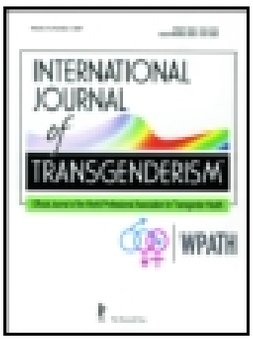

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Gender recognition and the rights to health and health care: Applying the principle of self-determination to transgender people

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ABSTRACT

Transgender people worldwide are subject to discrimination and violence. They are either being denied legal rights and thus face marginalization and increased vulnerability or their recognition is subject to cumbersome legal and medical preconditions that often infringe on the rights to self-determination, privacy, family life, and physical integrity. This article will situate legal gender recognition in the human rights domain as key to the enjoyment of the right to self-determination and explore its role in fulfilling the rights to health and health care. Using examples from European Union members' legal frameworks, the author will argue that any mechanism for legal recognition of transgender identities should not draw on a pathological view of gender variance. Instead, lawmakers should acknowledge the existence of gender diversity within societies and respect the right to self-determination of transgender people, as enshrined in the Yogyakarta Principles (2007), by way of allowing them to *self-declare* their gender identity without the imposition of any discriminatory preconditions. Free of these requirements, gender recognition will not only assert the right to self-determination but also help transgender people achieve that state of physical, mental, and social well-being necessary for their enjoyment of the highest attainable standard of health.

KEYWORDS

Gender recognition; right to health; self-determination; transgender

The issue of gender recognition is of paramount importance to transgender[1] people. In order to be able to lead a fulfilling life a person's gender identity[2] must be recognized by all parties—first, by society, whose acknowledgment of the existence of gender variance phenomena in the context of diversity can bring a sense of acceptance and second, by medical professionals, who can enable or hinder their living in the experienced gender (Hines, 2013). Last, by the State, who can enshrine gender diversity in law and equip its transgender citizens with full legal capacity, thus contributing to their enjoyment of equality in human and civil rights. The latter, which is the focus of this article, has more pragmatic and direct implications. By having to repeatedly produce identity documents that do not align with their acquired name and appearance, transgender people are risking forced exposure that can exacerbate their experiences of prejudice, harassment, discrimination, and abuse in everyday life. Therefore, the lack of legal recognition can contribute, in some instances, to limited access to vital services such as health care, employment, social welfare, and education and, thus, increase vulnerability.

Following the recent enactment of the Gender Recognition Act (2015) in Ireland, all EU member states now allow for the change of gender marker in birth certificates, which are considered the most fundamental proof of identity and, as mentioned above, are often required for the purpose of employment, social welfare, education, and other services, depending on the country. Nonetheless, the vast majority of European gender recognition frameworks impose eligibility criteria that often infringe on human rights to privacy, family life, and physical integrity[3] and, by consequence, the right to health.[4]

Therefore, the author's two principal aims in this paper are (1) to demonstrate that legal gender recognition is vital to the fulfillment of the right of self-determination[5] and, by extension, the rights to health and health care and (2) to argue that gender recognition laws should be based on the principle of self-declaration of one's experienced gender and, consequently,

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that any legal mechanism for granting such recognition must be free of medical and legal preconditions that explicitly or implicitly violate other human rights. Moreover, gender recognition laws should help to facilitate access to the required medical and welfare services based on informed consent, thus contributing to the improvement of the health of transgender people.

It should be noted that the author has given special regard to legal frameworks within the European Union (EU), whose members have strong human rights commitments yet, too often, their respective laws and procedures draw on the prevailing view of *gender variance*[6] as a form of mental health condition. Therefore, the EU serves as a good illustration of the current debate surrounding gender recognition laws and their compatibility with the human rights obligations of democratic governments contained in the Yogyakarta Principles (2007).

The author will begin by providing examples as to why gender recognition is important in the context of transgender health and health care. Next, he will examine gender identity's place in the International Bill of Human Rights[7] followed by a discussion of the significance of the Yogyakarta Principles (2007) in specifying transgender rights and their corresponding states' obligations. Subsequently, the author will discuss gender recognition procedures across the European Union (EU), appraise the prevalence therein of legal and medical preconditions that infringe on human rights, and examine the role of the European Court of Human Rights (ECtHR) in shaping gender recognition law in Europe. Next, the author will discuss the notion of recognizing self-declared gender identity by law and the key arguments for and against it. Finally, the author will provide examples of selected legislations that respect the transgender people's right to self-determination and discuss their ethical and legal significance.

