# Trans* care done differently

*a vision statement for an alternative approach to trans* healthcare for the Netherlands*

an initiative by PRINCIPLE 17
in collaboration with the trans community

# About Principle 17

Principle 17 (P17) is a Dutch activist collective that is committed to personalised transgender health care. Healthcare if you need it, when you need it, as you need it. We name ourselves after Yogyakarta Principle 17, which describes the right to the highest attainable standard of care.

In 2006 human rights specialists, amongst whom two trans activists, have drawn up international human rights for LHBTI people. These human rights were copied from existing treaties, such as the Universal Declaration of Human Rights of the United Nations (UN) and applied to specific cases concerning gender identity and sexual orientation. This document is called the *Yogyakarta Principles*. These Principles are concerned with matters such as the right to life, the right to recognition by law (gender recognition!), the right to non-discrimination in a variety of circumstances, the right to legal recourse, the right to privacy, the right to health, etcetera.

Principle 17 expresses the right to the highest attainable standard of health:

> "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."

Principle 18 is concerned with the right to indemnity from unnecessary medical treatment or excessive treatment:

> “No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed.”

Many transgender healthcare recipients however experience (sadly) that these rights are not recognised as their obvious rights. Including in the Netherlands. P17 is convinced that transgender people, medical practitioners and politicians too often are not aware of these human rights. That is why P17 was created and why we provide this vision statement for an alternative approach to trans* healthcare for the Netherlands, with the aim to improve this situation.

# Contents

# Summary

## Introduction

Since 2019 the Quality standard for transgender healthcare (concerning somatic care) and the Quality standard for transgender mental healthcare (concerning mental healthcare) exist in the Netherlands. This is an important step forward. Unfortunately, these standards of care violate fundamental rights of transgender care recipients, because they stick to the outdated ‘gatekeeper model’. This means that care recipients require a psychiatric diagnosis, to gain access to somatic care. This requirement is otherwise unheard of in the Netherlands.

This vision statement for an alternative approach to trans* healthcare for the Netherlands assumes the principle that medical care is and should be available to those who needs it, when they need it and how they need it. This is a human rights principle. This report is intended as a source of inspiration for trans* care recipients and for providers of care.

## The right to health

In the past a conscious decision was made for a pathologizing approach to transgender healthcare to reduce societal opposition. Since then, insights into what constitutes good transgender healthcare have changed radically. Nevertheless, transgender health care providers continue to apply this pathologizing approach. The result is a strange situation: a double standard in health care with one approach that applies for any other type of care and another standard that applies only to transgender healthcare.
The medical approach to transgender healthcare assumes the applicability of the psychiatric diagnosis ‘gender dysphoria‘ (DSM-5, Diagnostic and Statistical Manual of Mental Disorders) or the diagnosis of a condition related to sexual health ‘gender incongruence’ ( ICD-11, International Statistical Classification of Diseases and Related Health Problems (ICD)). The human rights approach however assumes the right of existence for all people. Sometimes however, existence requires healthcare.

### Human rights

From the Yogyakarta Principles, a set of international principles relating to sexual orientation, gender identity, gender expression and sex characteristics, it follows that the only legitimate approach is informed consent. From a human rights perspective the only possible approach to transgender healthcare is a personalised approach.

### Right to health

International human rights treaties describe health as a positive right. This means that health is more than merely the absence of disease. Lawsuits have confirmed that this human right applies to transgender health recipients as well.

### Terminology

The Law on medical treatment agreements (Wet geneeskundige behandelingsovereenkomst (WGBO)) defines that a care recipient should be enabled to consent to medical treatment after having been informed. Health care providers usually assume that healthcare recipients are competent to do so, unless evidence suggests otherwise. Transgender health care recipients are the exception: they must undergo a *psychiatric* evaluation which assesses whether they are competent in this regard. After having received the psychiatric diagnosis ‘gender dysphoria ‘, transgender health care recipients are allowed access to *somatic* healthcare. This is a violation of human rights.
Due to, amongst other causes, the excessively long waiting lists in transgender healthcare there are plans to allow transgender healthcare provision through GPs after a preliminary assessment by triage groups. Principle 17 considers this to be an excellent development, provided that the gate keeping role of psychologists disappears.

### Informed consent

The WGBO determines how informed consent is put into practice in Dutch healthcare. Transgender health care is again the exception, because in case of transgender health care responsibility is granted to the health care

provider. The best solution is *strong informed consent*, which primarily assigns responsibility to the care recipient, in so far as this is possible.

## Commentary on the Quality standard for transgender healthcare

There are fundamental problems with the underlying principles and the conditions for access to transgender healthcare, as they are defined in the Quality standard for transgender healthcare (concerning somatic care) and the Quality standard for transgender mental healthcare (concerning mental healthcare). The result is that these standards violate the human rights of transgender health care recipients. This summary addresses the most important issues.

### *Non-medical care*

Gender related care transcends healthcare related to transitioning. Transitioning includes a legal change, a social transition and/or medical treatment. A good standard for transgender care includes support for all aspects of gender related care.
Many transgender people benefit from receiving psychosocial support. A suitable financial compensation is required.
Often transgender people benefit from receiving psychological support, because of underlying or more complex mental health issues. Additionally, the excessively long waiting lists for accessing gender related care often have a major impact on the care recipient's mental wellbeing.
Some transgender people require psychiatric support.  Care providers need to consider the possible influence of gender incongruence on psychiatric disbalance in their considerations.
Trans cultural competence is lacking greatly with these healthcare providers. A substantial investment in further training and education is required.

### *Medical care*

Medication should be personalised, however in the context of transgender care the cheapest available medication is prescribed by default. Principle

17 insists on the prescription of medication that is personalised. Gender related surgery exists in many forms and should be made available unrelated to hormonal treatment. Honest information provision about possibilities is a requirement.
Postoperative care should be a standard component of transgender healthcare and should not depend upon individual care provider initiatives. Here also trans cultural competence is of great importance.

### *Post-transition healthcare*

Trans people should be afforded lifelong access to the community and to specialised health care providers. After all they remain transgender for life. Usually, it is possible for a GP to perform the annual check of hormone levels. In some cases, a referral to an endocrinologist is required. Health care providers should acquire necessary trans cultural competence.
The societal lack of understanding, the discrimination, the exclusion and the violence that many transgender people face on a day-to-day basis should be addressed. Transgender citizens have a right to a safe life just like any other citizen.
Transgender people who are a member of multiple marginalised societal groups, experience additional problems. This can only be addressed by an intersectional approach.
Principle 17 wants the Netherlands to stop registering the gender of their citizens. Registering this information no longer serves a purpose and conflicts with citizens privacy.

## Highlights

### *Smoking and substance use*

While Principle 17 supports the medical reasons for the advice to stop, we are also alive to the observation of the counter productiveness of sticking to the follow-up of this advice at all costs.  Smoking and/or substance use is often a survival tactic to be able to face a stressful life.

### *Healthy body weight*

Being under- or overweight is a serious issue. The BMI criterion that is used is however dubious. A more effective approach is to observe a person's physical fitness, muscularity and other physical aspects that are indicative of a person's fitness to endure a surgical procedure.

### *Trans and hiv*

An HIV-positive status does not need to be a barrier to transition care. The social circumstances of a person could however be a problem.  Principle 17 stresses that it is possible in such cases as well that care recipients are suffering greatly from body dysphoria.

### *Reimbursements*

Concerning reimbursements from health insurance, a lot of things are wrong. The reimbursement of testosterone and oestrogen are arranged reasonably well. Bigger problems exist with medications that are used off-label, such as finasteride.

Aside from that, there are many essential interventions that are not or barely reimbursed, such as laser hair removal and liposuction of the hips. These treatments have a major impact on someone's acceptance in society.

### *COVID-19*

Trans people are in a marginalised position relatively frequently, due to which the corona pandemic has had a very large impact on the trans community – and it still does. Many trans people are isolated to a degree that is above the average and have relatively few options to meet likeminded people.

### *Marginalised groups*

Principle 17 held two round table meetings with people form the trans community that are marginalised in other ways in addition to being transgender. At these meetings the experiences of non-binary trans people, trans people with a handicap or chronic illness, trans people of colour, trans refugees and trans people with a residence status were shared.
These meetings made it painfully clear that anyone who is not white, binary, able bodied, neurotypical and Dutch is very likely to encounter problems when trying to access trans healthcare.

## Children and young people

### *Inconsistent standards*

Current medical standards do not treat human rights of children consistently. For instance, article 3 of the UN treatise on the rights of the child (CRC) puts the interests of the child first. Nevertheless, the ICD-11 includes a ‘gender incongruence in children’ as a diagnosis. The result is that healthy children, who do not receive medical treatment, are pathologized by receiving a psychiatric diagnosis.

### *Screening*

In what way can one determine whether a child is transgender? The screening of gender creative children is currently done by child-psychologists and -psychiatrists, from a cisgender-normative viewpoint.

### *Watchful waiting*

The usual approach with gender creative children is watchful waiting, which means that one waits how the child develops. In addition, care providers advise against social transitioning, even though a grown-up's role should be to support a child in their development – also including their gender development. Children can know what their gender is from a young age.

### *Gay or trans?*

A well-known argument against trans health care for children is that it is uncertain whether the development will be towards a gay identity or a trans identity. By pathologizing gender creative children, sexual and gender diversity are once again being medicalised. This is a worrying development.
Childhood is characterised by 'mobility', behavioural 'variation'. The point is, that it is not a cause for concern when a child develops a new expression of gender or returns to a previous one.

### *Puberty blockers*

Medical interventions for young trans people can begin only after the onset of puberty, when secondary sexual characteristics begin to develop. Gender creative children, who indicated that their body and gender identity do not match long before the onset of puberty, might possibly start cross-gender hormone treatment (with due care). This approach aligns with the SOC-8, which no longer upholds an age criterion at all.

### *Neurodiversity*

The prevalence of neurodiversity amongst gender creative young people has received a lot of attention in recent years. What is worrying however is that this attention is framed within a mindset of concern. Principle 17 holds the opinion that it is important to always take in to account the emotional, cognitive and neurological capacities of recipients of care. It goes without saying that their requirements should be considered just as well.

### *Criticism*

Vocal criticism toward support of the social transitioning of children can be heard, originating from ‘gender critical’ circles, also known as Trans Exclusionary Radical Feminists (TERFs). Their primary goal is to prevent access to gender affirming health care for trans people in general and gender creative young people in particular.

## Commentary on Quality standard for transgender mental healthcare

We also have some reservations about the Quality standard for transgender mental healthcare, the standard for mental health care for trans people.

### *Commentary*

For Principle 17 the hottest issue is that the Quality standard still sticks to psychological assessment with a gate keeping purpose. Transgender care recipients are the only care recipients in The Netherlands who need to prove their competence *before* being allowed to access necessary medical treatment, after having received a psychiatric diagnosis. Another fundamental problem of the assessment psychologist is the unchecked power dynamic between the care recipient and the care provider. Principle 17 is a proponent of non-pathologizing health care.

By using the terminology ‘detection’ of ‘gender dysphoria’ in a specialised standard for a specific target group the impression is created that the writers thereof have been thinking from a cis-normative frame of reference. Gender healthcare is normal health care.

Of course, health care providers are required to possess trans cultural competence and should (on a general level) be knowledgeable concerning issues that are current in the trans* field.  However, the situation is that this competence is often absent.

## Alternatives: how should things be done?

Principle 17 notices a necessity for a different approach in the Quality standards for transgender healthcare for somatic health care and mental health care for trans people.

### *Political framework*

A different structuring of (trans) health care requires a different structuring of the flow of money, because these are linked inextricably in the Netherlands. The Minister mentions a tripartite consultation in which the care providers, the health care insurance companies and representatives of care recipients take part as a solution. However, there is a fundamental disbalance of power between these groups.

### *Fundamental criticism*

Principle 17 is convinced that the issue can only be solved by adopting a radically different approach of transgender heath care. Stop using assessment psychologists and use the resulting budgetary windfall for actual care.
The final goal should be: “simple whenever possible, specialized whenever nescessary”. This requires a solid investment in knowledge acquirement for the (para) medical and social professions.
All of this can be achieved only with the intensive involvement of the trans community.

### *Waiting times*

The waiting time for accessing medical assistance for gender transition are extreme. Efforts to resolve these within the system have been ongoing for years but have yielded no results. In other words, an entirely different approach to trans health care is needed.

### *General practitioners*

Endocrine health care for transgender people is in and of itself not a complex matter. Nevertheless, general practitioners often do not feel

comfortable providing this type of trans health care. An NHG-standard could bolster the GP's confidence levels.
A GP can fulfil anther role as well: by monitoring mental and emotional wellbeing, checking in on status of work, study, income and housing and similar.
An approach in which being transgender is a normal trait would be much welcomed as would a more positive stance of the Knowledge and Care Centre for Gender Dysphoria in Amsterdam. The standard procedure of collegial contact and knowledge sharing should be the standard way of working in trans healthcare as well.

### *Hormone treatment*

The somatic standard of care sets conditions for gender affirming hormone treatment. This, again, is indicative of distrust towards the care recipient: they must 'prove' that they are sufficiently trans to be allowed to be trans. The precondition that 'side problems' should be under control, is problematic. Body dysphoria can be strong enough that it leads to severe stress which (apparently) shows up as psychiatric issues. With a view to 'damage control, it is possible to explore whether hormone treatment relieves these psychiatric issues.

### *Specific proposals*

Principle 17 proposes the following changes:
- An approach based on human rights, medical or physiological conditions. The needs of the trans care recipient should be the starting point.
- Put an end to diagnosis, instead perform an extensive intake.
- Put an end to the Watchful waiting approach for gender creative young people.
- Cross gender hormone treatment should be allowed to be initiated for gender creative young people once competence to decide on matters that concern their own gender identity has been determined.
- Starting up hormone treatment can take place over several months. This is not an obstacle to proceeding with a possible social transition.
- Reimbursement of hair removal is required, as long as necessary or wanted, including in the case of excessive body hair.

- Gynaecological surgery needs to be available for trans young people from the moment they want it, and it is physically possible.
- Breast augmentation and facial surgery should be available, with and without hormonal treatment.
- Mastectomy should be available without hormone treatment as well.

### *Protocols and standards*

We must remain conscious of the fact that protocols are standards which provide a suggestion for a way to act. Treatment should always be personalised.

### *Financing*

To be able to provide good (trans) care The Netherlands must invest in education and research. Trans experts and advocates should be involved at all stages.
Additionally, healthcare financing must be arranged differently. Principle 17 is of the opinion that care should not be a ‘product’, instead, it should be a service.

## Closing remarks

By presenting a perspective from the trans community Principle 17 wants to make an important voice heard. Too often, decisions about our lives are made about us, not with us.

# 1. Introduction

For several years now the Netherlands have specific standards of care for gender transition related healthcare. This vision statement for an alternative approach to trans* healthcare was inspired by dissatisfaction with the current standards of care, which are pathologizing and old fashioned. This document serves as a source of inspiration for trans* healthcare recipients and healthcare providers.

> **In this docment 'trans* healthcare recipient' is anyone who is at the recieving end of gender confirming healthcare, irrespective of their genderidentity or -expression. In this document, from here on, trans* healthcare will be written as "trans healthcare" with this broad definition in mind.**

Only the trans community itself can indicate what is needed, which care should be provided when and how and on which basis. A new version of the official standards of care is in preparation, however bearing in mind current international developments Principle 17 does not see any reasons for leaning back.

