality, diversity and inclusion and social policy: Silences, absences, and erasures in Ireland and the UK

SURYA MONRO
University of Huddersfield, UK

SEAN SAIFA WALL
University of Huddersfield, UK

KATE WOOD
University of Huddersfield, UK

Abstract

Intersex people suffer human rights abuses and harms because of non-consensual early medical interventions. They have historically been rendered outside of welfare regimes and equality, diversity and inclusion policies, or forcibly subsumed within sex-binaried institutions. This article draws on critical intersex studies to interrogate the policy silences and collusions that have taken place regarding intersex people's suffering. Using Ireland and England as case studies, we show that current formations of equality and diversity policies are inadequate in relation to intersex issues. Analysis of policy documents from Ireland and the UK using Bacchi's method reveals the erasure and/or marginalisation of intersex people, despite some stated commitments to gender and sexual equality. We conclude that there is a pressing need for social policy work

---

Corresponding author:
Surya Monro, University of Huddersfield, UK.
Email: s.monro@hud.ac.uk

Critical Social Policy 1–20

DOI: 10.1177/02610183231175055 journals.sagepub.com/home/csp

Sage

around intersex issues and for reform to support intersex people’s equality, diversity and inclusion.

Keywords
diversity, DSD, equality, intersex, variations of sex characteristics

Introduction

Intersex people have sex characteristics such as hormones, chromosomes, genitals, and reproductive organs that are considered atypical for males and females by the medical establishment (Hart and Shakespeare-Finch, 2021). There are up to 40 variations of sex characteristics that do not fit stereotypical definitions of ‘male’ or ‘female’ sex characteristics, including Congenital Adrenal Hyperplasia, 46 XY, Gonadal Dysgenesis, 5-ARD, and 46, XX Testicular Difference of Gonadal Sex (Petersen, 2021). ‘Intersex’ as a term is contested (Griffiths, 2018) and the acronym used in medical settings, ‘DSD’ (Disorders or differences of sex development) is widely criticised by intersex people as pathologising (Carpenter, 2019; Rubin, 2017). The term ‘variations of sex characteristics’ is inclusive and increasingly used for this highly diverse group (Monro et al., 2017). The United Nations estimates that between 0.05% and 1.7% of infants are born with intersex traits (HCHR, n.d.), which is similar to the occurrence of transgender people (Goodman et al., 2019), yet intersex populations have been widely overlooked by social policy makers and practitioners.

This article contends that intersex people have been widely erased within welfare systems, policy frameworks and equality, diversity and inclusion (EDI) initiatives. Whilst the focus of the article is on EDI policies, it also foregrounds some of the broader social policy issues concerning intersex people, because of the lack of currently available literature. In terms of EDI policies, Monro et al. (2017) reported a dearth of EDI initiatives concerning intersex and variations of sex characteristics in England in 2017. The UK government launched a call for evidence about intersex in 2019 (Government Equalities Office, 2019), and intersex is included in a few UK equalities documents, for example in periodic reports to the United Nations. However, there is uncertainty about enforcement of intersex equality policies (Bauer et al., 2020) and an absence of protective legislation and initiatives due to factors such as the pathologisation of intersex, and gender binarism (Monro et al., 2019). Whilst the Republic of Ireland is a member state of the European Union and mandated by human rights frameworks that exist within, social policy does not consider intersex experiences outside of a medical context, if at all.

In this article, we use material from two case study countries chosen for their contrasting colonial, religious, and welfare contexts. We wanted to examine how intersex identities and experiences were understood in these countries, as well as their respective advancements toward intersex rights. Because the treatment of intersex is understood as a healthcare issue, briefly delving into how Ireland and England's respective healthcare systems were developed gives more insight into how these systems upheld the gender binary at the expense of intersex children and adults. Ireland's relationship to healthcare is interwoven with a legacy of colonisation, independence, and the influence of the Catholic Church. Following independence, Heavey (2019: 279) states that 'The Catholic Church filled most of the gaps in social provision, including health, education, and maintenance of the poor'. The church also shaped gender norms which would ultimately erase intersex bodies in Ireland. Ní Mhuirthile (2015: 161) argues that 'surgeons began to disappear intersex individuals from society' through surgeries that reinforced normative, binaried sex characteristics. Wren (2003: 285) notes that at the time the Catholic Church was formidable in terms of 'owning hospitals' and employing medical professionals which solidified the relationship between the church and medicine. The alliance between the church and the medics would prove to shape Irish healthcare for years to come. In post-war England, with the advent of the Beveridge Report (1942), binaried gender norms were also reinscribed via the welfare state. With the development of the NHS, urology emerged as a specialty in medicine, providing a livelihood for medics and a new field of specialism (Williams, 2003). This was shaped by gender ideologies in the 1950s that rigidly defined male and female bodies, as well as what Thane (2010: 1) describes as the period after 1945 where 'most forms of inequality—relating to age, race and ethnicity, religion, gender, sexual orientation or disability—were deep-rooted, taken-for-granted facts of British culture'. Since these surgeries were sanctioned by the NHS, intersex identity and management has become deeply entrenched in medicine and overlooked by the state.

Contemporary leads concerning intersex issues and social policy can be found in a recently published policy toolkit (Ghattas, 2019) but these are not integrated into academic discussions, nor policy interventions in most countries. Whilst Carpenter (2016: 74) argues that the disjunction between pro-equalities policy frameworks and reality is due to 'a framing of intersex issues as matters of sexual orientation and gender identity, rather than innate sex characteristics', we suggest that the erasure of intersex people is also far deeper, rooted in a sexed and gendered binary ontological system that underpins our key social institutions. Social policy as an academic discipline has colluded with this erasure; endosexist (non-intersex) assumptions such as the idea that only males and females exist are normatively embedded in the literature, even in the work of feminist and equality-focused authors such as

Bagilhole (1997, 2009). The erasure of intersex across these sectors can be seen as interphobic. Interphobia is a term used by some intersex activists such as Hida Viloria (Viloria and Nieto, 2020) in a similar way to homophobia, biphobia and transphobia. Interphobia includes not only intersex erasure, but also direct and indirect discrimination against intersex people, and social and individual fears about genital and other forms of intersex bodily diversity.

