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Health4LGBTI Training

Reducing health inequalities experienced by LGBTI people: what is your role as a health professional?

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REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE

Trans & Intersex Health

Module 4

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MAIN CONTENTS

1) Myths on trans and intersex people

2) Trans health

3) Intersex health

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Module 4: Learning objectives

After this module, participants will:

- ✓ Have a greater awareness and improved knowledge of concepts in the field of gender identity and sex characteristics;
- ✓ Be more familiar with the health needs of trans and intersex people;
- ✓ Be aware of the standard of care and human rights of trans and intersex people.

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Background information

The Assembly calls on member States to (...) provide information and training to education professionals, law-enforcement officers and health-service professionals, including psychologists, psychiatrists and general practitioners, with regard to the rights and specific needs of transgender people, with a special focus on the requirement to respect their privacy and dignity.

Council of Europe, Parliamentary Assembly, 2015

National and international medical classifications which pathologise variations in sex characteristics should be reviewed with a view to eliminating obstacles to the effective enjoyment, by intersex persons, of human rights, including the right to the highest attainable standard of health.

Council of Europe, Commissioner for Human Rights, 2015

Please remember this is a confidential space!

Activity 1: "To deconstruct myths"

20 minutes

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“All trans people need psychiatric assessment”

What is your opinion?
Share it with the group, and listen to other’s thoughts.

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"Intersex children should undergo cosmetic surgeries to avoid discrimination"

What is your opinion?

Share it with the group, and listen to other's thoughts.

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Teaching segment

Trans & Intersex health

An overview

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Inequalities within healthcare services

- Trans people experience significant health inequalities with healthcare services and providers
- Research reported negative interactions with health professionals
- Regardless of the setting, trans people feel they have to educate healthcare providers
- 19% of trans people say they were discriminated against by healthcare personnel in the last year (FRA, 2014).

Inequalities within healthcare services

Trans people were more likely to:

- have difficulties in gaining access to healthcare (TGEU, 2017);
- have to change a specialist on account of their negative reaction;
- receive unequal treatment when dealing with medical staff;
- forgo treatment for fear of discrimination;
- have specific needs ignored or inappropriate curiosity;
- feel pressure or being forced to undergo any medical or psychological test (FRA, 2014).

- Increased openness to medical staff/healthcare personnel is linked to more negative experiences and increased discrimination (FRA, 2014).

Inequalities within healthcare services

- Stigma, social exclusion, isolation and transphobia have a negative impact and may cause dropouts
- Trans friendly and inclusive treatment is related to positive treatment outcomes
- Research supports the requirement for training to educate healthcare practitioners, to challenge prejudice in practice settings, and to increase knowledge and competence on trans specific health needs.

(Lyons et al., 2015; FRA, 2014)

Well-being and mental health

- Research undertaken globally indicates considerably higher rates of mental distress amongst trans people, related to stressors such as discrimination, stigma, violence (Zeeman, 2017)

- Including:
  - Higher rates of depression and anxiety;
  - Significantly increased levels of suicidal ideation and suicide attempts;
  - Substance misuse.

- Impact of transitioning (Budge et al., 2013; Bailey et al., 2014)

Questions and comments?

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Gatekeeping and diagnoses

Historical note

- Gatekeeping is the practice of imposing requirements which control access to resources for trans people.
- It can be a challenge for both providers and patients (Bess & Stabb, 2009; Pinto & Moleiro, 2015)

"[Historically], the gatekeepers' job was to sort out the "true" transsexuals (who would be allowed to fully transition) from all other trans people (who would be denied any medical intervention other than psychotherapy)."

Julia Serano, 2007

Gatekeeping and diagnoses

Historical note

1975 "trans-sexualism" (sic) included for the first time in the ICD

1980 "transsexualism" appeared in the third edition of the DSM

Since their first appearances, these diagnostic classifications have changed various times, and - although the distress about one's assigned sex has remained the core feature of the diagnosis -, new diagnoses were mostly used as if they were identical with the initial diagnosis of transsexualism – which was often used as little else than a search for the "true transsexual". (Cohen-Kettenis & Pfafflin, 2010)

Gatekeeping and diagnoses

World Professional Association for Transgender Health, WPATH, 2011

- **Gender nonconformity** refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex;

- **Gender dysphoria** refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics);

Gatekeeping and diagnoses

"A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity."

WPATH, 2011

- Only some gender nonconforming people experience gender dysphoria at some point in their lives;
- Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights;

Gatekeeping and diagnoses

WMA, 2015

"The WMA [World Medical Association] *emphasises that everyone has the right to determine one's own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual's right to self-identification with regards to gender."*

"The WMA asserts that gender incongruence is not in itself a mental disorder; however it can lead to discomfort or distress, which is referred to as gender dysphoria."