Importance of gender recognition in the context of health and health care

Recognition by other parties is instrumental to human functioning in a social setting; therefore, legal recognition of one's identity is a fundamental human right. Lack of legal recognition of a person's true identity and, by extension, documents that match that person's true identity—both in name and in how they present themselves to the world—can obstruct access to education, employment, social welfare, and health care. Hines (2013) has also noted that in the wider context recognition also contributes to "important affective qualities and is fundamental to emotional characteristics, self-worth, respect and dignity" (p. 11). Without recognition, individuals or groups feel invisible or excluded. Therefore, legal recognition can advance visibility and has the potential to lay foundations toward inclusion and equality. Since gender identity is an inseparable part of personal identity, it also deserves full recognition.

However, according to the report of the Council of Europe Commissioner for Human Rights (Hammarberg, 2009), transgender persons often choose not to be involved with official procedures at all owing to discriminatory medical processes and inappropriate treatment, such as unwarranted medical examinations or psychiatric evaluations, or being compelled to undergo medical treatments prescribed by certain governments, such as hormone therapy and irreversible genital surgeries, often leading to sterilization. As a consequence, transgender persons are being denied legal recognition of their experienced gender and acquired name, or medical treatments that fit their own wishes and individual health needs. Therefore, the author claims that there is an inherent correlation between gender recognition by law and the right to health and health care for the following reasons:

(1) Contrary to the opinion of the World Professional Association for Transgender Health (WPATH, 2015), which is a leading professional authority on trans health, certain medical treatments are still required as a precondition for legal gender recognition in many Western jurisdictions, regardless of whether the type of gender variance phenomena and personal preference justify such treatment. However, law-enforced psychiatric evaluations or irreversible surgeries (often leading to sterilization), required solely for the purpose of granting legal gender recognition, may amount to violation of the principle of respect for patient autonomy[8] and the wider right to self-determination, with potentially adverse health consequences.
(2) Statutory recognition of transgender identities, based on the principle of self-determination could help justify the medical necessity of gender-affirming treatments and help to facilitate easier access to these treatments.

(3) Discrepancies between official identification documents and a person's experienced gender identity and/or outer appearance can lead either to denial of certain services or to forced exposure and can, thus, be harmful to the exposed individual. Therefore, legal recognition may serve as a form of protection against discrimination.
(4) Legal recognition may help to reduce social exclusion and increase societal acceptance, understanding, and legitimacy of gender diversity (Hines, 2013) and, in so doing, provide health benefits for transgender people and help in the achievement of their full potential as human beings.
(5) Legal recognition can empower many transgender people, increase their self-esteem (Hines, 2013), and help them overcome the fear and anxiety some may experience during public encounters. This in turn, could encourage their seeking of medical care when they need it and thus greatly improve their health status.

Transgender health and health care as a human and civil right

Transgender people worldwide are subject to widespread discrimination and even violence. For example, the recent U.S. (Grant, Mottet, & Tanis, 2011) and Irish (Transgender Equality Network Ireland [TENI], 2014a) reports highlighted the prevalence of harassment, gender bias in employment, and physical and even sexual assault. Globally, the Trans Murder Monitoring Project (TvT Project, 2015) reported 1,933 killings of transgender people in 64 countries between January 2008 and September 2015. Nevertheless, the protection of the human rights of sexual and gender variant minorities until recently was not explicitly guaranteed by human rights conventions. The following analysis will illustrate how the International Bill of Human Rights recognized gender identity and the rights to health and health care of transgender people.

Gender identity and the principle of nondiscrimination

In principle, human rights are interdependent and indivisible and are protected through a number of international law instruments. Very often, however, these instruments are general in their scope and content, as their goal is to transcend the multitude of cultures often governed by local tradition and religion and to maximize their dissemination. The principle of nondiscrimination applies to all human rights in all categories (economic, social, and cultural). Yet, the entitlement to that right is often dependent on specification of the grounds on which discrimination should be prohibited in the body of international human rights documents (Braveman, 2010). Therefore, without explicitly naming the grounds for discrimination, it is difficult to apply this principle to all whom it should protect. The evolution of international human rights instruments demonstrates a trend toward specification of rights, such as the right to health and health care, and prohibited grounds for discrimination, such as gender identity.

The Universal Declaration of Human Rights (1948) confirmed the right of everyone to a standard of living adequate for health and well-being, including medical care. The Constitution of the World Health Organization (WHO, 1948) and, later, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) defined the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and enumerated steps each state should take to create conditions that would ensure medical service and medical attention for all in the event of sickness. However, over time new social and cultural phenomena emerged—gender variance for instance (and others such as homosexuality)—and gained recognition; as a consequence, it became necessary to further specify the applicability of this right. The Covenant did not mention sexual and gender variant groups despite their being vulnerable to discrimination and violence. This gap allowed for an inference that these groups had a lesser entitlement to protection (O'Flaherty & Fisher, 2008). For this reason, the UN Committee on Economic, Social and Cultural Rights (CESCR) addressed issues of this kind in a series of general comments. They either defined particular rights or explicitly expressed basic premises of the principle of nondiscrimination. However, although the WHO (2001) explicitly confirmed that freedom from discrimination on account of gender role is a fundamental human right and an underlying social determinant of health (SDH),[9] it was not until 2009 that the committee recognized gender identity among the prohibited grounds for discrimination in its General Comment No. 20 (CESCR, 2009). At last,

it also identified transgender, *transsexual*,[10] and *intersex*[11] individuals as being particularly vulnerable to serious human rights violations.

