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International Classification of Diseases (ICD-11).
Sexual disorder chapter' rephrase:
the transgender Issue

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Abstract

La tendenza a creare sistemi di catalogazione ha coinvolto anche il campo medico. La prima classificazione delle malattie risale al 1893 e dalla seconda metà del '900 l'Organizzazione mondiale della Sanità ha ricevuto il compito di tenerla aggiornarla. Prima "del come" (catalogare) occorre però decidere "il cosa" e ciò merita attenzione qualora si tratti di aspetti legati alla sfera sessuale. Si tratta infatti di una scelta non solo giuridica, ma anche sociologica e politica. Con specifico riguardo a questo aspetto, la riformulazione dell'ICD è interessante poiché include i transgender nel capitolo sui disturbi sessuali non più in quello delle malattie mentali. La decisione arriva al termine di un lungo processo che ha coinvolto le Istituzioni, internazionali ed europee, in uno alle corti di giustizia, e merita di essere scrutinato, in particolare per le conseguenze che potranno derivarne.

The trend to shape system of cataloging, universally recognized, has also involved medical field. The first diseases' classification dates back to 1893 and in the second half of 20th century the World Health Organization received the task of keeping it up to date. Before dealing with the "how" (to catalog) it is necessary to decide the "what" and this aspect deserves particular attention when it concerns sexual related aspects. These latter require not only a juridical choice, but also a sociological and political one. In this regard, ICD' rephrase is interesting because it has qualified transgender' issue as a sexual disorder, thus excluding it from chapter on mental illnesses. This decision comes at the end of a long process that has involved Institutions, international and European, and courts and it deserves to be scrutinized, in particular for the consequences that may trigger with it.

1. Introduction

In a World with no boundaries, there is a pressure to use uniform vocabularies to name and qualify "things". This approach smooths communications all over the world, help people in understanding each-others and it should also guarantee equal treatment among individual being in a very same posi-

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tion. As a way of explanation, it is enough to recall the Universal Timing Calculation (UTC), uniform qualification of certain international trade instruments (such as contracts and way of payments), along with the work constantly done by the International Organization for Standardization and the Internet Corporations for assigned names and numbers.

This run towards uniformity has also caught naming of diseases and guidelines' definition to cure them. As of today, this end is pursued by the International Classification of Disease (ICD) a catalogue, worldwide recognized.

In brief, the ICD is a tool prepared and approved by the World Health Organization in order to provide a complete classification of diseases¹. One of the most challenging aspect has always been – and keep on being – to understand what is a disease, so to include it into the Classification. Once solved this conundrum, it is reassuring to think that very same symptoms will be recognized, named and treated no matter where an individual find him/herself. The history of ICD dates back to last century when medical Community perceived the need for standardizing classification concepts. First attempt in this direction was made by W. Farr, who in 1837 proposed the best possible classifications of diseases. It was inevitably imperfect because of the lack of instruments of collecting data available at that time but, still, it represented a good starting point. Few years later, in 1891, the International Statistical Institute, constituted a Working Group, chaired by Mr. J. Bertillon, conferring it the mandate to prepare a comprehensive classification of causes of death. The Classification provided, adopted by the International Statistical Institute in 1893, received a general approval and was implemented in many countries, United States of America and Canada included. Afterwards, following suggestions raised by the American Public Health Association, the list went under updates each ten years. Notably, the first revision, made in Paris in 1900, introduced a second classification of disease, apt for use in statistics of sickness. In 1946 the by that time new born WHO received by the International Health Conference the mandate to review the ICD and to establish an International List of causes of Morbidity. These latter have then been included in ICD-6, published by WHO in 1948. Since then, each ten years WHO updates ICD according to the *status quo* of medical research and given circumstances. Over time, a given symptom could indeed become less serious, not representing anymore a cause of death or a virus could meanwhile have been eradicated. Vice versa, new pathology can be recorded for the first time while already existing ones could deserve a reconceptualization. In this regard, worth of mention is the fact the ICD-10, lastly revised in 1993, excluded homosexuality from chapter on mental diseases². To speed up the updating process, the Tenth Revision Conference highlighted the need to have updates even between the ten years period of revisions. Two working groups have been constituted. The first one, named Updating and Revision Committee (“URC”), make recommendation for submission to the meeting, of Centers head (WHO is helped by a network of so-called Collaborating Centers to develop, disseminate, implement and update national and international information systems). The second group, called Mortality Reference Group, support URC in revising mortality matters. This new mechanism become effective in 1997; since then, updates are available in annual list of changes approved each October by Heads of WHO Collaborating Centers for the families of International Classifications. This frequency renders ICD a photography of health conditions and related problems, making it a truly effective and useful tool. On 18 June 2018, WHO proposed 11th version of the International Classification of Diseases changing it deeply since the previous version.