Trans healthcare as it has existed in the Netherlands since the early eighties, has standards of care approved by the Knowledge Institute of the Federation of Medical Specialists (KIMS)[1] since 2019. There are two standards: Quality standard for transgender healthcare[2] (concerning somatic care) and the Quality standard for transgender mental healthcare[3] (concerning mental healthcare). Finally, there are formal documents that can be relied upon. This is an important step.

The transgender community has been involved from the sidelines during the process of creation through a sounding board group. However, in addition to not everyone in this group being of the same opinion concerning important issues, what also became apparent was that the proposals of the

1 Kennisinstituut van de Federatie Medisch Specialisten *(KIMS).*
2 *KIMS (2018).*
3 Alliantie Transgenderzorg*, Transgender Healthcare Alliance (2017).*

traditional (often cisgender) care providers were very old fashioned. Protests that aimed to create a non-pathologizing standards of care, which did not involve a gate keeping psychologist, have not been productive. This aim was a bridge too far for the traditional care providers.

While the Netherlands stick to the “gate keeping model”, the international trans community is letting go of this approach and is instead increasingly basing itself in a human rights centred approach. Unexpectedly for many, Argentina is leading the way. In 2012 a non-pathologizing trans law was adopted and in 2020 the standards of care were adjusted as well[4]

Another important development is that in the face of the increasing pressure on (ineffective) trans healthcare, people are increasingly finding their own way. Self-medication is an expression of this. Recent media attention has turned the insufficient availability and inaccessibility of trans healthcare into a commonly known phenomenon. The downside is that this is the only problem that is commonly acknowledged. The underlying issue, of trans healthcare being provided based on out-dated viewpoints, remains underreported.

This alternative approach to trans* healthcare for the Netherlands has human rights as it’s starting point. A fundamental problem of Dutch trans healthcare is that it does not consider the fundamental rights of care recipients. In a technical sense, legislation is mentioned as a conditionality (for example the law on medical treatment agreements: Wet geneeskundige behandelingsovereenkomst, WGBO), however a human rights approach is wholly absent from the current two-part standards of care. This means the trans community has had a very minimal part to play in the creation of these standards.

4 *Ministerio Salud (2020).*

The renewal of the WPATH[5] – de Standards of Care, version 8[6] (SOC-8) – are not far-reaching enough on essential points. Behind the scenes old-fashioned (cisgender) members (from the medical profession) still have a lot of influence, which results in less progress than is needed. Remarkably, the future SOC-8 of the WPATH does contain various references to human rights treaties and they explicitly refer to the Yogyakarta Principles. Unfortunately, a translation to a medical context is absent, with the result that these (theoretical) human rights have next to no influence on the (practical) standards of the SOC-8. The simplest step towards operationalization would have been to request all states to endorse the Yogyakarta Principles.

In addition, there is a lack of geopolitical awareness in the development of the SOC-8. The Standards of Care are based on a Eurocentric framework and are therefore Eurocentric in their conceptualization. This implicitly positions the Western North as a global knowledge producer and the non-Western South as a local knowledge producer. This is not only unjust, but

5 *World Professional Association for Transgender Health: www.wpath.org*
6 *WPATH (2022).*

also incorrect. It reflects a political attitude that has its roots in our colonial past.

Due to the limitations of the ‘quality standards’, Principle 17 now offers this vision statement for an alternative approach to trans healthcare in the Netherlands. A vision that assumes medical care for those who need it, when they need it and as they need it, embedded in a human rights framework. That is what is needed.
This approach uses state-of-the-art standards and principles. These are taken from, among others, the UC San Francisco Center of Excellence for Trans Health [7], New York's Callen-Lorde LGBT Community Health Center[8], Transgender Europe[9], Australian Professional Association for Trans Health[10], Equinox Trans and Gender Diverse Health Service (Australië)[11], New Zealand's Transgender Health Research Lab[12], and from sources in Spain[13], Uruguay[14] and Argentina[15]. What all these documents have in common is a non-pathologizing approach. The assumption is that the care recipient has a valid reason to request gender transition healthcare, or gender related healthcare in a broader sense. This is an essential difference compared with the position of distrust that is assumed in Dutch transgender healthcare.

In chapter two we explain how this came about, where this focus on being trans as a ‘disease’ or deviation comes from and why this is an outdated focus. A human rights perspective is the necessary alternative.
Chapter three goes into more detail about some of the criteria and forms of treatment, in which the official standards for physical healthcare and an authoritative section of the medical community have fallen behind.

7 *UCSF Gender Affirming Health Program (2016).*
8 *Callen-Lorde Protocols for the Provision of Hormone Therapy.*
9 *Transgender Europe (2019).*
10 *Telfer et al. (2020).*
11 *Thorne Harbour Health (2020).*
12 *Oliphant et al. (2018).*
13 *Tránsit Barcelona (2016).*
14 *Ministerio de Salud Pública, Uruguay (2016).*
15 *Ministerio de Salud Argentina (2020).*

Chapter four highlights several social and medical issues that (often unjustifiably) affect the provision of trans care and thus pose risks to trans people.
Chapter five explores fundamental problems with the treatment of minor trans people who are entering puberty.
Chapter six discusses how the Standards for Mental Transgender Healthcare approaches trans healthcare and what elements of it need to be improved.
Finally, chapter seven looks ahead to what good gender-related healthcare might look like.

Principle 17 would like to thank the trans community, who are the source of inspiration for writing this vision statement for an alternative approach to trans healthcare in the Netherlands. Principle 17 view themselves as part of this community and as a mouthpiece on the topic of trans healthcare. That is why the ‘we’ in this vision refers to the trans community, and not to the collective Principle 17.

# 2. Right to health, a human-rights perspective

This chapter provides a response to the question in what way being trans and trans healthcare are a human rights issue. As mentioned already by Principle 17 in the report “Transzorg in Nederland” dating from 2017, healthcare for trans persons should be approached from a human rights angle[16] As all healthcare should. In this same report Principle 17 concluded as well that trans healthcare in the Netherlands however operates mostly – if not exclusively- from a medical and pathologising framework. (see annex 1).

Historically, trans people have always been seen as delusional, as having got a few screws loose, or as having a mental developmental disorder related to gender or sexuality. Perhaps it was even a disorder related to intersex/DSD[17], as defended by transsexualist Prof. Louis Gooren, the first head of the Amsterdam Gender Clinic of the Amsterdam UMC.[18]

Historically, a conscious choice has been made for pathologizing care to reduce the resistance of the population and institutions.[19] In that sense, it is understandable that the Amsterdam UMC (then VUmc) went full speed in that direction in the 1980s. But it is very bad that trans care continues unabated on this pathologizing path to this day, while the insights around good trans healthcare have changed radically since then. In addition, the Amsterdam UMC apparently does not care about the fact that healthcare recipients – and therefore also trans healthcare recipients – have rights that are enshrined in Dutch law.[20]
The Dutch starting point for transgender healthcare still assumes that being transgender is an individual, congenital deviation of the mind. Therefore,

16 *Principle 17 (2017).*
17 *DSD: differences in sex development.*
18 *Prof.dr. L.J.G. Gooren was chair of the transsexuology department from 1988 to 2008 at the Vrije Universiteit in Amsterdam. His successor was prof.dr. P. Cohen-Kettenis, who has primarily focused on healthcare for trans and gender creative young people.*
19 *For instance: A. Bakker,* Een halve eeuw transgenderzorg aan de VU, *Half a century of transgender care at the VU, Amsterdam (2021).*
20 *Principle 17 published the flyer* ‘Patiëntenrechten zijn mensenrechten zijn trans*rechten’*, ‘Patient rights are human rights are trans* rights’ (2016) on this topic.*

only a psychologist or psychiatrist can diagnose ‘gender dysphoria’, because this is a psychiatric classification in the DSM-5[21]. According to the ICD[22] it is a biological, sexual abnormality and only a doctor can make the diagnosis. In any case, being trans is seen as a problem, a condition, that needs to be ‘cured’.
The human rights approach assumes that every person has the right to exist. All people have an identity that consists of various fundamental aspects, including gender. You have the right to recognition of your identity at all levels: legal, social, medical, etc. That is why it is so important that trans people are seen as bearers of human rights, instead of being reduced to 'patients'.

Anyone who examines the history of the development of thinking around LGBTI+[23], sees a shift towards depathologisation. While homosexuality was considered a mental illness until 1973 (DSM) and 1990 (ICD), respectively, it has since been seen as human diversity in sexual orientation. The reason for this was the powerful lobby by homosexual doctors and the gay emancipation movement that had emerged since the 1950s. Together they strongly opposed the idea that there was something wrong with them.

In the early years of trans healthcare, the transgender community was mostly grateful that medical care was available at all. As trans healthcare became commonplace, we noticed that the healthcare system had double standards: one standard for general healthcare and another standard for trans healthcare.
Slowly, transgender healthcare recipients have also changed into assertive ‘healthcare consumers’, in line with social developments. For years, the transgender community has been lobbying intensively with human rights organizations, such as the United Nations and the Council of Europe, and there have been international protests, such as ‘Trans October’ in 2011.[24]

21 *Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.*
22 *International Classification of Diseases, published by the World Health Organization.*
23 *Lesbians, homosexuals, bisexuals, transgenders, people with an intersex condition and everyone else.*
24 *‘Trans October’ was held in late 2011 to draw attention to depathologising of trans healthcare. In a number of locations, amongst others in Spain, this event continues to be organised annually to celebrate gender diversity.*

This creates an ever-increasing pressure to replace the pathologizing medical model with the human rights model, with the result that the medical and psychiatric community is slowly changing its course.

Current developments make it clear that many of the problems that trans people face mainly stem from a lack of understanding within the cis-hetero-normative society and from discriminatory legislation (which legitimizes possible discrimination by third parties).

## Human Rights

The paragraphs below explain some elaborations of the human rights principles.

### *Yogyakarta Principles*

The Yogyakarta Principles are an elaboration of existing international human rights laws relating to sex characteristics, gender identity, gender expression and sexual orientation.[25] They were compiled in 2006 by human rights experts, including two trans activists. A more extensive version, the

25 www.yogyakartaprinciples.org

YP+10, was published in 2017.[26] The Yogyakarta Principles have been explicitly recognized by the Netherlands, among others, as authoritative, as part of the human rights corpus. There is even an official Dutch translation of the original Principles.[27]

The Yogyakarta Principles explicitly address the right to health. For example, Principle 17 states:

> "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."[28]

The Yogyakarta Principles are also very clear about the view that coercion is not healthcare. Principle 18 states:

> "No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed".[29]

It follows directly that only informed consent is a legitimate method, which does justice to the human rights of transgenders. The current method of 'gatekeeping', where a 'assessment psychologist' must give permission for the somatic (!) treatment, is a violation of our human rights.

26 *www.yogyakartaprinciples.org/principles-en/yp10*
27 *yogyakartaprinciples.org/wp-content/uploads/2016/10/Yogyakarta_Principles_NL_versie.pdf*
28 *yogyakartaprinciples.org/principle-17*
29 *yogyakartaprinciples.org/principle-18*

Principle 32 elaborates on this further, with an emphasis on bodily integrity:

> "Everyone has the right to bodily and mental integrity, autonomy and self-determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to be free from torture and cruel, inhuman and degrading treatment or punishment on the basis of sexual orientation, gender identity, gender expression and sex characteristics. No one shall be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person.[30]

In addition to these health aspects, the Yogyakarta Principles are also very clear about the right to recognition before the law and the fact that no medical requirements may be imposed on this. From an international law perspective, it is therefore illegal to demand that people have to modify their bodies in order to be recognized in their gender. (Despite this international legislation, the Netherlands only dropped the infamous 'sterilization requirement' in 2014.[31])

## *Council of Europe*

In 1997, the Council of Europe drew up the *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine*.[32] This convention speaks about the interests of people, which go above the interests of society or science, about consent and about equal access to care and professional standards.

Furthermore, in 1953 the Council of Europe adopted the *European Convention on Human Rights* (ECHR). This treaty protects the human

30 *yogyakartaprinciples.org/principle-32-yp10.*
31 *Until July 1st, 2014, transgender persons were required to start a court case against the Dutch State to change their legal gender. As part of this court case, they were required to supply a declaration by a surgeon that they were 'permanently infertile' (sterilised).*
32 *Treaty No.164, also known as the Oviedo Convention.*

rights and fundamental freedoms of citizens of Europe. The Netherlands' apology to its transgender population (made in November 2021) for the infamous 'sterilization requirement' in the former Gender Recognition Act (valid from 1985 to 2014) stems from an ECHR case (Niçot v France).

### *European Union*

*The 2000 Charter of Fundamental Rights of the European Union*[33] speaks of the right of every person to integrity, to free and informed consent and to access health care.

A model for trans healthcare from a human rights perspective cannot do anything other than do justice to the individual healthcare recipient and will therefore by definition offer tailor-made healthcare. To this end, existing stereotypical and binary ideas about what is 'male' and 'female' will have to be abandoned. It would of course be ideal if society adopts this broad view of gender, so that we no longer condition children with ideas that certain physical characteristics belong to a 'male' or 'female' gender identity, role, expression or expectations.

Argentina has collected all important issues for trans people around legal gender recognition and healthcare in one law in law 26.743 of 2012. The Netherlands does not have a special transgender law, because the Dutch legal system has organised everything by theme.
Our legislation for changing legal gender does not (yet) have an 'X', the letter that internationally stands for 'unimportant' or 'irrelevant' as an alternative.[34] Incidentally, Denmark, Ireland and Malta, among others, already have this option.

Gender-related healthcare, and in particular transition healthcare, has no separate legal regulation and falls under the Medical Treatment Agreement Act (WGBO) and other (general) healthcare legislation. The regulations regarding the financing of this healthcare are complex and unclear. Since 2019, there is, finally, the Quality standard for transgender healthcare

33 www.europarl.europa.eu/charter/pdf/text_nl.pdf
34 *In recent years the expression of a need for an 'X' has primarily been heard from non-binary circles and the meaning consequently seems to drift towards 'non-binary'.*

(concerning somatic care) and the Quality standard for transgender mental healthcare (concerning mental healthcare), the reason for this vision statement for an alternative approach to trans healthcare.

## Right to health

The UN Universal Declaration of Human Rights (UDHR)[35], the International Covenant on Economic, Social and Cultural Rights (ICESCR)[36], also of the UN, the WHO Constitution (preamble) and the Social Charter[37] of the Council of Europe, among others, describe health as a positive right. That is to say: health is more than the absence of disease. In addition, states have the obligation to spend a fair share of their budget on healthcare and health promotion.

The World Health Organization (WHO) and the Office of the High Commissioner for Human Rights[38] have jointly published *Fact Sheet 31*, which further elaborates on the positive right to health.[39]

The above obligations are not only found in international treaties, but they have also been confirmed in concrete (legal) cases. For example, there is the ruling of the Committee on Economic, Social and Cultural Rights (CESCR) against Germany:

> "26. 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 Committee urges the State party to step up measures, legislative or otherwise, on the identity and the health of transsexual and inter-sex persons with a view to ensuring that

35 *Article 25.1.*
36 *Article 12, General Comment 14.*
37 *Article 11.*
38 *Office of the High Commissioner on Human Rights, in Genève.*
39 *www.ohchr.org/Documents/Publications/Factsheet31.pdf*

> they are no longer discriminated against and that their personal integrity and sexual and reproductive health rights are respected. The Committee calls on the State party to fully consult transsexual and inter-sexed persons for this purpose."[40]

The UN Committee Against Torture (CAT) considers compulsory sterilization, which is still practiced in many countries, to be a form of torture. The CAT therefore strongly criticizes compulsory sterilization as a condition for legal recognition of someone's gender identity. In this case, Hong Kong is the reason:

> "29. Hong Kong, China should: (a) Take the necessary legislative, administrative and other measures to guarantee respect for the autonomy and physical and psychological integrity of transgender and intersex persons, including by removing abusive preconditions for the legal recognition of the gender identity of transgender persons, such as sterilization"[41]

## Terminology

The Dutch WGBO stipulates that a care recipient must be able to give informed consent for the treatment and care that one receives. For care under duress – usually psychiatric in nature – a judicial decision is required. Trans healthcare should therefore be regular healthcare, for which care recipients give their informed consent for the various treatments. In practice, however, gender transition healthcare is in principle not accessible without taking an 'entrance exam'. Trans healthcare recipients must first undergo a psychiatric evaluation that assesses whether they are 'competent' in this regard. Only after the *psychiatric* diagnosis of 'gender dysphoria' has been received, one is given access to *somatic* trans healthcare. This is extremely strange. Genderconfirming healthcare is a recognized medical, non-psychiatric form of healthcare.