Content of the rights to health and health care of transgender people

Amongst all human rights, the rights to health and health care are notoriously difficult to define. Even more difficult is to specify the corresponding duties that can affect their dissemination and fulfillment. As Braveman (2010) pointed out, the right to health evoked in Article 12 of ICESCR has been criticized for being too vague or unrealistic and, therefore, of limited use in guiding policies. Although the CESCR General Comment No. 14 (2000) reaffirmed that health is a fundamental human right indispensable for the exercise of other human rights, it remained largely aspirational in nature. Eberl, Kinney, and Williams (2011) noted that this comment was too generally construed as a statement of right to ensure its stronger universal applicability. However, the comment does make it clear that the right to health is not limited to medical care but embraces a wide range of socioeconomic factors to promote conditions in which people can lead a healthy life (Braveman, 2010). Eleftheriadis (2012) interpreted the right to health, as defined in General Comment No. 14, as an inclusive right extending to the underlying social determinants of health (SDH) and entailing the creation of a complete health system and a particular public health policy within the states. These state parties' obligations are enumerated in paragraph 33 and include the positive and negative obligations to respect the right through noninterference, to protect the right through preventing third parties from interference, and to fulfill the right through legislation and specific policies (CESCR, 2000).

Yogyakarta Principles

Although the International Bill of Human Rights is in theory applicable to all humans, the very need for general comments suggests that unless the right is explicit in its content and identifies its beneficiaries, it is very often open to interpretation. This allows the states to "pick and choose" the elements that they are able to implement subject to resources, political will, and cultural compatibility. As a result of this inconsistency in approach in law and practice, a group of distinguished human rights experts and jurists met in Yogyakarta, Indonesia, and in 2007, they announced the *Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (2007).

The following selected principles define the right to health and its corresponding states' obligations in the context of gender recognition, access to health care, and protection from harmful medical practices.

Principle 3 specifies the right of transgender people to recognition before the law in accordance with *self-defined* gender identity. It prohibits forced medical procedures and divorce as a requirement for legal recognition of gender identity. This principle also stipulates the states' obligation to provide transgender people with procedures for changing identity documents to reflect the person's self-defined gender identity. These procedures must be nondiscriminatory and respectful of the dignity and privacy of the person concerned.

Principle 17 confirms the right to the highest attainable standard of health, with an emphasis on sexual and reproductive health. It also pronounces states' obligations to fulfill this right through legislation, equal access to health care, adequate facilities, policies of nondiscrimination, promotion of autonomy, information, and health care professionals' education in transgender matters.

Principle 18 calls for protection against harmful medical practices based on sexual orientation or gender identity, including on the basis of stereotypes, whether derived from culture or otherwise, regarding conduct, physical appearance, or perceived gender norms. This principle also forbids treating nonheteronormative sexual orientation and noncisgender[12] identity as intrinsic disorders to be treated, cured, or suppressed.

Principle 24 states that "everyone has the right to found a family, regardless of sexual orientation or gender identity." It acknowledges the diversity of family forms and implicitly prohibits forcing married couples to divorce or requiring sterilization for the purpose of granting gender recognition.

The importance of these principles is enormous in providing a coherent and comprehensive identification of governments' obligations to respect, protect, and fulfill the human rights of all people regardless of their sexual orientation or gender identity (O'Flaherty & Fisher, 2008). Although not legally binding, the significance of the Yogyakarta Principles in guiding law

and policy making was acknowledged by many governments, such as those of the Netherlands, Canada, Brazil, Argentina, and Uruguay. The principles were also referred to by numerous nongovernmental organizations (NGOs) in their submissions for the first cycle of the UN Universal Periodic Review (UPR) (O'Flaherty & Fisher, 2008). As Thoreson (2009, p. 336) noted, the principles do not assert any new rights, but they do compel states to treat sexual and gender identity minorities as vulnerable populations, entitled to the same universal human rights as everyone else.

Legal gender recognition in Europe

As demonstrated in the previous section, gender recognition plays an important part in fulfilling the right to health and health care of transgender people. The Yogyakarta Principles (2007) explicitly place an obligation on the states to provide a mechanism for recognizing noncisgender identities before the law that is clear, efficient, fair, and nondiscriminatory. There is a particularly strong positive obligation in the case of democratic states, whose freely elected governments should represent the best interests of their citizens and safeguard their equal rights and liberties, which cannot be guaranteed without recognizing everyone's identity before the law. Therefore, the following analysis will use selected examples from the European Union (EU), since the EU claims to stand for the values of democracy and respect for human rights.

