What’s the problem represented to be?

A policy analysis of the Danish Health Authority’s guidelines on healthcare related to gender identity

~ Master’s thesis in Development and International Relations,
specialization in Global Gender Studies ~

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Preface and acknowledgements

The basis of this thesis originally stems from my passion for freedom, equality and justice. Today, we have reached a point in history where we dare discuss notions of sexuality and gender, critically assessing controversial yet crucial topics such as transgender rights as human rights. Who decides over our bodies, citizenship, life? It is my passion not only to investigate these questions but to bring forth ethically considered arguments, so everyone can be secured autonomy over their bodies and life.

In truth, I could not have reached this point of achievement without a strong foundation of support.

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Abstract

Background: Today, issues related to sexual orientation and gender identity are being widely discussed, nationally as well as globally. Especially the topic of transgender rights has received an increasing amount of attention over the last decade, specifically regarding legislation on legal gender change and regarding trans-specific healthcare. In 2017, Denmark became the first country in the world to declassify being transgender as a mental disorder and later the same year, the Danish Health Authority (SST) issued new guidelines on healthcare related to gender identity. However, organizations and movements advocating for trans rights have remained skeptical of the changes, emphasizing the need for critical studies examining the practices surrounding trans rights in seemingly progressive, egalitarian welfare states as the current research on this in a Danish context, and including the narratives of transgender people and specifically care-seekers, is limited.

Aim: To analyze the complexities of trans-specific healthcare, including how constructions of gender identity related issues have been included in human rights discourse.

Theoretical framework: The theories used in this study consists of a Foucauldian approach to power and governmentality, theories on how to include trans rights in human rights discourse, and notions on the governing of bodies and citizenship.

Method: The analytical framework for this thesis is based on the WPR approach presented by Bacchi, which functions as a policy analysis of the guidelines on healthcare related to gender identity. The guidelines are conceptualized as 'health policy' and is analyzed through grounded theory, coding and discourse analysis.

Results: The identified 'problem' representations in the guidelines has been identified as SST's role in destigmatizing transgender people in terms of care-seekers, based on care-seekers reporting feeling disempowered and mistrusted in the clinic SK under the previous policy. An additional 'problem' representation has been identified to be the aim of securing that care-seekers are fully decided in their wish to pursue trans-specific care, to avoid regret. Though the overall language and terminology in the guidelines has been changed and modified to adopt a more inclusive and affirmative approach to trans-specific healthcare, the overall content and nature of the guidelines is still far from addressing and considering the obstacles care-seekers might experience when pursuing trans-specific healthcare in Denmark. These obstacles include but are not limited to the open-ended and loose definitions of (degree of) gender discomfort, psychosocial relations, long or comprehensive investigations and the disclosure of sexuality related subjects.

Key words: *trans-specific healthcare; WPR approach; policy analysis; human rights; gender identity; transgender; governmentality*

Glossary and abbreviations

Binary gender – People, both cis or trans people, who identify as either male or female

Care-provider – Used, in this thesis, to describe people, typically medical personnel in the clinics, who offer trans-specific healthcare

Care-seeker – Used, in this thesis, to describe people who seek trans-specific healthcare

Cis (gender) – From Latin, meaning “on the same side as”, used to describe people who identify with the gender they were assigned at birth

Cisnormativity – The default assumptions that all people are cisgender and have a binary gender identity

Cissexism – Used to describe prejudice against someone based on their gender (identity), most commonly through the assumption that everyone is cisgender by default (see also: transphobia)

CK	Center for Kønsidentitet, Center for Gender Identity
CTP	Critical Trans Politics
DAPC	Danish Agency for Patient Complaints
DPSA	Danish Patient Safety Authority
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EBM	Evidence-Based Medicine

Gender (identity) – The gender a person identifies with

Gender assigned at birth – The gender a person was assigned at birth based on genitalia, typically male or female

Gender characteristics – Breasts, Adam’s apple, facial hair or other physical attributes typically associated with the binary genders

Gender dysphoria – Conflict between a person’s gender identity and their assigned gender, typically described as feeling very uncomfortable with their body or expected roles of their assigned gender

Gender norms – Used to describe the behavior, roles and expression of a person based on their gender

Gender-nonconforming – Used to describe people, both cis and trans, whose gender expression or behavior does not match the gender roles or gender norms of their gender

Heteronormativity – The assumption that all people are heterosexual (i.e. are only attracted to a gender different than their own, for example a man who is attracted to a woman)

HRD	Human Rights Discourse

ICCPR International Covenant on Civil and Political Rights

ICD International Classification of Diseases

Legal gender change – Changing one’s assigned gender to match one’s gender identity in personal documents, such as social security number and passport

LGBT(QIA) – Lesbian, gay, bisexual, transgender (queer, intersex, asexual)

Non-binary (gender) – People whose gender identities are outside of the gender binary; genders that are neither men or women

Passing – Being perceived by others as the gender which you identify with

Sexual orientation – Used to describe who a person is sexually and romantically attracted to

SK Sexologisk Klinik, Sexological Clinic

SOGI Sexual orientation and gender identity

SST Sundhedsstyrelsen, Danish Health Authority

TA TransAktion

TPF Transpolitisk Forum

Trans – From Latin, meaning ”on the other side”, or “across”, used to describe people whose gender identity does not match the gender they were assigned at birth

Trans person – A person whose gender identity does not match the gender assigned at birth

Transgender – In English, used either as an umbrella term for the trans community or to describe a person whose gender identity does not match the gender assigned at birth (see also: trans person)

Transphobia – Used to describe a range of negative attitudes, feelings and actions towards the transgender community or individuals in the community based on them being transgender or gender nonconforming; for instance, fear, violence or discomfort felt or expressed towards people who do not live up to the accepted gender norms

Trans-specific healthcare – Used, in this thesis, to describe counselling regarding clarification of gender identity related issues and medical procedures to change gender characteristics

UDHR Universal Declaration of Human Rights

UN United Nations

UNHRC United Nations Human Rights Council

WHO World Health Organization

WPR What’s the Problem Represented to be?

YP+10 Yogyakarta Principles plus 10

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1. Introduction

In the following chapter I will provide an overview of the how gender identity related issues have been politicized and included in human rights discourse. Then, a brief description of the declassification of being transgender as a mental disorder in Denmark, including the Danish Health Authority's (SST) guidelines on trans-specific healthcare. Thereafter my aim, problem formulation and limitations of this thesis.

1.1 Gender identity as a human rights issue

Over the last decade, issues related to gender identity and expression have gained more attention than ever and has been widely defined, discussed and politicized. Nationally as well as globally, different trans- and human rights movements have been advocating for policy changes to include gender identity and gender expression in anti-discrimination laws, and most notably, to depathologize being transgender by removing it from the list of mental illnesses as provided by the World Health Organization (WHO) in their International Classification of Diseases (ICD) (Amnesty, 2014; Spade, 2015).

In November 2017, the Yogyakarta Principles plus 10 (YP+10) was adopted to supplement the original Yogyakarta Principles to secure that sexual orientation and gender identity (SOGI) related issues are protected in human rights law and legislation. Furthermore, international political institutions such as the United Nations (UN) are championing LGBTQIA rights; for instance, by launching the campaign *UN Free & Equal* to promote equal rights and fair treatment of LGBTQIA people (OHCHR, 2013), and by passing various resolutions implementing sexual orientation and gender identity in human rights legislation (OHCHR, 2018). The implementation of SOGI issues into human rights discourses can be understood as a paradigm shift regarding what is understood to be human rights and what should be included under the concept.

1.2 Declassifying being transgender

In January 2017, Denmark became the first country in the world to declassify being transgender as a mental illness, when the Danish' government's Ministry of Health decided to remove the diagnosis from the Danish Health Authority's (SST) list of mental illnesses as of primo 2017, if WHO had not done it before end of 2016 (Danmarks Radio, 2017; TV2 Nyhederne, 2016). The news made headlines worldwide, as the Scandinavian country paved the way for a progressive paradigm shift in the governing of transgender citizens, and the policy change was celebrated by both politicians, activists and naturally, members of the transgender community both nationally and internationally.

However, some were skeptical of the political act, as neither the government, their Ministry of Health or the SST had presented a plan on how this change would be carried out practically, for instance in terms of trans-specific healthcare. Before the change, transgender people needed to be diagnosed under the diagnosis code

F64.0[1] and undergo psychiatric evaluations before getting offered any medical procedures. The removal of 'transgenderism' on the list of mental illnesses then also raised questions regarding the practical implementation of the policy change and which lived effects it would have on the transgender community in Denmark.

1.3 The guidelines on trans-specific healthcare

In September 2017, the SST published their new guidelines on trans-specific healthcare, replacing the old and vastly criticized guidelines of 2014 (see Amnesty, 2014). The new guidelines were updated to correspond to the new political changes of how to understand and define being transgender. Various human- and trans rights organizations had been invited to participate in the consultation processes and thus, contribute to the discussion on the guidelines in areas such as terminology and how to offer care in practice. For instance, in their campaign for trans rights in the Danish healthcare system under the name *#SygtSystem*, Amnesty International (hereafter just Amnesty) had advocated for the implementation of the concept informed consent which has now been included in the new guidelines (Amnesty, 2017).

However, other groups advocating for trans rights such as Rådgivning for Transpersoner[2] (now and hereafter: TransAktion) stayed critical due to various points in the new guidelines which they found problematic. Some of their critique points included the centralization of the trans-specific healthcare in so-called gender identity clinics requiring the presence of a multidisciplinary team (MDT) and lack of properly defined terms resulting in expressions open to interpretations (Friborg &Vinther, 2017).

After being implemented for almost one year, the SST released an updated version of the guidelines, titled *'Guide on healthcare related to gender identity'* in August 2018 and thereby replacing the former guidelines, no. 9921 of September 2017 (Sundhedsstyrelsen, 2018). According to SST, the main change in the guidelines is regarding castration, following the Danish parliament's changes to section 115 of the Health Law (regarding castration)[3] (Sundhedsstyrelsen, 2018).

1.4 New paradigm, new policy: how?

Critical questions of when identity political related issues should be included under the concept of human rights have been widely discussed, as the topic of gender identity has yet to be normalized. The politicized status of transgender rights has started the discussion on how institutions and states should govern our bodies and lives, and how to define what is and what is not to be considered and included in the discourse of human

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[1] ICD-10 diagnosis codes F64.0: 'transsexualism' (Dustman, 2016)

[2] Rådgivning for Transpersoner (new name: TransAktion) is a free, community-based counselling agency for transgender people, offering counselling and guidance on trans-related issues such as trans-specific healthcare, gender identity questions, questions on stigmatization and such (Friborg & Vinther, 2017).

[3] The changes entail that only in very carefully selected cases should the SST approve castrations

rights. How states decide to govern through policies is also to be questioned and examined. As many scholars argue, policies are complex and needs to be assessed from a critical standpoint – they function not only as a government or state's way of 'fixing' a 'problem', but also as strategies to dictate political agendas (Bacchi, 2009; Spade, 2015; Foucault, 1991).

1.5 Aim

The overall aim of this thesis is to analyze the complexities of trans-specific healthcare, including how constructions of gender identity related issues have been included in human rights discourse.

2. Problem formulation

This thesis seeks to problematize the SST's guidelines on healthcare related to gender identity, conceptualized as trans-specific healthcare, from a critical perspective. This is done by drawing on Carol Bacchi's *"What's the Problem Represented to be?"* (WPR) approach to policy analysis. The thesis implements the first question of the analytical approach as the main problem formulation, by asking:

What is the 'problem' of trans-specific healthcare represented to be in the SST's guidelines on healthcare related to gender identity?

