

Transgender patients sidelined by attitudes and labelling

In spite of an enlightened constitution and enabling legislation, South Africa's small transgender population continues to battle medical prejudice and ignorance in addition to huge societal pressure to conform to socially constructed sexual stereotypes. An *Izindaba* investigation showed that transgender people need precise information and deep pockets to access hormone treatment and/or gender-reassignment surgery, be it in the public or private sector.

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Attempts to access care in the public sector where facilities, staff and protocols exist, often result in humiliation, up to 6 years waiting on surgical lists and sometimes being routed via the private sector at major expense, with no guarantee of an outcome.

This emerged late last year at a pioneering inaugural conference held in Hout Bay where transgender men and women, health care providers and the national Department of Health met to establish a long-awaited research and policy agenda. A transgender person may have a male body but feel inside that they are female, or vice versa. They experience a deep incongruence between their physiological gender and their basic internal sense of gender self (or core gender identity). They may choose hormone treatment and/or surgery to address this or simply live their lives according to their internal sense of their 'gender'.

Parental pressure to conform 'deadly'

Research in the USA has shown that transgender children whose parents pressure them to conform, when compared with accepting, supportive parents, have a four times higher suicide and drug abuse rate, twice the risk of contracting HIV/AIDS and a five times greater chance of suffering depression.¹ The best available evidence points to transgender children being born that way, but society (and science to a lesser extent) tend to view the incongruence as a 'disorder', attributing it to more esoteric reasons, like divorce, parental neglect,

parents wishing they had given birth to the other sex, using fertility drugs to conceive, encouraging children to play sports too often or not enough or a range of other parental thoughts, behaviours or influences.

While supporting a child's transgender behaviour is challenging, research shows that loving and accepting children 'as they are' helps them lead happier, healthier lives, reduces risk and, in many cases, literally saves their lives.

In some parts of Europe and the USA puberty is delayed by means of hormone blockers, enabling the person to transition at 17 or 18 years old when surgery is generally more successful because the patient is not 'masculinised or feminised'.

Transgender delegates to the Hout Bay conference, convened by human rights NGO, Gender DynamiX, shared some deeply touching stories of isolation, discrimination and problems in accessing medical services. The inaugural gathering called for the 'de-pathologisation' of the current transgender diagnosis, from 'Gender Identity Disorder,' to 'Gender Incongruence' in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM V) – which is on the discussion agenda for the next World Health Organization (WHO) sexuality committee meeting. (Sexuality and gender-adjustment experts spoken to by *Izindaba* emphasised that an added benefit of sex-change surgery was being able to escape such labelling.)

You can have naturally effeminate men attracted to women and every other variation and combination along the identity spectrum and sexual orientation spectrum. Doctors need to be sensitive to the spectrum of their clients out there and awake to their own blind spots.

Prior to the advent of the first Standards of Care (SOCs) for cross-gender persons in the 1960s there was no consensus on psychiatric, psychological, medical and surgical requirements or procedures. Few countries offered safe, legal medical options and many criminalised cross-gender behaviours or mandated unproven psychiatric treatments. In response, the Harry Benjamin International Gender Dysphoria Association (now known

as the World Professional Association for Transgender Health (WPATH)) authored one of the earliest sets of clinical guidelines for the express purpose of 'ensuring lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment'. These standards, last revised in 2001 (sixth edition)² are the best known, although other sets of SOCs, protocols and guidelines do exist, especially outside the USA.