40 *Cited in Theilen (2014).*
41 *Concluding observations on the fifth periodic report of China with respect to Hong Kong, China (2016).*

In 2019, the WHO published version 11 of the *International Classification of Diseases* (ICD). In the ICD-11, problems around gender identity have been given a new place. Although ‘gender identity disorder’ had been classified as a mental disorder since 1992, ‘gender incongruence’ has been classified in a new chapter 17 on sexual problems[42], since 2019. After a long discussion, the WHO classification committee has concluded that this classification fits better. This means that gender incongruence is no longer a psychiatric disorder and therefore no (psychological) assessment is needed to determine gender incongruence.
The DSM-5 still speaks of ‘gender dysphoria’ and that is the most used diagnosis in the Netherlands.

The *Diagnostic Statistical Manual of Mental Disorders* (DSM)[43] is used in the Netherlands for mental health problems and for transgender healthcare. That is why trans people in the Netherlands still have to go to a 'assessment psychologist' to gain access to trans heathcare.

42 *Code HA60: Gender incongruence of adolescence or adulthood, code HA61: Genderincongruence of childhood, HA6z: Gender incongruence, unspecified*
43 *The DSM is published by the American Psychiatric Association (APA).*

There are several reasons why gender dysphoria is still included in the DSM. First, American insurers would otherwise no longer reimburse trans healthcare, which means that it is the insurers who demand pathologization of trans healthcare. Furthermore, there is a strong medical-pharmaceutical lobby that benefits from inclusion in the DSM. Finally, there is a lack of independence among DSM reviewers.[44]

The extent to which manuals such as the ICD and DSM are updated or renewed will depend largely on lobbying and activism. There is no schedule for an automatic update.
In any case, the recent DSM-5-TR[45] of March 2022 does not indicate any significant shifts in trans-related terminology or criteria.

The historical roots of trans pathologization have been explained above. By emphasizing the approach that *everything* must be measurable and observable, positivistic scientific practice, physicians tend to assume that everything around gender is a biological given. While a human characteristic like gender is not only shaped by our genes, but also by our social context. If the latter is not considered, this cannot but lead to mismatches in trans care.

Partly due to the extremely long waiting lists in trans care, a new approach is being considered, in which trans care recipients are treated by the GP via triage groups. Late 2022, Trans in Eigen Hand[46] launched the first webinars for GPs, with the aim of eliminating existing gaps in knowledge and removing ‘cold feet’ among Gps. Principle 17 considers this to be an excellent development but remains alert that treatment by GPs will be directly accessible and not only after an ‘entrance exam’ or an alternative form of assessment. The involvement of GPs, which is primary care, is a requirement for depathologisation.

44 *The process of determining the ICD is different from the DSM: the ICD focuses on scientific value or medical relevance. For this reason, a number of paraphilias that are not related to others and therefore do not lead to victims, such as certain forms of transvestism, are no longer included in the ICD-11.*
45 *DSM-5-TR: DSM-5 text revision.*
46 Trans in Eigen Hand*, Trans In Own Hands, is an initiative of transgender professionals, with the support of the Quartermaster Transgender Care: transineigenhand.nl*

Shifting the role of the 'assessment psychologist' to a specialist psychology department is *not* an acceptable solution. Psychological care must be freely chosen and may not be a mandatory step which allows access (somatic) medical healthcare, as stipulated in the WGBO.

## Informed consent

The WGBO regulates how informed consent works in Dutch healthcare. Roughly speaking, this means that a doctor must properly inform the healthcare recipient about the consequences of a treatment and must inform them of risks (if these are greater than 1%). Ideally, Dutch trans healthcare would go a step further and apply *strong informed consent*. In strong informed consent, the responsibility lies where it belongs: the healthcare recipient is the leading figure, and the healthcare provider facilitates. In the SOC-8, published in September 2022, the WPATH clearly moves towards strong informed consent, but does not yet apply it everywhere and completely. In short, healthcare providers do not yet dare to completely depathologize gender identities.

Within the WPATH there is great division concerning the role that the consent of the healthcare recipient should play and of course also concerning the attitude of the healthcare provider. Healthcare providers who are themselves trans and/or see being transgender as part of human diversity often have a different approach than healthcare providers who see being transgender as a pathology. The first group of healthcare providers will more readily use strong informed consent, while the latter group will more often have a desire for psychological assessment.[47]

In addition, we need to see trans healthcare more broadly than just clinical: "Trans healthcare does not stop at the doorstep of the clinic."[48] On the contrary, trans healthcare is more than transition healthcare, because being trans goes beyond medical treatment. It is connected to the social life of trans people.

47 *Ashley (2021) provides an in-depth discussion of informed consent and associated models.*
48 *Ashley (2020).*

That is also what Grant Schulman[49] calls for in his article about what a psychologist should ask about. Eus van der Grift puts it beautifully in his book *Tour de Trans* (2022): “The psychologist at the gender clinic told me that first I had to find out who I was and what I wanted outside of the clinic. But he couldn't tell me with whom I should do that.”

For example, the Tránsit Barcelona guideline provides good information about what a first visit for trans healthcare might look like:

> “During the first visits, life history with regard to identity, current life situation and needs of the person and their desire with regard to physical changes are investigated. The knowledge and support that the person receives from the direct affective environment (family, friends, partner, etc.) and the learning and/or working environment are assessed as well as the knowledge that the person has about models of trans* persons.
>
> A clinical history that includes family background with cardiovascular risks, hormone-dependent cancers and osteoporosis, lifestyle (toxic substances, diet, exercise, etc.), background of physical and mental illnesses, bullying, physical violence, sexual abuse or suicidal thoughts and attempts.”[50]

49 *Shulman et al. (2017).*
50 *Tránsit Barcelona (2016), quotation of segment on page 7. Translation Principle 17.*

# 3. Commentary on Quality Standard Transgender Care

There are several standards for trans healthcare, including the international Standards of Care, version 8 (SOC-8) of the WPATH.[51] Nevertheless, Transgender Europe in 2020 notes that in practice, healthcare often has the character of being “insured but not cared for”[52]. Since 2019, the Netherlands has had a two-part healthcare standard: the Quality standard for transgender healthcare (concerning somatic care) and the Quality standard for transgender mental healthcare (concerning mental healthcare). In a technical sense, these standards are not wrong. They appear to adhere to existing laws and regulations, such as the Medical Treatment Agreement Act (WGBO). They also correctly describe what is prescribed, when and in what quantity.

Fundamental problems with these standards lie in the assumptions used and the conditions for access to trans healthcare. As a result, these standards violate the human rights of trans healthcare recipients. This chapter describes our fundamental criticism of the assumptions and underlying principles of the current standards, without going into too much medical detail.

> **Disclaimer: This document describes Principle 17's vision statement for good trans healthcare. It is emphatically not a manual. Guidelines for how and when to use which medication and in what quantity can be found in existing medical literature. Only a doctor can give personal advice.**

## Non-medical care

Being transgender is about (much) more than just transition healthcare. Gender-related care can consist of a legal change, social transition and/or medical treatment. A good standard for trans healthcare therefore describes support for all aspects of gender-related care.

51 *WPATH published the SoC-8 in September 2022.*
52 *Transgender Europe (2020).*

## Psychosocial support

Many trans people benefit from psychosocial support, such as coaching, social work or psychosocial therapy. Some need more: psychological support (see below). Not every trans person has the skills or capacities to discover and develop their own gender identity without any form of help, to shape their life in the desired gender role or expression, or to find their way in the confusing jungle of support agencies.

Appropriate compensation for psychosocial support, for example through the WMO or health insurance, is necessary. Only in this way can there be a guarantee that everyone who needs this support can actually access it, regardless of income or financial situation.

## Psychotherapy

Often, trans people can benefit from psychological support, because there are deeper and/or more complex problems at play than psychosocial support can handle. Various studies have shown that LGBTI people are more likely than average to experience discrimination, unemployment, low income, substance abuse (alcohol and/or drugs), psychological problems (including trauma), etc.[53] It is also known that relatively many LGBTI+ people experience eating disorders.[54] It is also known that these kinds of problems are even more pronounced for trans people than for lesbians and homosexuals. This has a lot to do with minority stress.[55]

Another major problem is the extremely long waiting times for gender-related healthcare (currently approximately 2.5 years for an intake interview at the Amsterdam UMC[56], the largest provider of transition healthcare). This causes extra stress for healthcare recipients, which keeps people trapped

53 *For instance: Chodzen et al. (2019).*
54 *For instance: Nagata et al. (20202), Diemer et al. (2018).*
55 *For instance: Scandurra et al. (2017), McNeil (2016).*
56 *The Quartermaster Transgender Care has made an overview of waiting times for transgender healthcare: [zorgvuldigadvies.nl/wp-content/uploads/2022/12/3.-Bijlage-voortgangsbrief-Kwartiermaker-Transgenderzorg-november-2022.pdf](zorgvuldigadvies.nl/wp-content/uploads/2022/12/3.-Bijlage-voortgangsbrief-Kwartiermaker-Transgenderzorg-november-2022.pdf) (reference date July 2022) (Dutch only).*

in limbo for years. In the trans community, sad stories are known of people who did not survive the waiting list.

### Psychiatry

Some trans people need psychiatric treatment. As always, this should be aimed at treating psychiatric problems, such as depression, anxiety, psychosis, and should focus on the well-being of the person seeking care and their needs through a holistic approach. Instead of immediately focusing on psychiatric medication, as is often the case nowadays, healthcare providers should consider the possible influence of the healthcare recipient's gender incongruence on the psychiatric imbalance in their considerations. Sometimes, for example, hormone treatment or blockers can provide a much simpler solution with much better results. Within the trans community, there are various experiences known of trans people who, for example, suffered from psychoses, that (strongly) decreased or even stopped completely after the right gender-related healthcare.[57]

### Cultural competence

There is a great shortage of transcultural competence among providers of psychosocial, psychological and psychiatric support. This is not surprising, because gender variation or being transgender is not or hardly included in the training of social workers, psychologists, psychiatrists, etc. As a result, many healthcare providers have outdated or incorrect views on transgender people. It goes without saying that this can potentially have serious damaging consequences for trans clients.

There must therefore be substantial investment in both training for new healthcare providers and in further and refresher training for practicing healthcare providers. Experts from the trans community must be actively involved in the development of training programs, so that cisgender bias can be prevented. As has been customary in various other areas for years: nothing about us without us.

57 *From conversations with trans people who are familiar with psychosis (before transitioning).*

### *Corrective clothing*

For those who want to have their body modified, it is important to look as much as possible the way they want. Clothing that accentuates certain parts of the body (bra with room for breast prostheses, underwear with room for a packer) or that conceals them (binders, vests, tucking underwear) can be an important tool. Healthcare providers should be aware of this in broad terms so that they can inform their trans clients about it.

### *Body hair epilation*

Almost all female trans people want to get rid of their facial hair and do so through laser treatment. Where this is not possible, for example because the hair is too light, other methods must be chosen. Professionals in hair removal often have (too) little experience with this or (too) little understanding. Health insurers also regularly make it difficult to reimburse alternatives. This has to change. In addition, everyone who provides this service must also have cultural competence.

### *Diet*

The Body Mass Index (BMI) is often taken as a starting point to measure someone's health, even though the BMI is not suitable for this purpose (see chapter 4, lemma BMI). Dietary advice should be aimed at a healthy(er) body and at improving quality of life, without taking the BMI as a starting point.

## Medical care

### *Blockers*

To prevent or to slow down physical changes in puberty, general analogue hormone blockers are used in trans youth. Hormone blockers are also often used in adult trans clients, especially in trans women.[58] In that case, these agents serve to increase the pace of physical changes, but also to let a client experience what life without the well-known, negatively experienced hormones can be like.

Well-known agents are the testosterone blockers cyproterone acetate (CTA), known by the brand name Androcur, and decapeptyl. All hormone blockers should be reimbursed by default, so that care recipients can use the most suitable medication for them.

### *Hormone treatment*

Medication is customised by definition – or at least, it should be. Because standard medication does not always work as expected, just as happens with healthcare recipients who are prescribed medication for other reasons. Sometimes the usual medication does not work or does not work sufficiently. Or the healthcare recipient suffers from serious side effects. Or the healthcare recipient might be hypersensitive to one of the components. In trans healthcare, the cheapest drug is provided by default, while that is not always the most effective or the (for other healthcare recipients) most commonly available drug.

58 *Drs. A. van Diemen, physician, gave a lecture on hormones, blockers and side effects during FreePATHH: principle17.org/wp/nl/free-pathh-2016/resultaten/lezing-bijwerkingen-hormonen-en-blokkers (Dutch only)*

Principle 17 therefore urges the prescription of medication that is tailored to the individual. The most suitable drug for the particular healthcare recipient must be reimbursed. Costs are not a reason, given the relatively small number of people concerned and the relatively low price of each of the drugs.

### *Surgery*

There are many forms of gender-related surgeries possible, including breast surgery, facial surgery (mostly in trans women), genital surgery, liposuction (for example of the hips in trans men), surgery on the vocal cords or larynx (mostly in trans women), sterilization and more. All of these types of surgery should be allowed to take place with or without hormone treatment.

In the area of surgery, both transcultural and intercultural competence are of great importance. The group of healthcare recipients with a desire for surgery is very diverse and has (very) different wishes that are not always realistic. At the same time, healthcare recipients are not always aware of all the above-mentioned possibilities. That is why clear and honest information about what is and is not possible is necessary. Only then can a healthcare recipient make a well-informed choice about which interventions they do or do not find suitable for them.

In addition, there is a great need for a support network for trans people – preferably from their own communities – who can provide reliable information and advice on the health effects of interventions. Think for example of pumping or fillers (often in trans women).

### *Postoperative*

Postoperative healthcare should be a standard part of trans healthcare and should not depend on individual care providers. The first check-up should be done by the treating surgeon, but follow-up checks, such as wound checks, can usually be done by a GP. In addition, providers of postoperative care should be both technically and culturally competent and should be tailored to the individual care recipient. Of course, this applies to both medical care and psychosocial or psychological care.

## Post-transition care

Once a legal change, social transition and/or medical treatment have been completed, to the extent desired or possible, people often withdraw from the trans community for a longer period of time, or even permanently. In doing so, people often lose relevant contacts in the trans community and their access to medical care by healthcare providers specializing in trans healthcare. It is important that trans people can always continue to be able to access the community and specialized healthcare providers. After all, people remain transgender for the rest of their lives, even if it is no longer an acute problem. That is why the paths must be easy to find and sufficiently equipped.