To answer this question and investigate the complexities of the guidelines further, I draw on carefully chosen textual sources and implement the additional five questions of the WPR approach:

1. What assumptions underlie this representation of the 'problem'?
2. How has this representation come about?
3. What is left unproblematic in this problem representation? How can the 'problem' be thought about differently?
4. What effects are produced by this representation of the 'problem'?
5. How and where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

The main documents used in this thesis are official documents issued by the SST, such as the guidelines (2018) and various consultation reports (2017c; 2017d), supplemented with studies by Amnesty (2014, 2016 & 2017) and TransAktion (see Friborg & Vinther, 2017). The theoretical framework of this study consists of critical and poststructuralist theories of human rights, critical trans politics and citizenship.

2.2 Limitations

As described above, the focus of this thesis will be on trans-specific healthcare in Denmark. Therefore, the scope of this thesis has been limited to the guidelines *'Guide on healthcare related to gender identity'* issued by the Danish Health Authority (SST).

As of this limitation, other aspects of trans-related issues, such as legal gender change have not been included in the problem formulation. For example, the thesis mentions legal gender change but does not seek to investigate it alongside trans-specific healthcare, and further, trans-specific healthcare is not investigated on a global scale. Though investigating and analyzing trans-specific healthcare in a comparative study between the Danish model and a different country which has yet to change its practice regarding trans-care would bring forth relevant aspects of trans-specific healthcare, as Denmark is currently a unique case by working from an approach which does not pathologize trans care-seekers by not diagnosing them alongside mental disorders. This thesis also limits itself to focus on adult care-seekers as different rules and laws apply to trans children and adolescents who pursue trans-specific healthcare.

Further, the situation of Denmark currently being the only country in the world which does not recognize being transgender as a mental disorder makes the Danish model a unique case. This has limited the thesis as there are no other welfare systems or countries to compare with as they do not exist (yet). However, the thesis finds inspiration from both Sweden and Norway as other Scandinavian countries with egalitarian welfare states.

Additionally, as the guidelines have been in practice for just more than a year, there is currently little to no accessible data on which effects the implementation of it has had. For instance, I have not been able to access any statistics on how many transgender people have sought care, what the care-seekers (and -receivers) think of it, what the medical professionals at the clinics thinks about it and how they have worked with it, and if the guidelines have had the wanted effect of making trans-specific healthcare more and easier to access and receive, and the experience of and meeting with healthcare personnel less stigmatizing for the care-seekers.

The sources of data have also been limited to accessible documents, such as reports, articles and consultation notes from different involved and relevant actors, such as the SST, the Danish government, Amnesty and other involved trans rights activist groups. It would have been relevant to interview chosen key actors, such as Transpolitisk Forum, TransAktion, LGBT Danmark and Amnesty to get valuable insights from the processes leading up to creating the new guidelines such as the activism they have done, which topics or points in the guidelines they find more crucial and also to bring forth an otherwise often neglected yet important perspective: the user groups and their experiences.

3. Previous research

To position this thesis within the fields of Development, International Relations, Global Gender Studies and Transgender Studies, previous research from within these fields will act as bases from which I understand, examine and analyze the dynamics of (health) policy, welfare states and trans-specific healthcare both in a political, social and medical sphere. Previous research within these fields have contributed with relevant background knowledge, such as narratives of care-seekers, activists and the medical personnel and professionals working in the fields of trans-specific healthcare, and further, theories to examine and analyze both structures and dynamics related to trans-specific healthcare and the policing hereof. In the following chapter I will situate my analysis of the SST's guidelines on trans-specific healthcare within existing relevant research.

3.1 Trans-specific healthcare in a Nordic context

Searching after existing research on the topic of trans-specific healthcare, and specifically in a Scandinavian or Nordic context, I discovered the work of Linander et. al. (2017; 2018). First their study, *"It was like I had to fit into a category': Care-seekers' experiences of gender regulation in the Swedish trans-specific healthcare"* (2017), in which Linander et al. analyzes the *"narratives of individuals with trans experiences (sometimes called transgender people) to examine how gender performances can be regulated in trans-specific care in Sweden."* (Linander et al., 2017: 1) and later, the dissertation *"It was like I had to fit into a category: People with trans experiences navigation access to trans-specific healthcare and health"* (2018), which is based on the previously mentioned study and three others. The research done by Linander et. al. (2018) seeks to analyze how constructions of trans experiences and gender can affect trans-specific healthcare practices and does so by drawing on a Foucauldian approach to power and governmentality (ibid.). The methodology of the dissertation has greatly inspired the one of this thesis, as Linander et. al. includes two different types of studies: two interview studies which are based on interviews with 18 people with trans experiences and a policy analysis of the guidelines on trans-specific healthcare published by the Swedish National Board of Health and Welfare (ibid.). The guidelines on trans-specific healthcare in Sweden were analyzed using Bacchi's WPR approach, hence why my thesis draws a lot of inspiration from this Swedish study.

Additionally, Linander's work on trans-specific healthcare in Sweden has presented new terminology to use in all work related to trans-specific healthcare, both academically and professionally. Their study finds inspiration from Foucault and Haraway's arguments regarding knowledge production, as both scholars have argued *"that the practice of defining, names and categorizing is a normative act and involved the exercising of power"* (Linander, 2018: 10). Linander shows extreme caution and ethical consideration in their choice of terminology; for instance, by using the term "trans experiences" they seek to include all experiences of transcending the normative expectations of a 'linear gender'. The term is inspired by Bremer (2011), as they argue that 'trans experiences' can be understood as experiences of deviating from the normative 'linear gender', like how queer sexual orientation deviates from the 'straight line'. Furthermore, Linander notes, that they also draw on Ahmed's (2006) queer phenomenological approach to orientation, seeking to describe how bodily orientation is connected to repetitive bodily actions and further, how these actions create lines which could be understood as 'the normative' (Linander et al., 2017: 4). Cisnormativity is also a term included in Linander's work, as it can be used to describe *"social discourses and practices that assume that individuals* *have linear genders*" and by inclusion in the theoretical considerations, can be used to investigate normative categories such as linear gender and how the cis-position is defined through constant reproduction of a 'deviant other position' (Linander, 2018).

Lastly, I adopt certain terms in my thesis, such as "care-seeker" instead of "patient", "medical procedures" and "trans-specific healthcare" instead of "treatment" to avoid reproducing pathologizing discourses and connotations within the already powerful institution of medicine and healthcare, as Linander et al. argues (2017). I also almost exclusively use the term and concept of gender, and almost never sex, as I follow Linander's logic: *"This is connected to the fact that I find the distinction between sex and gender problematic and as reproducing ideas about gender being (only) social and sex as something (only) biological"* (Linander, 2018: 12; see also Kessler, 1990; Kessler & McKenna, 1978; Moi 2001).

3.2 Trans rights and -activism in Denmark

Working with the guidelines on trans-specific healthcare published and issued by the SST, I find it necessary to include and investigate some of the organizations and activists who were active in the debate leading up to the policy change. Some of these actors are Amnesty, TransAktion (TA), Transpolitisk Forum, (TPF) and LGBT Danmark, who allied in their activist strategies when lobbying and campaigning for trans rights, specifically regarding trans-specific healthcare in Denmark. Situating this thesis in the fields of International Relations and Human Rights, I draw inspiration from Amnesty's international and global advocacy as one of the leading NGO's working with trans rights as human rights, especially in the context of the policy change nationally in Denmark.

In 2014, Amnesty's international secretariat published a study on transgender rights in Europe, titled *"The state decides who I am – Lack of legal gender recognition for transgender people in Europe"* (2014) which focuses on the legal rights of transgender people. In 1992, the European Court of Human Rights (ECtHR) first deemed a state's refusal of allowing transgender citizens to change their legal gender markers on official documents (such as passport and other IDs) a violation of the European Convention on Human Rights (ECHR); however, as Amnesty argue, today, more than 20 years later, trans people still struggle to have their gender identities legally recognized (Amnesty, 2014). This report investigated several European countries, including Denmark, and found that though Denmark had a reputation for championing (gender) equality and human rights, the country still demanded that transgender Danes underwent irreversible sterilization to obtain a legal gender change (ibid.). Amnesty argued, that the requirement to undergo this irreversible surgical procedure violated transgender people's rights to be free from *"inhuman, cruel or degrading treatment, which is protected under several international human rights instruments including the ICCPR (Article 7) and the UN Convention against Torture and Inhuman, Cruel or Degrading Treatment or Punishment (Article 16)*" (Amnesty, 2014: 25).

Following Amnesty's international report on transgender rights in a European context, the Danish wing of the organization published the study "*Transkønnedes adgang til sundhed i Danmark – En opfølgning på Amnestys rapport fra 2014"*[4] (2016) which focuses on the issue of transgender people's rights in Denmark, specifically regarding trans-specific healthcare. The report includes a collection of interviews with Danish trans people, who describe their experiences with Sexologisk Klinik (SK) which, at the time, was the only clinic in the country permitted to offer trans-specific healthcare. Most of the interviewees reported feeling uncomfortable and stigmatized during their meetings with the care-providers due to the methods used to diagnose the care-seekers with "transsexualism"; for example, by asking the care-seekers questions of sexual character, such as if the care-seeker thought of their parents while masturbating or if they were sexually aroused by animals (Amnesty, 2016: 7). Following these documented observations, Amnesty investigated the diagnostic requirements for accessing and receiving trans-specific healthcare and concluded, that care-seekers were forced to choose between either their right to privacy and dignity, and their right to equal healthcare (in this context, trans-specific healthcare) (Amnesty, 2016: 15).

Based on these studies, Amnesty Denmark launched the national campaign *#SygtSystem* in 2016 to raise awareness of the issues of transgender people's rights, especially regarding access to trans-specific healthcare. The aim of the campaign was to appeal for policy change (to declassify being transgender as a mental disorder) and in March 2016, Amnesty – together with TPF, Copenhagen Pride and LGBT Danmark – handed over more than 48,000 signatures and 1500 personal letters to then Minister of Health Karen Ellemann to appeal for this (Amnesty, 2017). My thesis finds inspiration from Amnesty's methodological approach to examining and investigating the issues of trans rights as human rights, and I draw on their experiences and narratives of both representing an international human rights organization and national activist groups and movements, including care-seekers.

3.3 Critical trans politics (CTP)

From my previous work on trans-specific healthcare, and after becoming familiar with Linander's research, I have been inspired by Spade's approach to Foucault's theories of power structures and governmentality; exemplified by using the concepts as analytical tools in implementing trans discourse to a legal rights framework. In times of reformation and progressive change in policy, it becomes crucial to investigate relationships of power when discussing trans rights as human rights. Spade calls this critical trans politics (CTP).

As described on the very first page of the introduction in his book titled *"Normal Life"* (2011), Spade identifies CTP as a form of politics that *"(...) demands more than legal recognition and inclusion, seeking instead to transform current logics of state, civil society security, and social equality."* (Spade, 2011: 1). The

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[4] English: "Transgender people's access to healthcare in Denmark – A follow up on Amnesty's report from 2014"

essence of CTP is to be critical of its own effectiveness, aiming to focus more on the practice and the process of achieving rights rather than the act of reaching a point of "liberation". Spade further argues, that practicing CTP means critically examining what law is, what power is and to investigate what role reforming laws play regarding changing norms that are harmful or violent towards trans people (Spade, 2011: 2).

To describe how CTP can identify these harmful norms (systems of meaning and control, such as transphobia, sexism or racism), Spade uses the term "subjection" instead of "oppression" because the term "oppression" insinuates that one group of people dominates others, or that one group of people "have power" and others do not (Spade, 2011: 6). "Subjection" seeks to include other aspects of harmful norms, for instance how power relations affect how we know, feel and experience ourselves as subjects in these systems of meaning and control, thus affecting our relationship with our bodies, our relationships with other people and institutions, and ultimately how we imagine change and transformation in all its meanings (ibid.).

