



## **Critique and Alternative Proposal to the “Gender Incongruence of Childhood” Category in ICD-11**

**GATE Civil Society Expert Working Group  
Buenos Aires, April 4-6, 2013**

### **INTRODUCTION AND SUMMARY**

Access to legal recognition and transition-related health care are two key interrelated issues that affect trans people around the world. These two issues are very often combined into a third major issue for trans people: How can we ensure that trans people can change their gender markers and access transition-related health care services without pathologizing trans experiences of embodiment, identity, and expression? The answer to this question has become a central human rights question posed by trans movements and their allies worldwide.

In this context, the process of reviewing the tenth version of the International Classification of Diseases (ICD-10) and producing a new version (ICD-11) at the World Health Organization (WHO) constitutes a historical opportunity to secure trans people’s full access to both legal recognition and transition-related health care in circumstances compatible with the full enjoyment of their human rights.

GATE (Global Action for Trans\* Equality) is an international organization whose work is focused on promoting trans people’s human rights, supporting their political organizing worldwide, and adding to the body of critical knowledge on trans issues. From that standpoint, GATE organized a civil society meeting of experts on trans issues in The Hague in November 2011, with the purpose of opening a vital space for sharing, analyzing, and discussing viewpoints on the process of ICD reform. The outcome of that meeting was a report titled “It’s Time for Reform: Trans\* Health Issues in the International Classification of Diseases.”<sup>1</sup> This report was submitted to WHO in January 2012.

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<sup>1</sup> Available at [www.transactivists.org](http://www.transactivists.org)

Since that meeting in The Hague, new and relevant developments in the field of trans health and human rights have taken place. In May 2012 the Argentinian Senate passed the first gender identity law in the world that recognizes the human right of trans people to access legal recognition and transition-related health care services (including hormone therapy and surgical procedures) without requiring any kind of diagnosis.<sup>2</sup> In October 2012, forty eight cities in different regions of the world hosted more than one hundred activities on the International Day of Action for Trans\* Depathologization,<sup>3</sup> organized by STP.<sup>4</sup> In November 2012 the Public Health Program at the Open Society Foundations released “Transforming Health: International Rights-Based Advocacy for Trans Health,” which called on WHO to stop pathologizing gender diversity and trans identities.<sup>5</sup> The publication of the article “Minding the Body: Situating Gender Identity Diagnoses in the ICD-11”<sup>6</sup> introduced a new diagnostic category, Gender Incongruence, as a replacement for ICD-10 Gender Identity Disorder (GID). By the end of 2012 the American Psychiatric Association (APA) had announced the completion of the revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*,<sup>7</sup> with the proposed category of Gender Dysphoria as a replacement for GID. And in January 2013, the WPATH meeting in San Francisco facilitated reflection, discussion, and recommendations around the proposed concept of Gender Incongruence and its articulation into diagnoses, diagnostic criteria, and placement in the ICD-11.

In the context of the DSM revision, the WPATH meeting, and the upcoming ICD-11 field tests at the country level, GATE decided to convene a second meeting on trans issues, which took place in Buenos Aires at the beginning of April 2013. This meeting, titled “The Time Has Come: An International Conversation on Health Reform and Human Rights,” was attended by the following experts on trans health and human rights<sup>8</sup>:

- Emiliano Litardo, Lawyer (Argentina)
- Iñaki Regueiro de Giacomi, Lawyer (Argentina)
- Alan Prieto, Trans Activist with CAPICUA (Argentina)
- Marlene Wayar, Futuro Transgenerico (Argentina)
- Karen Bennett, GATE Executive Assistant (Argentina)
- Sonia Correa, Research Associate at Associação Brasileira Interdisciplinar de AIDS (ABIA) and Co-Coordinator of Sexuality Policy Watch (Brazil)
- Dr. Paula Machado, Universidade Federal do Rio Grande do Sul (UFRGS) (Brazil)

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<sup>2</sup> An English-language version is available at [www.transactivists.org](http://www.transactivists.org). Information about the civil society meeting in The Hague and its outcomes can also be found in the article “Minding the Body,” by Drescher, J., Cohen-Kettenis, P., and Winter, S. (2012).