We start this article by providing some contextualisation and outlining critical intersex theory (Dreger, 1998, 1999; Holmes, 2009) which underpins our approach. The methodology is described next. Then we address the erasure of intersex in social policy as a discipline, and in equality and diversity policies, and provide a Bacchian analysis of policy documents to further drill down into the dynamics associated with intersex erasure. Finally, we explore possibilities for intersex people's equality and diversity policies.

Background

Intersex people are subjected to medical abuse despite recognition at international levels of a pressing need for reform and redress (Carpenter, 2020); the violations include '…forced and coercive medical interventions…' (Carpenter, 2020: 13). Intersex people face stigmatisation, discrimination, and hate crime (FRA, 2015; FRA, 2020; Ghattas, 2013; Suen et al., 2021). Of particular concern is the continued practice of medically unnecessary surgical procedures and coercive gender restrictive hormonal replacement therapy on babies and children with variations of sex characteristics, where outcomes are typically reported as being poor and/or damaging (Diamond and Garland, 2014). To be clear, minors who are too young to give consent are being forcibly assigned to a male or female gender that they may not identify with in later life and then subjected to procedures such as clitoral reductions, penile operations, vaginoplasties and gonadectomies to make them fit the bodily norms associated with that gender. These procedures are often severely damaging to the individual's sexuality, mental health, and physical wellbeing (Davis, 2015; Viloria and Nieto, 2020). It should be noted that on rare occasions, a medical intervention is required to save a child's life, as in the case of some congenital adrenal hyperplasia cases (Dickens, 2018). Crucially, person-centred healthcare provision is important for all intersex people and their families; this is different to the healthcare practices that currently dominate (Crocetti et al., 2020).

Bauer et al. (2020) argue that non-consensual, unnecessary, irreversible childhood intersex medical interventions form serious human rights abuses; they are harmful cultural practices comparable to FGM, torture, and degrading and inhumane treatment. Others describe some of the practices that continue to take place, such as neovaginal dilation on children, as forms of rape which has devastating long term effects for some survivors (Monro et al., 2017). At an international level, a raft of human rights proclamations by UN Committees, the Council of Europe, and other bodies – driven by the work of intersex human rights defenders - increasingly argue against genital surgery on minors too young to give consent, and other ethically problematic procedures such as coercive sterilisation, experimental treatment, and traumatising medical examinations (Carpenter, 2020, 2020a). However, whilst some national laws now exist to support intersex people's rights, notably the Malta Gender Identity, Gender Expression and Sex Characteristics Act (Carpenter, 2020), there is a yawning gap between international human rights proclamations and policies regarding intersex at national levels (Bauer et al., 2020).

Historically, intersex was recognised as a social category along with male and female and some legal rights existed in countries such as the UK (see Coke, Sheppard and Liberty Fund, 2003: 79). Subsequently, in matters related to intersex identity and gender assignment, the courts deferred to medical practitioners who dictated which bodies qualified as intersex (Reis, 2019). Surgery was introduced as a 'corrective' measure to address intersex variations and enforce the gender binary. Fausto-Sterling (2020) recognizes that a shift in the recognition of intersex people occurred during the nineteenth and early twentieth centuries when doctors were able to access technology that allowed for the 'surgical and hormonal suppression of intersexuality.' As a result, people with surgically corrected and atypical bodies were not protected by social policies because intersex people as a protected class were rendered 'nonexistent' and viewed as either male or female (Dreger, 1998). This may partly explain why there is a dearth of policy discussion about intersex, beyond human rights oriented (Carpenter, 2019, 2020) and legalistic (Garland and Travis, 2018; Horowicz, 2017) approaches.

This article draws on critical intersex studies, which stemmed from the work of Kessler and McKenna (1985), Kessler (1998), Dreger (1999), and Reis (2009).These authors contributed to a critique of the institutionalisation of sex and gender binarisms (the ideas that both biological sex and socially constructed gender, are formed of two discrete categories: male and female). Intersex scholars such as Holmes (2009), Morland (2009), and Rubin (2017) have used poststructuralist approaches to expose the hegemonic ways in which the institutions of medicine, the law, and the family erased intersex. This included framing the birth of an intersex baby as an 'emergency' and fostered silencing and shame concerning sex variance. Historically, capitalism (Hall, 1996), colonialism (Viloria and Nieto, 2020), and Western science (Rubin, 2017) demanded and fuelled discrete identity categorisation. Colonised people who had variations of sex characteristics were stigmatised and persecuted (Eckert, 2017; Viloria and Nieto, 2020), shoring up the gendered and racial hierarchies that were central to the imperial industrial project. Crucially, the power inequalities that underpin the pathologisation of intersex and its social erasure stem not only from rigid social categorisation, but also from eugenics (Petersen, 2021).

At a micro level, issues of bodily autonomy and self-determination are key to critical intersex studies. Whilst critical reflection on intersex activist agendas is part of this approach (Morland, 2009), lived experience is centrally important, reflecting the core aspects of other critical approaches, notably critical race theory and Black feminisms (Crenshaw, 1989). Drawing on the understandings of micro-macro dynamics as explicated by theorists such as Delgado and Stefanic (2017), individual endosexist acts (such as a medical team deciding that a baby should have genital surgery to make their genitals conform to the gendered expectations of their parents) act to consolidate institutionalised and cultural endosexism and interphobia. Endosexism, or the assumption that bodies are always either male or female, forms an unseen force that structures action within institutions and in wider society. Intersex people occupy widely ranging spaces along the sex and gender spectra, including male, female and non-binary (Monro et al., 2017). Gender binarist, cisgender, heterosexist, biphobic, transphobic, and patriarchal forces all shape the oppression that intersex people face, and their lack of access to basic citizenship rights (Monro et al., 2019; Crocetti et al., 2020). Also, importantly, assumptions that genitals should look a certain way can be seen as disablist (Holmes, 2008). Some intersex activists fight against the stigmatisation of variations of sex characteristics as ‘disorders’ (Karkazis, 2008). However, others argue that medicalising definitions of intersex place it within the WHO definition of disability (Carpenter, 2012), which sites intersex in the disability equalities arena and within the remit of critical disabilities studies (Crocetti et al., 2020).