As Spade argues throughout his book, the operations of power are so complex and multi-dimensional that it's a pitfall for many scholars interested in researching transformation and social resistance formations to oversimplify power structures and how they operate. It is necessary to expand the understanding of how power operates by ceasing to view power as a top-down function only focusing on the roles of oppressor/oppressed as it prevents one to investigate opportunities for interventions and over-looked alternatives for transformation (ibid.).

An example of how Spade implements these notions of power in working with trans issues (also included under the term cisnormativity in the context of this thesis) is by drawing on Foucault's idea of modes of power (Spade, 2015: 51). The three modes of power can be categorized and illustrated by comparing them like so:

	Exclusion/Subtraction	**Disciplinary power**	**Population-management power**
How it operates	Top-down, based on legal framework/laws	"Invisible" (is not governed through laws), exists in society	Top-down, uses legal framework/laws as strategies and tactics
Works through	Discrimination and 'othering' of marginalized groups	Social relations, norms	The arrangement of provided security/insecurity
Results in	Some groups being privileged while others lack equal opportunities, for example in	Labels to avoid, some groups being vulnerable to discrimination based on hegemonic norms	A legal system imposing laws and policies based on hegemonic norms,

	healthcare or financial status		punishing those who deviate the laws (norms)
Critique points	As it focuses on laws/legal regimes, it does not consider complexities of, for example, transphobia or racism	Difficult to challenge norms and fight discrimination when laws often follow the perpetrator/victim mode of power (leaves biased standards in place)	Creates general laws and policies which mobilize norms that target categorized populations rather than working on an individual-based level; reproduces stereotypes

I find inspiration in this Foucauldian approach to power by viewing the system of trans-specific healthcare as terms of governing; the SST being the state entity governing and policing care-seekers' access to trans-specific healthcare by gate-keeping who should be allowed to access it or not.

4. Theoretical framework

In the following chapter I will present the theories that constitute the theoretical framework for the analysis in this thesis. Firstly, Bacchi's notions on how to theorize health policy. Secondly, theories and concepts included under human rights discourse, including notions on trans bodies and citizenship.

4.1 Theorizing 'health' policy

As mentioned previously, this study implements Bacchi's WPR approach to analyzing policy. However, Bacchi also notes that there are more, in-depth theoretical considerations to policy analysis than "just" asking what the problem is represented to be. For instance, how to examine discourse in different policy fields, such as the field of 'health' (Bacchi, 2009). As this thesis is concerned with the SST's guidelines on trans-specific healthcare, it is interesting to draw on Bacchi's theoretical considerations regarding health policies generally. 'Health', Bacchi argues, is a particularly debated concept as there are many theoretical approaches to how it should be understood. Within the field of health policy, there are mainly two competing theoretical paradigms:

1. Biomedical paradigm: *"(...) focuses on technology-based medical care and biomedical public health interventions such as immunization and health screenings. (...) Health is understood as the absence of disease, and the focus is primarily on physical disease. Bodies are considered to be like machines that break down and that can be fixed."* (Bacchi, 2009: 128-129; Lewis, 2005: 95).

2. Social paradigm: *"(...) understands health as a social phenomenon, a product of complex environmental and social factors. (...) 'Health' is understood as more than just the absence of disease. The term 'wellbeing' is often used to signal a more holistic understanding. (...) health is described as a 'state of complete, physical, mental and social wellbeing'."* (Bacchi, 2009: 128-129).

The two paradigms intersect and cross-over in their preventive and curative approaches to health. As Bacchi notes, it is a key dispute between the different paradigms; to what extent which people should be held responsible for their 'health' due to their lifestyle 'choices' (Bacchi, 2009). For example, the biomedical paradigm typically assesses 'health' from a primarily *curative* approach, however has a *preventive* dimension as well. An example of 'preventive medicine' or procedures is screening programs or immunization through vaccines, which has recently also been used to direct attention towards certain lifestyles or behaviors that are believed to cause these diseases (such as unprotected sexual activities, smoking or lack of exercise) (Alexander and Lawrence, 2002; Bacchi, 2009).

In the social paradigm, the understanding of 'health' stems from a more holistic approach, as 'health' understood as 'well-being' goes beyond screenings and immunization procedures. Working with 'health' from a social paradigm, factors such as peace, social justice (anti-discrimination) and a stable ecosystem can be included in the considerations for measures taken against ill-health (Bacchi, 2009: 130). Following the Alma-Ata Declaration (1978), health is declared a fundamental human right which demands actions from other sectors, like the social and the economic, in addition to the health sector.

A third way of viewing and working with health policy, that crosscuts both the biomedical and the social paradigms, can be described as 'evidence-based' medicine (EBM). The main premise of this paradigm is, when *"healthcare professionals perform an action, there should be evidence that the action will produce the desired outcome"* (Holmes et al., 2006: 181).

Generally, EBM argue that clinicians and other healthcare personnel are to follow research and/or practice to discover 'what works', based on the assumption that it will ultimately benefit the patients (Bacchi, 2009). The argument for following an EBM paradigm/approach is that it can challenge an ideologically-driven policy, however, as focus in EBM is on effectiveness and efficiency, the evidence-based approach fits comfortably in governments inspired and influenced by *"the instrumentalist mood of managerial reforms"* and *"infiltrated practices in western democracies over the past three decades"* (Marston and Watts, 2003: 146). However, the main critique of this approach rests on the privilege the healthcare personnel is given; as the evidence-based knowledge deemed acceptable is quite narrow, the care-providers are *"presumed to know the truth of disease"* and thus, delegitimizes other embodied ways of 'knowing' (for instance, through personal experiences of transness amongst care-seekers in this context) (Holmes et al., 2003: 148). Other concerns, as pointed out by Marston and Watts (2003), include governments being able to choose specific 'evidence' that best suit their political agenda.

I draw on these theoretical considerations when analyzing the SST's guidelines on trans-specific healthcare, as I wish to investigate the ways in which trans-specific healthcare is understood and how the different paradigms are represented.

4.2 Trans rights as human rights

The perspective of including trans rights in human rights is a relatively new field emerging within advocacy towards equality for transgender people both locally, nationally and globally. In order to conceptualize and analyze trans-specific issues as human rights issues, the (historical) context and ideal underlying human rights will be emphasized and investigated in the following chapter. In addition, political concepts of citizenship will be assessed critically regarding trans issues.

4.2.1 Human Rights Discourse (HRD)

Following the traumatic and horrific events of World War II, the Universal Declaration of Human Rights (UDHR) was adopted and implemented by the United Nations General Assembly in December 1948. The declaration states, among other important points, that *"all human beings are born free and equal in dignity and rights"* (Universal Declaration of Human Rights: Article 1) and that *"everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status"* (ibid.: Article 2). However, scholars and activists across fields have argued that such rights have remained symbolic as a political and organizing concept, and almost non-existent as a movement (Moyne, 2010). In the 1970s, concerns were raised regarding a new kind of emerging imperialism or colonialism, as the moral of the Western world shifted, following the utopianism that 'coalesced in an international human rights movement that never existed before' (ibid.: 2).

In the 1990s, the Western concepts of "homosexuality" and "sexual orientation" were implemented in the (political) agenda by several international LGB(T)[5] movements, focusing on the different UN human rights organs (Kollman and Waites, 2005). However, the concept of "gender identity" (referring to issues experienced by or affecting trans people specifically) was not included in mainstream LGB(T) movements until the next century (Balzer & Lagata, 2014). The inclusion of trans people in the agenda of the LGB(T) movement can be described as a paradigm shift in both the perception and the overall framing of trans-specific concerns and issues, however still dominated by the globalized Western medical-psychiatric perspective. The leading Western medical-psychiatric paradigm has typically pathologized and stigmatized trans people by defining them as deviations of hetero-cisnormative standards of an unquestioned, seemingly natural binary gender order, but is now being challenged by new and critical discourses (ibid.).

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[5] Up until the 2010's, mainstream LGB(T) rights movements focused primarily on issues related to sexual orientation and thus, did not include issues related to gender identity in their agenda. Therefore, in this paragraph, I put the T for transgender in parenthesis to emphasize the historical exclusion of trans issues in the LGB(T) movement.

These challenging perspectives and discourses typically focus on both social and legal issues affecting trans people, usually proven to egregiously violate universal human rights; for instance, globally, these violations include severe forms of transphobia such as hate-fueled violence, including killings, rape and torture; forced criminalization and prostitution; and other forms of sexual and gender (identity) based violence (ibid.). Additionally, other forms of structural violence against trans people have roots in policies created and implemented by states and governments due to decades of Western stigmatization and pathologizing of transness (Balzer & Hutta, 2012). However, the challenging perspectives understand trans people as equal members of society in the context of human rights and thus, emphasizes the importance of viewing transphobia and other violent acts against trans people as human rights violations.

Finally, a prominent indicator of a paradigm shift in how trans rights have been included in the human rights framework is the implementation of the Yogyakarta Principles on the Application of International Human Rights Law in relation to sexual orientation and gender identity (Balzer & Lagata, 2014). Especially important for trans issues is the inclusion of Principle 18, 'Protection from Medical Abuses', as it states:

> *"No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Not withstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed"* (Yogyakarta Principles, 2007).

Since the release of the principles, they have been cited by various UN bodies, national governments, the Council of Europe and different human (and trans) rights organizations, such as Amnesty International. The national chapter of Amnesty in Denmark published a report researching trans people's access to trans-specific healthcare in Denmark and argue trans people's *"right to the highest attainable standard of health"* (Yogyakarta Principles, 2007: Article 17) based on the international conventions and principles regarding human rights (Amnesty, 2016). Other key indicators of a paradigm shift in attitudes towards trans rights as human rights has been the historical resolution by the UN Human Rights Council in 2011, which became the first resolution specifically targeting sexual orientation and gender identity to recognize the systemic human rights violations that LGBT people face worldwide (UNHRC, 2011; Balzer & Lagata, 2014).

In context of the thesis, the paradigm shift is also experienced on a national level in Denmark, when the government's Ministry of Health decided to remove being transgender from the list of mental illnesses (DR, 2017). Thereby Denmark became the first country in the world to introduce a reformation of how the state views trans people.

4.2.2 What is an egalitarian welfare state?

Another interesting aspect to consider when working with trans rights as human rights is how the different institutions, states and governments implement and ensure them for its users/citizens. As the struggle for trans rights mainly centers around access to trans-specific healthcare, I find it relevant to outline and investigate the definition(s) of egalitarianism in the political society, especially in terms of access to healthcare in welfare states. As this thesis analyzes the SST's guidelines on trans-specific healthcare in Denmark, the concept of an egalitarian welfare state is crucial to investigate further when analyzing the argument(s) and 'logic' a policy, for example, is based upon. In the following chapter I will briefly outline two theories on how to grasp the dimensions of egalitarianism and how to include trans rights in a theoretical framework for an egalitarian welfare state.

The first notions on egalitarianism I include are by legal and political theorist Ronald Dworkin, who argue for a resource-based form of egalitarianism. To illustrate his idea, he introduces two market mechanisms to ensure equality: an *auction system* where everyone has an equal amount of currency, which they may use to bid on various external resources (Lippert-Rasmussen, 2009: 681; Binsfeld, 2014: 93) and a *hypothetical insurance market* to secure equality in internal resources, such as talents and health (ibid.). The idea behind using an auction system is to avoid envy amongst the people, as everyone has equal abilities to get/access what they want as they have had equal opportunities to bid on each item/resource. However, the wish to avoid envy fails when considering the internal resources, as not everyone is equal in that sense (for instance, some trans people experience gender dysphoria which cis people do not).