Gatekeeping and diagnoses

WPATH, 2011

- Treatment is available to assist people who are experiencing gender dysphoria in exploring their gender identity and finding a gender role that is comfortable for them;

- Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. Hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Standards of Care

World Professional Association for Transgender Health (WAPTH, 2011)

- The overall goal of the SOC is to provide clinical guidance for health professionals to assist trans and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment.

- This assistance may include primary care, gynaecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counselling, psychotherapy), and hormonal and surgical treatments.

Healthcare provision to trans people

Information about national context

https://www.ilga-europe.org/rainboweurope

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Legal Situation

Sterilisation for Legal Gender Recognition (TGEU, 2017)

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Legal Situation

Diagnosis for Legal Gender Recognition (TGEU, 2017)

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Legal Gender Recognition in (insert here the name of the country where the training is being conducted)

Information about national context

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Questions and comments?

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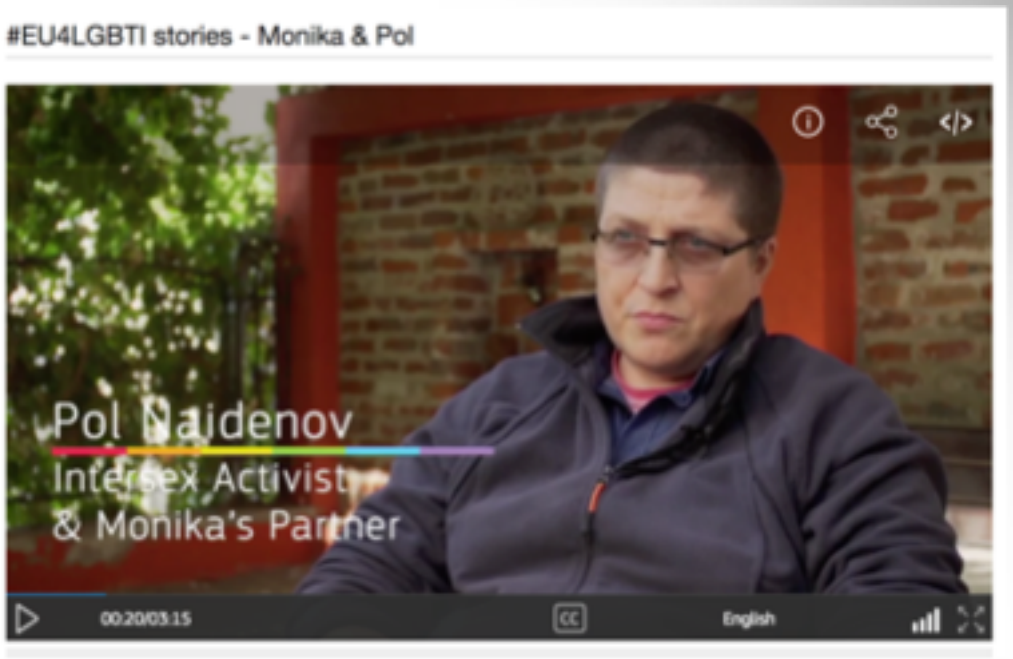
Who are intersex people?



Video:
https://ec.europa.eu/avservices/video/player.cfm?ref=I142954&lg=EN&sublg=none

Who are intersex people?

Intersex individuals are born with physical sex characteristics that don't fit medical or social norms for female or male bodies. These variations in sex characteristics may manifest themselves in primary characteristics (such as the inner and outer genitalia, the chromosomal and hormonal structure) and/or secondary characteristics (such as muscle mass, hair distribution and stature).

ILGA-Europe, 2017

faced by intersex people in

- Healthy intersex bodies are considered to be a ‘medical problem’ and a “psycho-social emergency” that needs to be fixed by surgical, hormonal, other medical and sometimes psychological means;
- In most cases, ‘normalising’ surgeries are not medically necessary and can have extremely negative consequences on intersex children.
- In at least 21 EU Member States, sex ‘normalising’ surgery is carried out on intersex children.

ILGA-Europe & OII Europe, 2015

INTERSEX HEALTH

"Intersex persons, in particular, have been subjected to cosmetic and other non-medically necessary surgery in infancy, leading to sterility, without informed consent of either the person in question or their parents or guardians. Such practices have also been recognized as human rights violations by international human rights bodies and national Courts."