Methodology

In this article, we use Bacchian policy analysis to explore the gap regarding intersex issues, policy making and EDI. A critical approach to intersex studies seeks ways to challenge the epistemic injustices experienced by intersex people, who have been misrepresented and exploited by medics and by some scholars historically (Eckert, 2017; Rubin, 2017). Methodologies that foreground intersex people’s knowledge are central to the project of epistemic justice (Darlington Statement, 2017 reviewed 2019) and this paper is therefore a collaboration between an intersex author (Wall) and two endosex authors (Monro and Wood).

The article draws on policy analysis by Wall, using the *What’s the Problem Represented to Be?* (WPR) approach developed by Bacchi (2009, 2016). The WPR approach was chosen because of how Bacchi interrogates the ‘silences’ in policy. In Question 4 of her poststructural policy analysis, she asks specifically where the silences are (Bacchi and Goodwin, 2016). This form of interrogation is useful when looking at intersex erasure from both a policy and historical standpoint because it asks how intersex identity has been erased from social consciousness and subsequently controlled by medics. Intersex erasure is predominant across policy sectors and in EDI contexts, hence the prioritisation of this aspect of Bacchi's work.

Wall purposely searched for and reviewed equality and diversity statements across sectors that included healthcare, education, law enforcement, social care and social work. The documents were located using Google search terms that specifically mentioned 'equality and diversity statements'. These institutions were chosen based on the likelihood that people with intersex variations interface with all these institutions in some capacity or another. Ultimately, eighteen policy documents were selected in both Ireland and England, with the aim of gaining insights into the situation concerning intersex people and social policy in these countries. In order to capture the depth and breadth of omissions across a range of sectors and institutions, where intersex service users are rendered invisible, we have considered both government policy documents and practice-based policies developed by a number of professional bodies or organisations. This includes key professions such as the police or social work that are working directly with intersex service users in a number of critical ways. Including institutional or professional policies is important when thinking about how such discourses are constructed and produced in and through practice. Professional policies are also developed to capture or direct the everyday practices of professionals in their fields.

Equality, diversity and inclusion

Equality policies developed after the Second World War initially addressed disability (Bagilhole, 1997) and were advanced by protest movements (see Richardson and Monro, 2012). These protest movements did not include a visible intersex component since one of the early sites of the intersex movement emerged in the United States during the 1990s, with the founding of the Intersex Society of North America by Cheryl Chase (Greenberg, 2012). At first, equal opportunities aimed to tackle inequalities in access to welfare and employment (Bagilhole, 1997). Aspects of this, such as appropriate healthcare provision, could have been useful to intersex people, but as noted above, medical institutions were moving in the opposite direction, entrenching the erasure of intersex and the assimilation of intersex people within a binary sex and gendered system. The linking of equal opportunities with diversity around 2000 acknowledged intersectionality and the possibility that different groups had varied requirements (Bagilhole, 2009). This would have been relevant to intersex people, who are a heterogenous group with many intersectional issues, for example an intersex person might be disabled, female, and young, as well as intersex. However, intersex people remained invisible at this stage and at the subsequent stage, that of equality, diversity and inclusion (EDI), an approach that leans towards an individualisation of diversity (Garg and Sangwan, 2020).

Individualistic approaches to intersex are important, given the aforementioned credence that intersex people give to issues of bodily autonomy and self-determination (Morland, 2009). The more structural stances adopted by earlier equalities policies, which looked at group-based inequalities at a systemic level (Bagilhole, 2009) are also necessary, given endemic interphobia and endosexism in social policy spheres. However, intersex people have been overlooked by structural approaches to equalities as well, and the reasons for this will be explained shortly. First, it is worth looking briefly at the rationales for equality, diversity and inclusion (EDI) policies, drawing on Bagilhole (2009): the moral case for social justice (it is fair that intersex people are treated equally), the business case (intersex people will contribute more to society if properly included) and the social cohesion case (violence and conflict are more likely in unequal societies). Whilst the first two can easily be argued as a basis of intersex equality, diversity and inclusion, the latter may be less easy to leverage, intersex people are a small minority, many or most of whom are traumatised and/or have health issues.

The equalities work of the 1970s–2000 period could well lend itself to unpacking the structural patriarchal, gender and sex-binaried underpinnings of intersex people's oppression. The core thinking, that of linking social inequalities with institutional sexism (Bagilhole, 1997), is there. However, gender equality policies from the start were concerned with women's inequality, and assumptions were made that gender related only to males and females as discrete categories. This binaried thinking continued in the work of key authors such as Bagilhole (2009). Non-binaried identities and bodies were directly erased, and the focus on issues such as women's wages and caring responsibilities, whilst important, are irrelevant to some intersex people, especially those who have been rendered disabled and unable to work due to medical abuse and who have been forcibly sterilised.

It is not just in gender equalities work and scholarship that intersex people are erased. Their invisiblisation is also present in the work of authors addressing LGBT equalities. For instance, Norris and Quilty (2021) in an Irish study of 'LGBTQI+' youth homelessness in Ireland indicate that they include intersex research participants. However, there is no evidence of this, or signs of knowledge about key issues for intersex youth, such as experience of non-consensual medical interventions and related trauma and fallout with family (Callens et al., 2021; Henningham and Jones, 2021). The attachment of the 'I' onto 'LGBT' without specific attention to intersex issues is a broader problem (Monro et al., 2017), although there is some good, effective

LGBTI policy analysis at an international level (see FRA, 2020). Also, importantly, some intersex people are also LGB and/or T (Monro et al., 2017) but little work has taken place to examine the shared equality policy agendas with endosex LGBT people.