<sup>3</sup> Press release available at [http://www.stp2012.info/old/en/news#pressrelease\\_october2012](http://www.stp2012.info/old/en/news#pressrelease_october2012)

<sup>4</sup> STP is the International Campaign Stop Trans Pathologization, whose website is [www.stp2012.info](http://www.stp2012.info).

<sup>5</sup> Available at <http://www.opensocietyfoundations.org/sites/default/files/transforming-health-20130213.pdf>

<sup>6</sup> Drescher, J., Cohen-Kettenis, P., and Winter, S. (2012).

<sup>7</sup> APA, American Psychiatric Association. American Psychiatric Association Board of Trustees Approves DSM-5. December 1, 2012. <http://www.psych.org/File%20Library/Advocacy%20and%20Newsroom/Press%20Releases/2012%20Releases/12-43-DSM-5-BOT-Vote-News-Release--FINAL--3-.pdf>

<sup>8</sup> GATE Working Group on ICD reform is also integrated by Julius Kaggwa (Uganda) and Amitava Sarkar (India).

- Michel Riquelme, Trans Activist with Organizacion de Transexuales por la Dignidad de la Diversidad (Chile)
- Dr. Karine Espineira, Maitre de Conférence, LIRCES, University of Nice Sophia Antipolis and Co-Manager of The Observatory of Trans-Identities (France)
- Dr. Sam Winter, Psychologist, Associated Proffesor, University of Hong Kong. Director, WPATH (Hong Kong)
- Khartini Slamah, Founder and Board Member of the Asia Pacific Transgender Network (Malaysia)
- Jack Byrne, Trans\* Activist (New Zealand)
- Amets Sues, Research Fellow at the Andalusian School of Public Health in Granada, Spain, and Member of the Coordination Team for STP – International Campaign Stop Trans Pathologization (Spain)
- Aitzole Araneta Zinkunegi, Sexologist and Specialist in Gender Studies (Basque Country)
- Dr. Arnaud De Villiers, GenderDynamix (South Africa)
- Maria Sundin, Board Member of RFSL Swedish Federation for LGBTQ Rights and Steering Committee Member of Transgender Europe, Member of WPATH (Sweden)
- J. Vreer Verkerke, Gender Educator and Trans Rights Advocate (The Netherlands)
- Rena Janamnuysook, GATE HIV/AIDS Policy Officer (Thailand)
- JoAnne Keatley, Director of the Center of Excellence for Transgender Health at the University of California at San Francisco, Member of WPATH (US)
- Kellan Baker, Associate Director for LGBT Health Policy at the Center for American Progress (US)
- Dr. Kelley Winters, Founder of GID Reform Advocates, Member of WPATH (US)
- Cori Zaccagnino, GATE Executive Assistant (US)

The meeting was also attended by Rebecca Fox (Wellspring Advisors), David Scamell (Open Society Foundations), and Eszter Kismödi (Consultant to the World Health Organization), who are not part of the working group. Mauro Cabral, the Co-Director of GATE in Argentina<sup>9</sup>, coordinated the meeting.

One of the key goals of the meeting was to analyze current processes of health reform in relation to trans health care, including the process of reviewing ICD-10 and producing ICD-11 that is currently underway at WHO, and their implications for the health and human rights of trans people worldwide.

On the basis of the discussion, working the group of civil society expert attendees at the meeting (the “Expert Working Group”) agreed on the following positions:

1. Strong support for the deletion of all F66 codes concerning gender identity.
2. Strong support the proposed removal of gender identity from ICD-10 Chapter V, *Mental and Behavioural Disorders*.

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<sup>9</sup> Mauro Cabral is also a WPATH member.

3. The new proposed category of Gender Incongruence of Adolescents and Adults (GIAA) requires further scrutiny, and the Expert Working Group will be sending a more detailed comment of that proposed category to WHO as a separate document.
4. The Expert Working Group is extremely concerned about the proposed category of Gender Incongruence of Childhood (GIC) and is therefore submitting this document as a critique and alternative proposal for addressing the issues that gender-variant children experience.<sup>10</sup>

The reasoning with regard to the proposed GIC diagnosis is based on the following concerns:

First, there is no clear consensus among researchers and health care providers with regard to the need for or global applicability of such a diagnosis.<sup>11</sup>

Second, gender variance in childhood does not require any medical interventions such as hormone therapy or surgical procedures. Rather, children need information and support in exploring their gender identity and expression and dealing with sociocultural environments that are frequently hostile to gender variance.