Here, Dworkin's idea of an insurance market comes into play. To secure that everyone is treated equally, and has equal access to resources, Dworkin argues that the state should provide compensations to those with lesser or fewer internal resources through taxation of those with greater or more resources (ibid). The idea behind this way of redistributing resources is to secure that everyone is equal, no matter their internal resources which they have no control over (Cohen, 1989; Lippert-Rasmussen, 2001). As Binsfeld argues, *"Dworkin's model uses equality to achieve liberty, in an attempt to avoid victimization."* (Binsfeld, 2014: 93), but acknowledges that the theory is problematic to apply in real life, mainly since people do not have the opportunity to achieve or access equal resources for various reasons.

Another way to assess egalitarianism is presented by Irish-Australian political philosopher Philip Pettit, who argues for the implementation of three core concepts to create an egalitarian system: equal freedom, a mixed constitution and contestatory citizens (Binsfeld, 2014: 94). Pettit's main theory centers around non-domination, meaning a society where everyone's equal freedom is secured by being allowed to live freely without hindrances (ibid.). This theory is based upon the notion that if someone is being dominated through being subjected to an external will of others, they are no longer free nor equal. These external forces are often described as either invasion or vitiation. However, Pettit argues that there are clear lines between

having your choices invaded without consent (direct domination) and voluntary (consented) invasion. To illustrate this, Binsfeld (2014) uses the example of a person giving their car keys to a friend before drinking. In this case, if the now drunk person wants their car keys back, and they feel as if they are being dominated, this is not considered domination as they consented to giving away their keys before drinking.
The other external force mentioned is vitiation, which is a circumstantial though another legitimate form of domination.

Pettit describes two different forms of vitiation forces, which are invigilation and intimidation; invigilation being when the dominating force (state or government, for example) observes the individual (citizen) and their choices, and ultimately has the power to strike at any given moment to ‘correct them’ if their choices fall outside of what is accepted by the said dominating force (breaking a law, for instance) (Binsfeld, 2014). Intimidation is more direct in comparison, as it describes when an individual is actively threatened with negative consequences if they were to make a decision that for some reason falls outside of what is accepted by the dominating power. As Pettit argues, all these forces (except voluntary invasion) are forms of domination that keep individuals from what they want, and as domination keeps the people from choosing and getting what they want, they have lost their status as equal and free (ibid.).

However, Pettit does not only focus on the equality of freedom but also focuses on the aspect of equality in recourses like Dworkin, though from a different angle. Pettit argues, that to keep a free and equal system, there must be economic factors supporting it (Binsfeld, 2014: 95). Dworkin refers to envy, but Pettit mentions the ‘eyeball test’, in which a person can look another person in the eyes without any shame due to (socio)economic inequalities. Much like Dworkin, Pettit also suggests a taxation system that divides the resources to those most in need of them as a form of protection for those most vulnerable to inequality. The concept of protection is illustrated in terms of infrastructure (institutional elements, such as education and policies), insurances (both social, medical and judicial) and insulation (housing/shelter, health clinics and other emergency resources). Pettit argues the need for these protection systems to ensure basic social resources to those citizens outside of the privileged population, to secure that all citizens have access to the resources needed for a fulfilling life, regardless of (socio)economic status (ibid.).

4.2.3 Trans citizenship

When working with policy, it is relevant to examine the relationship between citizenship and bodies. In nature, policies typically indicate what bodies can or cannot do, how they should look like, what resources they can expect to survive, and where and when they can appear and assemble (Bacchi & Beasley, 2002: 331). As Bacchi & Beasley (2002) argue, these two key terms in contemporary theorizing, citizenship and embodiment, are rarely connected (ibid.: 328). Both Bacchi and Beasley argue, that this separation of the concepts stems from a disciplinary division of labor, where the political theorists place more importance on the institutional components of belonging to a community, where body theorists (mainly from the fields of sociology, philosophy or cultural studies) seek to address a broader conception of the mechanisms that shape, create and represent bodies (ibid.: 328). However, in order to understand the dynamics between citizenship, bodies and embodiment, I will define the terms in the following.

Firstly, there are various models of citizenship. It can be defined as a collection of rights and duties (typically determining and determined by socio-political status) which provides access to resources and benefits (Turner and Hamilton, 1994), which also includes access to the political-legal society (Roche, 1992). Feminist scholars have challenged the mainstream definitions of citizenship, for instance by drawing on Ruth Lister's (1997) work on the historical exclusion of women from citizenship (conceptually and politically) as traditional notions of citizenship have been portrayed typically as a white, heterosexual, able-bodied (cisgender) male (Monro & Warren, 2004).

Another aspect of citizenship is described in the term 'sexual citizenship' which is often used to describe the sexual rights of groups, such as access to basic recourses and rights, and the impact of this on sexuality; and also, what impact the dynamics between the state and the market has on sexuality as a whole, but especially on sexualities often deemed 'immoral' (Evans, 1993; Richardson, 2000). Further, Kenneth Plummer (1995) speaks of 'intimate citizenship', which he defines as a set of rights concerning the individual's rights to self-determination to choose what to do with and to their bodies, emotions, relationships, gender identities and overall desires. 'Intimate citizenship' emphasizes the discourses on intimacies, for instance how they overlap and thus, pose potential conflicts (Plummer, 2001).

5. Methodology and research design

Working with the topic of trans-specific healthcare in Denmark, seeking to analyze the problem representations in the guidelines, I have chosen to work with a qualitative research design. As Bryman (2016) notes, qualitative research is more interested and concerned with *words* rather than *numbers* as in quantitative research, and places emphasis on examining the social reality through the perceptions of both participants (in this thesis, the collected sources of data) and an active researcher (Bryman, 2016: 375). I aim to use the collected data to analyze the guidelines through the WPR approach as a (health) policy analysis, emphasizing the discourses apparent in the data sources.

5.1 Feminist qualitative research

An interesting strategy to add dimension to this qualitative research study is by implementing a feminist approach to it. As a scholar within the field of Global Gender Studies and Transgender Studies, I seek to implement this approach to my research, to (1) ensure representation of different opinions and perceptions of social reality amongst the chosen sources of data and, (2) bring forth marginalized groups and provide them with a space to share their experiences without being objectified to be controlled by a researcher's technical procedures, and (3) to be aware of power structures and privileges the researcher holds, for instance during data collection (Bryman, 2016: 488).

By being aware of my own privileges and power positions as the researcher doing this study, thus seeking to work strategically from a feminist approach, I also acknowledge the otherwise hidden power structures that quantitative research would have failed to bring forward – for example, the intersectionality of gender norms and transphobia, or the structural cissexism in the institutionalized medical field experienced by trans people (Linander et al., 2017). As this study seeks to examine the discourses in terms of the rationales and 'logics' underlying the guidelines, I draw on qualitative data in shape of relevant documents on trans-specific healthcare in Denmark, as my focus is on perceptions as *experiences* of social reality to illustrate the wider picture of *social structures* in which those experiences are embedded (Scott, 2010).

5.2 What's the problem represented to be? (WPR)

As the aim of this thesis is to analyze the complexities of trans-specific healthcare, including how constructions of gender identity related issues have been included in human rights discourse, thus examining the problem representation in the guidelines, the analytical framework draws upon Carol Bacchi's (2000) *What's the Problem Represented to be?* (WPR) approach to analyzing policy. Even though there is a growing interest in understanding and examining policy as discourse there is no universal 'method' per se for analyzing it as such, thus leading Bacchi to develop the WPR approach as a useful analytical tool for investigating the discursive aspects of policy, while claiming that the problems represented in policies are socially constructed (Goodwin, 2012). In this study, focus is on understanding the guidelines on trans-specific healthcare from a questioning perspective rather than a problem-solving perspective, which is what the WPR approach outlines by "(…) [presuming] *that some problem representations benefit the members of some groups at the expense of others. It also takes the side of those who are harmed. The goal is to intervene to challenge problem representations that have these deleterious effects."* (Bacchi, 2009: 44). Following this, the aim of implementing the WPR approach is to investigate how certain representations come about (and how these shape both the subjectivities and the solutions) rather than finding the 'real' problem (in the policy, in society) and the 'right' solution for this (Bacchi, 2012: 21-44). The WPR approach provides a list of questions which works as a guide in the analytical process, investigating different aspects of how 'problems' are represented in policies:

1. What's the 'problem' represented to be in a specific policy or policy proposal?
2. What presuppositions or assumptions underpin this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5. What effects are produced by this representation of the 'problem'?

6. How/where has this representation of the ‘problem’ been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

Following this ‘checklist’, the questions have been included in the problem formulation and as research questions when examining the guidelines. However, the WPR approach contributes with much more than just these guiding questions as it digs into the different aspects of policy, such as asking questions on how we are governed (through policy), how rules take place and how order is maintained (Bacchi, 2009: 127). Furthermore, policies are often understood to set up ‘guidelines’ for political rules, and thus, shape political discourse. Therefore, policies play an important role in how and what the individuals affected by the policies think of themselves and about their relationships with others; thus, do policies constitute possibilities for political subjectivity (ibid.). Additionally, policies pose an opportunity to examine the relationship between the state and other ‘knowledges’, as policies challenge the idea of viewing states as dominant actors in social relations. Instead, policies depict the boundaries of responsibility between state institutions and professional groups (Bacchi & Beasley, 2002: 331).

5.3 Policy as discourse

Continuing the section on using the WPR approach as analytical framework for this study, I draw on the notions of understanding policy as discourse. As I situate myself within the fields of post-structuralism and social-constructionist traditions, I adopt the understanding of discourses as a way in which to control and regulate knowledge. In addition, Bacchi notes, that most policy-as-discourse theorists define ‘discourse’ as ways to accomplish and achieve goals deemed worthwhile and I, too, draw on this definition (Bacchi, 2000: 46). I follow this definition of policy as discourse to investigate which discourses are used to further specific political agendas for change, as they tend to be politically progressive and positioned somewhere on the left of the political spectrum (ibid.). Further, by understanding policy as discourse as ways of meaning making it illustrates how difficult change can be to obtain, due to ongoing processes of problem representations which are often conflicting, contradictory and simultaneous. Discourses can sometimes make it difficult to understand the ongoing power structures underlying certain problem representations and draw attention away from the structures that create unequal outcomes. In sum, focusing on ‘how problems are represented’ directs attention to language and terminology, and ultimately, ‘discourses’ as the conceptual frameworks used to describe these social processes (ibid.).

I also draw on Bacchi’s notes on discourses in health-specific policies. One particular area of interest when working with health policies from a poststructuralist perspective is how policies are viewed as ‘productive’, as they are viewed as a government’s ‘response’ to certain health ‘problems’ and further, how ‘health’ is thought and understood (Bacchi, 2009: 138). Additionally, the so-called subjectification effects of the discourses in policy are also interesting from a poststructuralist angle, as the individuals targeted by the policies are not considered to be ‘standing outside of’ the policy; in this context, how care-seekers view and understand trans-specific healthcare and what they think of themselves as care-seekers are deeply influenced by the discourses in the policy.

5.4 Documents as data sources

As the main sources of data in this thesis, I draw on sampled documents as data in the analysis, as the analysis is based on the WPR approach to policy analysis. Hence, the most important document included in this thesis is the SST's guidelines on trans-specific healthcare, "*Guide on healthcare related to gender identity"* (2018), as the thesis seeks to investigate the problem representations in these. To supplement the analysis of problem representations in and about the subject of trans-specific healthcare, other relevant articles, reports and documents published by the SST are included to provide additional understandings of terms, policy procedures, practical implementations of the guidelines and so forth.

Other relevant documents included as data are published by different trans- and human rights organizations, such as Amnesty International, the United Nations and TransAktion (formerly known as Rådgivning for Transpersoner). Amnesty has published independent research done on the topic of trans-specific healthcare, both in an European context in their study "*The State Decides Who I Am: Lack of Legal Gender Recognition for Transgender People in Europe"* (2014) and, as an addition, the following study "*Transkønnedes adgang til sundhed i Danmark"* (2016), thus contributing with both quantitative statistics in and related to trans-specific healthcare (in Europe and in Denmark); and qualitative data, such as interviews and statements from care-seekers. Additional relevant statements on trans-specific healthcare has been sampled through Amnesty's campaign *#SygtSystem*, as it was a national campaign in alliance with other trans rights activist groups, aiming to create awareness on the topic of trans-specific care in Denmark but also advocating for the change in policy.