Other areas of EDI policy analysis also usually overlook intersex people, notably disability equalities (for example, Ebuenyi et al., 2021) and children's equalities, which are more broadly underdeveloped in the EDI literature (for example Bagilhole, 1997, 2009). Thus, whilst key aspects of equality, diversity and inclusion policy work, such as social justice, tackling discrimination, and assembling legal and policy infrastructures to ensure that these are implemented are highly relevant to intersex people, they are not realised or even visible. This is due to a range of factors including sex/gender binarism and endosexism, the ongoing pathologisation of intersex (Carpenter, 2019), and the lack of substantial disruption to date of endosexism by protest groups. There is also an underlying key issue of nomenclature at play here: the term 'gender' is generally used in equalities discourse, which elides (biological) sex, so that either sex diversities are erased, or intersex people, where they are included, are mistakenly wrapped into the categories of 'transgender' or 'sexual orientation' (see Norris and Quilty, 2021).

Analysis of Irish and English policy documents

Further insight into the lack of intersex EDI initiatives can be provided by our Bacchian analysis of policy documents in Ireland and England. Needless to say, problematisations vary by policy document in both countries, and are typically based either on sector interests or by generic focus on an issue such as equality. In Ireland, several policies include intersex within the title and broad focus, for example the *National LGBTI+ Inclusion Strategy 2019–2021*[1] and the Health Service Executive *(Looking after your mental health for LGBTI+ people*[2]*)* strategy. However, there was only one policy amongst those we analysed that shows that intersex-specific concerns were part of how a problem is conceptualised: the *First Annual Report on the implementation of the Lesbian Gay Bisexual Transgender Intersex (LGBTI+) National Youth Strategy 2018–2020.*[3] Unfortunately, this strategy document misrepresents intersex issues by conflating transgender and intersex issues. It demonstrates a lack of knowledge about intersex variations and the only solution to issues that it provides focus on developing clinical guidelines around care, which fails to account for other aspects of intersex experiences. The proposals that specifically concern intersex youth only address inclusion by keeping intersex identity in the realm of medicine where it is pathologised or by placing it in relationship to transgender young people. Attaching intersex to 'LGBT' issues may be strategically useful in some contexts, and policy makers should recognise that some LGBT people are also intersex. EDI initiatives could raise awareness to address the homophobia, transphobia and biphobia that some patient groups and parents may harbour (see Davis, 2015; Viloria and Nieto, 2020). However, there are also difficulties with the 'LGBTI' acronym when no work is done on the specific issues facing intersex people (Monro et al., 2017), or where there is a failure to recognise the risks of association with LGBT issues in illiberal contexts (Rubin, 2017).

Other Irish policies, typically those with generic sector-specific foci, represent the problem from an entirely endosexist perspective. For instance, the An Garda Síochána *Equality, Diversity and Inclusion Strategy Statement and Action Plan 2020–2021* states that there is a lack of diversity in the Garda and outlines steps toward making the Garda an inclusive place to work. However, the diversity statement does not account for variations of sex characteristics. Whether known or not, there are officers with intersex variations and service users who are not accounted for, acknowledged by, or supported by this action plan. Similar deficits are found elsewhere, for example the Social Care Ireland *(Protection of Children and Vulnerable Adults Policy)* frames child abuse in such a way as to exclude intersex people. Although the proposal recognises how child abuse can manifest in different ways (physical, emotional and sexual) and even in institutional settings, there is no awareness or knowledge shown of how intersex children can be harmed in medical settings.

English policies are more endosexist and interphobic than those in Ireland, as the erasure of intersex people and issues is ubiquitous. The only exception amongst those we analysed is the Government Equalities Office *LGBT Action Plan* which does include intersex people but only in a very limited way. The framing of the problem encompasses intersex issues, asserting that despite great strides in equality advancement, people are still facing discrimination based on sexual orientation, gender identity and variations of sex characteristics. However, this representation of the problem elides the fact that no substantive progress has been made regarding intersex equality in England and that human rights violations continue (Bauer et al., 2020; Monro et al., 2017). The document shows a lack of awareness about how intersex people are impacted in society in all parts of their lives, including education, work, and personal life. As Lawrence and Taylor (2020: 595) note, the only action regarding intersex people in the plan is to gather more evidence, and 'The commitment to gather more evidence therefore manifests the forestalling of equalities, with intersex rights suspended in enduring stasis'.

It is notable that both Irish and UK policy documents dealing with EDI contain useful broader representations of generic rights issues. For instance, the British Association of Social Workers *Human Rights Policy* represents the issue as the protection of human rights for clients (vulnerable and protected classes) who are in the purview of social workers. However, by failing to recognise the harms that intersex people currently face, and by perpetuating endosexist discourses, these documents erase intersex issues. Another issue in England is that whilst the Equality Act 2010 is undoubtably important in driving equalities work (Richardson and Monro, 2012) it is deficient regarding intersex issues. In several policies that the impact of the Equality Act 2010 orients, equalities discourse and policies focus on legally protected strands, which is problematic given the lack of legal protection for intersex people (Monro et al., 2017). Several policy documents, such as the *NHS England response to the specific equality duties of the Equality Act 2010*, would potentially be very useful if the problem framing was extended to include intersex as well as the protected strands, and/or if the issues facing intersex people were specifically brought into existing protected strands. There are many other instances where the specific framing of a policy problem shuts out consideration of intersex issues, for example the National Police Chiefs Council *The Honour Based Abuse National Delivery Plan 2018–21 (England)* responds to the issue of female genital mutilation or female genital cutting (FGC). However, the issue of female genital mutilation in this document is narrowly defined as female genital mutilation, with the assumption that females are all endosex; mutilation can also be seen as taking place via the cutting of intersex genitals in medical settings (Viloria and Nieto, 2020). The exclusion of intersex issues at the problematisation stage of policies takes place at a local level as well as nationally, for example Manchester City Council's *Equality Objectives 2020* addresses diversity and inequality more broadly, but silences and marginalises intersex issues. Overall, whilst many policy documents contain frameworks or provisions that could be useful for intersex people's EDI, intersex people continue to be overlooked.