Third, attaching a medical diagnosis to gender diversity in childhood contradicts WHO's commitment to respecting rather than pathologizing sexual diversity. Specifically, research indicates it is impossible to reliably distinguish between a gender-variant child who will grow up to become trans and a gender-variant child who will grow up to be gay, lesbian, or bisexual, but not trans.<sup>12</sup> As such, by conflating gender variance and sexual orientation, the proposed GIC category amounts to a re-pathologization of homosexuality.

Taking into account these considerations, the civil society Expert Working Group focused its discussion on the Content Form and other documents produced by the ICD-11 Working Group on Sexual Disorders and Sexual Health (WGSDSH) as part of replacing the existing ICD-10 category of Gender Identity Disorder in Childhood (F64.2). The analysis of these documents

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<sup>10</sup> The group of experts convened by GATE considers "gender variance" to be an extremely problematic concept that is rooted in a binary and hierarchical understanding of gender. Nevertheless, the concept of "gender variance" has been maintained in the text to provide continuity and intelligibility with regard to the Content Form and other background documents produced by WHO. When appropriate, the notion of "gender diversity" has also been introduced as a critical synonym for "gender variance," in an attempt to encompass *all* forms of gender identity and expression.

<sup>11</sup> According to the 2012 *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, "The optimal approach to treat pre-pubertal children with gender variance, including DSM-defined GID, is, therefore, more controversial than treating these phenomena in adults and adolescents. And additional obstacle to consensus regarding treatment of children is the lack of randomized controlled treatment outcome studies of children with GID or with any presentation of gender variance (Zucker, 2008). In the absence of such studies, the highest level of evidence available for treatment recommendations for these children can be characterized as expert opinion. Opinions vary widely among experts, and are influenced by theoretical orientation, as well as assumptions and beliefs (including religious) regarding the origins, meanings, and perceived fixity or malleability of gender identity."

<sup>12</sup> According to the *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, "It is currently not possible to differentiate between preadolescent children in whom GID will persist and those in whom it will not. To date, no long-term follow up data have demonstrated that any modality of treatment has a statistically significant effect on later gender identity." (American Psychiatric Association Task Force 2012:9).

was grounded in multidisciplinary perspectives and centered on the internationally recognized rights of the child as a guiding human rights principle.

**On the basis of this analysis, the Expert Working Group is submitting the following recommendations to WHO concerning the proposed category of “Gender Incongruence of Childhood”:**

- 1. To consider the complete deletion of the proposed category of Gender Incongruence of Childhood.**
- 2. To consider field-testing a combination of existing Chapter XXI codes and newly developed Z codes for the ability to facilitate access to appropriate counseling and adaptive environments for gender-variant children and their families.**
- 3. If WHO moves forward with field-testing the proposed GIC category, the Expert Working Group strongly recommends that the proposed category be further analyzed and modified. We further recommend that this modified GIC category be tested against the Z code alternatives and a “no specific children’s diagnosis” option.**

The first two recommendations are explored in detail below. With regard to the third recommendation, the Expert Working Group is currently developing a separate analysis and suggested modifications of the proposed GIC Content Form.

## **DISCUSSION OF RECOMMENDATIONS**

***Recommendation 1: The proposed category of Gender Incongruence of Childhood should be deleted.***

The civil society Expert Working Group convened by GATE recommends the complete deletion of the category of Gender Incongruence of Childhood from the ICD-11 draft. We have reviewed the “ICD-11 Field Studies Overview” and other relevant WHO documents and drew upon several criteria from those documents when formulating this recommendation:

**Usefulness: The proposed category has no usefulness in facilitating access to health care services.**

\* Children do not have medical needs related to gender diversity, such as hormone therapy or surgical procedures, that require a specific diagnosis. Instead, their primary needs are for information, counseling, and support, which the ICD can facilitate access to via other means, such as Z codes. (Winter 2013).