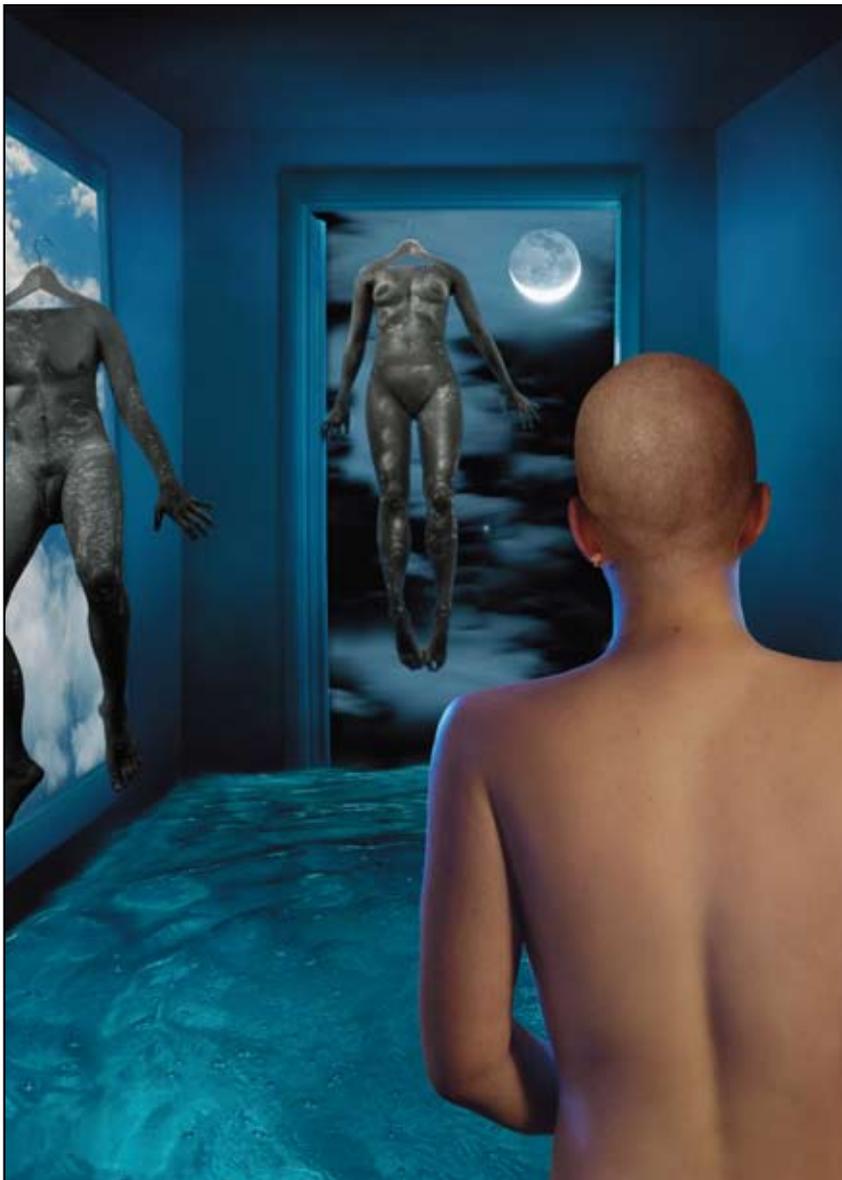
Two public sector transgender clinics in SA

Two public sector transgender clinics exist in South Africa, one at the Steve Biko Academic Hospital in Pretoria and the other, more comprehensive service, at Groote Schuur Hospital (GSH) in Cape Town, both with links to the main referral NGOs, the Triangle Project and Gender DynamiX. Both NGOs were set up in Cape Town as a response to harmful stereotyping, attitudes and behaviours towards transgender, transsexual and gender-non-conforming people and to advocate for their human rights.

GSH uses the services of a dedicated psychologist, psychiatrist, clinical social worker, endocrinologist, gynaecologist and plastic surgeon to assess and help gender-incongruent candidates with elective hormone treatment and surgery. The Steve Biko Academic clinic, subject of much complaint by transgender delegates to the conference because of its alleged use of a private psychiatrist as 'gatekeeper', is less holistic in its approach, with half the annual number of full transition surgeries.

Ronald Addinall, a clinical social worker and sexologist with the Department of Social Development at the University of Cape Town (UCT), runs support groups for and counsels gender-variant or 'gender-questioning' people at the Triangle Project. He acts as an initial assessor for the GSH Transgender Clinic and has 71 persons representing the full gender spectrum on his books, mostly Capetonians, either long-time or newly resident and a minority who travel from elsewhere, including from as far afield as Zimbabwe.