Intersex erasure in policy contexts occurs because of what Garland and Travis (2020) refer to as 'medical jurisdiction' over intersex embodiment. They argue that without intervention from the state to challenge medical authority, the law will continue to defer to medics regarding the management of intersex bodies. Because intersex embodiment exists outside of conventional notions of the male/female binary, medical providers are the 'arbiters' (Fausto-Sterling, 2020) of how sex is determined. When speaking about intersex embodiment and citizenship, Grabham (2007) asserts that intersex children are precluded from experiencing bodily autonomy if they are marked as having a body that is deemed 'abnormal'. The combination of medical intervention and silences that occur at the state level create the conditions where sex characteristics are not acknowledged as protected categories.

Key areas for intersex EDI policies

In this article we have shown how intersex people's lived experiences and the related EDI issues are erased by linguistic and institutional practices across a range of sectors and at different levels. Ghattas (2019) highlights key areas for policy reform, which include healthcare (specifically, medical violations of bodily integrity and access to appropriate healthcare), tackling discrimination and hate crime, ensuring fair access to education and employment, and supporting especially vulnerable groups such as intersex refugees and asylum seekers. Discriminatory and deficient legislation is a key issue for intersex equality, including anti-discrimination legislation, redress for harms experienced, and addressing the issue of gender registration (Ghattas, 2019; Monro et al., 2017). Our analysis of policies shows that whilst intersex issues are now visible at the broadest sense in a few policies, especially in Ireland, this is done in a shallow way that lacks any real meaning for intersex equalities and that in effect perpetuates their erasure. Whilst national legal reform in Ireland and England is required, including making intersex and variations of sex characteristics into a stand-alone protected strand (Monro et al., 2017), there are other approaches that we now indicate.

The first way to develop substantive intersex EDI policies is by considering how intersex people can be supported in a sector-specific way. Within the health sector, which is central to intersex EDI, there is a pressing need for measures to stop irreversible non-consensual medical interventions. These could be included in policy documents such as the Health Information and Quality Authority *Guidance on a Human Rights based Approach in Health and Social Care Services-Ireland,* NGO documents like the LGBT Foundations *LGBT Health Inequalities in the UK* and in EDI documents such as the Government Equalities Office *LGBT Action Plan.* At the same time, appropriate healthcare provision is very much needed for intersex people of all ages (Crocetti et al., 2020), and this could be addressed in relation to specific areas of healthcare in documents as well as more generally. For instance, the Irish Health Service Executive document, *Looking After Your Mental Health for LGBTI+ people* currently shows assumptions that LGBTI+ people share similar mental health issues, and it focuses on coming out, isolation, harassment and bullying, losing a partner or spouse, and relationships. Whilst some aspects may be useful for intersex people, it fails to demonstrate explicit understanding of intersex issues. This could change by the inclusion of directives to develop therapeutic provision for traumatised intersex people (see Ferrara and Casper, 2018), and by recognising the specific challenges that they often face, such as relationship rejection and intimacy difficulties (Frank, 2018). Further key areas for healthcare reform include the practice of late-stage terminations for foetuses with variations of sex characteristics in countries such as England, due to the framing of variations of sex characteristics as abnormalities (Monro et al., 2019).

Changes to support intersex EDI are needed in employment, such as supporting intersex people if reasonable adjustments to work are needed, preserving their privacy, and tackling discrimination (UNISON, n.d.). Reform is also needed across policy sectors. For example, in the UK at present there is a relative silence within social work around the needs of intersex service users, both in terms of policy guidance put forward by professional organisations such as the British Association of Social Workers, and in wider practice literature. Focused practice guidance (such as inclusion in the BASW Human Rights Policy for instance) could help to address the harms that minors with variations of sex characteristics are subjected to in medical settings and beyond and identify ways to protect them. This may include diversity training for professionals and education for families (Monro et al., 2017). In another example, the Ireland DEIS Plan 2017 *Delivering Equality of Opportunity in Schools* discusses the impact of disadvantage on education; it could be revised to recognise that intersex pupils face disadvantages such as interrupted education due to repeated medical interventions, experiences of sexualised medical abuse and related trauma, stigmatisation and bullying (Jones, 2016), and secrecy, shaming and isolation (Henningham and Jones, 2021). A plan of this type could also tackle the lack of basic information about intersex in the school curricula, especially in health sex education, and in biology. Lundberg et al. (2020) in a Northern European study found need for open discussions about variations of sex characteristics within curricula to raise awareness and counter isolation. It should be noted that rolling out intersex EDI will not be easy, for example Sperling (2021) in a USA-based study found that even where there were progressive discourses about LGBTQIA+ issues and supportive legislation regarding education, there were discriminatory discourses and practices in classrooms. There are many tensions in the area, such as those between parents wishing to maintain privacy around early non-consensual irreversible interventions for their children, and intersex people who support awareness-raising and reform (Monro et al., 2017). However, tensions, implementation gaps and resistances are part and parcel of equalities work (Richardson and Monro, 2012) and as with other areas, finding ways forward such as the development of equality impact assessments and monitoring will be required.

The second means of starting to develop intersex EDI work is to take a more top-down approach. This involves structural analysis, tracing the ways in which endosexism, interphobia and related problems such as gender binarism and homophobia function within institutions, and proactively developing strategies to address them. As indicated above, there are core problems, including the pathologisation of intersex and the discursive erasure of intersex via a framing of diversities concerning physical sex as issues of gender and sexual identity. Overall, a severe absence of impactful intersex EDI work allows the continued relegation of variations of sex characteristics to the medical sphere, and medics whose careers are built on specialisation and who may have an emotional attachment to the continuation of non-consensual irreversible interventions on minors (Crocetti, 2020). However, reframing intersex as primarily an EDI issue (with the inclusion of a need for appropriate healthcare as one aspect of that) could provide a basis for policy and practice change. This has been undertaken regarding other equality strands, such as race, with the term ‘diversity’ being used strategically in contexts such as higher education to align to institutional values (Ahmed, 2006). However, Ahmed (2006) showed that such attempts at reform were only effective when attached to equality and justice drives, in fact, notions of diversity’ can be used by institutions to defuse conflict and erase power dynamics (Ahmed, 2012).