\* Children who experience clinically significant distress or impairment due to gender variance are able to access health care under the same diagnoses that are used for any child with clinical depression or anxiety. **Attached to this document are numerous letters from WPATH members attesting to this point (“Letters of Support”)**

- \* Children facing challenges such as family opposition, bullying at school, or social rejection due to gender variance should be able to access services through codes that address these hostile environments without pathologizing the child. Parents, other family members and other relevant individuals, such as teachers and social workers, should similarly be able to access information, counseling, and support through codes that target their specific needs, without projecting their own distress on the child. (Hill & Meinville 2009; Raj 2008; Riley, Sitharthan, Clemson & Diamond 2011; Winter 2013; Winters 2008)<sup>13</sup>

**Validity: The proposed category is not a valid predictor of health care needs.**

- Research has repeatedly affirmed that there is no way of reliably forecasting gender identity and/or gender expression in adolescence and adulthood based on gender variance in childhood.<sup>14</sup> This lack of predictive capacity and poor specificity strongly discourage using this diagnosis on children. (Langer 2004, Ansara 2010; Ansara, Hagerty 2011)

**Utility: The proposed category and its related definitions and diagnostic guidelines do not have significant global clinical utility.**<sup>15</sup>

- The socioanthropological evidence indicates that, in many cultural settings, children's experiences of gender identity variance do not necessarily imply suffering or distress and do not require any clinical intervention (Gómez 2004; Vasey, Bartlett 2007; Winter 2013)<sup>16</sup> studies and reports from different theoretical perspectives indicate the existence

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<sup>13</sup> "While peer ostracism is indeed a problem for gender-variant children, therapists should focus their efforts on systemic interventions such as sensitivity training in schools or violence prevention programs. Families need assistance overcoming their antipathy toward their child's gender choices and assistance developing skills to deal with family members, peers, and school officials who might not support a gender nonconforming child. Parents might also need assurance that their child's gender was not caused by their parenting practices and that supporting their child's gender will have a positive impact on self esteem." (Hill, Menvielle, et. al. 2010:10).

<sup>14</sup> *Supra* note 10

<sup>15</sup> Reed (2010).

<sup>16</sup> "I highlight the period of five to twelve as the beginning of an early period of conciseness for the muxhe because myself and the majority of those that I have talked to or lived with say that this is the age when they first noticed their different identity. (...) During this age the muxhe will show a series of behaviors, mannerisms and ways of being which will characterize him and at the same time he naturally begins to find his place in the public space. A muxhe, when he realizes that family and neighborly support networks are needed, looks for an opportunity to momentarily help with the economic situation of the family, which may be finding a job selling fried goods, helping sell tortillas or fish with his mother and/or another close relative. In another sense the muxhe starts looking to get closer to older muxhes so as to know their surroundings and behaviors, also the muxhe begins to form strategies for establishing "innocent" erotic-affectionate contact with other boys." (Gómez 2004: 3-4).

"That being said, we wish to stress that Samoans do *not* conceptualize femininity in males as indicative of mental disorder. Thus, when it comes to sex and gender diversity, what counts as mentally disordered in one culture is conceptualized as benign behavioral variation in another. It would be an overstatement to say that *fa'afafine* never experience *any* discrimination as a result of gender-atypicality or atypical sex-identities. Nevertheless, the level of societal acceptance they enjoy, the manner in which they are integrated into the quotidian fabric of Samoan life, and their highly public presence, stand in stark contrast to their

of culture-specific forms of gender diversity worldwide which may differ from Western conceptualizations (Besnier 1994; Coleman, Colgan, Gooren 1992; Costa, Matzner 2007; Gómez 2004; Graham 2001, 2002; Graham-Davies 2007; Jackson 2003; Matzner 2001; Nanda 1990, 2000a,b,c; Newman 2002; New Zealand AIDS Foundation 2005; New Zealand Human Rights Commission 2008; Peletz 2006; Pulotu-Endemann 2004; Schmidt 2001; Vasey, Barley 2007; William 1986; Winter 2013).

**Consistency: The proposed GIC category is substantially inconsistent with other proposals that are part of ICD reform.**

- The proposed GIC category contradicts the motivations and reasoning underlying the deletion of the entire ICD-10 F66 block (“psychological disorders associated with sexual development and orientation”), which includes F66.0 (sexual maturation disorder), F66.1 (ego-dystonic sexual orientation), and F66.2 (sexual relationship disorder). A major rationale for deleting these F66 diagnoses is the understanding that they unnecessarily and inappropriately pathologize people with diverse sexual orientations. In a similar manner to how these discredited F66 diagnoses helped perpetuate discrimination against gay and lesbian people, the proposed GIC diagnosis would unnecessarily and inappropriately pathologize children with diverse gender identities and would contribute to discrimination against these children.
- The proposed GIC category contradicts WHO’s position with regard to sexual orientation by unjustifiably differentiating between children exploring their sexuality and children exploring their gender identity or expression.