### *Hormone checkups*

In the vast majority of cases, a general practitioner can perform the annual hormone checks. Only in the case of abnormal hormone levels or in complex situations is referral to a specialist, in this case an endocrinologist, indicated. Both general practitioners and endocrinologists must acquire the necessary transcultural competences through further training and courses.

### *Societal factors*

Transgender people are not just trans – they are students or employees, they are parents of their children, they rent or own a home, etc. They have a context, are often in the middle of life. In addition to factors that directly relate to gender-related care, there is the social problem of misunderstanding, discrimination, exclusion and violence that many

transgender people face on a daily basis. These issues need to be addressed so that transgender people can enjoy the same rights as other citizens.

The corona pandemic, and especially the lockdowns, has also caused extra stress for trans people. Because the stress level for many trans people was already very high to begin with (for the reasons mentioned at the beginning of this chapter), this was the straw that broke the camel's back for many people.

### *Intersectionality*

If someone does not belong to the group that conforms to the societal norm for multiple reasons, problems become much more difficult to solve, and this also increases the risk of mental health problems and suicide. As an example of such a group that is outside the norm in multiple ways, think of transgenders with a refugee background or a migration background or transgenders with a disability or a chronic illness. An intersectional approach is necessary to gain a better understanding of the well-being, or lack thereof, of these healthcare recipients.

### *Legal change*

Principle 17 would like to see the registration of the gender of citizens come to an end in the Netherlands. It is an archaic practice that no longer serves a purpose. Therefore, gender registration is a violation of the General Data Protection Regulation (GDPR), the privacy legislation.[59]
In addition, gender registration has another major disadvantage. If gender is registered incorrectly, this has very unpleasant consequences for the person in question. It costs a lot of time, money and effort to have an incorrect registration corrected.

Until the time when the Netherlands abolishes the practice of gender registration, changing name and/or gender registrations should be possible

59 *The GDPR states that personal data of people may not be requested or stored without reason. From the moment that the legal equalization of genders became a reality, gender registration no longer served a purpose, and therefore registration is in fact no longer permitted since that time.*

everywhere without any problems and at an atmost very low cost. The GDPR offers sufficient handles for removing outdated information (or for having it removed).

# 4. Featured topics

In addition to the general commentary in Chapter Three, several topics from the Quality Standard for Transgender Care deserve further attention.

## Smoking and drug use

Undoubtedly, it's better if a care recipient does not smoke and/or uses drugs and if they do it's better if they stop doing so (preferably well before) an operation, if necessary, with guidance. Everyone agrees on that.

At the same time, it is also known that many transgender healthcare recipients live in complex circumstances with above-average levels of stress[60] and often also experience trauma (PTSD or cPTSD[61]). Smoking and/or substance use is therefore often a coping strategy, a survival mechanism, to cope with that stressful life. Long-term or even permanent cessation of smoking and/or substance use is extremely difficult or even impossible under those circumstances. Demanding that a care recipient quit, nevertheless, does not sufficiently take into account the severity of the stress that trans healthcare recipients experience. Principle 17 urges that the impact of body dysphoria (gender dysphoria that is strongly focused on the body) and the need for surgery be taken into account more fully in this type of advice. In case of severe body dysphoria, it is quite possible that only surgery can provide the desired relief.[62] This can then provide the breathing space that someone needs to stop smoking and/or using other substances.

Again, Principle 17 fully supports the medical reasons behind the advice to stop but also recognizes that adhering to this advice at all costs is counterproductive. The recommendation is therefore a more nuanced approach, which does justice to the individual healthcare recipient and their circumstances. A trans competent smoking cessation support worker or a

60 *See chapter three.*
61 *PTSD: post-traumatic stress disorder, cPTSD: complex PTSD.*
62 *For instance: Digitale (2022), Turban et al. (2022).*

smoking cessation competent trans therapist can play an important role in this.

## Healthy body weight

The Quality standard for transgender healthcare (almost) exclusively uses the Body Mass Index (BMI) as an indicator of the amount of body fat. This is problematic for several reasons.[63] First of all, the designer himself emphasizes that BMI is a statistical tool for populations and therefore should not be used as a diagnostic tool for individuals. In addition, BMI measures the ratio between weight and height, which is different from the amount of body fat, which is not directly related to a person's health. Finally, BMI has a racist component, because a different BMI range is considered healthy for white people than for black people, even though good medical substantiation for this view is lacking.

Principle 17 is of course aware that being underweight or overweight is a serious matter, which can have major consequences for people's health. However, the criterion of BMI is dubious. Maintaining a BMI limit of more than 18 and less than 30 (for white people) offers false security about someone's health status, because BMI does not actually measure what healthcare providers are intending to measure.
A more correct and effective way to assess the extent to which a person's body size has pathological aspects is to look at fitness, muscularity and other physical aspects that indicate a person's capacity to undergo surgical intervention. Principle 17 therefore recommends abandoning BMI as a criterion and instead looking at the above-mentioned characteristics.

In addition, just as is the case with smoking and/or other substance use, eating too little, too much or unhealthy food can be a coping mechanism to cope with a life that is (too) stressful. In the case of severe body dysphoria, it is also quite possible that only surgery can provide relief, because body and self-image only match sufficiently after a surgical procedure. Principle 17 therefore urges to include the influence of body dysphoria and the need for surgery more in this type of advice.

63 *In general: Tomiyama et al. (2016), trans specific: Brownstone et al. (2021).*

## Pumping

Within some groups of trans women, it is common to inject liquid silicone (pumping) for a quick and visible result of larger breasts and buttocks. In environments where little to no healthcare is available and there is a lot of poverty, the habit has arisen to use random industrial silicone oil for this. This is life-threatening and regularly leads to particularly nasty inflammations and prolapses.

Principle 17 is concerned about these practices, which also occur in the Netherlands – despite what one would like to believe. Healthcare providers must be aware of these practices so that they can warn healthcare recipients about them. Furthermore, outreach within risk groups is also necessary so that these practices can be actively prevented. This must be carried out by culturally competent persons, who are knowledgeable about transgender people, about the risks of pumping and who have an affinity with this specific target group.

## Trans and HIV

An HIV-positive status need not be an obstacle to transition haelthcare, such as hormone treatment and surgical interventions. Particularly, if a healthcare recipient uses medication (such as cocktails), n=n applies. This means that an immeasurable number of viruses is not transferable.
The social circumstances in which the healthcare recipient in question lives could possibly be a problem. For example, it may be that someone's life is not stable enough to be able to obtain HIV medication or PrEP[64] on a structural basis. In that case, this needs to be addressed. It is known that a stable and safe living situation is the most important necessary condition for being able to start getting your life back on track.[65] Only when this condition is met can work be done on other basic necessities of life, such as a stable income, daily and healthy food, structure in the daily schedule, etc. Specialized personal guidance that is also transculturally competent is of inestimable value here.

64 *PrEP: Pre-Expositie Profylaxe. This is the use of HIV blockers to prevent an HIV infection.*
65 *For instance: Regan and Bailey (2021).*

Principle 17 wants to emphasize that it is also possible in these situations that care recipients suffer severely from their body dysphoria. Therefore, it may also be in these cases be true that once a care recipient can start hormone therapy, they then have the space to take better care of themselves and create a stable living situation for themselves.

## Reimbursements

A lot is wrong with the reimbursement of (hormone) medication. Testosterone and oestrogen are also used in comparable doses by cis-gender people with a hormone deficiency. These are therefore reasonably regulated, even though there are strange reimbursement omissions.

For example, until very recently (until October 2022), the drug Nebido was only reimbursed for one third, while it creates a long-acting and very evenly releasing testosterone depot. Before that, care recipients only had a choice of testosterone gel (which has an even release but has to be applied daily) or short-acting injections (which are injected every two weeks, but cause major hormone fluctuations). Or they had to pay a substantial additional fee for the three-monthly injections with Nebido.

Important detail: Nebido is considerably cheaper than all types of testosterone gel, which are none the less reimbursed. It's relevant to mention this, because this seems to be a specific exception. There is still regular bickering about other hormone agents and forms of administration.

Bigger problems exist with drugs that are used off label[66]. Such as Finasteride, which is used off label as a testosterone blocker and is not reimbursed. It is only substantiated as a remedy for prostate problems, in a five times higher dosage. In the low dosage it is only known as a hair loss preventive which is considered to be a cosmetic use and is therefore not reimbursed.

In addition, there are also essential interventions for many trans care recipients that are not or hardly reimbursed. For example, interventions such as laser hair removal (for trans women), hair transplantation (for trans women) and voice coaching and/or speech therapy. These treatments are reimbursed only when the referral is made by a gender team. This is a discriminatory restriction that leads to arbitrariness and unnecessary delay. Liposuction of the hips (for trans men) is not reimbursed, because it is considered cosmetic. All these treatments not only have a great influence on one's self-confidence, but also on one's appearance and thus on social acceptance. It is common knowledge that bald trans women with beard growth and a low voice are more likely to encounter misunderstanding, discrimination, exclusion and violence than average.

The gaps in reimbursement of necessary trans healthcare may (partly) be caused by the lack of trans healthcare in the Dutch Medicines Reimbursement System (GVS). Principle 17 wants to push for more extensive reimbursement of medicines and interventions, so that all trans healthcare recipients can receive the healthcare they need.

## COVID-19

As described in chapter three, trans people are relatively often in a marginalized position. As a result, the corona pandemic that raged through

66 *Off label: The medicine is prescribed for an indication other than or for a patient group other than that for which the indication is intended.*

the world in 2020 and 2021 imposed a very heavy toll on the trans community. Many trans people are still experiencing the consequences. Trans people are often isolated to an above average degree and have little to no opportunities to meet like-minded people.
Those who have fled, are undocumented or are in an asylum seekers' centre (AZC) are in a particularly difficult position (see below).
Principle 17 emphasises the importance of ensuring good social support for those who need it (by trans culturally competent support workers) and easy access to vaccines, regardless of a person's residence status.

## Gemarginaliseerde groepen

In 2019, Principle 17 held two roundtable meetings with people from the trans community who face additional problems in trans healthcare, because in addition to their transgender-related healthcare needs, they have other characteristics that lead to a marginalized position in society.[67] The reason for these meetings were several disturbing stories we received from frustrated healthcare seekers in the trans community. Principle 17 invited representatives from different groups within the trans community to collect their stories and to better investigate these stories. During the meetings, experiences were shared by non-binary trans people, trans people with a disability or chronic illness, trans people of colour, trans refugees and trans people with a residence status.

Their stories were sad and shocking. The most poignant story came from a **Deaf** trans man who is still waiting for his gender reassignment surgery after more than ten years, because the doctors do not take him seriously. The story of **autistic** trans healthcare recipients is better known and is mainly caused by the prevailing neuro-normativity in the gender teams. This means that autism, ADHD and related conditions are seen as a pathological deviation from the norm, instead of as natural forms of neurodiversity. Here too – just as with non-cerebral (not concerning the brain) disabilities and diversity – the old-fashioned medical model plays a role versus the social model, as outlined in the UN Convention on the

67 *For instance: Paine (2021).*

Rights of Persons with Disabilities[68]. Apart from this, it is particularly strange that the gender teams are aware of the relatively high incidence of autism in trans people on the one hand, but on the other hand appear unable to provide proper assistance to these care recipients.

Trans **refugees** also report major problems. For example, they are not allowed to start hormone treatment or even psychological consultations if they are still in the asylum procedure. Trans refugees who have previously used hormones have the greatest difficulty in continuing this hormone therapy. Access to specialized trans care has extremely long waiting times and many general practitioners are hesitant to prescribe hormones to trans people. This practice is in flagrant violation of international agreements. Violence is common in many **asylum centres**, which is life threatening to trans people - sometimes literally. In addition, the refusal to provide

68 *The UN Convention on the Rights of Persons with Disabilities (CRPD) has the social model as it's starting point: people with a disability are normal human variations. A disability (the physical condition) only becomes a disability (impediment) if society is inaccessible. The Netherlands ratified the CRPD in 2016.*

healthcare regularly leads to life-threatening situations. AZC doctors are often unwilling to prescribe anything more than 'an aspirin'.

The roundtable discussions made it painfully clear that anyone who does not meet the white, binary, able-bodied, neurotypical, Christian and Dutch-speaking norm has a high chance of experiencing problems in gaining access to trans care. It was also striking that many experienced unnecessary delays during transition healthcare, because care providers wanted to be ‘cautious’ and therefore deemed ‘extra guarantees and checks’ necessary.
Conclusion: the more intersections are represented in a person, the more complex healthcare providers find the situation to be, the more difficult it becomes to gain good access to trans healthcare.

# 5. Children and young people

The social attention for the well-being of gender diverse and gender creative youth is important. Children and young people definitely need support in their process of self-discovery – that is after all the essence of education. This also applies to gender creative youth. Incidentally, there is no medical intervention before puberty.

## Intersex

There is an overlap between gender diversity and creativity and non-normative development of sex[69]. This has several causes, including biology and medical policy in the Netherlands.
The policy of not intervening before puberty in gender-creative children should also apply to children with non-normative sex development. At least until the child in question is old enough to decide for themselves.[70]
Unfortunately, the current standard for treating children with non-normative sexual development in the Netherlands is different. Most doctors in the Netherlands still intervene as early as possible, with irreversible surgical treatments. This is an (incomprehensible for Principle 17) exception to the standard norms for decision-making authority, as laid down in the WGBO. The community of people with non-normative sexual characteristics has serious objections to this way of working. It is a positive development that more and more countries recognize the right to self-determination and prohibit early intervention without the consent of the child itself, such as Kenya and Greece have done recently. Principle 17 hopes that the Netherlands will soon follow suit.

## Inconsistent norms

Current medical standards, including the International Classification of Diseases (ICD), do not consistently address the human rights of children as

69 *Diagnosed by doctors as intersex condition or differences in sex development (DSD).*
70 *In case of non-normative development of sexual organs and all related issues parents should be referred to (support groups of) experts by experience. Additionally, it may be preferable to have an expert by experience present at doctor's appointments.*

enshrined in the UN Convention on the Rights of the Child (CRC)[71]. The CRC is of great importance for medical interventions in young people from puberty onwards. Article three states that the best interests of the child are paramount. A later, clarifying commentary[72] elaborates that the perspective is that of the child.

Nevertheless, the latest version of the ICD, the ICD-11, includes a diagnosis of 'gender incongruence in children'.[73] This pathologizes healthy children who do not receive or need medical treatment. It is particularly strange that the WHO no longer considers “gender incongruence” in adolescents and adults as a psychiatric diagnosis, but at the same time introduces “gender incongruence in children” as a new psychiatric diagnosis.
The inclusion of this diagnosis in the ICD-11 and its use is the result of a specific Western view of gender and sex, which is not shared by the rest of the world. And which is also not uncontested in the Western world itself. Important trans organisations such as Transgender Europe (TGEU)[74], Global Advocates for Trans* Equality (GATE)[75] and Stop Trans Pathologisation (STP)[76] have consistently opposed the inclusion of this diagnosis in the ICD-11. The European Parliament has also adopted a motion against this diagnosis.

## Screening

Another issue is the screening of gender-creative children. How do they think they can determine to what extent a child is transgender or not? At present, this is done by child psychologists or child psychiatrists, possibly in collaboration with child endocrinologists. The biggest problem with this practice is the cisgender normative assumptions, despite sexual and gender diversity being a completely normal biological phenomenon. *All*

71 *www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child*
72 *Committee on the Rights of the Children, General comments* 14 *(2013).*
73 *Code HA61 Genderincongruence of childhood.*
74 *tgeu.org*
75 *gate.ngo*
76 *www.stp2012.info/old*

societies, then and now, have at least three genders[77]. A major exception is in the West, where only two genders are recognized.
However, because cisgender people occur more often than other variations in gender diversity, and because this idea has developed historically, being cisgender is valued differently (read: more valuable) in our society than other variations in gender identity. Incidentally, our colonial past has played an interesting role in this.[78]

## Watchful waiting

The usual approach to gender creative youth is watchful waiting, which means waiting to see how the child develops. In addition, care providers advise against social transition, because the child could change his or her mind. Principle 17 disagrees with this advice, because this approach hinders children in their development. In social transition, there is no irreversible step, so there should be plenty of room for the child to change further or change back.