Whilst there are dangers associated with the managerialist approach to EDI, such as ‘box-ticking’ and institutional resistance (Ahmed, 2012), the techniques and governance mechanisms associated with EDI could be very useful for intersex EDI. Some standard EDI tools such as consultation frameworks to include service users (Ebuenyi et al., 2021) are especially important for intersex people who have historically been shut out of service planning and delivery, but they need to be properly resourced. Intersex organisations are already leading work in some ways, and they should be supported, and capacity built as key stakeholders (Monro et al., 2017). Mainstreaming intersex EDI across services such as education, employment, refugee services, policing, sport, and the media could be supported by specialist guidance and training bolted onto existing EDI provision. In order to ensure deep change in cognitive and discursive framings of variations of sex characteristics, we advocate ‘The use of organisational change methods in developing trainings for medics and medical policy stakeholders used to operating within the ‘DSD’/pathologising and sex-binaried frameworks that have predominated within medicine for the last 60–70 years in the Intersex and Variations of Sex Characteristics field’ (Monro et al., 2017: 55).

Conclusion

In this article we have demonstrated that the erasure of intersex people and their concerns is substantiated in social policy documents in both countries. Using Bacchian analysis of eighteen policy documents from different sectors such as healthcare, social work, policing, and education, we found that intersex is included in a few policy documents in an aspirational way, more prominently in Ireland than England. However, there has been little movement in implementation, and important errors in understanding intersex issues are present, for example the conflation of intersex issues with endosex transgender people’s issues. Yawning gaps in provision exist, for instance the failure in child protection policies to address non-consensual genital operations on intersex children when discussing FGM. Legal reform is of course crucial to support the EDI of intersex people, but this is beyond the scope of this article. For social policy stakeholders more generally, there needs to be a multi-sectoral approach to intersex rights to challenge the historical and endemic erasure of intersex, with specific provisions brought in to support intersex children and their families, intersex adults, and the practitioners charged with working with them. Intersectional crossovers exist with several equalities strands, notably age (most human rights abuses happen to children), disability (many intersex people have disabilities, often iatrogenic), and gender (including female-identified intersex people who have been subjected to harmful genital surgeries and forced sterilisation). There is scope for achieving change via interventions such as training and incorporation of intersex within EDI implementation mechanisms. The development of top-down approaches that recognise and commit to addressing systemic endosexism and interphobia is also crucial, and this could inform the work of professional associations and protocols. Although EDI frameworks can be problematic and have historically excluded protection for variations of sex characteristics, there is now an opportunity for the EDI framework to effect change for intersex individuals. We acknowledge that while confronting outdated institutional norms, policies and practices can be challenging, and negotiating between the claims of different stakeholders requires effort, it is evident that policy makers and practitioners are uniquely placed to support the equality of intersex people.

The push for intersex EDI is grounded in a fundamental urgency for basic civil and human rights. Intersex equality is based on a core belief system that centers body autonomy and the preservation of bodily integrity. The need for intersex equality arises from the acknowledgement that if medical practitioners are the sole arbiters of intersex health and wellbeing, then intersex people will continue to face exclusion, stigma and marginalisation within medicine and society. Because of endosexism and interphobia, intersex people are erased which makes them vulnerable to harm from medical practitioners. This harm manifests in invasive medical interventions which can affect the physical, sexual and psychological wellbeing of an intersex individual. As argued in this paper, intersex people are also contending with societal erasure which precipitates the demand for intersex equalities work in both the Republic of Ireland and England. This erasure is historical and endemic. It is intrinsically embedded in and foundational to the gender and sex binaried development of the modern welfare state in both countries. Furthermore, social policy as a discipline has reinforced the sex and gender binary, and body-normative ontological frameworks that underpin the erasure of intersex identities and the resulting human rights abuses that they continue to face. It is not just traditional approaches to social policy that reinscribe endosexism, but also feminist approaches and the work of authors with a focus on equality, diversity and inclusion. This discursive erasure perpetuates the highly inequitable situation of intersex people. Critical intersex scholars have widely pointed to the discursive and medical erasure of intersex bodies as problematic; in this paper we shed light on the policy dynamics of endosexism, in the hope that this will fuel future debates, and policy and practice change. For readers more broadly interested in the gendered, sexed, aged, and embodied aspects of social policy, pursuing critical intersex analysis will help to unpack the discriminatory norms and institutional processes within policy arenas in the case study countries and potentially elsewhere.

Acknowledgements

This paper reflects only the views of the authors, and the agency is not responsible for any use that may be made of the information it contains.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was undertaken as part of INIA, Intersex – New Interdisciplinary Approaches' Innovative Training Network supported by a grant from the European Commission's Marie Skłodowska-Curie Actions program under grant number 859869.

Notes

1. Department of Children, Equality, Disability, Integration and Youth (2019) National LGBTI+ Inclusion Strategy 2019–2021. Available at: https://www.gov.ie/en/publication/bab0fe-launch-of-the-lgbti-inclusion-strategy-2019-2021/ (accessed 25 March 2022).
2. Health Service Executive (2020) Looking after your mental health for LGBTI+ people. Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/resources/mental-health-and-lgbti.pdf (accessed 25 March 2022).
3. Department of Children and Youth Affairs (2019) First Annual Report on the implementation of the Lesbian Gay Bisexual Transgender Intersex (LGBTI+) National Youth Strategy 2018–2020. Available at: https://www.gov.ie/en/publication/619035-first-annual-report-on-the-implementation-of-the-lgbti-national-yout/ (accessed 25 March 2022).

References

Ahmed S (2006) Doing diversity work in higher education in Australia. *Educational Philosophy and Theory* 38(6): 745–768.

Ahmed S (2012) *On Being Included: Racism and Diversity in Institutional Life*. Durham and London: Duke University Press.

Bacchi C (2009) *Analysing Policy: What's the Problem Represented to Be?* Frenchs Forest: Pearson.