Starting from these premises, the present paper aims to scrutinize one of the main changes made to ICD-11, namely sexual diseases' chapter reshape. The research question is then to understand proceedings laying behind the final decision to include transgender issue in sexual chapter.

Para. 2 will briefly present ICD-11 formal and substantive aspects; the analysis will then proceed in para. 3 with a deep scrutiny of the reasons allegedly pushing for sexual disease chapter' rephrase. Subsequent para. 4 will attempt a comparison between international and European approach on sexu-

1 See <https://www.who.int/classifications/icd/en/>.

2 WHO, *The ICD-10 Classification of Mental and Behavioral Disorders, Clinical Descriptions and Diagnostic Guidelines*, <https://www.who.int/classifications/icd/en/bluebook.pdf>; Bryan Cave, *Regulatory guidance and legal implications associated with the transition to ICD-10*, in <https://www.lexology.com/library/detail.aspx?g=5fab7ed0-c7f6-4ad3-a373-7532c5c82522>, 2015; Donna J. Wright, *ICDD-9-CM to ICD-10-CM*, in *Advances in Wound Care*, Vol. 2, 2013, pp. 588.

al matters, namely on transgender issue. In this regard, attention will be paid on both, normative and jurisprudential european practice on this topic. Lastly, para. 5 will attempt to understand the impact that ICD-11 is expected to have in treating so called non-binary people. This scrutiny will also include a sociological understating of sexual related matter.

2. ICD in a nutshell

At date, World Health Organizations counts 194 Member States and, among all other issues, it has the power to set norms and standards and to monitor their implementation³. ICD is one of the instruments shaped within WHO but it is an instrument of soft-law; as such, it is a non-binding legal act. It is instead a tool appropriate for recording, reporting and grouping health trends and statistics world-wide. Each country has its own standardized, consistent data, that will become more relevant when it can be read and understand along with those made in other countries. Accordingly, ICD contains codes for injuries, diseases and causes of death internationally accepted. ICD then works as a common vocabulary allowing countries to rely on comparable nomenclatures. Put it differently, ICD covert a diagnosis into an alphanumeric code, which in turn favor collection, use and analysis of data. Moreover, ICD is useful to prepare statistics and make epidemiological studies in order to scrutinize every and each aspect of life that can affect health condition.

One of the intended outcomes is to allocate financial resources to diseases and pathologies where they are much needed. If, for instance, medical community in one or more specific geographical area, record an increase of deaths or injuries labeled under the same code, this may thrill international community or national states to decide to invest fund in that issue.

In May 2019 the ICD-11 will be presented at the World Health Assembly for member states' adoption. Once adopted, it will come into effect on 1 January 2022.

From all the above, it derives that ICD-11 is a regulatory instrument seeking to harmonize the qualification and treatment of diseases world-wide. The version just released presents some changes, under both a formal and a substantive perspective.

Regarding its format, WHO has shaped ICD-11 endorsing the request to make the new edition user-friendly. Accordingly, the new version has become completely electronic; it uses Arabic number and it translates diseases, diagnosis, and any other related problems into an easy to understand alphanumeric code. All entries are then described in a concise and developed manner.