Adults should support children in their development towards adulthood, including their sexual and gender development. In this light, as an adult you want to see and hear indications about how your child feels and behaves. And you want to hear this, in accordance with the rights of the child (see CRC), where possible, from the child itself, with the support of photos, videos and other material. So everything with the child, not about the child. In accordance with the guidelines for the treatment of gender creative children, as established by experts from the international trans community in 2013.[79]
Research confirms that social transition in gender-creative children is good for their mental well-being. Gender-creative children who have to stay in the gender role that matches their apparent sex suffer significantly more from depression and anxiety than gender-creative children who are allowed

77 *Some examples of genders outside the Western culture's binary man/woman classification: Kathoey (Thailand), Hijra (India), Travesti (Latin-America), Two Spirits (Native Americans), the seven genders in Talmud (Judism) and the five extra genders in Islam. See also Wikipedia on 'third gender' and 'transgender'.*
78 *For instance: Lugones (2008).*
79 *Global Action for Trans Equality (2013).*

to live in their desired gender role.[80] Comparable research into gender-creative youth, with and without hormone treatment, shows less depression and suicide in gender-creative youth who receive hormone treatment.[81]

## Gay or trans?

A frequently heard argument against trans care for children is that it is not clear whether the child will develop in a homosexual or transgender direction. This question sets cisgender and heterosexuality as the norm. Homosexuality is no longer seen as a psychiatric or medical phenomenon and therefore all references to homosexuality have been removed from the ICD. If gender-creative children are now included as an additional category of care, then sexual and gender diversity are again problematized. Prepubescent children do not receive medical gender related healthcare. In developmental coaching, it is not a problem that there might be a smooth transition back and forth between homosexuality and transgender. In any case, sexual orientation and gender identity are much more closely related than people often think. For example, many behaviours that are perceived as expressions of homosexuality also are behaviours that are perceived as expressions of gender.
A wait-and-see and dissuasive attitude, as stated earlier, goes directly against General Comment 14[82] on the CRC. Principle 17 therefore continues to explicitly state that the diagnosis Gender Incongruence of Childhood (code HA61) should be removed from the ICD-11 as soon as possible. The SOC-8 are also not unambiguous and in practice sometimes run the risk taking a wrong turn.

For the medical care of young people who are going to use puberty blockers, there should also (again) be primarily affirmative care that helps the healthcare recipient based on their needs. Furthermore, it is important that healthcare providers are explicitly open to and have knowledge of non-dichotomous gender development, which goes beyond male or female identification. In the US, almost half of young people no longer identify as

80 *Duurwood et al. (2017), Olson et al. (2016).*
81 *Green et al. (2021).*
82 *Committee on the Rights of the Children, General comments 14 (2013).*

necessarily hetero or cis[83]. In practice, we have seen that many healthcare providers lack this knowledge, which leads to friction between the healthcare provider and the healthcare recipient.

The proposal for social transition of prepubescent children under the supervision of an expert is not the position of Principle 17, because this again assumes watchful waiting. Social transition is characterized precisely by the fact that it is reversible, that the person who transitions can go in a different direction when they want to.[84] Childhood is characterized by 'mobility', by 'variation' of behaviour. At the same time, this does not mean that when the child indicates that he or she feels differently than expected by adults, everyone should be informed immediately, and everything should be turned upside down. The point is that it is not a problem when a child grows into another expression or retraces their steps.

It is this cisgender normativity that drives the wrong focus and wrong conclusions of the widely used Amsterdam prevalence study[85]. In this study, anyone who does not develop as "strictly transgender" is dismissed as a *desister*[86], which is unjustified. (Incidentally, certain other assumptions in this research are also questionable, with major consequences for the results. But this falls outside the scope of this report.)

83 *Bond,* Nearly 40 Percent of U.S. Gen Zs, 30 Percent of Young Christians Identify as LGBTQ, Poll Shows *(2021):* [www.newsweek.com/nearly-40-percent-us-gen-zs-30-percent-christians-identify-lgbtq-poll-shows-1641085](www.newsweek.com/nearly-40-percent-us-gen-zs-30-percent-christians-identify-lgbtq-poll-shows-1641085)
84 *Ashley (2019).*
85 *De Vries et al. (2014).*
86 *Desister: anyone who stops medical transition or who no longer identifies as transgender, especially children or young people.*

## Puberty blockers

Medical intervention in trans youth can only begin at the onset of puberty, when secondary sexual characteristics are developing. From that moment on, a young person may be eligible for, for example, the use of puberty blockers to counteract the development of unwanted sexual characteristics. These general analogue hormone blockers have a temporary effect: as soon as the young person stops taking these medications, the physical pubertal development will also resume.
In gender creative children who indicate long before puberty that their body and gender identity do not match, one can consider starting cross gender hormone treatment earlier and cautiously. This method falls within the framework of the SOC-8, which completely eliminates the fixed age limit.

## Neurodiversity

In recent years, there has been a lot of attention for neurodiversity among gender-creative youth. It is positive that this is being given attention, but it is worrying that this is mainly done from a ‘concerned’ perspective. People wonder whether these children ‘get it’. Whether they are ‘really’ trans or gender-creative (enough). Whether they can handle a social transition and/or medical treatment. These can be good and relevant questions, provided that they are asked from a trans and disability-positive starting point.
What Principle 17 observes, however, is healthcare providers who approach both transness and neurodiversity from a medical perspective and are therefore very reluctant. We also rarely hear or read input from neurodiverse experts and advocates.

Of course, Principle 17 also believes that it is always important to consider the emotional, cognitive and neurological capacities of a trans healthcare recipient. At the same time, it should be equally obvious that their needs should also be considered. Healthcare should be aimed at improving the quality of life of healthcare recipients.
Principle 17 advocates that gender-creative youth who are also neurodiverse should receive support on both aspects. This support should be provided from a social framework (see UN Convention on the Rights of

Persons with Disabilities), and not from a medical model. The ideal approach is that the healthcare recipient receives support from an expert by experience, who is also trans and neurodiverse.
The well-known ABA behavioural therapy[87] mainly aims to 'normalize' neurodiverse people and that is a problematic approach to neurodiversity.[88] Early on, attempts were made to normalize neurodiverse people only, but eventually LGBTI+ people also became targets of this practice.[89]

## Criticism

Vocal criticism of enabling social transition in children is heard as well from 'feminist' quarters. A growing group of mainly white, older feminists express serious concerns about the 'transition' of gender-creative children. These people call themselves 'gender critical' but are in fact trans haters. These people are known as Trans-Exclusionary Radical Feminists (TERFs).[90]

Like their foreign colleagues, Dutch TERFs use commentary and terminology that suggests that we are dealing with a dangerous phenomenon. They talk about 'gender ideology' and use terms such as 'social contagion' and 'Rapid Onset Of Gender Dysphoria' (ROGD). Their main goal is to deprive trans people in general and gender creative minors in particular of gender-related healthcare. These TERFs advocate the retention of psychological gatekeepers for transition healthcare. This view is gaining ground among 'gender right'. Unfortunately, sound criticism of the TERF position rarely gets the attention it deserves.[91]

Many "lesbian feminists" among TERFs do not recognize transgender people in their identity. They are especially concerned about "girls" having their breasts removed and no longer identifying as women. They consider trans women to be "surgically created lesbians" (quote from TERF Janice Raymond[92]).

87 *Applied Behavior Analysis, a popular behavioural therapy for autistic children.*
88 *For instance: neuroelfje.nl/neurodiversiteit/autisme/aba-problematisch (Dutch only)*
89 *For instance: Gibson et al. (2018).*
90 *TERF has by now become a name for all trans hating women.*
91 *A good critique can be found in: Winters (2021).*
92 *Zie vooral: Janice Raymonds (1994).*

TERFs often use rhetoric, scaremongering and false arguments. A campaign like 'Gendertwijfel'[93] also spreads disinformation and sows unfounded fear by, among other things, proclaiming that the new gender law would endanger cis women and girls. In response to this, Nanoah Struik, together with a number of other trans and bon-binary people, published the Gendervrijheid Manifesto.[94]

93 *Genderdoubt. The campaign takes place on social media and through their website Gendertwijfel.nl. The campaign is initiated by Voorzij, with assistance by, amongst others, columnist and trans hater Jan Kuitenbrouwer.*
94 *Gender Freedom Manifesto (2022): expreszo.nl/gendervrijheid-manifest (Dutch only)*

# 6. Commentary on  Quality Standard for Transgender Mental Health Care

A separate standard has been created for mental healthcare for trans people: the Quality standard for transgender mental healthcare. There are also considerable reservations about this. The standard describes detection (Dutch: *signalering*), diagnosis, treatment and, finally, how mental healthcare is organized.

## Detection

The chapter Signalering describes the course of ‘gender dysphoria’ from childhood to adulthood and concludes with some other considerations. In a background paragraph, the problem of a lack of knowledge and insight among healthcare providers is outlined. For example, it is assumed that there is unfamiliarity with gender incongruence and minority stress. In addition, it is acknowledged that – however shocking – there are prejudices about transgenders among healthcare providers. ‘Evidence’ of how and how often gender incongruence occurs is discussed based on social research.[95] The prejudices among the predominantly cisgender and hetero population are rightly pointed out; they are considerable. It is advised to radiate trans friendliness through adapted information, other gender options on forms and gender-neutral toilets.

## Diagnostics

The chapter Diagnostics distinguishes seven different groups: from young children to adults, who may or may not want gender-affirming treatment, with or without sufficient support. Reference is made to international standards and guidelines in use for trans-specific mental healthcare.[96]
It also monitors how treatment is arranged in Dutch healthcare programs, for which three models apply:

95 *Netherlands: Kuyper (2012, 2016), VS: Sanchez et al. (2006), Norton et al. (2013).*
96 *To wit: Dahl et al. (2015), American Psychological Association (2015).*

- Indication by multidisciplinary teams
- Indication by a psychologist and a psychiatrist (four-eyes principle)
- Indication based on informed consent[97]

A ‘trust-inspiring attitude’ is recommended for the healthcare provider. Furthermore, it is stated that the healthcare recipient is entitled to more than an indication for somatic care and is also entitled to diagnostics for psychological care.
There is no explicit opinion on whether the role of the indication provider and the practitioner should be combined. Nor on the (un)desirability of multidisciplinary decision-making.

## Treatment

The chapter Treatment discusses the seven groups of healthcare recipients in more detail and then covers various standards and qualifications for healthcare providers (such as WPATH). Attention is paid to the care needs that can also exist among relatives of trans people and the lack of all kinds of research is emphasized. The required competencies are discussed, referring to WPATH, APA[98], AACAP[99] and the need for (trans)cultural competence is pointed out.

## Organization of mental health care

Dutch mental health care (GGZ) for trans people consists of several institutions, which also perform the assessments. In addition, there are independent therapists and coaches who help trans people with their mental health questions. In 2021, a large provider of mental healthcare for trans people was declared bankrupt and turned out to be fraudulent. At the same time, new institutions are emerging that are seriously concerned with trans mental healthcare. Access is usually via referral by the general practitioner, just like other mental healthcare.

97 *The Dutch healthcare system uses* ‘indicatie’*, ‘indication’, as a word to describe an official recognition that someone needs healthcare and treatment, and that this healthcare will be reimbursed by healthcare insurance.*
98 *APA: American Psychiatric Association.*
99 *AACAP: American Academy of Child and Adolescent Psychiatry.*

## Commentary

At first glance, the Quality standard for transgender mental health care seems reasonable, but upon closer inspection it contains a considerable number of fundamental problems.

### *Assessment psychologist*

The hottest issue for Principle 17 is that the Standard continues to adhere to the psychological assessment with gatekeeper function. Three different models are discussed: 1. multidisciplinary, 2. assessment and guidance in one and 3. informed consent. The informed consent model is discouraged.[100]

100 *Quality standard for transgender mental healthcare, page 20.*

As described in chapter two, ‘gender incongruence’ is no longer a psychiatric condition in the ICD-11. However, the Netherlands still maintains the psychiatric diagnosis ‘gender dysphoria’ according to the DSM-5. This obliges transgender healthcare recipients to visit a psychologist who must issue a psychiatric health certificate before they can gain access to somatic care. Transgender healthcare recipients are the only healthcare recipients in the Netherlands who must prove that they are competent in this regard before they can gain access to necessary somatic care. All other healthcare recipients are assumed to be competent in this regard until a physician strongly suspects the opposite. A shocking situation.

Principle 17 advocates non-pathologizing healthcare. Gender incongruence can be determined in many ways, including based on what the healthcare recipient indicates. Trans healthcare recipients usually immediately tell how and for how long they have known that they are ‘different’. In an initial conversation, a healthcare provider can ask about this, and about how far the healthcare recipient has progressed in their gender discovery journey. In the case of gender-creative youth, there are excellent alternatives, such as accounts by others, acquaintances, family and carers, who are closely involved in the life of the young person who might provide additional information on what the young care recipient indicates. Photos, videos and stories can demonstrate that the person has previously shown that they are different. The most important thing is a competent healthcare provider who takes gender diversity seriously, regardless of the age of the care recipient.

Another fundamental problem is the uncontrolled power dynamic that arises between the healthcare recipient and the healthcare provider. Even if the expected judgment is shared with the healthcare recipient in advance, there is still a power imbalance. After all, the healthcare recipient is not able to vouch for themself but is dependent on the judgment of the healthcare provider. This inevitably leads to the care recipient telling the care provider what the care recipient thinks is the desired story.[101] This practice erodes

101 *It is well known in the trans community that very few healthcare recipients are honest about their gender identity towards the assessment psychologist. The reason is always the same: a fear of introducing delay or of being reused healthcare even.*

the authentic development of the care recipient and leads to distrust in the assessment process.

### *Cis normative*

By speaking of ‘detection’ (Dutch: ‘signalering’) of ‘gender dysphoria’ in a special standard for a specific target group, the authors give the impression that they have thought and worked from a cisgender normative framework ideas. Gender variation is normal variation and therefore an explanation of how this develops is not necessary. The standard does not explain how a cisgender identity develops either, does it?!

If you want to tackle gender-related healthcare properly, then, as a healthcare provider, you must refrain from making assumptions about someone’s gender, sex and sexual identity. An open and welcoming attitude does not assume the usual cisgender expectations and does not make assumptions about someone’s gender. This may take some getting used to for both healthcare providers and healthcare recipients, because we all grew up in this gendered society. A major advantage is that such an attitude makes it safer for hesitant or anxious healthcare recipients to open up to the healthcare provider.[102]

### *Trans cultural competence*

Of course, healthcare providers must have transcultural competence and (in broad terms) knowledge of and understanding of what is happening in the trans field. They must be familiar with the developments of the LHBTI+ community and of important nuances. If a healthcare provider does not have this, they are unsuitable for the position and that should be grounds for dismissal.
In practice, however, this cultural competence is completely lacking. That is why, under the leadership of, or at least under the supervision of, trans

102 *For instance: O’Banion et al. (2021). In the Netherlands the* Alliantie Gezondheidszorg op Maat*, Alliance for Customized Healthcare, has run a campaign “*Komt een mens bij de dokter*”, “A person goes to the doctor”, which is the source of this example: www.komteenmensbijdedokter.nl/knowledge/podcast-1-de-geslachtsoperatie-was-nooit-het-einddoel (Dutch only)*

professionals, good education must be provided as soon as possible, in the form of training and further education.
Especially now that in the United States 30% of Millennials and 39% of Generation Z identify as LGBTQ – a trend that is also visible here[103] –, it is even more urgent to demand queer competence from healthcare providers.