Bacchi C (2016) Problematizations in health policy: Questioning how 'problems' are constituted in policies. *SAGE Open* 6(2): 1–16.

Bacchi C and Goodwin S (2016) *Poststructural Policy Analysis: A Guide to Practice*. New York: Palgrave Macmillan.

Bagilhole B (1997) *Equal Opportunities and Social Policy: Issues of Gender, Race and Disability*. London: Addison Wesley Longman.

Bagilhole B (2009) *Understanding equal opportunities and diversity: The social differentiations and intersections of inequality*. Bristol: The Policy Press.

Bauer M, Truffer D and Crocetti D (2020) Intersex human rights. *The International Journal of Human Rights* 24(6): 724–749.

Beveridge W (1942) *Social Insurance and Allied Services Report*. London: HMSO. November 1942.

Callens N, Kreukels BPC and van de Grift TC (2021) Young voices: Sexual health and transition care needs in adolescents with intersex/differences of sex development – A pilot study. *Journal of Pediatric and Adolescent Gynecology* 34(2): 176–189.

Carpenter M (2012) Intersex: Intersectionalities with disabled people. Available at: https://ihra.org.au/21214/intersex-and-disability (accessed 29 June 2021).

Carpenter M (2016) The human rights of intersex people: Addressing harmful practices and rhetoric of change. *Reproductive Health Matters* 24(47): 74–84.

Carpenter M (2019) Joint Statement on the International Classification of Diseases 11. Available at: https://ihra.org.au/35299/joint-statement-icd-11/ (accessed 29 March 2022).

Carpenter M (2020) The OHCR background note on human rights violations against intersex people. *Sexual and Reproductive Health Matters* 28(1): 13–16.

Carpenter M (2020a) Intersex human rights, sexual orientation, gender identity, sex characteristics and the yogyakarta principles plus 10. *Culture, Health and Sexuality* 23(4): 516–532.

Coke E and Sheppard S, and Liberty Fund (2003) *The Selected Writings and Speeches of Sir Edward Coke*. Indianapolis: Liberty Fund.

Crenshaw K (1989) Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum* 1(8): 139–167.

Crocetti D, Monro S, Vecchietti V, et al. (2020) Towards an agency-based model of intersex, variations of sex characteristics (VSC) and DSD/DSD health. *Culture, Health and Sexuality* 23(4): 500–515.

Davis G (2015) *Contesting Intersex: The Dubious Diagnosis*. New York: New York University Press.

Delgado R and Stefanic J (2017) *Critical Race Theory: An Introduction*. New York: New York University Press.

Diamond M and Garland J (2014) Evidence regarding cosmetic and medically unnecessary surgery on infants. *Journal of Pediatric Urology* 10(1): 2–6.

Dickens B (2018) Management of intersex newborns: Legal and ethical developments. *International Journal of Gynecology and Obstetrics* 143(2): 255–259.

Dreger AD (1998) *Hermaphrodites and the Medical Invention of Sex*. Cambridge: Harvard University Press.

Dreger AD (1999) *Intersex in the Age of Ethics. Hagerstown*. Maryland: University Publishing Group.

Ebuenyi ID, Smith EM, Munthali A, et al. (2021) Exploring equity and inclusion in Malawi's national disability mainstreaming strategy and implementation plan. *International Journal for Equity in Health* 20: 1–8.

Eckert L (2017) *Intersexualization: The Clinic and the Colony*. New York: Routledge.

Fausto-Sterling A (2020) *Sexing the Body: Gender Politics and the Construction of Sexuality.* New York: Basic Books.

Ferrara M and Casper MJ (2018) Genital alteration and intersex: A critical analysis. *Current Sexual Health Reports* 10: 1–6.

FRA (2015) The Fundamental Rights Situation of Intersex People. Report, FRA-European Union Agency for Fundamental Rights, Austria, April.

FRA (2020) EU-LGBTI II: A Long Way to go for LGBTI Equality. Report, FRA-European Union Agency for Fundamental Rights. Austria, May.

Frank SE (2018) Intersex and intimacy: Presenting concerns about dating and intimate relationships. *Sexuality and Culture* 22: 127–147.

Garg S and Sangwan S (2020) Literature review on diversity and inclusion in the workplace, 2010–2017. *Vision* 25(1): 12–22.

Garland F and Travis M (2018) Legislating intersex equality: Building the resilience of intersex people through law. *Legal Studies* 38: 587–606.

Garland F and Travis M (2020) Making the state responsible: Intersex embodiment, medical jurisdiction, and state responsibility. *Journal of Law and Society* 47(2): 298–324.

Ghattas D (2013) *Human Rights between the Sexes: A Preliminary Study on the Life Situations of Inter* Individuals*. Berlin: Heinrich-Boll-Stiftung.

Ghattas D (2019) Protecting Intersex People in Europe: A Toolkit for Law and Policymakers. Available at: https://oiieurope.org/wp-content/uploads/2019/05/Protecting_intersex_in_Europe_toolkit.pdf (accessed 12 May 2021).

Goodman M, Adams N, Corneil T, et al. (2019) Size and distribution of transgender and gender nonconforming populations: A narrative review. *Endocrinology and Metabolism Clinics of North America* 48(2): 303–321.

Government Equalities Office (2019) Government calls for evidence on people who have variations in sex characteristics. Available at: https://www.gov.uk/government/news/government-calls-for-evidence-on-people-who-have-variations-in-sex-characteristics (accessed 16 February 2022).

Grabham E (2007) Citizen bodies, intersex citizenship. *Sexualities* 10(1): 29–48.

Greenberg JA (2012) *Intersexuality and the Law: Why Sex Matters*. New York: New York University Press.

Griffiths DA (2018) Diagnosing sex: Intersex surgery and 'sex change' in Britain 1930-1955. *Sexualities* 21(3): 476–495.

Hall DE (1996) BI-Introduction II: Epistemologies of the fence. In: Hall DE and Prammaggiore M (eds) *RePresenting Bisexualities: Subjects and Cultures of Fluid Desire*. New York: New York University Press, pp. 9–16.