Regarding the substance, one update worth to be mentioned is the revision of chapter on sexual disorder. Following controversies raised about gender identity diagnoses and civil society advocacy efforts, WHO has appointed a Working Group on Sexual Disorders and Sexual Health ("WGSDSH") to have it working close with the WHO Department on mental health. In particular, as part of the development of the 11th revision, WHO has recommended the appointed Group to revise a range of sexual and gender diagnosis and to recommend changes worth in the classification of mental and behavioral disorders⁴. As a consequence, gender incongruence has been excluded from the chapter on mental and behavioral disorder. Precisely, it is interesting to highlight that the chapter on sexual disorder, named *condition related to sexual health*, contains in the new version both gender incongruence and changes in female/male genital. The latter being, inevitably, correlated to the former. Vice versa, so

³ G.L. Burci, C.-H. Vignes, *The World Health Organization*, The Hague, Kluwer Law International, 2004; A. Clapham, M. Robinson (ed.), *Realizing the Right to Health*, Zurich, Rüffer & Rub, 2009.

⁴ J. Drescher, P. Cohen-Kettenis, S. Winter, *Minding the body: situating gender identity diagnoses in the ICD-11*, in *International Review of Psychiatry*, Vol. 24(6), 2012, pp. 568-77; S.D. Cochran, J. Drescher, E. Kismodi, A. Giam, C. Garcia-Moreno, E. Atalla, A. Marais, E. Vieira, G. Reed, *Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems, (ICD- 11)*, in *Bulletin of World Health Organization*, Vol. 92(9), 2014, pp. 672-9; P. Bucci, *The draft of the ICD-11 chapter on mental and behavioral disorders: an update for clinicians*, in *Rivista Psichiatrica*, Vol. 52, 2017, pp. 95 ss. See http://www.who.int/reproductivehealth/topics/sexual_health/icd_revision/en/

called sexual paraphilias have been maintained under chapter 6, gathering mental health issues (see ICD-11, Ch. 6)⁵. This means that the appointed Working Group had clear the distinction between sexual disorder requiring mental assistance and sexual health conditions, requiring medical assistance and even surgery.

Furthermore, in answering sustained calls from civil society, traditional medicine (such as Chinese medicine) has also been included in ICD-11⁶.

3. Sexual disorders Chapter' rephrase: the international perspective

As showed in paragraph 2, reframing of Sexual Disorders Chapter represents a step forward in protecting a category of persons, so-called persons with 'gender incongruence' who, born either male or female, have natural desire to live as a person of the opposite sex. Civil Society has always tended to stigmatized those people. This has been worsened by the fact that gender incongruence is a condition qualified differently according to countries and culture: those having an open approach⁷ are indeed few compared to those tending to let those people living at margin of the society, depriving them of basic human rights. It suffices here to recall that among USA have been raising many juridical proceedings dealing with the need to guarantee people with gender incongruence right to use the toilet of sex they perceive to be⁸; also, on 12, September 2018 State of New York issued a legislation according to which parents can register the new born child under the voice "unknown" sex. In Italy, back in 1986, Constitutional Court provided for an open and, for that time, progressive qualification of transsexualism. According to the Court: "*transsexual having had surgery, is able to have sexual relations with a partner of the opposite sex (the one to which he/she was originally born). However, as far as it is known, scientific research show that even with surgery transsexual cannot give birth to child*"⁹.

This approach recalls the one endorsed by ICD-11; indeed, for Italian Judges transsexualism is a question of sexual expression not a mental pathology.

Contrarily, in countries such as Brazil people with gender incongruence usually leave in dehumanized condition, at margin of society having access to bad medical assistance and cure¹⁰.

All incertitude surrounding the transgender issue renders particularly needed having an International Organization, enjoying world-wide consensus such as WHO, to tackle the issue focusing mostly on way to guarantee those people human rights, starting from that to health. This means allowing people with gender incongruence access medical treatment which in turn render them possible to realize their natural feelings to have sex reassignment. From this, all legal consequences derive, such as that to obtain insurance, have change of sex on birth registry, marry person of opposite sex or being in a legal relationship with a partner of same sex.

Accordingly, re-conceptualization of gender incongruence represents a major step forward in in-

5 ICD-11 states that "*paraphilic disorders are characterized by persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges, or behaviors, the focus of which involves others whose age or status renders them unwilling or unable to consent and on which the person has acted or by which he or she is markedly distressed. Paraphilic disorders may include arousal patterns involving solitary behaviors or consenting individuals only when these are associated with marked distress that is not simply a result of rejection or feared rejection of the arousal pattern by others or with significant risk of injury or death*".