Additionally, consultation reports, documents and statements published by the Danish Health Authority have served as primary sources to understanding the consultation processes and hearings regarding the guidelines. TransAktion's analysis of the guidelines as their response in the consultation process has also been included and has served as inspiration for the policy analysis in this thesis.

Though most academic texts used in this thesis have been in English, most documents used for the analysis have been in Danish. Though the guidelines have been published in English as well, I have gone over the Danish version as well to compare translations of certain sections. Translating always poses the risk of losing meaning, nuances and content, however I have strived to stay as true to the intended meaning of the phrases I have translated by prioritizing translations of meaning rather than word-for-word. In sections where I have translated quotes from Danish to English, I have included the original text in footnotes.

5.5 Reliability and validity of data

As the sources of data in this thesis mainly consists of official documents issued by either state entities, governments and internationally as well as nationally acknowledged organizations and movements, I claim that the chosen data is reliable and the statistics as well as analyses presented are valid. However, to claim reliability and validity one must define what this means and entails; usually, the terms are important criteria when assessing quantitative data (Bryman, 2012: 388). However, when implementing the terms and requirements in qualitative research, the definitions or meanings must be altered as the terms imply that validity and reliability can be ‘measured’, which, in qualitative research, is unlikely to do (ibid.).

In the context of the aim of this thesis, the reliability and validity of the used data is defined based on the authors of the documents used. As mentioned in the first section, the authors hold powerful positions in terms of their positions to conduct research and issue policies on trans-specific healthcare and thus, are they and their work (studies, policies, reports etc.) accepted as reliable.

5.6 Grounded theory and coding

As described by both Charmaz (2000) and Bryman (2012), defining what grounded theory is and entails has sparked many considerably controversial discussions. I will not describe all facets of grounded theory as it is simply impossible, but I will instead describe the main element of grounded theory which I have implemented in this thesis: coding.

Coding is usually described as one of the main pillars in grounded theory. In the analysis, coding has been used to *“label, separate, compile, and organize data”* (Charmaz, 1983: 186). By implementing coding, I view the data as potential indicators of concepts and have constantly compared them to discover which concepts fit best with my theoretical framework (Bryman, 2012). My way of coding the data is inspired by both Strauss and Corbin’s (1990) definitions of open coding and Charmaz’ (2006) definitions of both initial and selective coding.

5.6.1 Coding of sampled documents

When first assessing the guidelines on trans-specific healthcare, I followed the theory of initial coding posed by Charmaz (2006). As I was reading the guidelines, I focused on remaining open-minded to the text and wanted to generate as many codes as necessary to bring forth new ideas on how to understand the guidelines. After the phase of initial coding, I assessed the other sampled documents and repeated the procedure after obtaining enough initial codes to begin sorting. The initial codes of the guidelines contained of, for example, “reflection time and clarification phase”, “themes of psychological/psychiatric character” and “holistic and inclusive approach”.

Through selective (or focused) coding I emphasized the codes which I found to be most revealing about the data, dropping some of the initial codes or rearranging them (Charmaz, 2006; Bryman, 2012). The selective codes became inspired by the analyses done by both Amnesty and TransAktion, which provided me with a framework to understand and reassess my initial codes. The selective codes then became a tool to supplement both the theoretical and the analytical framework used when examining the guidelines, resulting in the creation of concepts and categories in which to problematize the guidelines and the problem representations within them.

5.7 Epistemological and ethical considerations

The question of epistemology concerns itself with the issue of what is and should be considered acceptable knowledge in a discipline or field (Bryman, 2012: 27). As I connect and draw on notions from the different disciplines of Development, International Relations, Gender and Transgender Studies in this thesis, I have reflected greatly upon my own role as a researcher. The field and topic of transgender studies and -rights have not only been debated politically and socially, but also from different epistemological perspectives (Linander et al, 2018; Stryker & Whittle, 2006).

Firstly, in contrast to most research in the field of natural sciences, I do not claim to hold a neutral position in my research and thus, do I reject the idea of positivism in my thesis. I recognize the power position I hold as the researcher, as I choose which data to include and how to analyze it, leading me to draw on Foucault's argument, that *"(...) power and knowledge directly imply one another"* (Foucault, 1995: 27), accepting that my research contributes to knowledge production on this field and thus, has consequences socially, because it contributes to the construction of (the social) reality (Linander et al, 2018).

Secondly, I also draw on Linander's (2018) reflections on the researcher as subject, especially regarding research on a sensitive topic such as trans-specific healthcare. Linander discusses the term 'transparency' regarding the role of the researcher, where transparency describes the process of reflecting upon one's own assumptions and biases in research, and in connection to epistemology, also includes an acknowledgement of one's own positionality and how this affects the research at large (ibid.). As Linander describes, *"(...) there is sometimes a demand for "confessional tales"; for example, a demand that researchers come out as trans or cis"* (Linander et al, 2018: 59) which places the researcher in a difficult position as different researchers have different stakes in researching the field of trans or gender generally. In addition, Linander argues that the division between trans and cis researchers illustrates an overly simplistic understanding of the researcher's experiences and their relation to the topic they are researching. Though I acknowledge the sensitive and sometimes controversial nature of transgender studies, and the historical pathologizing and dismissal of trans issues in research context in other academic field, I too refuse to occupy either of the positions mentioned before, following Linander's example: *"I will not come out as either one or the other, or dismiss such coming out as totally unimportant"* (ibid.).

6. Analysis

In the following chapter, the SST's guidelines on trans-specific healthcare in Denmark will be analyzed following the posed research questions inspired by Bacchi's WPR approach. The theoretical framework for the analysis will include coding based on key terms and concepts, such as equality in access to healthcare, equality in citizenship and trans rights as human rights. The six questions will be answered separately but summarized altogether in the conclusion.

6.1 Question 1: What is the problem with trans-specific healthcare represented to be in the SST's guidelines?

The first question posed in this analysis seeks to investigate and describe the problem representation in the guidelines on trans-specific healthcare as health policy. And the question is direct: if a government or state entity proposes to create or implement a new policy, what is it hoping to change? And thus, what is presented as the 'problem' that needs to be 'fixed'? To answer these questions, I will begin by describing apparent key notions in the '*Guide on healthcare related to gender identity'* (Sundhedsstyrelsen, 2018) and the language (terminology) used to communicate these.

In the introduction of the guidelines (chapter one), the SST state:

> *"The aim of this guide is to ensure a high quality and equal access to healthcare related to gender identity in Denmark. Healthcare includes counselling and supportive conversations on gender identity, just as it includes medical treatments to block the development of sex characteristics (hormone blockers) or to modify them (gender reassignment treatment with hormones or surgery). Furthermore, psychosocial support should be a natural part of the overall healthcare. (...) The healthcare must be holistic, coherent and multidisciplinary to support the individuals as much as possible."* (Sundhedsstyrelsen, 2018: 5)

In this paragraph, the identified 'problem' is represented through the SST's acknowledgement of their role in the previously reported stigmatization of trans care-seekers, as key notions and concepts such as 'high quality', 'equal access' and 'supportive conversations' are emphasized. These notions fall in line with the Yogyakarta Principles, as they state trans people's *"(...) right to the highest attainable standard of health"* (Yogyakarta Principles, 2007: Article 17). Further, the notions identified in the guidelines also reflect a coherence with the UDHR, which emphasize the importance of treating all humans with equality and respect, despite sexual orientation or gender (identity). The focus on care-seekers' rights related to trans-specific healthcare is central in the guidelines which is very evident in the third chapter, *"About rights and access of individuals to healthcare services related to gender identity"* (Sundhedsstyrelsen, 2018: 6). In this chapter, it is stated that the *"Individuals seeking healthcare related to gender identity should receive equitable healthcare"* (ibid.), followed by suggestions on how this is achieved through 'easy and equal access', 'treatment of high quality', 'freedom of choice' and 'easy access to information' to name a few. In the following sections of the chapter, the stigmatization of trans people as a marginalized group is recognized and acknowledged by stating that the healthcare personnel in the clinics must show special attention to care-seekers, as they *"(...) may have been exposed to stigmatization in society as well as in the healthcare system"* (ibid.). In line with Linander's (2017) observations on the medical field as specifically powerful in a trans context, the SST recognizes the power position of the medical field and healthcare personnel regarding the historical pathologizing of trans people by stating that *"(...) healthcare professionals must show respect and prevent stigmatization by using the name and the pronoun preferred by the individual as well as by respecting the individual's preferences regarding use of terms to describe body parts"* (ibid). Throughout the guidelines, but especially in the third chapter, emphasis is placed on ensuring that the *"healthcare must be based on respect, responsiveness, inclusiveness and flexibility"* and that *"(...) any treatment offered to the patient should be explained in an understandable, neutral and respectful language"* (ibid.: 7).

The emphasis on a supportive approach in the work with trans-specific healthcare acknowledges the stigmatization of the care-seekers and thus, seeks to promote an inclusive approach in the clinics. By acknowledging the importance of inclusivity and respect, the SST also recognizes that this has not been as prioritized in the 'old' system of trans-specific healthcare. Hence, the 'problem' representation in the guidelines can be identified partly as the stigmatization care-seekers have experienced in the past and thus, does the SST seek to address this 'problem' in the new guidelines.

Another identified 'problem' represented in the guidelines is the irreversible nature of some of the medical procedures offered and the possibility of care-seekers regretting them. In the third chapter it is stated: *"Information from the healthcare professionals should be given on both advantages and disadvantages of the offered treatment and the staff should provide information on other treatment options as well as <u>proper time frame for reflection</u>"* (ibid.: 7). The 'time frame for reflection' is part of the newly introduced concept of informed consent in trans-specific healthcare and serves to ensure that the care-seeker understands what the offered procedures entail. Additionally, in chapter five, *"Counselling and support on gender identity",* the need for support and counselling regarding trans-specific healthcare is mentioned alongside the statement that some care-seekers might be undecided regarding their gender identity or own preferences for medical procedures and thus, should they be offered counselling and support in the so-called 'clarification phase' (ibid.: 10). In chapter six, *"Assessment before treatment",* medical procedures such as hormone blockers are mentioned as *"(...) generally effective treatments of gender dysphoria, <u>with few patients regretting</u>"* (ibid: 11), followed by the statement, that before any medical procedures can be offered there must be a *"clear medical assessment and justification"* supporting the care-seeker's desire for any medical procedures. The medical assessment must include the *"nature of gender discomfort"* (ibid.: 11) or in other words, as mentioned in the seventh chapter, *"Gender reassigning medical treatment on adults", "the severity of gender discomfort"* (ibid.: 12). These statements support the identified 'problem' of care-seekers regretting their medical procedures due to lack of reflection time prior to beginning any procedures and lack of knowledge of the disadvantages of these.

6.2 Question 2: What assumptions underlie this representation of the 'problem'?

The second question seeks to investigate the background 'knowledge' that is taken-for-granted, including epistemological and ontological assumptions, when a 'problem' representation has been identified (Bacchi, 2009: 5). By examining the presuppositions, we can therefore identify the conceptual 'logic' that underpin the specific 'problem' representations in the policy (ibid.).

In line with the previous section, the 'problems' represented in the policy has been identified as the SST's role in the stigmatization of trans people (care-seekers, in this context) in trans-specific healthcare and the possibility of care-seekers regretting the (trans-specific) care they receive. To understand how these 'problem' representations have come about, I will analyze and outline the assumptions underlying these problematizations in the following.

Stigmatization and transphobia

The first presupposition that underpin the 'problem' representation of care-seekers being stigmatized is that the SST, a state-entity that issues guidelines on all kinds of health-related topics, thus advices various healthcare facilities nationwide, must play an active role in depathologizing and destigmatizing trans care-seekers.