The Expert Working Group has also identified two additional areas of concern, namely, bioethics and human rights, that argue against the proposed GIC category.

**Bioethical Concerns**

- The continuing lack of consensus among researchers and health providers regarding the proposed GIC category (or similar category) cautions against the adoption of this

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Western counterparts, for whom widespread discrimination is, unfortunately, the norm.” (Vasey, Bartlett 2007: 487).

“Today, in parts of the global south and east, many such children begin to identify in another gender quite early in life, doing so before puberty, and are recognized by others as being members of their affirmed gender group, even if in the modern world there are often, at home and school, limits to the degree to which they can express that identity. Those limits in any case often loosen by the time they approach school-leaving age. Many individuals growing up in these social environments appear to enjoy (in childhood, adolescence and adulthood) relatively good psychological adjustment (despite sometimes having to endure broader societal stigma).[footnote] Though a gender-different child’s gender identity and expression may not be universally celebrated by parents and teachers, that identity and expression tends to be accepted by them as *diversity* rather than mental or medical disorder. In thirteen years working in with transgender people in Asia I recall very few informing me that their parents had taken them to see a doctor when they were a child.” (Winter 2013: 3-4).

category and calls for urgent scrutiny of alternative codes that have the potential to adequately address children's needs for information, counseling, and support.<sup>17</sup>

- In addition to its manifest lack of medical necessity, evidence indicates that the proposed GIC diagnosis may in fact be potentially harmful. This evidence includes observations that diagnoses of gender variance or incongruence exacerbate stigma and discrimination for children and their families, as well as indications that such diagnoses have been used to justify the provision of harmful “reparative” therapies. (Langer & Martin 2004) Moreover, though the proposed GIC diagnosis will be regulated by definitions and diagnostic guidelines, the risk is unacceptably high that this diagnosis will be interpreted as pathologizing any form of gender variance in childhood.
- One of the reasons the category of GIC has been proposed is to help address negative parental reactions to gender variance in childhood. However, the introduction of this category has the potential to misdirect attention toward clinical interventions for gender-variant children instead of toward support for their parents and other adults in their lives.
- The psychopathologization of gender-variant children has been repeatedly identified as a source of stigma and discrimination<sup>18</sup> – and thus of anxiety, anguish, and depression – for these children. In replacing the diagnosis of Gender Identity Disorder in Childhood, the proposed GIC category is likely to simply reproduce the same pattern under a different name. (Ansara, 2010; Ansara & Hegarty 2011; Heflinger, & Hinshaw 2010; Langer & Martin 2004; Moses 2009; Mukolo 2012; Schomerus & Angermeyer 2008; Winter 2013).

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<sup>17</sup> “The primary way in which diagnostic labeling might harm children is through the experience of being stigmatized. Research has not examined the extent to which children might be stigmatized by the diagnostic label of GIDC. However, there is evidence that adults experience stigma associated with being labeled mentally ill or substance abusers (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Among those labeled, the effects of stigma were found to outlast improvements gained from mental health or substance abuse treatment. The most enduring forms of stigma were perceptions of devaluation and discrimination, and experiences of rejection. The effects of stigmatization included depressive symptoms such as social withdrawal (Link et al., 1997). Stigma might not necessarily result in negative effects on individuals’ self-esteem, but in order to counter the possibility of such effects, individuals must have the opportunity to identify with a community of others who are similarly stigmatized (Crocker & Major, 1989). Gender-atypical children who are brought into treatment by parents who want them to be “normal” are not likely to have this opportunity, and as a result their experience of stigma is likely to be far lonelier and more damaging. (...) (DiCeglie 1998) recommended that clinicians take a neutral stance toward the gender role behaviors and gender identity of children referred for treatment. Especially among older children and adolescents, more aggressive efforts might feed into common age-related fears of control, invasion, or intrusion. Clinicians should also heed Pleak’s (1999) advice by supporting “the parents’ acceptance and love for their child as he or she grows up regardless of future sexual orientation and gender identification” (p. 48). In addition to these recommendations, the mental health community should take a strong stand against the continuation of GIDC as a sanctioned diagnostic category, in light of its conceptual and psychometric weaknesses and the ethical problems associated with treating gender-variant children who receive this diagnosis” (Langer & Martin, 2004: 17, 19).