6 D. Cyranoski, Why Chinese medicine is heading for clinics around the world, in *Nature*, 448, 2018 pp. 561; Z. Xi Yi Jie He, X. Bao, Introduction of the World Health Organization project of the International Classification of Traditional Medicine, in <https://www.ncbi.nlm.nih.gov/pubmed/22088596>, 2011, pp. 1161.

7 In 2013 Indian Supreme Court issued a judgment declaring transgender people to be a "third gender"; see Indian Supreme Court, *National Legal Services Authority v. Union of India*, WP(Civil) No. 604 of 2013.

8 See <https://www.nytimes.com/2018/05/22/us/gavin-grimm-transgender-bathrooms.html>. See, Diana Elkind, *The Constitutional Implications of Bathroom Access based on Gender Identity: An Examination of recent Developments paving the way for the next frontier of equal protection*, in *Journal of Constitutional Law*, Vol. 9:3, 2007, pp. 895-928.

9 Italian Constitutional Court, decision n. 161, 1986.

10 See <https://www.theguardian.com/world/2018/oct/27/dispatch-sao-paulo-jair-bolsonaro-victory-lgbt-community-fear>.

creasing transgender life condition and enjoyment of human rights.

In this regard, it seems that WHO's willingness to reconsider the transgender question within the ICD is another move towards a full (or at least better) enjoyment of transgender people's human rights. In this regard, the idea to create a Working Group focused on sexual health issues show WHO's commitment to seriously dealing with the topic. Indeed, sexuality is '*a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors*'¹¹. Such a broad definition encompasses various aspects of sexual health and sexuality, avoiding rigid qualification according to which sexual health means absence of sexual related diseases¹². Contrarily, sexual health is also a state of mind, of complete wellness and freedom of expression. To attain this level, WHO recommended a World Health Assembly Resolution aimed at developing a strategy in order to boost progress towards attainment of development goals and targets related to health. Accordingly, Reproductive Health Strategy has been adopted with the aim to agree on actions, at legislative and programmatic level, to raise also sexual conditions¹³. It goes without saying that to attain and maintain sexual health, sexual rights shall be guaranteed and protected. Art. 1 of WHO's Constitution clearly states that '*[t]he objective of WHO shall be the attainment by all peoples of the highest possible level of health*'.

Within the above-mentioned panorama, the appointed Working Group has benefited from adopting a multidisciplinary approach in addressing this issue. Members of the Working Group were selected because of their competence in clinical and psychological field and included 11 clinical/scholars working in sexuality worldwide and drawn from nine countries and six continents. As a consequence, ICD-11 now includes an integrated classification of sexual dysfunctions, melting together in a single chapter those so called non-organic, originally included in the chapter included in the chapter on "mental and behavioral disorders", and those organic. In turn, this means having overcome the difference between sexual condition related to mind and to body. Contrarily, and more generally, sexual dysfunction is now described as conditions having both psychological and biological components, being '*syndromes that comprise the various ways in which adult men and women may have difficulty experiencing personally satisfying, non-coercive sexual activities*' (see ICD-11 Chapter 17)

Research and analysis developed by the Working Group has also led to gender incongruence now being qualified within ICD-11' Chapter 17 under two separate codes: one for adolescents and adults (HA60), the other for children (HA61)¹⁴. The decision to have two codes, derive from the assumption that the very same condition, namely that of suffering for gender incongruence, has to be treated differently according to the age of the person.

Besides, a portion of civil society still casts doubts on whether ICD-11 should even include gender incongruence, holding that this will associate non-binary people with stigma.

Vice versa, if one look at possible positive effects that inclusion will carry with it, it seems fair to submit that such inclusion is useful. As of instance, ICD has so far proved to be an effective instrument used by countries, world-wide, to decide whether or not people were eligible and could get access to health services. It goes without saying that being part of ICD increases chance for people with gender incongruence to have better access to health care services. It goes without saying that if a person does not prove to be sick, insurance or national health could question the request to pay for treatment.