In Denmark, the focus on being an egalitarian welfare state, offering free public healthcare for all its citizens, has been a core value for decades and is arguably what defines the country as Scandinavian/Nordic besides geographical location and shared history with Norway and Sweden. Being a welfare state has influenced how both public health and healthcare at large is defined, and who has the rights to access and receive it. As of the last decade, transgender issues have gained more attention internationally and in a political context; for instance, regarding trans-specific healthcare. Trans care-seekers have been especially marginalized in government policy formulation as lack of access to trans-specific healthcare such as hormones and gender affirming care can be directly linked to further stigmatization, mental health issues, violence and in the worst scenarios, killings and suicide (Schreiber, 2016). As Bacchi (2009) argues, this 'knowledge' is what the argument ('problem' representation) relies upon and in fact, the SST state that trans-specific healthcare must be *"holistic, coherent and multidisciplinary to support the individuals as much as possible"* (Sundhedsstyrelsen, 2018).

However, this way of approaching trans-specific healthcare is new compared to the circumstances under which it was offered prior to the implementation of the new guidelines in 2017. Before 2017, care-seekers needed to be diagnosed under the diagnosis code F64.0 for ‘transsexualism’ to receive care and often reported feeling dehumanized and disempowered when meeting the healthcare personnel and pursuing trans-specific healthcare (Amnesty, 2016). Further, in the period 2014-2017, the SST’s then guidelines gave Sexologisk Klinik (SK) de facto monopoly on offering trans-specific care, whereas general practitioners and private gynecologists had been offering trans-specific care up until this change.

Time for reflection

Through the analysis of the guidelines as policy, I find that another aim of the SST’s guidelines on trans-specific healthcare is securing that the care-seekers are completely decided when they pursue medical procedures, so they do not regret it afterwards. This shows a presupposition that underpins the representation of the ‘problem’ that care-seekers’ wish to pursue medical procedures can or should be questioned to some degree rather than just affirmed and provided based on informed consent.

As stated previously, though no longer officially considered a mental illness, being transgender is often leads to discrimination and violence. When using the term ‘violence’, one might think of physical violence such as punches and fights, however, distrust and skepticism of transgender people’s experiences are also considered violence when understanding it as transphobia or cissexism (NCTE, 2016; PP, 2018). Nevertheless, the underpinning presupposition of the SST seems based on a wish that no care-seekers regret starting medical procedures that are or can be irreversible.

However, several studies estimate that the percentages of transgender people regretting trans-specific medical procedures, such as hormones and surgeries, are at least below 4 % (Tannehill, 2016). Most commonly, these studies place the percentages of people regretting the medical procedures between 1 to 3 % (Cohen-Kettenis & Pfäfflin, 2003; Smith et al., 2005; Dhejne et al., 2014 as cited in Tannehill, 2016). For example, a longitudinal study of gender affirming surgery[6] in Sweden from 1960-2010 show that only 2,2 % of the transgender people who had pursued and undergone trans-specific medical procedures and surgeries applied for reversal to their first assigned legal gender[7] (Dhejne et al., 2014: 8).

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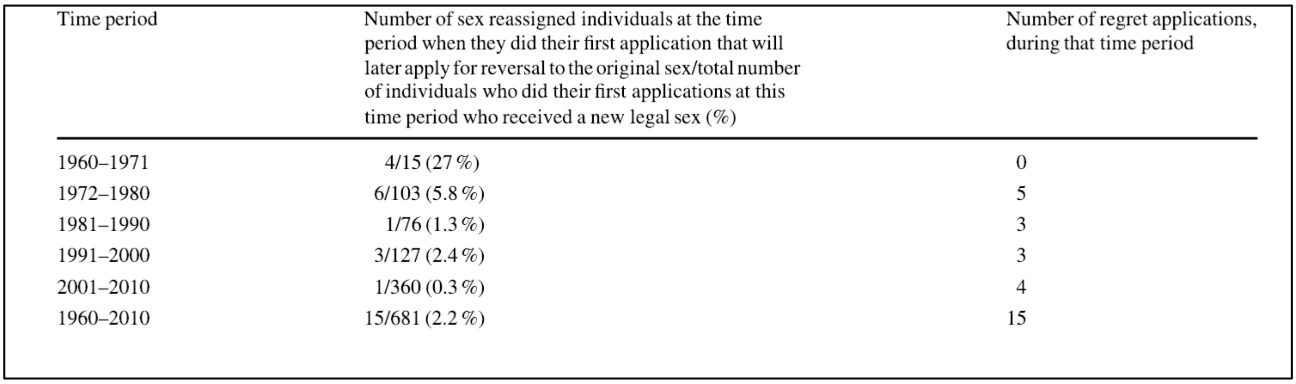
[6] In the study, the surgeries are referred to as ‘sex reassignment’, however I use ‘gender affirming’ to avoid reproducing stigmatization and misinformation, such as sex equals gender

[7] In the study, they say ‘original sex’, however I use ‘first assigned legal gender’ to firstly, emphasize that the respondents were assigned a legal gender at birth, and secondly, to distinguish between sex and gender

Table 1: Transgender people regretting gender affirming medical procedures and surgeries (Dhejne, 2014: 8)



Time period	Number of sex reassigned individuals at the time period when they did their first application that will later apply for reversal to the original sex/total number of individuals who did their first applications at this time period who received a new legal sex (%)	Number of regret applications, during that time period
1960–1971	4/15 (27 %)	0
1972–1980	6/103 (5.8 %)	5
1981–1990	1/76 (1.3 %)	3
1991–2000	3/127 (2.4 %)	3
2001–2010	1/360 (0.3 %)	4
1960–2010	15/681 (2.2 %)	15

Additionally, it is important to note that the reasons of regret are mainly due to lack of support from family and friends, poor social support or a poor surgical result (Cohen-Kettenis & Pfäfflin, 2003; Smith et al., 2005) and thus, not due to the person “changing their mind” regarding being transgender.

Another aspect of concern regarding care-seekers regretting their medical procedures could be by comparing the procedures with other surgical procedures modifying appearances, such as plastic/cosmetic surgery. A survey conducted by Medical Accident Group shows, that a staggering 65 % of the non-transgender respondents regret having cosmetic surgery compared to the fewer than 4% of transgender people regretting their irreversible trans-specific medical procedures (Medical Accident Group, 2014).

In sum, the care-seekers who regret trans-specific medical procedures are outliers and therefore not a general representation of care-seekers who receive trans-specific medical procedures.

6.3 Question 3: How has this representation come about?

The third question seeks to investigate and explore the circumstances in which the representation of the ‘problem’ has come about. As explained by Bacchi (2009), one of the objectives in this question relates to investigating the ‘history’ of the problem representation as competing problem representations exist both over time and across space. The question goes beyond the policy texts so to speak, by being interested in examining the context of the key concepts in the texts and how these have been legitimized through time and how they highlight both the political and cultural conditions *“(...) that allow specific problem representations to gain dominance”* (Bacchi, 2009: 11) This third questions is important to ask, as it provides an in-depth insight into the power relations that influence and affect both the success and the failure of certain problem representations, but also the defeat of others (ibid.). In this context, it also critically examines the statistics used to justify or defend a particular policy, and therefore we need to ask: why are these statistics used and not others?

In short, I will now examine and describe the origins, history and mechanisms of the identified ‘problem’ representations in the SST’s guidelines on trans-specific healthcare.

Trans-specific healthcare in Denmark

The history of trans-specific healthcare in Denmark has been difficult to trace and map out due to lack of available and accessible sources. There are no clear or official statistics over how many or how often transgender individuals have sought trans-specific care over time, neither at private gynecologists, endocrinologists, Sexologisk Klinik (SK) in Copenhagen or at Center for Kønsidentitet (CK) in Aalborg. However, a report issued by Amnesty in 2014 estimated that approximately 3000 people identified as transgender and wished to pursue trans-specific healthcare in Denmark during that period (Amnesty, 2014; Politiken, 2014). Though it is reasonable to assume that the number of care-seekers has risen over the years, due that transgender issues are now being discussed frequently in media, access to information about trans-specific healthcare has improved and the new medical approach to trans-specific healthcare in Denmark has changed drastically to focus on depathologizing and destigmatizing care-seekers.

Prior to 2012, trans-specific healthcare was hardly discussed in the media, politically or outside of transgender communities compared to the amount of attention it receives today. At that time, trans care-seekers had the opportunity of getting a referral from their general practioner to either a gynecologist or endocrinologist (care-provides) who could then offer the wished medical procedures. Granted that the care-seeker’s physical conditions met the standards of health, and at least one out of three criteria for the F.64 diagnosis of ‘transsexualism’[8] was met, the specialized medical practioner could prescribe hormones, for example[9].

Though this system of trans-specific healthcare functioned without complaints from neither care-seekers nor care-provides for decades, the system came under pressure after the news of a 15-year-old transgender boy getting a mastectomy made headlines in national news (Danmarks Radio, 2011; TV2 Nyhederne, 2011). The surgeon and the private hospital in which the boy was operated was heavily criticized by other medical professionals, such as the then chief physician at SK, Ellids Kristensen, who argued that the medical personnel at SK, at least, would always try to talk transgender minors out of getting such procedures due to the irreversible effects, because ‘transgender teenagers are likely to change their minds’ (Heissel, 2011). Following this, the case was brought before the SST, and their chief physician and head of supervision, Anne

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[8] ”According to the ICD-10, the following three criteria must be met before an individual may be diagnosed with transsexualism: (i) the person has the desire to live and be accepted as a member of the opposite sex, (ii) usually accompanied by a sense of discomfort with or inappropriateness of one’s anatomic sex; and (iii) a wish to have surgery and/or hormonal treatment to make one’s body as congruent as possible with one’s preferred sex” (Simonsen et al., 2014: 2).

[9] As explained by Linda Thor Pedersen, spokesperson for LGBT Danmark, during an interview conducted by me in October 2017 as part of a different study on trans-specific healthcare in Denmark (interview available upon request)

Mette Dons, called it worrying that a minor had not only gotten an irreversible procedure like the mastectomy done, but had also been prescribed hormones by a gynecologist prior to the surgery. However, the SST finally stated, that the performed procedure – the mastectomy – could not necessarily be classified as illegal, as the procedure could not necessarily be classified as cosmetic (ibid.). Despite SST's statement, the case was then brought before the Danish Patient Safety Authority (DPSA) and the Danish Agency for Patient Complaints (DAPC) who criticized the surgeon in question, arguing that he had violated the Danish law of authorization (Autorisationsloven). According to DPSA and DAPC, the surgeon had violated Chapter 5, §17 which states that an authorized healthcare-provider within the Danish healthcare system is obliged to show 'care and conscientiousness' in their practice (Munch, 2012; Sundheds- og Ældreministeriet, 2018).

On the grounds of all the criticism, the SST issued a new set of guidelines on trans-specific healthcare and distributed them to all cosmetic clinics in Denmark. The main change was the new age restrictions: only care-seekers older than 18 could be considered eligible for surgeries, but only after the care-seeker had turned 21 and undergone years of psychological tests as well as evaluations at SK, a surgery could be discussed and possibly offered (Munch, 2012).

Trans activism and -rights in Denmark

As with the healthcare aspect of trans rights, mapping trans activism has also been difficult to grasp due to lack of available and accessible sources. Trans activism in a Danish context has taken many shapes and forms through time, as many organizations, groups and movements overlap and intersect with each other, sometimes creating blurred lines between when what happened and was done by who. However, I shall provide an overview over the various actors working with trans rights specifically regarding trans-specific healthcare in Denmark, and how these forms of activism have both sprung out of, paved the way for and influenced the different rights transgender Danes have today.