Izindaba interviews with GenderDynamiX and Triangle staff, Addinall, a plastic surgeon and a clinical psychologist – all members of the GSH Transgender Clinic – revealed that more than 90% of transgender persons strongly aspire to a gender reassignment.



An androgynous figure contemplates passage through dissolution to environments that differ as day does from night.

Picture: Robert Hamblin, Advocacy Manager at GenderDynamix.

Says plastic surgeon, Dr Kevin Adams, who has 30 patients on his 'gender-dysphoric' waiting list and manages four full transitions (each patient undergoing several operations) per year: 'One patient told us he'd happily swap conditions with a cancer patient who has gross disfigurement of the head than forgo sex-change surgery.' His colleagues at the clinic echoed this sentiment; full gender 'alignment' was the ultimate goal for most gender-variant persons, though many settled for hormone and/or 'top surgery' for various reasons, especially the greater risk of genital surgery for female-to-male transsexuals, and a lack of funds.

Cape Town plastic surgeon hits 100% success rate

Adams has so far helped 10 patients transition, half of them from male to female and the other half the reverse, over the past 4 years. About 20% had complications, though for the past 18 months he's achieved a 100% success rate. 'I put it down to the learning curve; fortunately there were no major disasters, just minor complications. I'm still on very good terms with those patients – you have to be there for them; this is something that has consumed their lives.'

However, success has a wider definition for Adams and the clinic team. One of their 'transmen' (female to male) is now

married with a child (IVF) and is living a highly successful 'transrole' life. Another 'extremely happy woman' from the Eastern Cape reports enjoying multiple orgasms, testimony to Adams' micro-surgical skills.

Surgeon and physician attitudes could however do with a bit of psyche-surgery. One of Adams' up-country colleagues who conducts such operations once gauged his success by the lack of postoperative suicides. 'But they're much more likely to do it before the operation. The change is what they aspire to!' said Adams.

Lex Kirsten, a transman and founder member of Gender Dynamix, said that shortly after he turned 21, the first psychologist he ever consulted about a possible sex change asked him to demonstrate how he would pick up a baby. 'My mother taught me how to pick up my brothers, who are 15 and 8 years younger than me, without hurting them, but the psychologist said I did it the wrong way round and could therefore not recommend me for gender-reassignment surgery. The psychologist also gave the example of women striking a match away from them and men towards them. 'I spent several years after that observing people doing these things and found that both sexes do it both ways,' Kirsten laughed.

Dr Adele Marais, a psychologist with the UCT Transgender clinic, said that recently she had a referral from a GP, which was a first for her. She said the GP appeared well informed about transgenderism and had 'clearly engaged with his client in a sensitive and respectful manner', making their first contact with the (primary) health care system a positive experience.

Perhaps most pertinent is Addinall's description of health care professionals battling with a lack of any sexuality training in their academic curricula, and like society in general, still confusing gender identity with sexual orientation. He told *Izindaba*: 'Unfortunately (education) priorities lie elsewhere. One psychiatrist who saw one of my clients (a transman) asked him which sex he was attracted to. When he said men, the psychiatrist turned him down, saying he should be attracted to women!' 'There's confusion in differentiating gender identity and sexual orientation. For example, stereotypes are prevalent, such as if you're a man and naturally feminine you're gay and if you're female and butch (i.e. more 'masculine') you must be lesbian. You can have naturally effeminate men attracted to women and every other variation and combination along the identity spectrum and sexual orientation spectrum. Doctors

need to be sensitive to the spectrum of their clients out there and awake to their own blind spots. Not all your patients are straight (heterosexual) or gendered in the way you might perceive them to be,' he added.

The top WPATH experts described transgenderism as 'a medical condition with mental health components', not a mental health condition with medical components – the core of activist moves to have existing textbook definitions changed.

The bigger barrier however (to surgery for transgender persons) is that many surgeons have internalised the general stigma and prejudice that exists towards transgenderism.