Besides, statistics and data provided thanks to ICD are used as a base to formulate policies and

11 WHO, *Defining Sexual Health: Report of a Technical Consultation on Sexual Health*, Geneva, 28–31 January 2002, spec. p. 5 ss.

12 See G. L. Burci, A. Cassels, *Health*, in *The Oxford Handbook of International Organization* (ed.) *ivi*, 447-471.

13 WHO, *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of international Development Goals and Targets*, Geneva, 2004.

14 R. Kaltiala-Heino, H. Bergman, M. Työläjärvi, L. Frisé, *Gender dysphoria in adolescence: current perspectives*, in *Adolescent health Medical Th.*, 2018, pp. 31-41.

laws¹⁵. In addition to allowing for insurance schemes and medical aid necessary for transgender people to be able to afford specific (hormonal or surgical) treatment related to their conditions, the inclusion of transgender conditions in the ICD-11 will also assist in shedding light on the HIV epidemic suffered by transgender individuals in high proportion. In this specific regard, it is important to recall that, before the ICD current revision, WHO has been involved in programs addressing health and transgenderism for many years. Following the *WHO Guidelines on HIV prevention, diagnosis, treatment and care for key population* (2014)¹⁶, the Organization implemented a comprehensive HIV and STIs (Sexually Transmitted Disease) program with transgender people, the results of which were published in 2016¹⁷. The aim is to design and implement services accessible to transgender women who are, among all, those most exposed to HIV contamination.

4. ...: the European perspective

Once shaped reasons surrounding ICD-11, it seems important to adopt a more general overview, thus attempting a comparison among different levels. Indeed, it appears that works and efforts done at International level, through WHO, go along with those endorsed within other entities. Particularly, it appears that international and regional organizations influence each other, with European institutions having been a major source for WHO and vice versa. Accordingly, the decision to rephrase ICD Chapter on Sexual Disorders should be read alongside claims raised within the European Union and embraced by the European Court of Human Rights (ECtHR) in a number of rulings.

Regarding European Institution, it is worth mentioning that in 2015, the European Parliament has expressively declared that it *'[d]eplores the fact that transgender people are still considered mentally ill in the majority of Member States and calls on them to review national mental health catalogues, while ensuring that medically necessary treatment remains available for all trans people [...] European Parliament welcomes the initiative shown by the Commission in pushing for de-pathologisation of transgender identities in the review of the World Health Organization's International Classification of Diseases (ICD); calls on the Commission to intensify efforts to prevent gender variance in childhood from becoming a new ICD diagnosis'*¹⁸.

Regarding case law, the ECtHR has so far proved to be active in the area related to enjoyment of human rights by persons with gender incongruence which, according to the Court, *'raise complex scientific, legal, moral and social issues in respect of which there is no generally shared approach among contracting States'* (*Sheffield and Horsham v. The United Kingdom*¹⁹). Since 1986, transgender people have asked the ECtHR to scrutinize whether their enjoyment of human rights was being impaired by State's action (or omission) and primarily dealt with the (alleged) infringement of Art. 2 (right to life), Art. 8 (right to respect for private and family life) and Art. 11 (freedom of expression) of the European Convention of Human Rights²⁰. The claims before the Court have tended to center around two main issues: the first one concerns the existence, or not, of State obligation to change the legal status of an individual to

15 *Id.*

16 WHO, *Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key population*, July 2014; United Nations Development Program, *IRGT: A Global Network of Transgender Women and HIV*, 2016.

17 United Nations Development Program, *Implementing comprehensive HIV and STI programs with transgender people: practical guidance for collaborative interventions*, New York, 2016; WHO, *Defining Sexual Health: Report of a Technical Consultation on Sexual Health*, Geneva, 28–31 January 2002, 2006.

18 European Parliament, *Report on the situation of fundamental rights in the European Union (2013-2014) (2014/2254(INI))*, 16 July 2015, paras. 90-91.

