

I thank the Conference organisation for the opportunity to talk about the Standards of Care and their relation to Human Rights. My discussion will be focusing on a human rights approach of trans health care and touch upon some of the previous topics.

On me, I am Vreer verkerke, and I lost my gender ages ago, living a multi gendered life now. I loosely identify as a “trans man born in the wrong body”.

## NIHIL

This “Nihil nobis sine nobis”, nothing about us without us, is of ultimate importance in health care. And strangely enough where most health care gets more and more care user oriented, in trans health care an enormous resistance is felt against this.

The slogan was first used in the dis\_ability movement. Dis\_abled people use a social model of understanding that posits the source of the problems not in the individual and their limitations, but in a society that is not open for people with different abilities. The talk about “ableism” as the system. As with homo/bi-sexuality, it appears true that the biggest problems for trans people are lack of acceptance by the outside world and an unjustified mental health diagnosis.

## RIGHTS

Trans\* people, as everyone, have a right to health. And as a definition we use the WHO definition of Health: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

The Covenant on Economic, Social and Cultural Rights informs us on the definition of the *right* to health: “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” A right that many times is not realised. Contrary to many state and medical practices, the Standards of Care are on the road to compliance, but they still need improvement.

Human rights apply to everyone, but are mostly focused on what a State Party to a covenant or treaty is required to do. In your case, as in majority medical professionals, requirements come mostly by the ministry of health. Through policy decisions you get certain obligations. That may or may not be in accordance with human rights. And there you also have a task, to see if your work is always human rights compliant. In 34 European countries it is not.

## IRE

In its evaluation of Germany, the International Committee of the ESCR Covenant in 2011 concluded this: “The Committee notes with concern that transsexual and inter-sexed persons are often considered to be persons with mental illness and that the State party's policies, legislative or otherwise, have led to discrimination against these persons as well as to violations of their sexual and reproductive health rights. (art. 12, 2.2)” The importance of this concluding observation of a human rights body – the committee that oversees the implementation of the Economic,

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Social and Cultural Rights Treaty, is that the mental health diagnosis (“gender dysphoria”) that the SOC still require, must be thrown out. Re-branding it “gender incongruence” does not help. Keeping it raises the ire of human rights advocates and may amount to cruel or unusual treatment and therefore to a violation of the Convention against Torture. In general work related human rights awareness with medical professionals is not very high. Ethics is, but without being informed by human rights, ethics may stay a bit meagre and individualistic.

## YOGYAKARTA

Since I work for and with Principle 17, here the Yogyakarta Principles definition on the right to health. Yogyakarta Principles are the application of existing human rights legislation (not just discourse) on the theme of sexual orientation and gender identity. And this is another example of human rights argumentation. “Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity. Sexual and reproductive health is a fundamental aspect of this right.”

Care users must be taken as the mentally and emotionally capable people that we are. We need standard respect, as every care user in other circumstances. We are, until we are officially not capable to (officially discapacitated, but given the ex-Soviet region's politics, that is not enough on an international level either). The Standards of Care should be improved in this. So that is another human rights argument to change the protocols. Happily, by the January 19, 2015, statement, WPATH is now very clear that Legal Gender Recognition with requirements should be changed into a simple administrative procedure.

State parties look at you first, since trans\* people are still seen as having mental health issues, and thus not able to decide for themselves. So, advocate with us. Not for us. Remember? “Nihil nobis sine nobis!” Practices where you play together with the state, without involving the trans\* movement, are bad practice and need to be shunned. Unfortunately my home country gives a bad example in this. The Amsterdam Gender Team did not tell the Ministry of justice they were not ready to work without us.

I want to expand a bit on that from also a point of logic. Because, if someone is able to change their legal gender and then apply for medical assistance in getting their body aligned with their mental image, there is the situation that the state, the official authority on people's legal identities, already recognised someone's gender. Anything more than an assessment if someone is not seriously and intervention inhibiting mentally ill is absolutely out of place. And this assessment of course takes place, only when someone wants to enter treatment and is not to establish someone's “gender dysphoria”.

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## **Beyond**

So what should be the line of next version of the Standards of Care?

We need emancipation, not medicalisation. And there is roughly a reverse square relation between those two. A revamped edition of the Standards must centre around emancipation, empowerment. Because “*what bridged the gap between the norm and the need was the movement.*” Just as with the disappearance of homosexuality from the DSM. Thanks to emancipation of the gays and lesbians (bisexuals were unheard of), researchers started to understand they may have been looking in the wrong place for understanding. Diversity doesn't equal disorder.

This is a rights question: take people for who they are, and don't explain strange phenomena away by pathologising them. We are people with needs first. Not patients. As people we have rights, to be treated with respect. And to get the right medical interventions: according to our needs, not according to pre-existing, often unilinear treatment expectations.

