

Submission on Depathologising Gender Diversity in New Zealand

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New Zealand's health system is failing to respond to the needs of gender diverse populations. Gender diverse people have a right to the highest attainable standard of health (Yogyakarta Principle 17).

Key Human Rights Issues

1. Gender diversity is pathologised: when a gender diverse person seeks medical support (which may or may not be specifically related to a gender transition) they are treated as having a problem or pathology.

In most cases, in order to access healthcare or medical support, a person must be "diagnosed" with the clinical disorder most recently called "Gender Dysphoria" in the Diagnostic and Statistics Manual V (DSM V).

This is incompatible with current international research and practice relating to gender diversity, for example, the World Professional Association of Transgender Health released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative." The current Standards of Care produced by WPATH clearly state: "being transsexual, transgender, or gender non-conforming is a matter of diversity, not pathology" (Standards of Care Version 7 page 168).

2. Gender diverse people are required to undergo medical procedures in order to acquire legal recognition of their gender identity.

Principle 3 of the Yogyakarta Principles states, "no-one should be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity". New Zealand law in relation to amending sex details on a birth certificate is in breach of this requirement.

The requirement that gender diverse people undergo medical procedures in order to change the sex on their birth certificate is further exacerbated by the lack of adequate healthcare being provided. It is also inconsistent with New Zealand passport policy, which enables citizens to identify their own sex as "M," "F," or "X" without medical intervention.

3. When healthcare is provided it is inconsistent, discriminatory, and often of a low quality with inflexible treatment pathways.

Healthcare is not currently accessible to gender diverse people. When it is provided, it often does not meet international standards of care. Discrimination, in the forms of transphobia, homophobia, biphobia, and cisnormativity, is common when accessing health services.

The pathologising of gender diversity relates to discrimination, specifically cisnormativity (the assumption that being cisgender – not transgender – is superior and being gender diverse is abnormal or unnatural). It also relates to inflexible treatment paths, because treating gender diversity as a pathology reduces the complexity of lived experience and disempowers those accessing services.

Yogyakarta Principle 17 asserts that states shall “facilitate access by those seeking body modifications related to gender reassignment to competent, non-discriminatory treatment, care and support.” New Zealand does not meet this standard.

Recommendations

1. Depathologise gender diversity: Use Informed Consent

All medical professionals need to be trained and resourced to stop pathologising gender diverse people and start using an informed consent approach instead.

Yogyakarta Principle 17 specifically requires that “all persons are informed and empowered to make their own decisions regarding medical treatment and care, on the basis of genuinely informed consent, without discrimination on the basis of sexual orientation or gender identity.”

This standard is not met in New Zealand currently. Utilizing an informed consent model of healthcare, rather than a pathologising treatment path, would greatly increase access and quality of healthcare for gender diverse populations in New Zealand.

2. Remove any requirement to undergo medical procedures in order to acquire legal recognition of gender identity.

Specifically, amend the provisions of Section 28 of the Births, Deaths, Marriages, and Relationships Registration Act 1995 to remove any requirement to undergo medical or surgical procedures, including those that may result in sterilisation, and enable a gender diverse adult to amend the sex details on a birth certificate based solely on their self-identified gender identity.

3. Provide training and resources for health professionals about gender diversity, and provide information and resources for communities and individuals about accessing healthcare as a gender diverse person.

3.1 Specifically update the resource called “Gender Reassignment Health Services for Trans People Within New Zealand” (CMDHB 2011).

There are no national guidelines about providing respectful and sensitive care for gender diverse people but there is the single resource developed by a Counties Manakau District Health Board (CMDHB) working group. This resource is due for revision in 2014. It is already inaccurate and misleading because it relies on WPATH Standards of Care that are now out of date, which reinforce the pathologising of gender diversity. This resource must be updated to reflect an informed consent approach to healthcare.

Updating the CMDHB resource should be based upon the community feedback that was collected and summarised in 2011 on the following principles: Access, Safety, Wellbeing, Respect, and Diversity.

4. Five Key Principles for Depathologising Gender Diversity: increasing access to healthcare should be based upon an informed consent.

The following key principles offer useful guidelines for the provision of healthcare to gender diverse populations in New Zealand.

For example, these principles should underpin the updating of the CMDHB resource “Gender Reassignment Health Services for Trans People Within New Zealand” (2011).