19 European Court of Human Rights, Grand Chamber, Case No. 22985/93, 23390/94, *Sheffield and Horsham v. The United Kingdom*, 30 July 1998, para. 58.

20 C. Grabenswater, *European Convention on Human Rights: Commentary*, The Hague, Hart Publishing Ltd, 2014; A. Mowbray, *Cases, Materials, and Commentary on the European Convention on Human Rights*, Oxford, Oxford University Press, 2012; M. d'Amico, C. Nardocci, *LGBT rights and the way forward: the evolution of the case law of the ECtHR in relation to transgender individuals' identity*, ERA forum, *Journal of the Academy of European Law*, 2016, pp. 191-202.

female-to-male / male-to-female transsexual individuals. The second one concerns the legitimacy of a State decision to refuse to allow a marriage between two people of the opposite sex in the case where an individual has had gender reassignment.

In detail, Claimants complain that when States refuse to change register of births, they infringe art. 8 and art. 12 of the European Convention for Human Rights²¹.

According to Respondent States refusal was legitimate because changes asked for by Claimants would have required a fundamental modification of system for keeping the register of birth.

In the merit Court's jurisprudence has evolved. In very first decisions, ECtHR rejected claims holding that there was no infringement of neither art. 8 nor art. 12 (*Rees v. the United Kingdom*²²; *Cossey v. the United Kingdom*²³). Court's approach started to change when same allegations were raised against States, such as France, having different register of births system. Particularly, in *B. v. France*, Court held that 'According to the Court in the United Kingdom there were more obstacles in preventing birth certificates from being amended, in France these were intended to be update throughout the life of the person concerned'²⁴. Despite this, Court highlighted that many official documents in France revealed 'a discrepancy between the legal sex and the apparent sex of transsexual, which also appeared on social security documents [...] the refusal to amend civil status register in regard of the claimant had placed her in a daily situation which was not compatible with the respect due to her private life'²⁵.

Since then, ECtHR has endorsed a more open approach in recognizing infringement of Art. 8, no matter the system of birth register adopted by respondent State. For instance, in *Christine Goodwin v. United Kingdom*, 'there are no significant factors of public interest to weigh against the interest of the individual applicant in obtaining legal recognition of her gender reassignment, [therefore] the Court reaches the conclusion that the notion of fair balance inherent in the Convention now tilts decisively in favor of the applicant'²⁶. In the same decision, the Court saw also a violation of art. 12 on the assumption that 'it was not persuaded that it could still be assumed that the terms of art. 12 must refer to a determination of gender by purely biological criteria [...] the Court finds no justification for barring the transsexual from enjoying the right to marry under any circumstances'²⁷.

It is interesting to note that rulings subsequent to *Christine Goodwin* decision, have mostly related to request of sex reassignment, while the person was still married with a person of (originally) opposite sex. The obstacle in endorsing this request rely on the fact that making the change before divorce would lead to a marriage between persons of the same sex.

On this topic, the Court in the leading case *H. v. Finland*²⁸, found that it was not disproportionate for a State to require conversion of a marriage into a registered partnership as a precondition to legal recognition of an acquired gender. Vice versa, change of sex would have pose the married couple in an illegitimate position, given that traditional marriage between same sex people is generally not allowed.

The question is still controversial and difficult to deal with because it opposes individual right, that to marry or remain married, with a question of public policy. From one side, it seems not legiti-

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- 21 C. Ragni, *Sciogliere un matrimonio per tutelarne cento? Il divorzio imposto tra interesse pubblico e diritti individuali*, GenIUS; 1, 2014, pp. 99-107.
- 22 European Court of Human Rights, Case No. 9532/81, *Rees v. the United Kingdom*, 25 September 1986. In that case, UK refused to confer on Applicant a legal status corresponding to his actual condition but the Court rejected applicants' complaint stating that there were no violations of art. 8. This notwithstanding, that the Court highlight that it was conscious of the "seriousness of the problems affecting transsexuals and of their distress" and thus it recommended "to keeping the need for appropriate measures under review, having regard particularly to scientific and societal developments", para. 47.
- 23 European Court of Human Rights, Case No. 10843/84, *Cossey v. the United Kingdom*, 27 September 1990. In that case, the Court stated, again, that "gender reassignment surgery did not result in the acquisition of all the biological characteristics of the other sex", par. 40.
- 24 European Court of Human Rights, Case No. 57/1990/248/319, *B. v. France*, 24 January 1992, para. 59.
- 25 *Id.*
- 26 European Court of Human Rights, Case No. 28957/95, *Christine Goodwin v. the United Kingdom*, 11 July 2002, para.93.
- 27 *Id.* parr. 100 et 103.
- 28 See D.A. Gonzalez-Salzburg, *Confirming (the illusion of) heterosexual marriage: Hämäläinen v Finland*, in *Journal for International Comparative Law*, 2015, pp. 173 ss.