Working with the latest version of the SST's guidelines on trans-specific healthcare from 2018, focus will be on chosen consulting partners who were invited to participate in the consultation processes prior to issuing the first version of the new guidelines in 2017.

One of the biggest influencers in the discussion on trans rights in Denmark was Amnesty International, who published the international report "*The State Decides Who I Am"* in 2014, investigating the topic of legal gender change in seven European countries (hereunder Denmark). One of the areas Amnesty argued that trans care-seekers' rights were violated was the requirement of sterilization or castration, and the psychiatric diagnosis 'transsexualism', if they wanted to have their legal gender changed (Amnesty, 2014). Sterilization or castration was also a requirement to change names, as names are categorized as either male, female or unisex in Denmark (ibid.). However, as of September 2014, the Danish Central Person Register (CPR) made it possible for transgender individuals older than 18 years to change their legal gender before having started or pursued trans-specific healthcare (hormones, surgeries or both) and the requirement to get sterilized or castrated was removed (Det Centrale Personregister, 2018; Justitsministeriet, 2014: 20).

On one side, the change regarding legal gender change was celebrated as it made it possible for transgender people to change their gender without pursuing trans-specific healthcare or undergo sterilization/castration, but on the other side it was criticized for being a symbolic gesture, as trans-specific healthcare had been made much more difficult to receive. Amnesty argued, that the medical requirements to get diagnosed with ‘transsexualism’ under the ICD-10’s diagnosis code F64.0 was extremely harmful to the care-seekers, as the foundation upon which the diagnosis was given relied on psychological evaluations which included, for example, a questionnaire with sexual and intimate questions (Amnesty, 2014). The SST, and the leading doctors at SK, however, argued that a diagnosis was necessary as it served as foundation for which any trans-specific healthcare or medical procedures were offered. Without a specific diagnosis, any offer for trans-specific healthcare would be deemed medically and professionally irresponsible (Justitsministeriet, 2014: 6).

In the following years, Amnesty published the national report *“Transkønnedes adgang til sundhed i Danmark”* in 2016, investigating the conditions of trans-specific healthcare in Denmark (Amnesty, 2016). The report was issued as part of the campaign *#SygtSystem,* when Amnesty allied with both Transpolitisk Forum (hereafter TPF) and LGBT Denmark. The campaign was launched in 2016 to raise awareness about the new conditions and restrictions of trans-specific healthcare prior to the policy change, and thus appeal to the then Danish Minister of Health, Ellen Trane Nørby, to declassify being transgender as a mental disorder. The main argument put forth by Amnesty was that the treatment of trans care-seekers in SK was stigmatizing in such a degree that it violated the care-seekers’ human rights regarding access to healthcare (Amnesty, 2016; Sundhedsstyrelsen, 2017c).

6.4 Question 4: What is left unproblematic in this problem representation? How can the ‘problem’ be thought about differently?

The fourth question allows me to investigate the critical potential of the WPR approach (Bacchi, 2009). It seeks to bring forth the limits underlying a problem representation; in other words, to discuss other ways to think about the issue(s) that specific policies are otherwise limiting due their representation of certain ‘problems’.

In the following section I will draw on the analysis of both Amnesty and TransAktion (TA) regarding overlooked perspectives and issues, which has been left out of the identified problem representation(s) in the guidelines on trans-specific healthcare. The first identified problem representation that I will discuss is the SST’s recognition of how care-seekers have been stigmatized when seeking trans-specific healthcare prior to the policy change, and secondly, that care-seeker’s wish to pursue trans-specific healthcare should or can be questioned.

Psychiatrists in the multidisciplinary teams (MDT)

In the guidelines it is explained, that a care-seeker will be assigned a multidisciplinary team (MDT) which will consist of different care-providers in different fields (such as gynecology, psychology and endocrinology) and of different titles (doctors, nurses and psychiatrists), who will cooperate and be involved in the process of providing trans-specific healthcare to the care-seekers (Sundhedsstyrelsen, 2018: 9). One member of the MDT, typically a doctor, is chosen to be the head (or leader) of the MDT and thus, be responsible for organizing conferences and meetings within the MDT; and most importantly, is the care-provider held responsible for the overall decisions made by the MDT (ibid.). However, several consultants participating in the SST's consultation processes of the guidelines have expressed skepticism and concern regarding the inclusion of psychologists and psychiatrists in the MDT and have questioned the overall need for and consequences of establishing and implementing such teams in trans-specific healthcare (Sundhedsstyrelsen, 2017d).

In their consultation report, TA express concern regarding the SST's inclusion of psychologists and psychiatrists in the MDT as it *"(...) clearly signals that the SST still considers trans people as people with predominantly psychiatric issues and the assessment of trans people's wishes of and needs for trans-specific healthcare is questioned and pathologized"*[10] (Friborg & Vinther, 2017: 16). Additionally, they raise the question of what the argument for the inclusion of psychiatrists in the MDT is, when psychiatrists are not included in other cases of irreversible healthcare matters, such as abortions? (Sundhedsstyrelsen, 2017c). TA further argues, that it is problematic that the guidelines allow doctors specialized in psychiatry to be appointed leader of the MDT when the essence of the offered trans-specific healthcare is of somatic character (Friborg & Vinther, 2017). However, TA acknowledges care-seekers' need for psychosocial support, though suggests that the therapy- and support sessions are moved out of the MDT. The presented argument is, that a therapeutic and safe space cannot be achieved if these sessions take place in the same space in which the care-seeker is being evaluated regarding being offered trans-specific healthcare or not (ibid.: 26).

Specialized hospital services

Further, TA is critical of the requirement of classifying trans-specific healthcare as specialized hospital services, as this requirement limits the possibilities of opening for practices offering trans-specific care elsewhere than just in SK or CK. By classifying trans-specific healthcare as a specialized hospital service, it is a requirement that the private healthcare providers (such as gynecologists) offering trans-specific care can provide a MDT and take in at least 30 new care-seekers annually (Sundhedsstyrelsen, 2017c: 3). According

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[10] Translated from Danish: *"(...)sender et klar signal om, at Sundhedsstyrelsen fortsat betragter transpersoner som personer med overvejende psykiske problemstillinger, og at tilgangen til transpersoners ønsker om og behov for behandling er mistænkeliggørende og sygeliggørende."*

to both Amnesty and TA, this requirement is prohibiting private healthcare providers in providing trans-specific healthcare as they cannot guarantee that they can meet the requirements and thus, upkeeps the monopoly of providing trans-specific healthcare in the appointed gender identity clinics (ibid.).

Narrow definition of transgender people

Though acknowledging the SST for using more inclusive language and terminology in the guidelines of today compared to the guidelines from 2014, Amnesty and their allies argue that the newest guidelines still excludes non-binary identities. In the guidelines, it is stated:

> *"If the individual has just recently begun exploring their gender identity or if the gender discomfort has just recently surfaced, appears periodically or only to a lesser degree affects the individual's overall life situation and gender comfort, special care should be taken and time for reflection should be recommended."* (Sundhedsstyrelsen, 2018: 13).

Here, the consultation partners claim, that this can be understood in ways that exclude care-seekers with non-binary gender identities (or people whose gender identities are periodically fluid between the masculine and the feminine) are not considered eligible for receiving trans-specific healthcare (Sundhedsstyrelsen, 2017c: 6). The argument is based on the notion that the care-seekers are adults capable of making their own decisions based on informed consent, regarding if they want to receive trans-specific healthcare or not.

Also, the relevancy of investigating the *"the duration and nature of gender discomfort and results of previous gender modifying treatment (...)"* (Sundhedsstyrelsen, 2018: 14) is questioned by the consultation partners. They champion that the only person who can evaluate the duration and degree of gender discomfort is the care-seeker themselves, and it should be up to the care-seeker to decide the need for surgical procedures (Sundhedsstyrelsen, 2017c). TA further argues, that the requirement of defining the duration and degree of gender discomfort is removed completely, and that the SST should explicitly state, that it is neither a necessity nor the end goal of trans-specific healthcare that the care-seeker can live up to gender and sexuality related norms (Friborg & Vinther, 2017: 17).

6.5 Question 5: What effects are produced by this representation of the 'problem'?

The fifth question brings the possibility of continuing the critical approach of this policy analysis. It seeks to investigate and describe how the problem representation in the policy creates difficulties for some groups in society more so than others (Bacchi, 2009: 15). Furthermore, Bacchi argues that the inclusion of this question allows us to interrogate where and how these difficulties exist and function, and ultimately what can be done about it. Here, Bacchi introduces three overlapping and interconnected kinds of 'effects' which needs to be assessed: discursive effects, subjectification effects and lived effects.

Discursive effects: how we understand trans-specific healthcare

The first effect connects the fifth question with the previously answered questions as it seeks to investigate the discursive effects of the identified deep-rooted assumptions and presuppositions within the problem representation(s). By looking into the discursive effects of the identified problem representation it is possible to investigate how the framing of this 'problem' limits other ways of viewing, understanding and assessing the 'problem' (Bacchi, 2009: 16).

The identified representation of the stigmatization of trans care-seekers as a 'problem' in the guidelines poses the idea that the SST is responsible for the destigmatization of the care-seekers. However, acknowledging their position as powerful in terms of regulating the stigmatization of transgender people, the SST also acknowledge their position to gate-keep trans-specific healthcare. As the SST are the state entity regulating and issuing guidelines on healthcare services generally, in this context trans-specific healthcare, they ultimately have the last word regarding what is and what is not included in the guidelines; for example, the definition of who is and is not a trans person, and thereby, who is and who is not eligible to receive trans-specific healthcare.

As TA argue in their consultation report of the guidelines, the SST's definition of a trans person excludes care-seekers with non-binary gender identities and thus, does the terminology used in the guidelines dictate the discourse of how to view and understand trans-specific healthcare (Friborg & Vinther, 2017). Though the language and terminology has been updated compared to the guidelines of 2014, and being transgender is no longer considered a mental illness, the 'nature and degree of gender discomfort' must be evaluated by the MDT prior to considering offering care. This implies that there are "right" and "wrong" ways of being transgender, or, in other words, that one can be "more" or "less" transgender and thereby, eligible for receiving care.

Furthermore, TA criticizes the lack of a definition of what is meant by 'degree of gender discomfort' and raises the question of how this is measured or quantified[11] (ibid.: 21). In addition, they find the concept of measuring the degree of gender discomfort problematic as it indicates the assumption that a gender identity remains static throughout life and thus, does not reflect the understanding of gender as something that can be fluid or relational. It also manifests the idea that a newly discovered wish to pursue trans-specific care is somehow less legitimate and valid, compared to a longstanding wish (ibid.).

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[11] Translated from Danish: *"For det tredje fremgår det ikke, hvordan man gradbøjer kønsligt ubehag?" (Friborg & Vinther, 2017: 21).*

Subjectification effects: how we understand trans people as care-seekers

The second effect focuses on how the problem representation in the policy makes individuals become subjects ‘of a particular kind’ and how this affects the person’s own standpoint in the social world, how they (and ‘we’) feel about themselves and others, and ultimately, who they are (Bacchi, 2009). Bacchi also draws on Foucault’s notion of ‘dividing practices’ (Foucault, 1982: 208); for example, transgender care-seekers versus cisgender non-care-seekers, etc. According to Foucault, the stigmatization of the marginalized groups affected by the policy serves governmental purposes as it encourages a desired, or preferred, behavior among the majority in society (Bacchi, 2009). The notion of subjectification effects also brings forth the idea that problem representations usually have a “built-in” implication of who is to blame for the ‘problem’, hence why it is crucial to bring these implied attributions of responsibility into the open (ibid.: 17). This is indeed important, as Bacchi argues that in many situations, the marginalized groups themselves are considered the (creators of the) ‘problem’.