Following the passing of the Gender Recognition Act (2015) in Ireland, all EU member states have either a statutory or judicial procedure for recognizing the true gender identities of its transgender citizens. However, with the exception of Denmark, Malta, and Ireland, the vast majority of EU countries still impose various medical and legal criteria for the purpose of legal gender recognition. Therefore, it is important to analyze the current situation in Europe along with the European Court of Human Rights (ECtHR) cases that address the issue of gender recognition, whose rulings have helped to advance the necessary changes in many European countries.

Level of prevalence of legal and medical requirements in Europe

As mentioned earlier, currently all EU member states afford gender recognition either by statutory, judicial, or administrative means. Although these procedures vary from one country to another, their most common feature is the combination of cumbersome legal and medical requirements. They can include anything from psychiatric, psychological, and physical tests to medical procedures, such as irreversible genital surgeries, which often lead to forced sterilization, hormonal treatments, and unmarried status. The Council of Europe Commissioner for Human Rights (Hammarberg, 2009) noted with great concern that transgender people appear to be the only group in Europe subject to legally prescribed, state-enforced divorce, irreversible surgery, and/or sterilization, amounting to strong interference by the state in the lives of individuals. Also, the United Nations and WHO called on governments to ensure that sterilization, or procedures resulting in infertility are not a prerequisite for legal recognition of an experienced gender identity (WHO, 2014), as this constitutes a violation of human rights and of the principles of self-determination and respect for personal autonomy. In a recent statement the WPATH (2015) also confirmed its strong opposition to surgery or sterilization re-quirements to change the legal gender marker.

In spite of the opinion of professional and human rights bodies, the largest to-date legal survey of the transgender communities in 27 EU member states (Whittle, Turner, Combs, & Rhodes, 2008) revealed that although a majority of countries permitted the change or amendment of birth certificates, unmarried status precondition was confirmed in 13 of them. The more recent Fundamental Rights Agency's study (FRA, 2010) revealed that 12 countries required diagnosis of gender dysphoria, 12 required either hormonal treatment or some other form of "physical adaptation,"[13] 22 required medical opinion, 9 countries required forced or automatic divorce, and a staggering 18 countries required genital surgery leading to sterilization.

These extremely strict criteria often leading to irreversible body modifications and forced divorces were legally challenged in recent years. In Germany, in 2005, the Federal Constitutional Court (BVerfG, 2005) indicated that surgeries as a precondition for the change of gender were regarded as problematic amongst experts. In 2009, the Austrian Administrative High Court (VwGH, 2009) abolished surgery as a mandatory requirement for gender and name change and in 2011 the German Federal Constitutional Court (BVerfG, 2011) found that the irreversible surgery and sterilization requirements were unconstitutional and should be removed.

A similar trend of legal challenges on a national level has affected the requirement for divorce. First, in 2006, the Austrian Constitutional Court (VfGH, 2006) ruled that changing gender identity in official documents cannot be hindered by marriage. The German Federal Constitutional Court (BVerfG, 2008) ruled similarly in 2008. Both judgments called on the state to protect all of its citizens, without exception, from state-forced divorce, regardless of the argument that in a very few instances the gender change of one of the spouses may lead to same-sex marriages (Hammarberg, 2009). In doing so, Germany and Austria set the new standard for other countries to follow. Most recently this was exemplified in Italy, where the Supreme Court ruled against forced divorce (Supreme Court (2015a) and forced sterilization (Supreme Court, 2015b) requirements.

In January 2014, Amnesty International published the most up-to-date Europe-wide report on the issues surrounding gender recognition in Europe. This report confirmed the continuous widespread prevalence of medical and legal requirements, highlighting the issue of irreversible genital surgeries, sometimes leading to sterilization (as was the case in Belgium and France). However, it also highlighted some positive changes that have occurred in a few European countries, such as the Netherlands, Portugal, Spain, and Sweden, where invasive treatment requirements were abolished through legislative reforms.

Transgender Europe (TGEU, 2016), who publishes online the Trans Rights Europe Map annually, confirmed that, by April 2016, out of 28 current EU members states 25 still required either psychiatric or psychological evaluation, 20 imposed mandatory medical interventions (i.e., hormone therapy), while 14 countries required surgical interventions and 13 required sterilization as a precondition. Moreover, 13 countries required unmarried status—up from 9 in 2010 (FRA, 2010). This increase, however, may be the result of more countries (where same-sex marriage is still illegal) affording legal recognition; it may also be due to the enlargement of the EU since 2010. Nonetheless, these results are reflective of the rise in campaigning for transgender rights and recent legislative reforms across Europe and indicate that governments have begun to abandon some of the most controversial requirements. This slowly emerging trend was recently illustrated by the aforementioned Italian Supreme Court's rulings and, more significantly, by the Danish, Maltese, and Irish legislative acts effectively abolishing all medical and the most controversial legal criteria, which will be discussed later. However, these positive changes would not be possible without the judgments of the European Court of Human Rights (ECtHR), which played and continues to play a significant part in this process.