Global prevalence estimate

According to Adams the internationally accepted prevalence of transgender persons is between 1 and 5 per 10 000 people, though there is no research conducted so far in South Africa. He said the estimate was considered conservative due to the 'underground' nature of many transgender people.

Adams is allocated four surgery slots for gender reassignment surgery a year by his hospital chiefs and is as defensive of his transgender patients' right to a slot as anyone else. 'I try to be as consistent as possible but we just don't have the surgical capacity to meet the demand,' he shrugs.

There are 130 plastic surgeons in South Africa and, encouragingly, since 2003 (at UCT at least) very few new graduates have emigrated. The bigger barrier however (to surgery for transgender persons) is that many surgeons have internalised the general stigma and prejudice that exists towards transgenderism.

Patient feedback to Adams is that most surgeons will only agree to do one operation and 'try and get it passed through the system as quietly as possible, without arousing suspicion. I know many of the surgeons my patients mention and it's the first time I hear of them doing transgender ops. We need to demystify and destigmatise and get more people involved in doing the ops – in terms of technical satisfaction ... it's immense.'

Adams said that besides Ronald Addinall, fellow sexologist Dr Marlene Wasserman and himself and one or two colleagues teaching

registrars, virtually no one was educating the medical fraternity about sexuality, let alone about transgenderism. 'I have no problems with colleagues not wanting to be involved with transgenderism. To each their own. We just need to encourage people to open their minds and see this as part of being a doctor helping relieve human suffering.'

Medical aids not on board

When it comes to medical aids and affordability, Adams knows of only one case (a patient of his) who had a (relatively small) medical aid approve surgery. Asked by the assessor whether the procedure was cosmetic, Adams replied that it was 'the most ... no, probably the ultimate, reconstructive surgery I've come across.'

The UCT Transgender Clinic has outsourced health care costing to a firm of actuaries to solidly back up negotiations with medical aids and compare the relative costs of long-term psychotherapy with transgender surgery. Addinall emphasises that gender reassignment surgery is a quality-of-life issue and not a lifestyle choice or cosmetic surgery issue as it is sometimes argued by the medical aids. 'Usually we're dealing with young adults with their entire lives ahead of them. Compare this with end-of-life or late-life cancer care. Our patients are often incredibly conflicted and tortured people, often with multiple suicide attempts and depression. Once they've had surgery, they're cured,' he argues.

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on a continuum of somewhat lower costs. However, if they chose the state route and are indigent or earn about R1 000 per month, it will cost them just R75. The rub lies in declaring your income to the tertiary hospital's fees office which uses an income-related sliding scale to peg fees. Any earnings over 'about R4 100' will put state treatment on a par with private care. For example, a patient earning R4 1000 per month who wanted breast augmentation at GSH was quoted R29 000, slightly more expensive than the private sector.

Advice to doctors

Adams' advice to his fellow doctors is to 'try and empathise with your patients rather than be shocked and horrified ... treat them as human beings and recognise their suffering. If a GP is prepared to get involved that's fantastic, in fact a network of referring GPs would be wonderful, but like any medical condition, if you're uncomfortable in treating, you refer. In the same way HIV patients have the right to treatment, so do transgender patients.'

According to Act 49 of 2003 (the Alteration of Sex Description and Sex Status Act) 'Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolution through natural development resulting in gender reassignment, or any person who is intersexed, may apply to the Director General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register'. The reality, however, according to Robert Hamblin, Advocacy Manager and Deputy Director at Gender DynamiX, is that the act is not being implemented. Transgender people are being turned away irrespective of their transitioning status. 'Home Affairs officials are simply not informed of the basic documentation required for altering one's sex, and transgender persons are put through ridiculous, bureaucratic and punitive processes,' he adds.

Chris Bateman

1. Stephanie Brill, Director, Gender Spectrum Education and Training, USA, and Caitlin Ryan, PhD, ACSW, specialist in lesbian, gay, bi-sexual and trans-sexual studies, University of San Francisco on ABC TV News 20/20 story on transgender children, broadcast April 2007.
2. <http://www.wpath.org/journal/www.iiav.nl/eazines/web/IJTI/973/numbers/symposium/index-3.htm>