Firstly, as the guidelines are specific to trans-specific care, transgender care-seekers are the main group affected by the subjectification effects. Transgender individuals who do not pursue trans-specific care are still affected by the guidelines however, as the guidelines have been a controversial topic in the ongoing political discussions on not just trans-specific care but trans rights generally. Therefore, the guidelines have played an important role in dictating how we understand and talk about trans people as a group, and which issues they face in both the medical system and society; and ultimately, how they themselves understand and view each other as care-seekers and non-care-seekers, as trans people with and without ‘gender discomfort’.

In addition, one subjectification effect that can be described from the identified ‘problem’ representation is the hierarchal relationship between the care-seeker/care-provider. As mentioned in the previous section, the SST acknowledge their position regarding governing the stigmatization of care-seekers by being the main authority issuing guidelines on trans-specific healthcare. This position allows for the SST to play the role as gate-keepers in the field, as they control both what constitutes trans-specific healthcare and who is eligible to receive it. This division of “us”/”them” places in care-seekers in a position where they, again, need to “prove” themselves needy of this care to a gate-keeping “other”. This can be interpreted as expert discourses being privileged over the right to self-determination (Linander, 2018: 95). The inequal power relationship between the care-seeker/care-provider cannot be contested, because there are no other alternatives to access trans-specific healthcare in Denmark than by pursuing it at either SK or CK, which are both obliged to follow the guidelines issued by the SST. This inequality in power leaves the care-seeker extremely vulnerable and at risk for being stigmatized, as previously argued by both Amnesty (Amnesty, 2016; Sundhedsstyrelsen, 2017c) and TA (Friborg & Vinther, 2017).

Further, as care-seekers have previously reported stigmatization in the clinics and by the care-providers previously, the requirements of reflection time and clarification periods can be experienced as indications of care-seekers being untrustworthy, hence why care-seekers report finding support in their own communities, typically from other care-seekers with experience in navigating the system of trans-specific healthcare (Amnesty, 2016).

Lived effects: how the problem representation directly affects care-seekers' lives

The last effect concerns how the representation of the 'problem' in a policy directly affects the lives of those targeted by the policy. In other words, the notion of lived effects seeks to describe and highlight the ways representations of problems in policies can have effects in 'the real life' by materially affecting our lives (Bacchi, 2009: 18).

One of the main changes in trans-specific healthcare was the action of decentralizing the offered care. Instead of only offering trans-specific care at SK in Copenhagen, care is now also offered at CK in Aalborg. However, though the representation of the identified 'problem' seeks to combat the stigmatization and discrimination of trans people, the categorization of trans-specific healthcare as a highly specialized hospital service directly affect the lives of both care-seekers and potential care-seekers. As Amnesty argue, the classification of trans-specific healthcare as highly specialized prevents new clinics of opening as the requirements are unrealistic and random (Sundhedsstyrelsen, 2017c: 4).

Additionally, highly specialized hospital services are not included in the rights to self-determination regarding which hospital the care-seeker wants to receive care at. As there are currently only two clinics that live up to the requirements of, for instance, providing a fulfilling MDT and taking in at least 30 new care-seekers annually, a care-seeker has no other choice than to travel either to SK or CK to receive care which can result in various problematizations for care-seekers. Though Denmark is one of the smaller countries in Europe, the distance between the two clinics is approx. 500 kilometers. If a trans person from South Denmark wishes to pursue care, they must travel either approx. 300 kilometers North or East, which is both time-consuming and costly.

The lived effects of classifying trans-specific healthcare as a highly specialized hospital service can therefore result in inequality of who can afford it. Here, I have only considered transportation costs, but considering the amount of planning which goes into a consultation at a clinics, it also includes but is not limited to: access to transportation (either private or public) such as living close to a train station, being able to take leave from work (if the care-seeker is employed) and has the possibility of childcare/babysitting (if the care-seeker is a parent).

6.6 Question 6: How and where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and

replaced?

The final question included in this policy analysis is question six. As Bacchi explains, this question draws on the insights of question three as it investigates and emphasizes the *“practices and processes that allow certain problem representations to dominate”* (Bacchi, 2009: 19). This is done by examining the role of the media, for instance, through which the ‘problem’ representation reaches the target group or audience, and ultimately achieves legitimacy through repetition and dissemination. Further, it is also relevant to discuss the possible resistances, as discourses are plural and complex, and as Bacchi notes, sometimes inconsistent and contradictory (ibid.).

In the context of situating and bringing forth the subject of trans-specific healthcare and trans rights generally, the media has played an immense role. In today’s context, the media functions as a platform to share all kinds of information and can be used by anyone; from the medical professionals, care-providers, activists, care-seekers to other involved parties and others, who have an opinion on the topic, they want to express. In Denmark, freedom of speech is a proclaimed value and is enforced by encouraging people to get involved in the ongoing discussions. Trans-specific healthcare is no exception, arguably because it is a controversial topic in today’s political climate and thus, has it been contested, questioned, defended and discussed widely and vigorously.

International attention to trans rights

Over the last decade, transgender’s rights have been widely discussed internationally. The discussions include the UN resolutions from 2011, 2014 and the latest of 2016, regarding sexual orientation and gender identity (SOGI) (OHCHR, 2018). As the UNHCR has included SOGI in their resolutions, they acknowledge SOGI issues as human rights issues. The inclusion of SOGI in human rights discourse has made the issues of gender identity extremely politicized, urging nations worldwide to take a stance on the topic.

The international and global discussions on transgender issues also started the debate on whether being transgender should be reclassified, as trans rights activists globally urged for it to be declassified as a mental disorder. By listing being transgender as a mental disorder it results in more stigmatization of an already marginalized group, leading to exclusion of transgender people in different layers in society. Following the debate and ongoing discussions, WHO stated that ‘transgenderism’ would be moved out of the section on mental disorders and into sexual health conditions in their newest edition of the ICD (WHO, 2018), pressuring nations and states to adopt the new definition of transgender individuals as well, which Denmark then became the first country to do, in 2017.

Following the immense attention Denmark gained internationally due to the groundbreaking policy change, the SST experienced an interest in the guidelines on trans-specific healthcare unlike no other health policy prior to this, leading them to issue an extraordinary English version of the guidelines in 2018.

Today, the issue of trans rights (and SOGI issues generally) has arguably become a measurement of how progressive a state, nation or government is, depending on their laws and regulations on the topic. The inclusion of SOGI issues in the political debate has become inevitable, for example as seen in the United States; the so-called Bathroom Bill[12] started the discussion of trans rights, followed by the Trump Administration's proposal to ban transgender individuals from serving in the US army (BBC, 2018a).

Social media and engaging the public

The rise of social media has also impacted the amount of attention that has been given to SOGI and specifically trans issues. On social media, the issue of trans rights and the concept of identity politics have been both questioned and defended endlessly, internationally as well as nationally, academically as well as out in society. News outlets as well as official political institutions are represented on social media, posting and interacting with their followers online. The rise of social media has made it possible for people worldwide to stay up to date with the ongoing political discussions, and trans rights are no exception. Many news outlets use platforms such as Facebook or their own websites to engage their readers in discussions, which leads people to comment online. Social media allows for transnational discussions as the platforms are both used by national and international media, on national as well as international topics.

In a Danish context, social media has played an immense role in engaging the average population in the discussion on trans rights. Specifically, in terms of trans-specific healthcare and the declassification of being transgender as a mental disorder. It is reasonable to assume that most of the general population were not concerned with trans rights issues before the policy change, but the media's attention to it started a national discussion. The general population started discussing whether being transgender should be considered a mental illness regardless of the policy change, and further, whether trans-specific healthcare should be included under the welfare state and thus, be free of charge like other medical procedures offered in the Danish welfare system. Here, it is also reasonable to assume that the high interest in trans issues as a welfare state issue stems from a notion of self-interest, as the welfare state is mainly funded through the taxation system and thus, the taxpayers.

As well as trans-specific healthcare, the issue of legal gender change was also discussed widely on social media amongst the general population in Denmark. The issue started a debate on how to view and understand gender – in terms of biology and genitals or as a social construct produced in society – often leading to concerns of how the implementation of legal gender change would affect the governing of gender segregated spaces, such as public bathrooms, changing rooms and in prison. However, most concerns represented in the debate on trans inclusion rely on outdated and invalidated assumptions of trans women

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[12] The terms 'Bathroom Bill' or 'Restroom Bill' describes bills that restrict transgender people's access to restrooms and other single-sex facilities (NCTE, 2018)

being sexual predators or gender identity being a made-up concept, just to name a few examples (Bianco, 2015; BBC News, 2018b; Weber, 2018).

Activists' use of media in campaign strategies

In addition, the media has also served as a great tool for mobilizing activists and organizing campaigns. Many human-, trans- and LGBT rights organizations are present on social media and use their platforms to engage their followers in the current political topics, such as trans rights. In Denmark, Amnesty used social media broadly to launch and run their campaign *#SygtSystem*, which allowed them to reach a greater audience. Nowadays social media also serves as a tool for organizing events, such as events on Facebook, making it possible for activist organizations to organize demonstrations, for instance, and creating awareness of these more effectively than working the streets, such as handing out flyers.

Furthermore, the media also serves as a 'life-line' through which marginalized groups – such as transgender individuals (care-seekers as well as non-care-seekers) can reach each other. In this way, individuals can connect and organize, though they live far apart. Generally social media serves as an important tool in organizing social movements and communities online, and grants access to reach audiences and potential activists across domestic regions as well as across international borders.

7. Conclusion

This thesis focuses on the policy change in Denmark regarding the declassification of being transgender as a mental disorder as of 2017 and thus, the change in problem representation in the guidelines on healthcare related to gender identity issued by the SST, and how this change constitutes the eventual framework for transgender people's access to trans-specific healthcare and experienced lived effects of this. The analytical framework for this thesis includes six questions of Carol Bacchi's WPR approach combined with a discourse analysis, seeking to examine and investigate how problem representations of and dominant discourses on trans-specific healthcare and transgender care-seekers appear in the guidelines, and how these affect understandings, solutions and subjectivities in this regard.

By analyzing the guidelines and other related official documents, I conclude that the guidelines aim to secure high quality and equal access to healthcare related to gender identity in Denmark, by taking responsibility for providing guidelines for the practice of trans-specific healthcare which do not stigmatize nor pathologize care-seekers. Thus, has the identified 'problem' representations in the guidelines been coded to be the SST's role in destigmatizing transgender people in terms of care-seekers, based on the previously reported experiences amongst care-seekers of feeling disempowered and mistrusted in the clinic SK. An additional 'problem' representation has been identified to be the aim of securing that care-seekers are fully decided in their wish to pursue trans-specific care, to avoid regret. However, the classification of trans-specific healthcare as a highly specialized hospital service, the repetition of suggested reflection time and the continued inclusion of psychologists and psychiatrists in the MDT is argued to prevent destigmatization.

Though the overall language and terminology in the guidelines has been changed and modified to adopt a more inclusive and affirmative approach to trans-specific healthcare, the overall content and nature of the guidelines is still far from addressing and considering the obstacles care-seekers might experience when pursuing trans-specific healthcare in Denmark. These obstacles include but are not limited to the open-ended and loose definitions of (degree of) gender discomfort, psychosocial relations, long or comprehensive investigations and the disclosure of sexuality related subjects. Furthermore, the SST's argumentation as to why these requirements are posed invites for a critical examination of on which basis these decisions are made, and the requirements posed: are ethics in medical care prioritized over the ethics of ensuring trans people their human rights regarding access to trans-specific healthcare?

Finally, after performing an analysis using the WPR approach combined with a discourse analysis, this thesis concludes that trans-specific healthcare and transgender issues are more relevant than ever, as trans-specific politics and policies are still based upon problematic views of transgender people and their personal experiences. Inviting and including activists and organizations representing the care-seekers and the transgender community in the debates and decision-making that affect them is fundamental to achieve change that is not only symbolic but just, right and necessary.

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