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## **Trans and Gender Variant Citizenships and the State in Norway**

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### **Abstract**

The last decade has seen the expansion of trans identities that are gender queer, non-binary, androgynous, or multiply-sexed and gendered in Western Europe. These developments mark a shift from a uniformly gender-binariated system to one that encompasses some degree of gender pluralism, as reflected to an extent in policy changes in some European countries. However, gender binarism is still prevalent. This article uses the case of Norway to demonstrate a contrast between the citizenship statuses afforded to transsexual men and women, and the lack of citizenship rights that people with non-binary identities, and other gender-variant people who are not diagnosed as transsexual, face. The article addresses the historical role of the Norwegian state in perpetuating gender binaries, in key areas such as identity recognition. It then explores the ways in which Norwegian social policy is changing towards more trans-sensitive positions.

**Keywords:** Trans citizenship; non-binary and transsexual political values; medico-legal complex

### **Introduction**

The issue of gender variant and non-binary identities is now becoming pressing for policy makers, given the increasing prominence of non-binary and genderqueer identities (McNeil et al 2012), and of gender incongruence more broadly (Bouman et al 2016). The diverse groups known as non-binary or gender-queer include ‘...people [who] have a gender which is neither male nor female and may identify as both male and female at one time, as different genders at different times, as no gender at all, or dispute the very idea of only two genders’ (Richards et al 2016: 95). Non-binary people are lacking in citizenship rights in most countries across Europe (see FRA 2014) and trans people in general continue to experience human rights abuses (Stock 2015). The structural determinants behind gender binarism can be traced to patriarchal forces (hooks 2004), which are grounded in a socially enforced distinction between ‘male’ and ‘female’. Feminist institutionalism shows how cis females’ unequal social positions are normalised via male-dominated organisations and mechanisms (see Kenny 2014); this process also applies to the normalisation of gender binaries.

Policy makers, practitioners, and those concerned with human rights issues more broadly, need to address the challenges posed by those with gender variant and non-binary identities. This has been recognised since at least 2000, when Monro suggested that ‘...a citizenship-based social model of transsexual and transgender health must be developed, including treatment, where necessary, based on client autonomy and choice’ (2000: 34). In 2003, Monro argued that ‘full transgender citizenship entails fundamental changes in the way that gender is conceptualised by politicians and policy makers’ (2003: 435) and that ‘Full transgender inclusion would appear to entail fundamental changes to the current system of sex and gender categorization, which could be framed in terms of rights and social inclusion’ (2003: 449). This normative approach draws on gender pluralist theory: sex and gender are conceptualised as a spectrum, or continuum, or set of spectra/continua, rather than a discrete male/female binary system (Monro 2005, Van der Ros 2013a). Other approaches can also be used to complement gender pluralist approaches, notably degendering. Building on the work of feminist authors such as Lorber (1993), Monro (2005, 2017) developed ideas of degendering regarding gender diversity, for example the removal of gender markers from official forms and documents.

The last decade has seen increasing attention from many EU Member States concerning the fundamental rights of trans persons. Article 35 of the EU Charter of Fundamental Rights states that individuals are entitled to healthcare, and a high level of human health protection (see also [http://www.europarl.europa.eu/charter/pdf/text\\_en.pdf](http://www.europarl.europa.eu/charter/pdf/text_en.pdf) 2000/C 364/01). In 2015, the Council of Europe passed a resolution addressing breaches in the fundamental rights of transgender people, including requirements to undergo sterilisation and lengthy processes with medical gatekeepers in order to gain legal recognition (Resolution 2048:2015 Discrimination against transgender people in Europe). The resolution supports reforms to enable the legal, political and social recognition of transgender individuals based on self-determination. It encourages countries to consider adopting third options on legal documents, enabling individuals to identify as non-binary (see for example Malta Assembly debate on 22 April 2015, report of the Committee on Equality and Non-Discrimination. Text adopted by the Assembly on 22 April 2015 [15th Sitting]).

In this article, we discuss the ways in which Norwegian non-binary and trans people without a diagnosis are rendered outside of the boundaries of full citizenship, indicating that gender-binaried status underpins full citizenship status in Norway. We demonstrate the evolving situation, in which trans citizenship is developing but full rights for all gender variant people have not been attained. The Norwegian situation can be contextualised in relation to international developments, in which ‘...gender identities outside of the binary of female and male are increasingly being recognised in legal, medical and psychological systems and diagnostic classifications in line with the emerging presence and advocacy of these groups of people’ (Richards et al 2016: 95). The Norwegian political context has specific characteristics, such as a (relatively) high level of (cis) gender equality, a participative democratic culture where affected parties are involved in policy making processes, a corporative culture between labour and capital, and a national self-understanding as a peace loving, egalitarian and humanist population (Van der Ros 2016a). However, gender binarism is highly institutionalised via the Norwegian political and cultural context, including welfare and labour market policies, which are based on nuclear, primarily heterosexual, familial models.