## Good example

The standard of care in Catalonia clearly indicates in paragraph 6.3.3 which psychological services may be possible and/or useful, including:

- The support related to psychological aspects will always be at the person's request.
- The health care professional basic functions are giving information, accompaniment, support in the personal process of the trans* person. The person is the one to take the ultimate decision.
- Giving support to the identity construction process respecting and enhancing their subjectivity.
- Validate and legitimate the variety in emotional expressions generated along the transition; getting rid of guilt and normalising the psychological suffering that might result from the process.
- Empower trans* people's autonomy in their transitional process.[104]

103 *As yet there are no good data form the Netherlands. ZonMw has been tasked with researching this.*
104 *Trans forma la Salut,* Proposal of an integrated health care model for trans* people in Catalonia.

# 7. Alternatives: how should things be done?

Principle 17 establishes a need for a different approach to the standards for somatic and transgender mental healthcare. Even the existing standard for transgender mental healthcare states that trans healthcare needs a different approach. This chapter describes how trans healthcare can be improved.

## Political organisation

A different structuring of (trans) healthcare requires a different structuring of the flow of money, because these are linked inextricably in the Netherlands Currently, financing is provided through the Health Insurance Act[105]. Within this framework, money and capacity are requested and released via purchasing strategies based on measured and extrapolated needs.
The government has made itself the director or playmaker by placing the authority to make decisions with third parties. The minister is boasting of a three-way consultation between care providers, insurers and representatives of care recipients (in this case Transvisie) as a solution. There seems to be no political will for substantive government involvement. This current approach is not productive, because there is a fundamental inequality in power between these three parties. Health insurers can enforce rates and decide whether to reimburse certain procedures (whether elective or not[106]). The only requirement from the government is that all treatments in the base package must be reimbursed. Healthcare providers are no match for this power. Representatives of healthcare recipients are even more at a disadvantage, because these are often volunteer organizations.

## Fundamental criticism

In the previous chapters, Principle 17 has already given principled reasons why the care standards need to be changed and in what way this should be done. Principle 17 believes that if what you want is a truly different vision of

105 *Can be found at: wetten.overheid.nl/BWBR0018450/2023-01-01 (Dutch only)*
106 *According to the judgment of the health insurers.*

trans care, this is only possible if it is tackled radically. The writers of the current care standards (now) realize that there is more variation than ‘man’ or ‘woman’. They are aware that there is also a non-binary identity. Nevertheless, both care standards are still written entirely from a cisgender frame of reference, with the result that the standards are imbued with cisgender normativity.

For example, the first paragraph of the Quality standard for transgender healthcare states that it is important to know how many people are transgender. But that has been known for a long time: approximately 4% of the population is transgender.[107] Incidentally, not everyone in those 4% needs transition care.
Principle 17 agrees that it is important to know figures to the extent that it could informative because the current supply of transgender health care has not been able to meet the demand for years. In short, the supply must be increased enormously, otherwise the waiting times will increase even further.

At the same time, Principle 17 is convinced that a real solution to the problem is only possible with a radically different approach to trans healthcare. Stop using the assessment psychologist as a gatekeeper and use the resulting budget for actual care. Because the obligation to see an assessment psychologist who assesses whether you are trans enough to be allowed to be trans is of course not a useful undertaking. That is work creation for care providers. The budget might also be better spent by using it for education, training and further training of care providers.

Ultimately, we need to move towards a situation where the following applies: “simple where possible, specialist where necessary”. This means that hormone treatment will generally be performed by general practitioners. They are perfectly capable of doing this, because during their training they have acquired knowledge about basic endocrinological care. Where necessary, a general practitioner can consult with a specialist. In rare or complex situations involving hormone care, the general practitioner can refer to a specialist, as is generally customary.

107 *For instance: Keuzenkamp (2012).*

Medically complex care must be provided at the level of specialism required. For example, surgery will continue to have a high level of specialisation, because it requires a minimum number of procedures performed per year per surgeon, for them to maintain their required level of experience.
It is also important to share knowledge well between specialists and primary care providers, so that specialist care is reserved only for those who really need it.

To get there, there needs to be a solid investment in knowledge building in the (para)medical and social work field. The fact that there is no structural attention for transgender people in education and the frame of reference still mainly comes from the DSM and also the ICD, indicates that there is still a world to be won here. (Para)medical and social professions also have a need to acquire more relevant knowledge, because various developments indicate that the division of gender as we are accustomed to in the West is coming to an end[108].

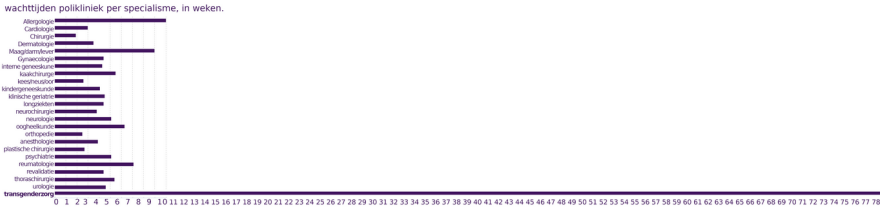
Psychologists and psychotherapists also need more knowledge about gender incongruence. It is still too common for trans people to receive (incorrect) psychiatric diagnoses because the healthcare provider has no knowledge about what being transgender means and therefore incorrectly assesses symptoms of gender incongruence.

108 *See end of chapter 6, top of page 64.*

All of this cannot and should not happen without intensive involvement of the trans community, for whom this care is intended. The adage “nothing about us, without us” is very true in this field, because it is the only way to eliminate cisgender prejudice from trans healthcare. Various studies from and years of advocacy by transgender experts and professionals have already resulted in many changes. For example, hormone use was considered necessary for surgery for a long time, but it has now been accepted that this is not necessary at all.

## Waiting times

Waiting times for medical assistance in gender transition are extreme.[109] Fortunately, all parties involved agree that the various stopgap measures of the past decades have at most been able to provide temporary relief. In short, these chronically enormous waiting times require a completely different approach to trans healthcare to put a definitive end to this. The Quality standard for transgender healthcare is also concerned with waiting times.[110] Some waiting times have a good medical reason, such as the time between surgical treatments. One must first be sufficiently cured before a subsequent intervention is justified. Other waiting times, such as those for the ‘assessment psychologist’, are completely unnecessary because the assessment itself is unnecessary. Waiting times for mental health support or endocrinological support, for example, are ‘unfortunate’. Medical decision-making should not lead to long waiting times. Significant exceedances of the Treek standards[111] (6 weeks) are highly undesirable.




*Outpatient clinic waiting times per specialty, in weeks (2021).*

109 *See Letter from the Quartermaster Transgender Care (2022), Impuls Economen (2021).*
110 *See Quality standard for transgender healthcare, page 19.*
111 *See for example: [www.jaaah.nl/snel-regelen/zorgadvies/treeknormen](www.jaaah.nl/snel-regelen/zorgadvies/treeknormen)*

Professional support is urgent in the current social situation, where trans people are disproportionately and increasingly confronted with misunderstanding, discrimination, exclusion and violence.[112]

## General practitioners

The Quality standard for transgender healthcare mentions a desired role for general practitioners, provided that the general practitioner has the required medical competence. The plea for an NHG Standard[113] is fine and acknowledges the desire for further decentralisation and de-specialization. It is important to realize that hormone care for trans people is not very complex in principle. In adults, little shift in hormone levels or physical development is to be expected. In addition, professional information about standard values can be found in various accessible places.[114] If a situation exceeds the knowledge or level of familiarity of a GP, he or she can always consult and, if necessary, refer. Even though GPs acquire knowledge about basic endocrinological care during their training, they often do not feel comfortable providing this care to trans clients. This must therefore be changed through encouragement.
Hormone treatment for young people is a different story. Young people are developing during their puberty, both in terms of body and (gender) identity, so this requires customization in a way that exceeds the knowledge of the average GP. Supervision by a (paediatric) endocrinologist is therefore recommended for young trans people.


*(Outpatient clinic waiting times, follow-up)*

112 *See for example:* [www.transgendernetwerk.nl/veiligheid](www.transgendernetwerk.nl/veiligheid)
113 *The* Nederlands Huisartsen Genootschap*, Dutch College of General Practitioners, (NHG) publishes guidelines for the diagnosis and treatment of common conditions in general practice.*
114 *See professional websites, like:* [www.rainbowhealthontario.ca/TransHealthGuide/gp-mascht.html](www.rainbowhealthontario.ca/TransHealthGuide/gp-mascht.html) *and* [transcare.ucsf.edu/hormone-therapy](transcare.ucsf.edu/hormone-therapy)

The standard procedure of collegial contact, as it generally applies in healthcare, should also be common in trans care. So, if a GP has difficulty interpreting the results of a blood test correctly or indicates that he or she does not have sufficient expertise, he or she should be able to request additional information and thus gain knowledge. In summary, a GP who wants to can already train in transgender hormone care and provide it. This does not alter the fact that a greater role for the second line, the general hospitals, is still needed for the time being. This could significantly reduce waiting times in the not-too-distant future. At least, if the 'entrance exams' come to an end…

A GP can, apart from prescribing hormones and monitoring their effects on the healthcare recipient, also fulfil another very important role: monitoring how things are going mental health wise and emotionally, checking how things are going with work, study, income, housing and the like. As recommended by the National Gender Service Ireland.[115]

## Hormone treatment

The Quality standard for transgender healthcare states that gender-affirming hormone treatment is approved if the following criteria are met:

- Persistent gender incongruence
- Secondary problems (!) under control
- Mental capacity for self-assessment present
- Trans care recipient is informed and has actively consented
- In case of abnormalities in the blood count: approval by a specialist (due to possible medical contraindications)
- In case of young people: approval by a paediatric endocrinologist

Again, the standard assumes distrust of the care recipient: "prove that this is who you are or that this is how you feel!" Being transgender is seen as a deviation from the cisgender norm for identity and bodies. Principle 17 advocates a human rights-based approach to healthcare, with naturally occurring biological variation in gender as a starting point.

115 *See: Advice for GP's, nationalgenderserviceireland.com/advice-for-gps*

As chapter three already described, the requirement that ‘other problems’ must be under control is problematic. Body dysphoria can be so strong that it in itself leads to serious stress, which can (apparently) manifest itself as psychiatric problems, smoking, substance abuse, under- or overweight. These are therefore direct consequences of gender incongruence and not ‘other problems’.

Furthermore, the standard states on page 32: “Transgender people are often insecure about their passability and hormone treatment is important for many of them to suppress these feelings.”[116] Here the standard completely misses the mark. Trans care recipients use hormones to change their bodies in the desired direction (whatever that may be), so that their bodies better match their gender identity. So it is definitely not about ‘suppressing feelings’. It is about achieving the desired physical changes, so that the gender incongruence decreases.

## Specific proposals

Principle 17 proposes the following changes:

### *General points*

Take human rights, medical and physiological conditions as ingredients. Take the needs of the trans healthcare recipient as a starting point, which will sometimes break through cis-heteronormative and/or binary assumptions and dogmas.

### *Diagnostics*

This will be dropped in favour of an extensive intake.[117] The reason for diagnostics is the assumption that something can be diagnosed. However, gender diversity is not a psychiatric or sexual disorder; it is normal, human variation. In addition, diagnostics creates an (in this case unnecessary) power imbalance between healthcare recipient and healthcare provider.

116 *Translation Principle 17.*
117 *As described in the Informed Consent for Access to Trans Health (ICATH) model. The site is defunct, but can still be accessed via the Web Archive: web.archive.org/web/20191029023431/http://www.icath.org*

Healthcare insurers do require a diagnosis for reimbursement, but this can also be solved differently. For example, consider pregnant people who need healthcare, for whom a special code 'other care' has been created. We could learn from Denmark, which solved this with the code 'contact in connection with gender questions' in their national classification.

### *Social transition*

A social transition is defined as: moving away from the ‘gender one was raised in’ as publicly as possible, part-time or full-time, and/or moving towards the experienced gender identity and/or gender expression, part-time or full-time. When someone feels that it is time to present themselves in their own gender, that choice should be supported as best as possible - and not held back because the outside world is not (yet) ready for it, or the child or young person is “insecure”. The standard approach of watchful waiting for children must stop. The child or young person in question must be supported.

### *Hormone treatment*

Cross gender hormones in transgender children and adolescents may be used as soon as it it has been established that they are competent to judge on matters that affect their own lives with regard to their gender identity, in accordance with the CRC. Research shows that there is little correlation between age and competence.[118] In contrast to general somatic care, this can be quite early. Most gender-creative children understand very well what they are asking for, despite their age.

### *Hormone adjustment phase*

Correctly setting the hormone treatment can be done in a few months. This does not have to be an obstacle to continuing with a social transition (where desired). Attention should also be paid to a possible desire for microdosing for as long as the care recipient prefers this. Sometimes it is a hesitant start, sometimes it is the desire for a slight or slow change.

118 *Lieke et al. (2021).*

### Facial hair removal

This should be accessible to anyone with facial hair, as already described in chapter three. There is little scientific literature on facial hair removal, but in the trans community we all know how extremely frustrating it is if this is not or insufficiently reimbursed. Award and reimbursement are indicated as long as necessary or desired, also in the case of heavy general body hair.

### Gynecological surgery

For children and young people, this should be available from the moment that there is a desire for it and it is also physically possible. The Quality Standard Transgender Care also endorses this, more or less. The SOC-8 currently assumes a minimum age of 14 or 16 years.

### Breast enlargement

For clients who do not use hormones, breast enlargement is indicated immediately.
For clients who do use hormones, breast enlargement should be possible after a good assessment of the effect of the hormone treatment has been made. As the current standard of care also describes. This is often after about a year of hormone use.

### Mastectomy

There is no strict medical necessity for hormone treatment prior to breast removal. This should therefore also be possible without hormone treatment, if desired, as the existing standard also describes.

### Facial surgery

For a significant portion of the (mainly) trans female population, facial surgery is an important tool to be seen as a ‘woman’ by society[119] For care recipients who do not use hormones, facial surgery is immediately indicated. For care recipients who do use hormones, facial surgery should

119 *Facial surgery for trans women is also known as Facial Feminisation Surgery (FFS) and for trans men as Facial Masculinisation Surgery (FMS).*

be possible after a good assessment of the effect of the hormone treatment has been made. This is often after about a year of hormone use.

In addition, Principle 17 believes that much needs to change regarding the cis-hetero-normativity in our society, and the hostile attitude towards trans people with it. But that falls outside the scope of this report.

## Protocols and guidelines

It is good to continue to realize that protocols are drawn up as general rules based on good practices. They are guidelines that provide an indication for action. But as every healthcare provider knows (or should know): treating people is custom work. Protocols are therefore not set in stone.

Healthcare providers must therefore also apply their own knowledge and experience to a situation, with the official guidelines and this alternative vision in mind. Check and discuss the specific situation and the specific question with the care recipient in question. If necessary, they should consult a colleague with more experience or a more in-depth specialization. Care recipients must realize that everybody is different. A healthcare provider cannot simply say: “The protocol says A, so I will do A.” The healthcare provider must work with you. It is possible that your body and your life react differently than the guideline requires.