<sup>18</sup> Recent reports reflect a high exposure of gender variant children to experiences of stigmatization and discrimination (GLSEN 2012; McBride 2013; New Zealand Human Rights Commission 2008; Sood 2010; Whittle, Turner, Al-Alami 2007; UNDP 2012)

## Human Rights Concerns

In addition to the bioethical concerns, the proposed GIC category may also contradict international human rights standards, particularly those concerning the rights of the child.

According to Article 3 of the *Convention on the Rights of the Child*, the primary concern for any action influencing the wellbeing, health, or development of a child should be in accordance with the child's best interest. Further, States must take all necessary actions to protect the child's best interests.<sup>19</sup> The Committee on the Rights of the Child has commented that States should "place children's best interests at the centre of all decisions affecting their health and development, including...the development and implementation of policies and interventions that affect the underlying determinants of their health."<sup>20</sup> The Committee on Economic, Social and Cultural Rights also supports this position.<sup>21</sup>

Thus, in determining what constitutes the best interests of gender-variant children, a starting consideration must be the degree to which a particular action or decision may have the potential to cause harm to these children. A diagnosis of GIC has the potential to be harmful, both in terms of the stigma and discrimination associated with being diagnosed as "gender incongruent" as a child and the likelihood that this diagnosis will create new pathways to "reparative" therapies for gender diversity in children. The pathologization of gender variance in childhood through the imposition of a diagnostic category that has no positive clinical utility and that, on the contrary, actually poses potential harm to children, clearly contradicts the principle of the best interests of the child.

Another major consideration with regard to the rights of children is the importance of recognizing the developmental phases and evolving capacities of children. According to the *WHO Constitution*, "the healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development." The Committee on the Rights of the Child expands on this point in its *General Comment 15*, where the Committee states, "each phase [of childhood] is significant as important developmental changes occur in terms of physical, psychological, emotional and social development, expectations and norms. The stages of the child's development are cumulative and each stage has an impact on subsequent phases, influencing the children's health, potential, risks and opportunities." The Committee also "recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues... with children who are particularly vulnerable to discrimination often less able to exercise this autonomy."<sup>22</sup>

Further, the imposition of a diagnosis of gender incongruence on a child contradicts the principle that childhood development is a process of change and exploration. Such a diagnosis, which attempts to establish a concrete definition of a child's gender identity precisely during

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<sup>19</sup> "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (CRC Article 3).

<sup>20</sup> CRC, General Comment 15 (2013)

<sup>21</sup> CESCR, General Comment 14.

<sup>22</sup> CRC, General Comment 15 (2013).

the phase of life when essential aspects of identity are most in flux, is likely to create the presumption that the child is transgender, whether or not that is in fact the case. It also runs counter to the principle of respecting the evolving capacity of children to make independent decisions regarding their health.

In its *General Comment 13 on the Right of the Child to Freedom from All Forms of Violence*, the Committee on the Rights of the Child states, “the concept of dignity requires that every child is recognized, respected and protected as a rights holder and as a unique and valuable human being with an individual personality, distinct needs, interests and privacy.”<sup>23</sup> The proposed GIC category pathologizes children with diverse gender identities by describing them as having a “problem” that needs to be fixed. Instead of problematizing these children, health systems should value and respect the gender expression and identity of all children and should focus their problem-solving energies on addressing any distress or impairment that may arise for children as a result of a social environment that is hostile to or unsupportive of gender variance.

The recently adopted General Assembly *Resolution on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* “calls upon States to take all necessary measures to ensure that the right of the child to the enjoyment of the highest attainable standard of physical and mental health is promoted and protected, without any kind of discrimination, including through the enactment and implementation of laws, strategies and policies, gender- and child-responsive budgeting and resource allocation, and adequate investment in health systems, including comprehensive and integrated primary health care.”<sup>24</sup> It also “reaffirms the right of the child to express their views freely in all matters and decisions affecting their health, and that those views should be given due weight in accordance with their evolving capacities, and calls upon States to provide disability-, gender- and age-sensitive assistance to enable active and equal participation of all children,” while calling upon States “to ensure the enjoyment by all children of all their civil, cultural, economic, political and social rights without discrimination of any kind, and to take effective and appropriate measures to ensure the right of all children to the enjoyment of the highest attainable standard of health, on an equal basis with others, as well as access to quality, affordable and equitable health care and social services, without discrimination of any kind.” That includes, undoubtedly, gender-variant children.