### **NEED**

A mental health diagnosis that states we have “gender dysphoria” is not needed either. A good informed consent procedure renders regret to statistically insignificant. There is evidence supporting this: Radix and Eisfeld showed last year, that in a population of more than 1,700 care users in New York - that need no gender dysphoria diagnosis but only informed consent – in a period of two years, there are zero individuals that withdrew for reasons of regret. So we can eliminate that fear. We need Full Prior Informed Consent procedures.

### **NEGATIVITY**

Many of us do suffer from trans-negativity. That gives us shiploads of depression and anxiety or other mental health issues. If gender dysphoria exists, then the diagnosis is applied to the wrong group. You need to diagnose the cisgender society with gender dysphoria. We bear the consequences of their trans misogyny. Because of the social constructedness of gender and our feelings, we demand access to medical and psychological assistance because of our complaints, our issues, our needs. In the eyes of too many professionals, there is something wrong with us and the stress would relate to something essential. To most of you it is difficult to understand we are part of a bigger gender diversity than just man/woman, that these are just two (often enforced, coerced) identities in a cloud of possibilities.

As for surgery requirements: of course you have the right to check if the care user presenting themselves is convinced and knows what they ask for, what are the consequences etc. But for that you don't need a referral letter, stating one's “real life experience” and

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previous hormone usage. That is pretty patronising.

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## **CONSENT**

Let me use the last minutes of my time to comment on the Standards' Informed Consent model. Informed consent is great and that is what WPATH agrees upon. But the way it is conceptualised and carried out is not good enough, not respectful enough to the care users' interests. Because a list of do's, don'ts and a talk about the responsibilities of the care user, ending in a signed letter, is a rather meagre approach of informed consent.

The reaction of the treating psychologists and doctors to doubts or strong emotions are often “Shall we then reduce the dosage of your hormones?” I would say “How dare you!”. The STP Campaign labels the improved version an “informed decision approach”, in which the focus is not the treatment but the well being of the trans person seeking health care. Sometimes the question is for more information, or an exchange in which the precise medication or the way surgery is done, are the topic. Or the interplay of trans-negativity outside with previous experiences, with sensitivities enhanced by the process of physical and social changes. This requires support – sometimes just attention. I think for the psychologists it will be also nicer, since they don't have the role of an “inspection psychologist” but can give real support to their client.

## **DESIST?**

Last but not least I want to spend a few words on Gender Incongruence in Childhood diagnosis in the coming ICD. Which also touches on the way the SOC deal with it.

Do not focus any longer on persistence versus desistance. That is a false binary. We know there are more than just two sexes. Fausto-Sterling is the best known advocate for this, or read Claire Ainsworth's article in Nature last month. This majority of “desisting” youth may identify as ambiguous, genderqueer. Just not 'strictly' transgender. Yeah? So? They still form part of the growing non-hetero, non-cisgender world. Or they may be “Straight but not narrow”. For me, the important is that they don't end up in the fucked up world of cis-hetero-normativity with all its prejudice and fears for diversity. I cordially invite you as well to join the rainbow world. We got colourful cookies and lemonade ;)

Your sometimes invaluable medical assistance can be a great way to help people find the strength to live a fulfilling life. But we do not need it by default. So when asked by the state party for “what should we do, how should we arrange the availability of help for this patient group”, check in with us, refer to us, or shut up. Don't act on your own, you are not the experts to talk about our lives. Also when a new edition of a medical classification or text book is being worked on: check with the trans organisations. And listen to them. Don't dismiss their wishes for extraneous. As you have rights, so have we. And our rights are not less than yours. With this as a guideline, I trust the SOC 7.x will become way closer to truly serving trans\* people's interests.

Notes to self:

Persistence or desistence and the many sexes.

SOC talks about gender non conformity and genderqueer. But still form the idea there is male and female as natural absolutes instead of historically and socially constructed genders that in the western world are to eliminate all deviance (have done so literally in the past).

(Persistence pre-adol 12-27%; adol. Much higher). Sex ratios preadol 6:1/3:1 boys; adol more equal. In Westworld

SOC doesn't mention childplay etc. Only DSM/ICD do

If they are so troubled they need professional assistance, it is support how to deal with their turbulent feelings and possibly how to deal with their social world that may not understand them, think them to be too young to know and decide for themselves. A psychological or medical diagnosis is not the only way to document pre-existing gender trouble. There will – surely in these digital times – be photographs, stories, video clips, stories from school or after school social environment. As a rule of thumb I would say: the child will tell you themselves and parents, school, church, whatever will corroborate these stories. This is also the interest of the child. Doing nothing is not a neutral and harmless approach.