## Financing

To provide good healthcare, the Netherlands will have to invest in education for current and newly trained healthcare providers, and in research. Trans experts and advocates will have to be involved at all stages.

In addition, healthcare financing needs to be arranged differently. It is fundamentally wrong to let parties with a business interest determine healthcare budgets through purchasing. One of the consequences is that healthcare providers are forced to work below decent price standards, because otherwise they will not get enough clients to maintain their level of expertise, or even to make ends meet.

The liberalization of healthcare has already led to poorer care, lower salaries for healthcare personnel, longer waiting times and, remarkably enough, an increase in the (total) costs of healthcare. Two major providers of transgender care have recently collapsed, with major consequences for trans healthcare recipients.

Furthermore, the decentralization of healthcare that has been in effect since 2015 has many disadvantages. This is one of the reasons why a provider such as Stepwork could fail.

Principle 17 states that healthcare should not be a ‘product’ but should be a service.

## Drug reimbursement system

The drug reimbursement system (GVS) also needs to be adjusted. In general, but certainly also for trans medication. The problems with hormone medication and blockers were already described in chapter four.

# 8. In conclusion

Principle17 hopes that this vision statement for an alternative approach to trans healthcare will provide a clear picture of the current situation surrounding trans healthcare and our objections to the most recent care standards. By presenting a vision from the trans community, Principle 17 wants to make an important voice heard, namely from those who need trans healthcare. Too often, decisions are made about us, not with us, about our lives. It is of great importance that as many people as possible become aware of this vision.

This vision statement for an alternative approach to trans healthcare has been developed using a variety of sources: the different experiences within the trans community in the Netherlands, knowledge of various standards at home and abroad, human rights treaties and social developments. In this document, Principle 17 has formulated clear and specific proposals for how things can be done differently.

We invite you as a reader to take the recommendations in this vision for an alternative approach to trans healthcare to heart. In addition, we would like to ask you to take steps, within your possibilities, to improve trans healthcare. This can be something small, such as talking to another trans person or a healthcare provider. It can also be something big, such as setting up a demonstration for better trans healthcare.

We would like to discuss this vision statement for an alternative approach to trans healthcare. You can reach us via: info@principle17.org.

# 9. Literature


- Alipour, M. (2017). *Islamic shari'a law, neotraditionalist Muslim scholars and transgender sex-reassignment surgery: A case study of Ayatollah Khomeini's and Sheikh al-Tantawi's fatwas*, International Journal of Transgenderism, 18:1, 91-103.
- Alliantie Transgenderzorg (2017). *Kwaliteitsstandaard Psychische Transgenderzorg*.
- American Psychological Association (2017). *Diagnostic Statistical Manual of Mental Disorders (DSM)* (edition 5).
- American Psychological Association (2015). *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. American Psychologist, 70 (9), 832-864.
- Ashley, F. (2021). *The continuum of informed consent models in transgender health*.
- Ashley, F. (2019). *Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth.* Clinical child psychology and psychiatry, 24(2), 223-236.
- Ahsley, F. (2021). *Transgender Healthcare Does Not Stop at the Doorstep of the Clinic*.
- Bakker, A. (2021). Een halve eeuw transgenderzorg aan de VU. Boom.
- Bond, P. (2021). *Nearly 40 Percent of U.S. Gen Zs, 30 Percent of Young Christians Identify as LGBTQ, Poll Shows*.
- Brownstone, L.M., DeRieux, J., Kelly D.A., Sumlin L.J. & Gaudiani J.L. (2021). *Body Mass Index Requirements for Gender-Affirming Surgeries Are Not Empirically Based*. Transgender Health, 121-124.
- Callen-Lorde Community Health Center. *Callen-Lorde Protocols for the Provision of Hormone Therapy*.
- Chodzen, G. (2019). *Minority stress factors associated with depression and anxiety among transgender and gender-nonconforming youth.* Journal of Adolescent Health, Vol. 64, Issue 4, 467-471.
- Coleman, E., Radix, A.E., Bouman, W.P., Brown, G.R., De Vries, A.L.C., Deutsch, M.B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A.B., Johnson, T.W., Karasic, D.H., Knudson, G.A., Leibowitz, S.F., Meyer-Bahlburg, H.F.L., Monstrey, S.J., Motmans, J., Nahata, L., Nieder, T.O., Reisner, S.L., Richards, C., Schechter, L.S.,

Tangpricha, V., Tishelman, A.C., Van Trotsenburg, M.A.A., Winter, S., Ducheny, K., Adams, N.J., Adrián, T.M., Allen, L.R., Azul, D., Bagga, H., Başar, K., Bathory, D.S., Belinky, J.J., Berg, D.R., Berli, J.U., Bluebond-Langner, R.O., Bouman, M.B., Bowers, M.L., Brassard, P.J., Byrne, J., Capitán, L., Cargill, C.J., Carswell, J.M., Chang, S.C., Chelvakumar, G., Corneil, T., Dalke, K.B., De Cuypere, G., De Vries, E., Den Heijer, M., Devor, A.H., Dhejne, C., D'Marco, A., Edmiston, E.K., Edwards-Leeper, L., Ehrbar, R., Ehrensaft, D., Eisfeld, J., Elaut, E., Erickson-Schroth, L., Feldman, J.L., Fisher, A.D., Garcia, M.M., Gijs, L., Green, S.E., Hall, B.P., Hardy, T.L.D., Irwig, M.S., Jacobs, L.A., Janssen, A.C., Johnson, K., Klink, D.T., Kreukels, B.P.C., Kuper, L.E., Kvach, E.J., Malouf, M.A., Massey, R., Mazur, T., McLachlan, C., Morrison, S.D., Mosser, S.W., Neira, P.M., Nygren, U., Oates, J.M., Obedin-Maliver, J., Pagkalos, G., Patton, J., Phanuphak, N., Rachlin, K., Reed, T., Rider, G.N., Ristori, J., Robbins-Cherry, S., Roberts, S.A., Rodriguez-Wallberg, K.A., Rosenthal, S.M., Sabir, K., Safer, J.D., Scheim, A.I., Seal, L.J., Sehoole, T.J., Spencer, K., St. Amand, C., Steensma, T.D., Strang, J.F., Taylor, G.B., Tilleman, K., T'Sjoen, G.G., Vala, L.N., Van Mello, N.M., Veale, J.F., Vencill, J.A., Vincent, B., Wesp, L.M., West, M.A. & Arcelus, J. (2022). *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*. International Journal of Transgender Health, 23:sup1, S1-S259.

- Committee against Torture (2016). *Concluding observations on the fifth periodic report of China with respect to Hong Kong, China*. CAT/C/CHN-HKG/CO/5.
- Committee on the Rights of the Children (2013). *General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*. CRC/C/GC/14.
- Dahl, M., Feldman, J.L., Goldberg, J., Jaberi, A., & Vancouver Coastal Health (2015). *Endocrine therapy for transgender adults in British Columbia: Suggested guidelines*. Vancouver, BC: Vancouver Coastal Health.
- Diemen, A. van (2016). *Lezing Bijwerkingen hormonen en blokkers* tijdens FreePATHH.
- Diemer, E.W., White Hughto, J.M., Gordon, A.R., Guss, C., Bryn Austin, S. & Reisner, S.L. (2018). *Beyond the Binary: Differences in*

*Eating Disorder Prevalence by Gender Identity in a Transgender Sample*. Transgender Health 2018 3:1, 17-23

- Digitale, E. (2022). *Better mental health found among transgender people who started hormones as teens*.
- Durwood, L., McLaughlin, K.A., & Olson, K.R. (2017). *Mental health and self-worth in socially transitioned transgender youth*. Journal of the American Academy of Child & Adolescent Psychiatry, 56(2), 116-123.
- Eisfeld, J. (2016). *Lezing: Geïnformeerd consent* tijdens FreePATHH.
- Europese Unie (2000). *Handvest voor de Grondrechten*.
- ExpresZo (2022). *Gendervrijheid Manifest*.
- Gibson, M.F. & Douglas, P. (2018). *Disturbing behaviours: Ole Ivar Lovaas and the queer history of autism science*. Catalyst: Feminism, Theory, Technoscience, 4(2), 1-28.
- Global Action for Trans Equality (2013). *Critique and Alternative Proposal to the "Gender Incongruence of Childhood" Category in ICD-11*.
- Green, A.E., DeChants, J.P., Price, M.N., & Davis, C.K. (2022). *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*. Journal of Adolescent Health, Vol.70, Issue 4, 643-649.
- Impuls Economen (2021). *Rapport Wachttijden genderzorg*.
- Nagata, J.M., Murray, S.B., Compte, E.J., Pak, E.H., Schauer, R. Flentje, A. Capriotti, M.R., Lubensky, M.E., Lunn, M.R. & Obedin-Maliver, J. (2020). *Community norms for the Eating Disorder Examination Questionnaire (EDE-Q) among transgender men and women*. Eating Behaviors, Volume 37, 101381.
- Kennisinstituut van Medisch Specialisten (2018). *Kwaliteitsstandaard Transgenderzorg - Somatisch*.
- Keuzenkamp, S. (2012), *Worden wie je bent. Het leven van transgenders in Nederland*, 2012-30.
- Kuyper, L. (2012). *Transgenders in Nederland: prevalentie en attitudes*. Tijdschr Seksuol; 36: 129-135.
- Kuyper, L. (2016). *Opvattingen over en ervaringen van lesbische, homoseksuele, biseksuele en transgender personen*. Sociaal en Cultureel Planbureau.

- Kwartiermaker Transgenderzorg (2022). *Bijlage 1 Voortgangsbrief: Ontwikkelingen in de wachttijden, aantal wachtenden en capaciteit van zorg*.
- Kwartiermaker Transgenderzorg (2018-2022), diverse voortgangs-brieven en meer.
- Vrouenraets, L.J.J.J., De Vries, A.L.C., De Vries, M.C., Van der Miesen, A.I.R. & Hein, I.M. (2021). *Assessing Medical Decision-Making Competence in Transgender Youth*. Pediatrics, 148 (6).
- Lugones, M. (2008) *The coloniality of gender.* Worlds & Knowledges Otherwise.
- McNeil, J. (2016). *An exploration of transgender people's mental health.* PhD thesis.
- Ministerio de Salud Argentina (2020). *Atención de la salud integral de personas trans, travestis y no binarias. Guía para equipos de salud*.
- Ministerio de Salud Pública (Uruguay), Dirección General de la Salud (2016). *Guía Clínica para la Hormonización en personas trans*.
- Neuroelfje (2021). *Waarom is ABA problematisch? En waarom die discussie?*
- Norton, A.T., Herek, G.M. (2013). *Heterosexuals' Attitudes Toward Transgender People: Findings from a National Probability Sample of U.S. Adults*. Sex Roles 68, 738–753.
- O'Banion, D., Barr, S.M. (2021). *Obtaining a Gender-Affirming Sexual History.* Transgender and Gender Diverse Health Care: The Fenway Guide, 130.
- Oliphant, J., Veale, J., Macdonald, J., Carroll, R., Johnson, R., Harte, M., Stephenson, C., & Bullock, J. (2018). *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa, New Zealand*. Transgender Health Research Lab, University of Waikato. Growingup-transgender.com maakte een korte samenvatting.
- Olson, K.R., Durwood, L., DeMeules, M. & McLaughlin, K.A. (2016). *Mental health of transgender children who are supported in their identities.* Pediatrics, 137(3).
- Overheid.nl, *Zorgverzekeringswet*. Geraadpleegd in augustus 2022.

- Paine, E.A. (2021). *"Fat broken arm syndrome": Negotiating risk, stigma, and weight bias in LGBTQ healthcare.* Social Science & Medicine, Volume 270, 113609, ISSN 0277-9536.
- Principle 17 (2017). *Transzorg in Nederland*.
- Principle 17 (2016). *Patiëntenrechten zijn mensenrechten zijn trans*rechten*.
- Raad van Europa (1997). *Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (*Oviedo Convention*)*.
- Raad van Europa (2015). *European Social Charter*.
- Raymonds, J. (1994). *The Transsexual Empire, The Making of the She-Male*.
- Regan L.M. & Bailey L. (2022). *Too Hard to Reach, Too Easy to Ignore: Improving Routes for Engagement for Women with Complex Lives*.
- Sanchez, N.F., Rabatin, J., Sanchez, J.P., Hubbard, S., Kalet, A. (2006). *Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients*. Fam Med. 38(1):21-7. PMID: 16378255.
- Scandurra, C., Amodeo, A.L., Valerio, P., Bochicchio, V. & Frost, D.M. (2017). *Minority Stress, Resilience, and Mental Health: A Study of Italian Transgender People*. Journal of Social Issues, 73: 563-585.
- Scheinerman, R., *The Eight Genders in the Talmud. Judaism has recognized nonbinary persons for millennia*.
- Shulman, G.P., Holt, N.R., Hope, D.A., Mocarski, R., Eyer, J. & Woodruff, N. (2017). *A review of contemporary assessment tools for use with transgender and gender nonconforming adults.* Psychology of Sexual Orientation and Gender Diversity, 4(3), 304–313.
- Telfer, M.M., Tollit, M.A., Pace, C.C. & Pang, K.C. (2020). *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.3*. Melbourne: The Royal Children's Hospital.
- Theilen, J.T. (2014). *Depathologisation of Transgenderism and International Human Rights Law*, Human Rights Law Review, Vol.14, Issue 2, 327–342.

- Thorne Harbour Health, Equinox Trans and Gender Diverse Health Service (2020). *Protocols for the Initiation of Hormone Therapy for Trans and Gender Diverse Patients*.
- Tomiyama, A.J., Hunger, J.M., Nguyen-Cuu, J. & Wells C. (2016). *Misclassification of cardiometabolic health when using body mass index categories*. NHANES 2005–2012, International Journal of Obesity.
- Transgender Europe (2019). *Guidelines to Human Rights-Based Trans-specific Healthcare*.
- Transgender Europe (2020), *Trans Healthcare Lottery: Insurance coverage for trans specific healthcare*.
- Trans forma la Salut, Plataforma per a un nou model de salut trans*. *Proposal of an integrated health care model for trans* people in Catalonia*. English translation from part of *Reivindicació d'un nou model d'atenció a la salut de les persones trans** (s.a.).
- Tránsit Barcelona, Institut Català de la Salut (2016). *Protocol d'atenció a la salut de les persones trans* a catalunya*.
- Turban, J.L., King, D., Kobe, J., Reisner, S.L. & Keuroghlian, A.S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PLOS ONE 17(1): e0261039.
- UCSF Gender Affirming Health Program, Department of Family and Community Medicine, University of California San Francisco (2016). *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition*. Deutsch MB, ed.
- Vries, A.L. de, McGuire, J.K., Steensma, T.D., Wagenaar, E.C., Doreleijers, T.A. & Cohen-Kettenis, P.T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 134(4):696-704. Epub 2014 Sep 8. PMID: 25201798.
- VN (1948). *Universele Verklaring voor de Rechten van de Mens (UVRM)*.
- VN (1966). *Internationaal Verdrag inzake Economische Sociale en Culturele Rechten*.
- VN (1989). *VN-Kinderrechtenverdrag*.
- WHO (1946). *Constitution of the World Health Organization*.