Gender recognition in the rulings of the European Court of Human Rights (ECtHR)

As demonstrated above, the situation in Europe is slowly improving and some of the driving forces for these changes are the rulings of the ECtHR that call for legislative changes arising from states' violations of the European Convention on Human Rights (1950). Since all EU member states have ratified this Convention, the judgments of the ECtHR have a significant legal potency in that they can be very persuasive, although not legally binding.

The majority of judgments relating to transgender rights found violations of privacy (Article 8) and/or the right to marry and found a family (Article 12) on the grounds of gender identity. In *B v. France* (1992), the court concluded for the first time that the state had violated Article 8 in refusing to amend the civil status register in accordance with the wishes of a transgender woman. The court noted the frequent discrepancy between the legal sex and the apparent sex in French transsexual[14] individuals' documents. Therefore, the court held that this refusal placed B in a situation whereby the respect for her private life could be compromised on a daily basis.

However, it was the landmark *Goodwin v. UK* (2002) case that set the legal precedent for gender recognition in Europe. The court found the violation of Articles 8 and 12 and was of the opinion that the margin of appreciation among European countries, driven by increased social acceptance, was shifting toward granting gender recognition to "post-operative transsexuals" (*Goodwin v. UK*, 2002). Following this and the similar *I v. UK* (2002) judgment, the UK passed the Gender Recognition Act (2004), which allowed British transgender people to apply for a gender recognition certificate.

It is important to stress that although the *Goodwin v. UK* case did advance legal gender recognition in Europe, its applicability is limited to "transsexual" people and "gender reassignment" in its choice of language. It effectively excluded a variety of other gender

and gender identity variants, such as preoperative and postoperative transgender people, as well as *genderqueer*[15] and intersex individuals who do not identify as transsexual. It also allowed the UK to determine the conditions and legal and administrative procedures for applicants (TENI, 2014b) and thus set a precedent. This could explain the widespread endurance of the cumbersome legal and medical requirements in the majority of European countries that currently allow legal gender recognition and suggests the need for further judgments explicitly ruling against these requirements. However, the recent judgment in *Hämäläinen v. Finland* (2014) represents a significant setback as the court ruled that forcing a transgender woman to *convert* her marriage into civil partnership (or common law in some jurisdictions) did not breach her human rights. In the court's opinion this option provided the required legal protection for same-sex couples. This negative ruling can be attributed to the wide margin of appreciation of same-sex marriage among European countries deriving from the lack of consensus regarding this contentious issue.

With regard to sterilization, the recent judgment of the ECtHR in the case of *YY v. Turkey* (2015) directly challenges the infertility precondition for accessing "gender reassignment surgery"—a treatment acknowledged by the court as necessary for the establishment of the applicant's gender and, by extension, for the enjoyment of the right to self-determination. Moreover, as Dunne (2015) argued, indirectly the court's decision may also have an impact on the process of gender recognition throughout the EU as governments may need to provide more-robust justification for sterilization requirements based not merely on society's sense of discomfort toward the idea of pregnant transgender men, for example. Therefore, the *YY v. Turkey* case may accelerate the recent European trend of progressing transgender human rights even further.

Legislation based on self-declaration?

As illustrated in the previous section, medical and legal criteria for gender recognition prevail across the EU; yet, more and more countries acknowledge the rights of their transgender citizens—a process influenced by shifting social and political attitudes and more favorable jurisprudence informed by expert opinion and human rights activism. As a result, more countries are moving toward the *self-declaration* model, which allows individuals to self-declare their gender identity, without the need to satisfy medical or legal preconditions that may infringe on one's human rights. This section will briefly discuss the debate surrounding the very notion of self-declared gender identity and the very few existing examples of gender recognition laws that appear to apply it as their founding principle.

Should law sanction self-declared gender identity?

Experts in human rights law recognize that gender identity is a matter of privacy and deeply felt individual conviction, which should not be subject to arbitrary third-party scrutiny, nevermind human rights violations. They strongly oppose discriminatory requirements and call for their abolition (Agius, Köhler, Aujean, & Ehrt, 2011). However, there is a concern that states should not be expected to legally sanction any choices that their citizens wish to make and that proper controls are a necessity. These concerns were challenged by Köhler, Recher, and Ehrt (2013), who have effectively countered the most common arguments against easy access to gender recognition. They referred to scientific and legal evidence against stereotypes and myths, such as the belief that only an expert can determine if the transgender identity of an individual is legitimate, or claims that transgender people may be switching identities back and forth.