World Health Organisation (WHO),
Office of the High Commissioner for Human Rights (OHCHR)
UN Women
Joint United Nations Programme on HIV/AIDS (UNAIDS)
UN Development Programme (UNDP)
UN Population Fund (UNFPA)
UN's Children's Fund (UNICEF)

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"Human rights and intersex people"

Council of Europe Issue Paper (2015)

- Variations in sex characteristics of intersex people are currently codified in medical classifications as pathologies or disorders, usually referred to as 'disorders of sex development';
- "Normalising" interventions can result in self-harming and suicidal behaviour;
- Although parents of intersex children are asked to provide their proxy consent to the treatment, they are often ill-informed and impressionable, and are not given adequate time or options necessary to provide fully informed consent.

Access to general healthcare

- Lack of knowledge around intersex lives
- Difficulty in finding intersex-specific health services
- Critiquing widespread assumptions that intersex is an illness which requires 'fixing'

McGlynn *et al.*, 2017

Access to general healthcare

- Access to general healthcare is often impaired by prejudices of healthcare professionals and the refund policies of health insurance companies.

- Disbelief, prejudices and disgust expressed by health care personnel can lead intersex people to avoid seeking healthcare. They can also lead health professionals to deny intersex people access to health services, or to commit psychological and physical abuse.

ILGA-Europe & OII Europe, 2015

Well-being and mental health

- There is a need for large-scale research into the psychological and emotional wellbeing of intersex people, as well as the long-term impact of 'normalising' treatments for older intersex people.
- Younger intersex people report experiencing isolation due to stigma, bullying, discrimination or rejection from family or peers. (Jones, 2016)
- Specialist long-term follow up services for intersex people should include psychological support to address psychosexual, emotional and social wellbeing.
- Isolation may impact negatively on mental health: practitioners should advise intersex people and their families to contact support groups/associations

Questions and comments?

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"Role-play"

45 minutes

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Part 1 (15min)

In small group, discuss "Situation A" or "Situation B", trying to answer to the following questions:

SITUATION A > ALEX

- **What are the problems in both healthcare practitioners performances? Give specific examples.**
- **In this example, how the healthcare provision comply – or not – with international standards of care? Give specific examples.**
- **How do you think Alex felt during this medical appointment?**
- **As a healthcare professional, what would you do differently?**

SITUATION B > BIANCA

- **What are the problems in both healthcare practitioners performances? Give specific examples.**
- **How do you think Maria and her parents felt during this conversation?**
- **As a healthcare professional, what would you do differently?**
- **Which impact do you think this approach by a healthcare professional may have on the rest of Bianca's life?**

Part 2.1

SITUATION A > ALEX

Alex is a trans man. He is 19 years old, and he socially lives according to his identity since he was 15. Most of his colleagues and teachers at the university, and also his friends and family, recognise him as a boy. Nevertheless, and although his gender expression is noticeably "masculine", he didn't undergo any gender confirmation treatment (e.g., hormones, surgeries...). Only now he is sure about the changes in his body that he wants to accomplish. Moreover, for years he avoided to resource to health professionals because of what he read online and heard from other trans people, on the lack of competence and the prejudices of some practitioners.

This is a role-play on the first appointment with a clinical psychologist, expert in trans health, recommended to Alex by an online friend, John.

Part 2.2

SITUATION B > BIANCA

Maria is 36 years old. For many years she dreamed about being a mother. She is single, and doesn't expect to be in a relationship soon. Maria decided to be a single mother, with the use of medically assisted procreation techniques. Her decision was supported by her family. The pregnancy went well, and the doctors said that she was going to have a daughter. Bianca was the name that Maria chose to her baby. When Bianca was born the doctors immediately noticed that the baby's genitalia was not common.

This is a role-play of the conversation that a doctor had with Maria on the day Bianca was born.

Wrap-up

Think of something that you have learned.

Think of something that you would put in place after the training!

Share it with your neighbour.

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The information and views set out in these slides are those of the authors (Francesco Amaddeo, Valeria Donisi, Francesco Farinella, Clizia Buniotto, Juliette Sanchez-Lambert, Nuno Pinto, Sophie Aujean, Ruth Davis, Massimo Mirandola, Lorenzo Gios, Magdalena Rosinska, Karolina Zakrzewska, Marta Niedźwiedzka-Stadnik, Michał Pawlęga, Marcin Rodzinka, Laetitia Zeeman, Nigel Sherriff, Kath Browne, Nick McGlynn, Anne Pierson) and do not necessarily reflect the official opinion of the Commission. The Commission does not guarantee the accuracy of the data included in this report. Neither the Commission nor any person acting on the Commission's behalf may be held responsible for the use which may be made of the information contained therein.

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