With regard to sexual and reproductive health issues, the same Resolution urges states “to ensure that the right to sexual and reproductive health as a fundamental part of the right to health is fully realized by giving full attention to the sexual and reproductive health needs of children and adolescents, consistent with their evolving capacities, by providing information, education and services...on an equitable and universal basis, with their full involvement and the support of the international community, with full respect for their privacy and confidentiality, free of discrimination, and to provide them with youth-friendly and evidence-based comprehensive education, consistent with their evolving capacities, on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality.”

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<sup>23</sup> CRC, General Comment 13 (2011)

<sup>24</sup> A/HRC/22/L.27/Rev.2

The *Yogyakarta Principles on the Application of Human Rights Law to Sexual Orientation and Gender Identity* affirm, in Principle 18 (Protection from Medical Abuses), that “no person may be forced to undergo any form of medical treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classification on the contrary, a person’s sexual orientation and gender identity are not, in and by themselves, medical conditions and are not to be treated, cured or suppressed.”<sup>25</sup> The principles urge States to “take all necessary legislative, administrative and other measures to ensure full 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” and to “ensure that any medical or psychological treatment or counseling does not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed.” The Expert Working Group’s recommendation to WHO regarding the deletion of the proposed GIC category is fully consistent with these frameworks.

Finally, in addition to being problematic for all the reasons discussed above, the proposed GIC category is simply unnecessary. Children with diverse gender identities do not need medication, surgery, or other medical intervention – they need supportive mental health services and the freedom to explore themselves and their environments without the burden of an unnecessary and stigmatizing diagnosis. These services can readily be provided through the use of Z codes, as we discuss below.

***Recommendation 2: A combination of existing Chapter XXI codes newly developed Z codes should be field-tested for the ability to facilitate access to appropriate counseling and adaptive environments for gender-variant children and their families.***

The civil society Expert Working Group finds that the Z codes, which are the non-pathologizing codes currently located in ICD-10 Chapter XXI (“*Factors influencing health status and contact with health services*”), may offer a promising path forward for providing gender-variant children with the services and support they need to thrive.

The Z codes are introduced thus in ICD-10:

*Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as “diagnoses” or “problems.” This can arise in two main ways:*

- a. When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination or to discuss a problem which is in itself not a disease or injury.*
- b. When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Such factors may be elicited during*

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<sup>25</sup> Yogyakarta Principles (2006).

*population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some illness or injury.*<sup>26</sup>

Both of these points describe the circumstances under which some children seek health care services for reasons associated with gender variance.

The Z codes are currently organized in the following major blocks:

- [Z00-Z13](#) Persons encountering health services for examination and investigation
- [Z20-Z29](#) Persons with potential health hazards related to communicable diseases
- [Z30-Z39](#) Persons encountering health services in circumstances related to reproduction
- [Z40-Z54](#) Persons encountering health services for specific procedures and health care
- [Z55-Z65](#) Persons with potential health hazards related to socioeconomic and psychosocial circumstances
- [Z70-Z76](#) Persons encountering health services in other circumstances
- [Z80-Z99](#) Persons with potential health hazards related to family and personal history and certain conditions influencing health status.

Of these, blocks Z55-65 and Z70-76 are particularly relevant to the needs of gender-variant children. The clinical utility of Z codes in this case includes the following considerations:

- **Access to supportive counseling:** Z codes can be used when coding is required for a child to access counseling services related to gender identity, gender expression, or gender-role transition, but where there is no psychopathology and a mental disorder diagnosis is not appropriate.<sup>27</sup> These codes can also be used to provide support and services to parents and other relevant adults in properly coping with the needs of gender-variant children.
- **Access to school in authentic roles:** Z codes can be used in specific circumstances in which diagnostic coding is required by local laws or policies in order to secure access to education for children who have transitioned to an affirmed gender role that differs from the sex they were assigned at birth. For instance, in some jurisdictions, school records, name usage, pronoun usage, and access to appropriate facilities for these children may require some kind of diagnostic framework.
- **Modify/contextualize mental health codings:** Z codes can be used in conjunction with other diagnostic codings to modify their context and identify special needs. In the case of gender variance, this may include children who are severely distressed with their natal sex characteristics; who are anxious about impending pubertal changes that are wrong for them; or who have separately been diagnosed with mood, anxiety, or other