mate to impose a divorce, from the other there are legal obstacles preventing a marriage of same sex persons²⁹. The question is of easy understanding. If a marriage between same sex person is allowed in case one of the two has had sex reassignment, why should marriage between homosexuals keep on being prohibited? Correlatively, issues related to right to adopt will raise.

In the end, it seems that under a legal perspective there are two major aspects deserving uniform and clear definition, to eventually allow transgender would effectively enjoy their human rights. Firstly, uniform conditions legitimizing sex reassignment on birth register, along with harmonized system of register are strongly required. In this regard, it is also questionable whether, or not, surgery is a peremptory condition in order to get sex reassignment on birth register. Indeed, if Legislator at national and supranational level will opt for a not stringent definition of transsexualism, also those not having had surgery could legitimately ask for, and obtain, sex reassignment. This approach will in turn guarantee transsexual people to freely live and express their sexuality without the burden of a surgery imposed from above.

Secondly, and as a consequence of what just said, it is important to endorse request of having transgender enjoy their right to marry, once having had sex reassignment.

5. Sexual Disorder Chapter' rephrase: possible impact on understanding transgender' issue

Precedent paragraphs tried to show that changes introduced in ICD-11 do not come out of the blue, being instead the result of a long process involving national, international and European level. Results reached in the ICD version just released pose some questions regarding the role played by International Organizations, such as WHO, and possible effect of its normative instruments within the civil society. Regarding the first one, the decision to reconceptualize ICD-10 categories related to gender identity currently classified a mental and behavioral disorders certainly raises a question regarding the role an International Organization such as the WHO plays. In general, States constitute international organization conferring upon them a mandate to attain specific results³⁰. The question is whether ICD can contribute to accomplish the mandate conferred upon WHO. So far, it seems fair to answer this question positively. In particular, changes endorsed by ICD revision prove that WHO abided by its own mandate. As international organization on health, the WHO has the role to attain and guarantee the highest possible level of health; namely, health is defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*³¹. This means that also sexual health has to be provided because otherwise people won't effectively enjoy a truly effective status of health.

In this regard, it is interesting to highlight that, as above-said, ICD-11 introduces a clear subdivision between paraphilias, classified under the chapter on mental conditions, and sexual health conditions³². This distinction seems to us correct given that it poses a line between what concerns a mental pathology, thus requiring mental support, from what is a sexual condition. This latter requires specific medical treatment in order to allow people affected to reach the status of complete health. Accordingly, it is not surprising that gender incongruence, namely the feeling to perceive him/herself as being of the opposite sex, goes along the need to changes in genital. Indeed, it is often that people with gender incongruence won't be able to reach a perfect health condition without having passed through surgery³³.

²⁹ See P. Dunne, *Marriage dissolution as a pre-requisite for legal gender recognition*, in *Cambridge Law Journal*, 2014, pp. 510 ss.

³⁰ For a topic overview, see J. Katz Cogan, I. Hurd and I. Johnston (ed.), *The Oxford Handbook of International Organizations*, Oxford, Oxford University Press, 2016; José E. Alvarez *International Organizations as Law-Makers*, Oxford, Oxford University Press, 2006.

³¹ See WHO Constitution, Preamble.

³² Cfr. *supra* par. 2.

³³ See <https://www.surgeryencyclopedia.com/Pa-St/Sex-Reassignment-Surgery.html>.