There are, however, more cogent arguments against legitimizing self-declared gender identity. The first one is based on the notion of permanence. As Grabham (2010) noted, governments prioritize permanence whereas transgender people represent potential fluidity, which needs to be curtailed by way of imposing various legal and medical criteria to ensure gender stability (p. 109). However, this need for gender permanence can be easily addressed by requiring transgender people to sign legal declarations in which they confirm their commitment to remain in their experienced gender indefinitely. Nonetheless, even this solution was opposed by some experts, such as O'Flaherty (2015) in Ireland and Grabham (2010) in the UK, who claimed that forcing all applicants to have an intention to live in their experienced gender for the rest of their lives shows disregard for the fluid nature of some gender identities and undermines free choice.

The second argument is that law requires solid foundations in the form of existing standards supported by expert opinion. The fact that diagnosis of gender variant phenomena persists is seen as a justification for requiring it for the purpose of recognizing transgender identities. However, as Drescher, Cohen-Kettenis, and Winter (2012) demonstrated, there is a lack of consensus among scientists, clinicians, human rights experts, and transgender communities, surrounding the placement of gender variance phenomena in diagnostic classification systems; therefore, in the opinion of the author, this disagreement undermines the reliability of diagnosis in the process of law making even further.

To illustrate the persistence and potency of psychiatric diagnosis in shaping social and political attitudes toward noncisgender identities, Drescher (2010) drew parallels with the history of the term *homosexuality* in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA). Although, as a result of evidence-based research and gay rights activism, homosexuality was removed from DSM-II in 1973, the APA replaced it with Sexual Orientation Disturbance (SOD), which in turn was replaced by Ego-Dystonic Homosexuality (EDH) in DSM-III in 1980, to finally be removed from the revision of DSM-III-R in 1987. The example of homosexuality illustrates how the APA was reluctant to depathologize this phenomenon over the years only to implicitly accept its normal variant view by way of removing it from the DSM altogether (Drescher, 2010). Correspondingly, the idea of transgender individuals declaring their gender identity does not appear so radical anymore but rather supports the view that *being transgender is neither a lifestyle nor a mental health condition but a normal variant that remains unchangeable.*

Gender recognition laws respecting the right to self-determination

The Yogyakarta Principle 3 clearly states that gender identity is integral to a person's personality and is one of the most basic aspects of self-determination, dignity, and freedom. Therefore, any person, regardless of their gender identity, should have the right to determine who they are.

The Argentinian Gender Identity Law (Ley de Identitdad de Género, 2012) was the first legislative act of its kind in the world, based as it is upon the concept of "the right to identity,"[16] as intended in the Yogyakarta Principles. Therefore, the Argentinan law serves as an example of legislation that respects the right to self-determination of all transgender *and* intersex people by not imposing any preconditions, legal or medical, except that of legal capacity[17] to make decisions (Köhler, Recher, & Ehrt, 2013). Furthermore, the law makes provision for access to trans-specific medical care for those individuals who *choose* to transition to their experienced gender. The United Nations Development Programme fully endorsed the Argentinian model (United Nations Development Programme, 2013). The law is also considered to be in full compliance with the Council of Europe Commissioner for Human Rights' recommendations (Hammarberg, 2009) recommendations that require states to adopt legislation based on the Yogyakarta Principles and relevant international human rights law (Köhler, Recher, & Ehrt, 2013).

In Europe, Denmark was first to pass its Bill to Amend the Act on the Civil Registration (Government of Denmark, 2014). It effectively abolished all medical criteria, such as surgery, hormonal treatment, and psychiatric diagnosis, and allowed the applicant to self-declare his or her gender identity (TGEU, 2014).

Malta followed with the even more progressive Gender Identity, Gender Expression, and Sex Characteristics Act (2015), which explicitly asserts transgender people's rights, both adult and minor, to gender identity, bodily integrity, physical autonomy, and family life, and prohibits the imposition of any requirements other than a declaration of intent to change one's gender marker. The Maltese act also introduced "gender identity" to the list of grounds of nondiscrimination found in the country's constitution and provided for psychosocial counseling, support, and medical interventions related to sex and/or gender. In so doing, the law's scope was explicitly extended to encompass protection from discrimination and the provision of vital health and welfare services.

The case of Ireland

The Irish Gender Recognition Act (2015) is the culmination of a long road to recognition, dominated by the case of Dr. Lydia Foy, who in 1993 launched a more than 20 years' long legal fight against the Irish state for a new birth certificate reflecting her true gender identity. The new Irish law is free of any unfair

medical or legal criteria; but its significance lies also in its long and controversial legislative process.