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<sup>26</sup> <http://apps.who.int/classifications/icd10/browse/2010/en#/XXI>

<sup>27</sup> Lev, A.I., Winters, K., Alie, L., Ansara, Y., Deutsch, M., Dickey, L., Ehrbar, R., Ehrensaft, D., Green, J., Meier, S., Richmond, K., Samons, S., Susset, F. (2010).

mental health disorders (F-codes in Chapter V of the ICD-10).<sup>28</sup> For example, a child with gender variance experiencing symptoms of depression or anxiety related to anatomy or birth-assigned sex will likely have very different needs from a child with symptoms of depression and anxiety but no indications of gender variance. Without this differentiation in diagnostic coding, children with gender variance might be denied support for their gender expression or social transition and only offered psychotropic medications to treat depression or anxiety. Z-codes clarifying the specific circumstances of children with gender variance could be combined with mental health F-codes to provide this clarity when needed.

- **Establish history prior to puberty and adult diagnosis:** Z codes can be used for prepubescent children who may need to establish a documented history of their need for access to puberty-blocking medications at a later age. The current WPATH Standards of Care, for example, require “a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),” a criterion that can be met by Z codes.<sup>29</sup>

The Expert Working Group therefore proposes four Z codes to cover the various circumstances in which prepubescent children may need access to services or social support for reasons related to gender variance:

1. In block Z60 (*problems related to social environments*), we propose that category Z60.4 (*social exclusion and rejection*), which currently reads as follows in ICD-10:

“Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behaviour”

be amended to read as follows:

**“Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behaviour, sexual orientation, or gender identity or expression.”**

2. We propose that category Z60.5 (*target of perceived adverse discrimination and persecution*), which currently reads as follows in ICD-10:

“Persecution or discrimination, perceived or real, on the basis of membership of some group (as defined by skin colour, religion, ethnic origin etc), rather than personal characteristics. Excludes social exclusion and rejection (Z60.4)”<sup>30</sup>

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<sup>28</sup> Global Action for Trans\* Equality (2011).

<sup>29</sup> World Professional Association for Transgender Health (2011), “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.”

<sup>30</sup> Other codes currently in Block Z60 include problems of adjustment to life-cycle transitions (60.0), atypical

be amended to read:

**“Persecution or discrimination, perceived or real, on the basis of membership of some group (as defined by skin colour, religion, ethnic origin, sexual orientation, gender identity or expression, etc.) rather than personal characteristics.”**

3. We propose a new category Z70.4 in the Z70 block. This block is currently titled “*Counseling related to sexual attitude, behaviour and orientation*,” but its proposed new title is “***Counseling related to sexual attitude, behaviour and orientation, or gender identity or expression.***”

The new category Z70.4 would read:

**“Counseling for a child to support gender identity or expression that differs from birth assignment.”**

4. Finally, we propose a new category Z70.2x (x indicating a fourth digit, as yet undetermined). Z70.2 currently reads, “Counseling related to sexual behaviour and orientation or third-party advice sought regarding sexual behaviour and orientation of child, partner or spouse.”

We propose that the new category Z70.2x read:

**“Counseling for families and service providers related to the gender identity or expression of a child.”**

To assess the validity and utility of these proposed Z codes, the Expert Working Group strongly recommends that they be included in the ICD-11 field test. Specifically, these proposed Z codes should be tested to see how they perform against the alternative of “no specific children’s diagnosis.”

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parenting situation (60.1), living alone (60.2), acculturation difficulty (60.3), other problems related to social environment (60.8), problem related to social environment, unspecified (60.9).

The positions and recommendations articulated in this document summarize the substantial body of research, analysis, and dialogue produced by trans movements and their allies regarding the critical questions of depathologization, access to health care, and, in particular, gender diversity in childhood. These recommendations, as well as the conceptual framework and references that support them, can be further developed upon request from the World Health Organization.

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