- WHO (2019). *International Classification of Diseases, version 11*.
- WHO en OHCHR (2008). *The Right to Health: Fact Sheet No. 31*.
- Wikipedia: Derde gender, Hijra, Kathoey, Transgender, Travesti, Two Spirit (geraadpleegd februari 2023).
- Winters, K. (2021). *Transgender Affirmation in Retrograde: Historical Context for the Littmanian "ROGD" Media Blitz*.
- Wylie, K., Knudson, G., Khan, S.I., Bonierbale, M., Watanyusakul, S. & Baral, S. (2016). *Serving transgender people: clinical care considerations and service delivery models in transgender health*. Lancet. 23;388(10042):401-411. PMID: 27323926.
- *Yogyakarta Principles* (2006). Nederlandse vertaling: Yogyakarta Beginselen (2016).
- *Yogyakarta Principles plus 10* (2017).

# Appendix 1: Informed Consent

In the Netherlands, a healthcare recipient must give permission for medical treatment, otherwise the healthcare provider acts unlawfully. In order to give permission, a healthcare recipient must first be adequately informed about the treatment. “Treatment” includes all medical procedures performed by the healthcare provider, including examination and aftercare. The healthcare provider must therefore provide information about: the diagnosis, the nature and purpose of the treatment, the risks of the treatment, possible alternatives and the prognosis for the patient. At the request of the healthcare recipient, the healthcare provider must also provide information about the care offered, including rates and quality, about the experiences of other healthcare recipients with that care and about the effectiveness of that care. Furthermore, healthcare providers must be open about any waiting times for treatments.

This principle is called informed consent.

There are different views on how informed consent works in practice. The gender teams work with a definition in which the care recipient is informed and the practitioner then makes a decision about the treatment to be followed. Principle 17 has a different view: we assume that the practitioner informs the care recipient, after which *the care recipient* makes a decision about the treatment, in consultation with the practitioner. This seems like a subtle difference, but there are very essential consequences for who is responsible. In the current model, the responsibility for treatment lies primarily with the gender teams. According to Principle 17, this responsibility should primarily lie with the care recipients.

## Assessment psychologist

After all, making a psychiatric diagnosis is no longer necessary with this method. This means that the practice for transgender care recipients is similar to the one that has been common practice in Dutch healthcare for all other care recipients for much longer: during the anamnesis, the practitioner determines whether the person concerned is sufficiently aware

of the implications and consequences of the desired (somatic) treatment. Only if the practitioner believes that this is not the case, can he or she refer the care recipient to a therapist.

A practitioner is of course free to advise a care recipient to seek psychosocial support, just as any practitioner is always free to do so. A transition is a major change for many people and support can be pleasant, and sometimes even necessary. But that choice is up to the healthcare recipient, because (psycho)therapy can never work well if it is mandatory. That is also the starting point of all (psycho)therapists.

> The Callen-Lorde Community Health Center in New York has been working with informed consent for 20 years. Their intake consists of a conversation with a nurse, after which hormone treatment can often be started immediately.[120] 70% of their clients opt for psychosocial support. A Callen-Lorde practitioner explains: “We thought all those conversations about boys playing with dolls were very pointless. We now see that people use the psychologist for things that really matter in their lives.”

## Careful action

A well-known argument for the exceptional position of transgender care recipients is the argument of “carefulness”. Doctors would like to make a careful recommendation about the healthcare for transgender healthcare recipients. At first glance, this seems like a good reason, but there are several downsides to it.

Firstly, under the motto of “carefulness”, a method is used that removes responsibility from the healthcare recipient. That is a careful approach. The result is an undesirable situation in which the healthcare recipient has little say in their own treatment.

Secondly, this argument completely ignores the recovery risks of treating *too late*. Transgender healthcare recipients who are on a waiting list for a

120 *During FreePATHH in 2016, a Callen-Lorde board member gave a lecture on their approach: principle17.org/lezing-ge%C3%Afnformeerd-consent (Dutch only)*

(very) long time or are required to undergo psychological consultations, do not receive the fundamental somatic care they came for during all that time. A significant number of healthcare recipients cannot cope with this and ultimately, in desperation, turn to self-medication, drug use and/or self-harm. There are also several known cases of suicide, because people saw no way out in their despair. However, this downside of “careful action” is systematically ignored.

Thirdly, transgender people are unnecessarily pathologized and medicalized. Mandatory consultations with a psychologist or psychiatrist, which lead to a serious psychiatric diagnosis, are a condition for being able to receive somatic care. This practice exists in the Netherlands exclusively for transgender people; for all other types of somatic care, this method is absolutely unthinkable. This method is in flagrant conflict with human rights, as described in Yogyakarta Principle 18[121].

> In foreign clinics where the principle of informed consent has been in practice for years, there is a very low percentage of so-called “regretters”. The percentage at Callen-Lorde is 0.8%, while the figures worldwide are between 0.5% and 3%. Recent prevalence figures for the Netherlands can be found at the Quartermaster Transgender Care[122].

## Transgender & psychiatry?

Clinicians worldwide, including WPATH board members, agree that there is no contraindication to giving hormones to people with schizophrenia or other psychiatric diagnoses, if their condition is stable. The international SOC are very clear on this point: if the patient is stable and able to give informed consent, then there is no contraindication.

This guideline may pose a problem for transgender people with a psychiatric condition that is *not stable*. For some transgender people, their gender incongruence is so great that they cannot stabilize their psychiatric condition because the gender incongruence is too much of an obstacle.

121 *See page three.*
122 *zorgvuldigadvies.nl/transgenderzorg (Dutch only).*

In these cases, Principle 17 advocates that gender teams offer these patients integrated treatment: treatment for both their gender incongruence and their psychiatric condition. Simply sending the care recipient away with the message: “Come back when your psychiatric condition is stable”, as is currently done, is too easy. This can cost care recipients (literally) years of their lives, with all the unnecessary consequences and preventable costs that come with it, such as depression, medication, (mandatory or not) admissions, psychoses, solitary confinement, (attempted) suicide, etc. This applies to young people in particular.

Finally, practitioners learn to distinguish whether someone is capable of giving informed consent or not during their training. We can therefore trust that practitioners can do this.

# Appendix 2: Abbreviations

**AACAP:** American Academy of Child and Adolescent Psychiatry.
**ABA:** Applied Behavior Analysis, a popular behavioural therapy for neurodiverse children.
**AusPATH:** Australian Professional Association for Trans Health, the Australian professional association for trans health professionals.
**AZC:** *Asielzoekerscentrum*, Asylum Seekers Center.
**BMI:** Body Mass Index, is an index that represents the relationship between a person's height and weight. Also: Quetelet Index.
**CAT:** Committee Against Torture, is a treaty body of human rights experts that monitors the implementation of the United Nations Convention against Torture by member states.
**CESCR:** Committee on Economic, Social and Cultural Rights, is a United Nations treaty body charged with monitoring the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR).
**CRC:** United Nations Convention on the Rights of the Child, is an international human rights treaty that sets out the civil, political, economic, social, health and cultural rights of children. Also: UNCRC.
**CRPD:** Convention on the Rights of Persons with Disabilities.
**CTA:** Cyproterone acetate, testosterone blocker, known by the brand name Androcur.
**DSD:** Differences in Sex Development (of: Disorders of Sex Development, Diverse Sex Development), is the medical term for a non-normative sex development. Also: intersex condition.
**DSM:** Diagnostic and Statistical Manual of Mental Disorders, is the leading international manual in psychiatry. The DSM is published by the American Psychiatric Association, the American professional association of psychiatrists. Current version: DSM-5-TR, DSM-5 text revision.
**ECHR:** European Convention on Human Rights (formally: Convention for the Protection of Human Rights and Fundamental Freedoms), is the European treaty that regulates human and civil rights for all residents of the contracting states.
**FFS:** Facial Feminisation Surgery, facial feminisation surgery, is facial surgery for trans women.
**FMS:** Facial Masculinisation Surgery, is facial surgery for trans men.

**GATE:** Global Action for Trans* Equality, is committed to trans, gender diversity and intersex equality worldwide.
**GDPR:** General Data Protection Regulation, a European regulation that standardizes the rules for the processing of personal data within the European Union. Also: privacy legislation.
**Ggz:** *Geestelijke gezondheidszorg*, mental health care.
**GIC:** Gender Incongruence of Childhood, is a diagnosis in the ICD-11 (code HA61) for gender creative children and young people.
**GVS:** *Geneesmiddelenvergoedingssysteem*, Medicines Reimbursement System.
**ICATH:** Informed Consent for Access to Trans Health, is a care model for the treatment of transgender, intersex and gender non-conforming people, which promotes the use of informed consent as a recognised standard of care. The ICATH model reflects the fundamental human right to self-realisation.
**ICD:** International Classification of Diseases, is a diagnostic tool used worldwide for clinical purposes, among other things. The ICD is published by the World Health Organization. Current version: ICD-11.
**ICESCR:** *see CESCR*
**KIMS:** *Kennisinstituut van de Federatie Medisch Specialisten*, Knowledge Institute of the Federation of Medical Specialists.
**KZCG:** *Kennis- en zorgcentrum genderdysforie*, Knowledge and care center for gender dysphoria in Amsterdam. Popularly known as ‘the VUmc’ in the (transgender) vernacular.
**LHBTI+:** Lesbians, homosexuals, bisexuals, transgenders, people with an intersex condition and all others. Also: LHBTIQ+, with the Q for queer.
**SOC:** Standards of Care (formally: Standards of Care for the Health of Transgender and Gender Diverse People), is the international clinical protocol for the treatment of transgender and gender diverse people, including social, hormonal or surgical transition. The SOC is published by the WPATH (see there). Current version: SOC-8, September 2022.
**STP:** Stop Trans Pathologization, international campaign by trans activists that wants people to view being trans as a normal human variation.
**TERF:** Trans-Exclusionary Radical Feminist, are feminists who discriminate against trans people. In the Netherlands also: gender critical.

**TGEU:** Transgender Europe, is the European umbrella organization that strengthens the rights and well-being of transgender people in Europe and Central Asia.
**UDHR:** Universal Declaration of Human Rights, is an international document of the United Nations, which sets out the rights and freedoms of all people.
**UN:** United Nations, is the world's largest and best-known international organization.
**WGBO:** *Wet geneeskundige behandelingsovereenkomst*, Medical Treatment Contracts Act.
**WHO:** World Health Organization, is a specialized agency of the United Nations, responsible for international public health.
**WPATH:** World Professional Association for Transgender Health, the international professional association for professionals in trans health care. The WPATH publishes the Standards of Care (SOC, see there).
**ZonMw:** Collaboration between the organisation *ZorgOnderzoek Nederland* (Zon), Care Research Netherlands, and the *Medische wetenschappen* (Mw), Medical Sciences, of the Nederlandse Organisatie voor *Wetenschappelijk Onderzoek* (NOW), Dutch Research Council.

# Appendix 3: Glossary

**Assessment psychologist:** Sarcastic term for the imposed psychological (or psychiatric) consultations that transgender care recipients have to put up with. If these consultations lead to the psychiatric diagnosis of 'gender dysphoria', the care recipient can receive the desired somatic transition care for which he or she came. See also: gatekeeper model.
**Body dysphoria:** Gender dysphoria (see there) that is strongly focused on the body.
**Convention on the Rights of Persons with Disabilities:** The Convention on the Rights of Persons with Disabilities, in short CRPD, describes the internationally established rights of people with a disability or chronic illness. The UN Convention on Disabilities is based on the social model: people with a disability are normal human variations. A disability (the physical condition) only becomes a disability (impediment) if society is inaccessible. The Netherlands ratified the UN Convention on the Rights of Persons with Disabilities in 2016.
**Coping:** The way in which someone deals with difficult circumstances (stress). Often in the context of a coping mechanism or survival strategy.
**Crossgender:** ‘Of the opposite sex’. Usually used in the context of hormone treatment.
**Desister:** Anyone who stops medical transitioning or no longer identifies as transgender, especially in the context of children and young people.
**Gatekeeper model:** The model used by most gender teams for transgender care in the Netherlands, in which trans care recipients must undergo mandatory psychological consultations. During these consultations, it is assessed whether the trans care recipient is ‘competent for the purpose of the matter under consideration’, whether the request for transition care meets the criteria used and whether the care recipient has sufficient support from the environment. In trans slang often expressed as: 'You have to prove that you are trans enough to be allowed to be trans.' See also: assessment psychologist.
**Gender dysphoria:** Psychiatric diagnosis in the DSM-5 that considers human gender variation as psychopathology, if it meets the set criteria. In the Netherlands, this diagnosis is a necessary condition for access to transition healthcare (see there). See also: gender incongruence.

**Gender incongruence:** Diagnosis in the ICD-11 that regards human gender variation as a sexual deviation if it meets established criteria. See also: gender dysphoria.
**(Gender) transition care:** *see transition care*
**Gender-related care:** Care that has to do with your gender, including transition care (see there), legal change, social transition and/or other medical treatments, such as psychosocial support or psychological treatment (for example trauma processing).
**Informed consent:** Informed consent, see appendix 1. See also: strong informed consent.
**Intercultural competence:** Being able to establish relationships between different cultures, in terms of understanding, acceptance and appreciation. This is a necessary characteristic for care providers who work with people with a bicultural background. (All care providers, therefore.)
**NHG Standards:** Guidelines for the diagnosis and treatment of common conditions in general practice. These guidelines are intended to support medical policy in the daily practice of the general practitioner.
**Non-dichotomous gender development:** Gender development that goes beyond the male or female identification that is considered common in the West.
**Non-normative gender development:** Development of gender that cannot be clearly assessed as ‘male’ or ‘female’. Diagnosed by physicians as an intersex condition or diversity of sex characteristics (DSD).
**Off label:** Prescribing or using a medicine for a different indication or for a different group of care recipients than for which the indication has been assessed and approved in the Netherlands. Off label is permitted under certain conditions but often poses a problem for reimbursement from health insurance.
**Positive law:** According to international human rights, health is a positive right, which means that health is more than the absence of disease.
**Pumping:** Injecting liquid silicone for a quick and visible result on large(r) breasts and buttocks. This can have serious consequences for health, see page 45.
**Somatic:** Physical, bodily. A somatic treatment or care is therefore a physical treatment or physical care. In a trans context, this concerns matters such as hormone use and surgical interventions.

**Sterilization requirement:** Until July 1, 2014, transgender people had to take legal action against the Dutch state in order to change their legal gender. In doing so, they had to submit a statement from the surgeon confirming that the person was 'permanently infertile' (i.e. sterilized). In November 2021, the Dutch government apologized for this and made (symbolic) compensation available, see pages 26 and 27.
**Strong informed consent:** With strong informed consent, the care recipient is leading and the care provider facilitates. See also: informed consent.
**Transcultural competence:** Knowledge of and understanding of what is happening in the transgender field, in terms of understanding, acceptance and appreciation. One must be familiar with the developments of the LHBTI+ community and important nuances. Sound transcultural competence is a necessary characteristic for care providers who often or mainly work with transgender care recipients. All care providers should at least have basic transcultural competence.
**Transitional care:** The (physical) treatments that a trans person needs to be able to eliminate body dysphoria (see there), including hormone treatment and surgical interventions. See also: gender-related care.
**Watchful waiting:** The usual approach for gender-creative youth is watchful waiting, which means waiting to see how the child will develop in terms of gender identity.
**Yogyakarta Principles:** Elaboration of existing international human rights, such as the UDHR, for specific matters relating to sex characteristics, gender identity, gender expression and sexual orientation.

# Notes

# Colophon


## Principle 17

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## Translation

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With the exception of the photo on page 49: Jochem Verdonk, and the bar chart on pages 68/69: TransZorg Now!

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In this alternative approach to trans healthcare in the Netherlands, Principle 17 addresses the shortcomings of the current Quality standard for transgender healthcare and the Quality standard for transgender mental healthcare. The collective also offers alternatives for how trans healthcare can be better organized, based on human rights and tailored to the individual.