In 2007, an Irish High Court ruling found the state to be in breach of its positive obligations under Article 8 of the European Convention on Human Rights and, thus, its own Convention on Human Rights Act (2003), in failing to recognize Foy in her female gender and provide her with a new birth certificate (*Foy v. An t-Ard Chláraitheoir & Ors*, 2007). This landmark ruling provided the much needed momentum for the gender recognition movement in Ireland, which until 2015 remained the only European Union member without any mechanism for gender recognition. As a consequence, the Irish government became the subject of repeated criticisms from key human rights organizations and EU agencies, such as Amnesty International (2014), and the Council of Europe Commissioner for Human Rights (Hammarberg, 2009).

In 2010, the Irish government established the Gender Recognition Advisory Group (GRAG). In its report published in 2011, GRAG issued a series of recommendations with regard to the qualification criteria, which were reflective of the situation prevailing in Europe at the time. Contrary to the EU Commissioner for Human Rights' (2009) position and a number of submissions made during the consultation process (i.e., Ireland, the Equality Authority, 2010), GRAG recommended strict medical criteria that included formal Gender Identity Disorder (GID) diagnosis[18] and medical evidence of the applicant having undergone "gender reassignment surgery." The group also excluded married people or those in civil partnerships from the scheme, effectively recommending forced divorce as a precondition. The GRAG report sparked a strong response from the Irish transgender community and human rights organizations, who criticized the proposed eligibility criteria as too restrictive and in opposition to the recommendations of the Council of Europe Commissioner for Human Rights (Hammarberg, 2009), who explicitly called on all states to remove all discriminatory requirements, such as surgery, sterilization, GID diagnosis, and unmarried status (TENI, 2016).

In 2014, the government published a draft of the Gender Recognition Bill (2014), which continued to include discriminative medical and legal eligibility criteria. Although the draft law was welcomed as a positive development, the retaining of these criteria was opposed by human rights experts (O'Flaherty, 2015), the UN Human Rights Committee (2014), Amnesty International (2014), and transgender rights advocacy groups (TENI, 2015a). After a series of consultations, the government was compelled to remove the medical criteria for adult applicants from the final proposal. Furthermore, the passing of the Marriage Equality Referendum in Ireland in May 2015 effectively undermined the interpretive constitutional rationale (illegality of same-sex marriage) for the unmarried status requirement (Ryan, 2012) and led to the passing of the Gender Recognition Act (2015).[19] At last, the act eliminated the persisting legal vacuum experienced by Irish transgender people and established in principle the right to self-determination by allowing applicants to self-declare their gender identity. Although the Irish law now represents one of a small number of progressive legislations in the world, there are areas for improvement, since the act does not apply to children under the age of 16 or to intersex and *gender non-binary*[20] persons and still requires medical certification and a court order as a precondition for applicants under the age of 18 years. However, these groups fall outside the scope of this article and deserve undivided research attention.

Conclusions

Legal gender recognition is a fundamental human right. It is instrumental to the successful fulfillment of the rights to health and health care in that it affects a number of social determinants of health (SDH), such as access to services, social acceptance, visibility, legal capacity, and control over one's health (United Nations Development Programme, 2013). However, many jurisdictions impose discriminatory legal and medical eligibility criteria, which often violate the rights to privacy and family life, physical integrity, and nondegrading treatment.

Although the international human rights law prohibits discrimination on the basis of gender identity, it was the Yogyakarta Principles (2007) that specified the content of human rights and obligations regarding sexual and gender minorities. These universal principles call for the abolishment of all medical and legal requirements for legal gender recognition that violate the principles of self-determination, dignity, and freedom. They also define the content of the right to the highest attainable standard of health by listing its social determinants. Therefore, these Principles should

serve as a benchmark for any gender recognition and antidiscrimination legislation.

Although the judgments of the European Court of Human Rights (ECtHR) acknowledged transgender people's right to legal recognition, they also allowed the states to determine the process locally leading to the application of discriminatory and sometimes abusive requirements such as forced divorce, irreversible surgery, and sterilization. However, as an increasing number of EU countries opt for greater respect of transgender rights, thereby narrowing the margin of appreciation among member states, the ECtHR is now in a position to progress these rights further and influence the process of abolishing those unfair requirements.

Therefore, governments should fully endorse the Yogyakarta Principles (2007), which underpin the Argentinian, Danish, Maltese, and Irish gender recognition laws. These laws should serve as templates because they respect the right to self-determination of transgender people and are free of any discriminatory eligibility requirements. In particular, the Argentinian and Maltese legislations seem to embody the desirable harmonious relationship between legal gender recognition and the right to health and health care, as intended in the Yogyakarta Principles. They not only respect transgender individuals' self-declared identity but also assert the fundamental right to identity and facilitate access to trans-related health care on the basis of informed consent, guaranteeing the coverage of such medical treatments in the national health care plan (Köhler, Recher, & Ehrt, 2013; Government of Malta, 2015). In so doing, in principle, these laws best contribute to the improvement of the social determinants of transgender health and thus facilitate the fulfillment of transgender people's rights to health and health care.