Besides, an effective approach towards developing a comprehensive understanding to sexuality and sexual health is strongly required. This holds true, also considering that lack of information or data on sexual health conditions has slowed development of programs apt to support people experiencing suffering related with their health condition. Accordingly, WHO has proved to be good in exercising global governance; indeed, WHO approach could represent a unique opportunity to define and reconceptualize sexual health, as a fundamental human entitlement. ICD-11 proves also ability of WHO to coordinate and integrate work done at national level. This holds true, considering that ICD is a storage of data gather by multiple sources. ICD-11 revision has a double side effect; on one side, it represents in realizing Sustainable Development Goal n. 3 (need to provide universal coverage on health) and, correlatively, it is a step toward a definitive acceptance of transgender people in global society. On the other side, it proves the capacity of international organizations to address civil society calls strongly asking to reconsider the transgender among civil society. Accordingly, WHO' decision to reconceptualize transgender condition, while maintaining it in ICD-11 constitutes a clear step in improving transgender people health.

Regarding the second aspect, it seems safe to state that from a sociological perspective, ICD-11 contributes to changing society's perception towards people with gender incongruence. Abandoning psychopathological model for transgender people, based on a 1940s conceptualization of sexual deviance, will help medical and social communities to focus on what transgenders need and deserve as human beings.

Secondly, and as a consequence, the decision increases chance that national and supranational public entities enact binding provisions protecting rights of people having gender incongruence. To reach this end, it is desirable that a coordinated approach among all public institutions active in the field is put into place. It goes without saying that health is not just a domestic issue, having instead an international dimension. This require the development of truly effective global approach, aimed at defining effective models of governance.

In this regard, it is worth recalling that analogous positive results were reached earlier when WHO, in ICD-10, specified that sexual orientation by itself was not to be classified as a disorder. Since then, and following interrelated developments in other socio-political realms, homosexuality became instead an issue deserving specific attention from civil society, legislators and the judiciary at domestic, regional and international levels³⁴.

In conclusion, reframing gender incongruence might decrease discrimination and marginalization helping in turn people with gender incongruence to live freely, exercising their right to self-determination.

However, it seems that one critical point still has to be faced and promptly solved. It is urgent that, as originally requested by the appointed Working Group, gender incongruence in childhood stop being pathologized. At the age of puberty children could feel the need to explore their gender identity. Moreover, children won't have need of somatic gender affirming health care. Accordingly, children experiencing their sexuality should receive Q Codes, currently in Chapter 24 (Factors Influencing Health Status or Contact with Health services). This holds true and seem reasonable, but, there is still some part of the academia believes that retention of gender incongruence in childhood will provide better opportunities in development of standards and access to medical care and assistance³⁵.

34 In 1974 American Psychiatric Association's removed Homosexuality from the 6th printing of *Diagnostic and Statistical Manual of Mental Disorder (DSM-6)*. See <https://www.mentalhelp.net/articles/psychiatric-manual-of-mental-disorders/>.

35 S. Winter, *Gender trouble: The World Health Organization, the International Statistical Classification of Diseases and Related Health Problems (ICD)-11 and the trans kids*, in *Sexual Health perspective. Lancet Psychiatry*, 14 (2017), pp. 423-430; M. Calbral, A. Suess, J. Ehrh, J. Seehole, J. Wong, *Removal of gender incongruence of childhood diagnostic category: a human rights Gender trouble*, in *Sexual Health perspective. Lancet Psychiatry*, Vol. 3(5), 2016, pp. 405-6; J. Drescher, P. Cohen-Kettenis, G. Reed, *Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale*, *Lancet Psychiatry*, Vol. 3(3), 2016, pp. 297-304; D. Chou, S. Cottler, R. Khosla, G. Reed, L. Say, *Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond*, in *Report Health Matters*, Vol. 23(46), 2015, pp. 185-92; J. Drescher, R. Krueger, E. Atalla, S. Cochran, M.B. First, I. Cohen-Kettenis, S.J. Arango de Montis, Parish, P. Cottler-Briken, S. Saxena, *Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices*,

and human rights considerations, in *World Psychiatry*, Vol. 15(3), 2016, pp. 205–21