Hart B and Shakespeare-Finch J (2021) Intersex lived experience: trauma and post-traumatic growth in narratives. *Psychology and Sexuality*. 13(4): 912–930. DOI: 10.1080/19419899.2021.1938189.

HCHR (n.d.) Fact sheet: Intersex. Available at: https://unfe.org/system/unfe-65-Intersex_Factsheet_ENGLISH.pdf (accessed 30 March 2022).

Heavey P (2019) The Irish healthcare system: A morality tale. *Cambridge Quarterly of Healthcare Ethics* 28(2): 276–302.

Henningham M and Jones T (2021) Intersex students, sex-based relational learning and isolation. *Sex Education* 21(5): 600–613.

Holmes MM (2008) Mind the gaps: Intersex and the (Re-productive) spaces in disability studies and bioethics. *Journal of Bioethical Enquiry* 5: 169–181.

Holmes MM (2009) *Critical Intersex*. Farnham, Burlington: Ashgate.

Horowicz EM (2017) Intersex children: Who are we really treating? *Medical Law International* 17(3): 183–218.

Jones T (2016) The needs of students with intersex variations. *Sex Education* 16(6): 602–618.

Karkazis K (2008) *Fixing Sex: Intersex, Medical Authority, and Lived Experience*. Durham, North Carolina: Duke University Press.

Kessler SJ (1998) *Lessons from the Intersexed*. New Brunswick, New Jersey: Rutgers University Press.

Kessler SJ and McKenna W (1985) *Gender: An Ethnomethodological Approach*. Chicago: University of Chicago Press.

Lawrence M and Taylor Y (2020) The UK government LGBT action plan: Discourses of progress, enduring stasis, and LGBTQI+ lives 'getting better'. *Critical Social Policy* 40(4): 586–607.

Lundberg T, Roen K, Kraft C, et al. (2020) How young people talk about their variations in sex characteristics: Making the topic of intersex talkable via sex education. *Sex Education* 21(5): 552–567.

Monro S, Crocetti D and Yeadon-Lee T (2019) Intersex/variations of sex characteristics and DSD citizenship in the UK, Italy and Switzerland. *Journal of Citizenship Studies* 23(8): 780–797.

Monro S, Crocetti D, Yeadon-Lee T, et al. (2017) *Intersex, Variations of Sex Characteristics, and DSD: The Need for Change*. Huddersfield: University of Huddersfield Press.

Morland I (2009) What can queer theory do for intersex? *GLQ: A Journal of Lesbian and Gay Studies* 15(2): 285–312.

Ní Mhuirthile T (2015) Building bodies: A legal history of intersex in Ireland. In: Redmond J and Luddy M (eds) *Sexual Politics in Modern Ireland*. Dublin: Irish Academic Press, pp. 154–172.

Norris M and Quilty A (2021) Unreal, unsheltered, unseen, unrecorded: The multiple invisibilities of LGBTQI+ homeless youth. *Critical Social Policy* 41(3): 468–490.

Petersen JK (2021) *A Comprehensive Guide to Intersex*. London: Jessica Kingsley Publishers.

Reis E (2009) *Bodies in Doubt: An American History of Intersex*. Baltimore: John Hopkins University Press.

Reis E (2019) Did bioethics matter? A history of autonomy, consent, and intersex genital surgery. *Medical Law Review* 27(4): 658–674.

Richardson D and Monro S (2012) *Sexuality, Equality and Diversity*. Basingstoke: Palgrave MacMillan.

Rubin DA (2017) *Intersex Matters: Biomedical Embodiment, Gender Recognition, and Transnational Activism*. Albany, NY: SUNY Press.

Sperling J (2021) Comprehensive sexual health education and intersex (in)visibility: An ethnographic exploration inside a California high school classroom. *Sex Education* 21(5): 584–599.

Suen YT, Chan RCH and Badgett MVL (2021) The experiences of sexual and gender minorities in employment: Evidence from a large-scale survey of lesbian, gay, bisexual, transgender and intersex people in China. *The China Quarterly (London)* 245: 142–164.

Thane P (2010) Introduction. In: Thane P (eds) *Unequal Britain: Equalities in Britain Since 1945*. London: Continuum International Publishing Group Ltd, p. 1.

UNISON (n.d.) UNISON working for Intersex Equality. Available at: https://www.unison.org.uk/content/uploads/2016/12/Intersex-equality.pdf (accessed 8th September 2022).

Viloria H and Nieto M (2020) *The Spectrum of Sex: The Science of Male, Female, and Intersex*. London: Jessica Kingsley Publications.

Williams D (2003) The history of paediatric urology: Personal recollections 1948–1978. *BJU International* 92: 1–3.

Wren M (2003) *Unhealthy State: Anatomy of a Sick Society*. Dublin: New Island Books.

Author biographies

Surya Monro is a Professor in Sociology and Social Policy based at the University of Huddersfield, UK. Surya publishes in the fields of gender and sexuality, and she leads the Intersex: New Interdisciplinary Approaches (INIA) project in collaboration with intersex activists and academics. Her publications include Gender Politics: Citizenship, Activism, and Sexual Diversity (Pluto Press 2005) and Bisexuality (Palgrave MacMillan, 2015).

Sean Saifa Wall (he/him/his) is a Black queer intersex activist and rising scholar. Born and raised in New York, Saifa attended Williams College where he received a Mellon Mays Undergraduate fellowship to research topics such as The Social Origins of Hip Hop and Black middle-class gentrification in Harlem. Since graduating from Williams, he has worked on a number of research projects that amplify the voices of queer, transgender and people of colour populations. Currently, Saifa is a Marie Skłowdoska-Curie fellow at the University of Huddersfield in England examining the erasure of intersex people from social policy in Ireland and England.

Kate Wood is a Senior Lecturer in Social Work based at the University of Huddersfield, UK. She is a registered social worker, and her research focuses on gender, sexuality, and institutional practices. Recent publications have explored sex work, adoption and fostering, and family.

Address: 2/18 Ramsden Building, University of Huddersfield, Queensgate, HD13DH.
Email: kate.wood@hud.ac.uk