Notes

1. *Transgender* or *trans* is an umbrella term for individuals whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth (Drescher, Cohen-Kettenis, & Winter, 2012; Supplementary material).
2. In the Yogyakarta Principles (2007) *gender identity* has been defined as "each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth."
3. The right to physical integrity, although not explicit in the European Convention of Human Rights, has been cited in the judgments of the European Court of Human Rights under Article 8 (right to private and family life). For example, in *Y. F. v. Turkey* (2003), the court confirmed that a person's body is an intimate aspect of his or her private life, and in *Storck v. Germany* (2005), the court has held that even minor interferences with a person's physical integrity may fall within the scope of Article 8 if they are against the person's will.
4. The General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights (2000) states that "the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, nondiscrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health."
5. Article 1 of the UN International Covenant on Civil and Political Rights (ICCPR, 1966) and of the UN International Covenant on Civil and Political Rights (ICCPR, 1966) states, "All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development."
6. *Gender variance* or *gender variant* is a nonpathologizing way to describe individuals with gender atypical behavior or self-presentations (Drescher, Cohen-Kettenis, & Winter, 2012; Supplementary material).
7. "The International Bill of Human Rights consists of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and its two Optional Protocols" (UN Commissioner for Human Rights, 1996).
8. Beauchamp and Childress (2013) defined the respect for autonomy as an acknowledgment of "people's right to hold views, to make choices, and to take actions based on their personal values and beliefs" (p. 106). In account of health care such a respect "involves acknowledging the value and decision-making rights of persons and enabling them to act autonomously" (p. 107). Therefore, the principle of respect for autonomy is correlative to the patient's "right to *choose*" (p. 108) and, consequently, its observance is a "professional *obligation*" of health care providers (p. 110).
9. WHO (2015b) defines *social determinants of health* (SDH) as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries." SDH that may adversely impact human health are, for example, poverty, social isolation, and various forms of discrimination, such as racism, sexism, classism, ageism, ableism, homophobia, and transphobia.

10. *Transsexual* is a term used to describe an individual who has undergone or intends to undergo sex reassignment surgery (SRS), either male to female (MtF) or female to male (FtM) (Drescher, Cohen-Kettenis, & Winter, 2012; Supplementary material).
11. Intersex Society of North America (ISNA, 2008) defines *intersex* as a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male.
12. *Cisgender* is "a term used in the transgender community to describe individuals whose gender identities align with their assigned sex at birth (non-transgender)" (Drescher, Cohen-Kettenis, & Winter, 2012; Supplementary material).
13. The FRA (2010) report does not specify what is meant by "physical adaptation" other than surgery and hormonal treatments; however, it may be assumed that these are nonhormonal treatments aiming at either masculinizing or feminizing the person concerned—for example, genital and chest surgeries and voice and communication therapy (Coleman et al., 2012).
14. In this case, as in the *Goodwin v. UK* (2002) case, the court referred to *transsexual* individuals only.
15. *Genderqueer* is defined by Drescher, Cohen-Kettenis, & Winter (2012; Supplementary material) as "a colloquial term to describe the gender identity of a person whose internal sense is of being between two genders, neither purely masculine nor feminine."
16. Article 1 asserts everyone's right to his or her own gender identity (Köhler, Recher, & Ehrt, 2013; Annex 1).
17. Article 3 defines who is permitted to change legal gender, stating that every person can request to have the recorded sex amended and the first name changed "whenever they do not agree with the self-perceived gender identity." The only restriction is age, as applicants must be 18 years old or over; however, provision is made for persons who are under 18 years of age (Köhler, Recher, & Ehrt, 2013; Annex 1).
18. At the time of the GRAG report's publication in 2010, GID was the official diagnosis in both the *Diagnostic and Statistical Manual of Mental Disorders, 4th Text Revision* (DSM-IV-TR), published by the American Psychological Association (APA), and the *International Classification of Diseases, 10th Revision* (ICD-10), published by the World Health Organization (WHO). ICD is currently undergoing review and the anticipated publication date of ICD, 11th Revision, has been set by the WHO for 2017. The current WHO (2015a) proposal is to include the diagnosis of "Gender Incongruence" in ICD-11, although the World Professional Association for Transgender Health (WPATH) recommended the use of the term "Gender/Body Divergence," arguing that *divergence* is one of the synonyms of *variance* and more neutral (De Cuypere & Knudson, 2013).
19. It should be noted that at the time of writing the official text of the Gender Recognition Act (2015) still included the "unmarried status" requirement due to legal challenges made against the results of the Marriage Equality Referendum. The Irish government, however, did not commence this part of the legislation, and therefore, this requirement is not applicable (Ireland, Department of Social Protection, 2015).
20. *Gender non-binary* is an umbrella term for gender identities that fall outside the gender binary of male or female. This includes individuals whose gender identity is neither exclusively male nor female, a combination of male and female or between or beyond genders (TENI, 2015b).

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