These principles are the result of consultation with gender diverse communities in New Zealand, in 2011. (“Trans Community Feedback” compiled in February 2011 in response to the first release of the CMDHB resource.) They are outlined below in order to provide a clearer understanding of the issues relating to depathologising gender diversity in New Zealand.

1. **Access:** Trans and gender diverse people lack sufficient access to medical services. An example is an outdated requirement that people must have “real life experience” (living in their preferred gender for a certain amount of time without medical support) or a certain amount of therapy/counselling in order to access medical support like hormones or surgeries. Real Life Experience (RLE) is often dangerous for the person in question. Also, in some cases, a medical professional may misunderstand their role in this situation and believe they need to “evaluate” or “assess” the person’s gender presentation. This often results in sexist or inappropriate commentary on their appearance or behaviour. Requiring gender diverse people to access counselling or therapy is problematic because while it may

be desirable, it is not always available. There are significant financial barriers for many people in trying to access mental health support like counselling or therapy. Using an informed consent model (with a central focus on access) means being flexible about these kinds of requirements, and empowering the person as much as possible to find good support systems without making this yet another barrier to healthcare. It also means that GPs need to be encouraged to take responsibility for facilitating access to other specialist services, because GPs are often the first point of contact.

2. **Safety:** The safety of trans and gender diverse people is of paramount importance and should be considered in relation to all aspects of this resource. So in regards to the example above, RLE (Real Life Experience) can be dangerous for a trans person because the public world is not trans-friendly and we face discrimination and violence when we adopt a gender presentation that people around us do not appreciate or understand. Because of this, in some cases RLE will be inappropriate. On a similar level, because of general ignorance about trans or transgender identities, part of our safety involves confidentiality and respectful engagement. The option to change names and gender markers (without changing NHS number) is an example of best practice in this area.
3. **Wellbeing:** The wellbeing of trans and gender diverse people should be at the centre of this resource, and the focus of all medical interventions. This involves recognising that everyone is different and it is necessary to listen to each of us individually about what we need and how we identify our genders. Our wellbeing is important at every stage of life, and this resource should reflect the need for ongoing care as well as initial transition-related medical support. Just as with other populations, trans and gender diverse people have everyday health needs, in addition to whatever particular needs we have because of our particular treatment path. A wellness model focuses on the wellbeing of the person, and the support that they have from people around them (medical professionals, family, friends, workmates, schoolmates, teachers, employers etc) instead of concentrating on requiring trans people to fulfil criteria for a diagnosis. This involves asking questions in a respectful manner, rather than making assumptions about our situation, sense of self, or medical needs.
4. **Respect:** The best authority on a person is the person themselves. A person should not feel that they are being asked to tell a certain story, fulfil certain criteria, or “succeed” as whatever gender they know that they are, when accessing medical support. Respectful questions are welcome; keeping in mind that it is not the person’s responsibility to educate their medical service providers and that there is a lot of research that can be done (online or through networks of medical

professionals) without requiring the gender diverse person to provide information as part of educating their health professionals. In some cases a medical professional may need to tell the patient “I don’t know enough about this, I’m going to do some research and get back to you next week.” Throughout the interactions between medical professionals and trans people, it should be clear that the best authority on what it means for this person to be who they are is the person themselves.

5. **Diversity:** There are many different ways of being gender diverse (some common identities in New Zealand include trans, transgender, transsexual, genderqueer, whakawahine, tangata ira tane, fa’afafine, fakaleiti, vakasalewalewa, mahu, palopa, and many others). This resource must attempt to provide multiple pathways of care for this diverse population, so that medical professionals are aware of the need for flexibility. The best approach will be determined on an individual basis through conversation and negotiation with the person in question. Because there is a general lack of information in the public world about what it means to be gender diverse, it is important to remind medical professionals not to make assumptions about how a person will identify or what support they will need based on previous interactions with other gender diverse people. Similarly, it is good to be clear that gender and sexuality, while somewhat overlapping and related, are distinct, and trans people can be straight, bisexual, lesbian, gay, queer, asexual, or any other category of sexuality. Being heterosexual must not be a requirement for accessing medical support. On a related level, there are many gender identities that are not gender normative, such as genderqueer, and this resource needs to facilitate understanding between medical professionals and genderqueer people. Conversations about informed consent will involve ascertaining what kind of support this person requires and what the best treatment pathway will be for them.