The article shows how the Norwegian state has taken a strongly binaried approach to gender via the medico-legal institutionalisation of transgender policies, and changes to this are analysed in relation to notions of citizenship. It is the state, via the National Registry (which holds key population and citizenship data), that decides the administrative practices required to obtain legal gender change. The Registry demands proof of irreversible sterilisation, to be certified only by the Gender Identity Clinic (GIC), in order to process legal gender recognition. In Norway, gatekeeping of access to gender identity related medical care and legal gender recognition is located in the GIC, which together with the National Registry has taken an independent role towards trans. We understand this institutionalisation of care as embedded in a gender-normative model of citizenship.

The Norwegian community of ‘gender incongruent’ individuals (the official Norwegian terminology for individuals with gender identity issues (Helsedirektoratet 2015, WPATH 2011), is, as elsewhere, a diverse grouping which has internal conflicts. On the one hand, we find those diagnosed with, under examination, or in treatment for, transsexualism (F64.0<sup>1</sup>), together with post-operative transsexuals, referred to as ‘transsexual’ or ‘gender corrected’ women and men (this is the term used by GIC’s patient organisation, the Harry Benjamin Resource Centre (HBRS)). On the other hand, there is a varied group including a) those not acknowledged as transsexual by the GIC, b) those with gender incongruence who are not willing to undergo examination at GIC, and c) trans individuals who define themselves outside of the gender binary or in between gender categories. We use the term ‘gender variant’ when denoting this diverse and considerably larger group (estimated at 0.4-0.5 % of the population, i.e. 15-20,000 persons in Norway (Kuyper et al 2012, Van der Ros 2013a)). The term ‘trans’ is used to denote all transsexual and gender variant people. The term ‘cis’ or ‘cisgender’ denotes the opposite of trans; cispersons experience congruence between gender identity and sex assigned at birth.

We begin the main part of this article by outlining trans citizenship studies and the trans citizenship situation in Norway. The article then provides information about the research methodology. This is followed by a demonstration and critique of the gender binaried nature of the Norwegian approach,

and a discussion of the contested trend towards a more inclusive, non-binariated approach to trans. We recognise that we cannot address all citizenship issues for non-binary people here, such as those concerning socio-economic class (de Vries 2015), immigration and homonationalism (Ammaturo 2015).

### **Transgender citizenship: Background**

Citizenship is a concept ‘encapsulating the relationship between the individual, state and society’ (Yuval-Davis 1997: 4). This article uses and develops trans citizenship scholarship (Monro 2000, 2003, 2005, Monro and Warren 2004, Hines 2013) which has its roots in the sexual and intimate citizenship literature (for example Plummer 1995, Richardson 2000a, 2000b, 2015). In extending notions of citizenship and rights to include bodily autonomy and the transgression of social norms, this literature helps develop understandings of gender binarism and citizenship. The gender normativity found in binariated transsexual citizenship mirrors patterns associated with homonormativity. In other words, normative gays and lesbians ‘dutifully’ occupy the private sphere (see Richardson 2000a: 268), leaving heterosexist family norms undisrupted, whilst the ‘good’ transsexual passes as the woman/man s/he identifies as, leaving gender binariated social norms and structures undisrupted. In contrast, non-binariated trans people and others who visibly transgress gender norms challenge these norms and heteronormativity; they disrupt the assumptions of discrete male/female categories that underpin the institutions of heterosexuality and homosexuality (see Monro 2005).

Some aspects of trans citizenship analysis are shared with feminist approaches, notably a broadening of notions of citizenship to include concerns about the ‘spectre of incorporation’ (Roseneil 2013: 4) (the risk that in gaining citizenship rights, certain groups become assimilated into normative agendas). Notions of differentiated or particularist citizenship, which enable the recognition of trans people as having distinct characteristics and rights claims, also stem initially from feminist analysis (see Monro 2007). However, whilst feminist citizenship scholars are critical of the gender-blindness of conventional approaches to citizenship, they bring their own type of gender-blindness to the debate. The binary gender model, or cisgender model, is implicit in most feminist discussions of citizenship; Sanger observes ‘gender is still understood, both theoretically and culturally, as adhering to the dualism of male/female’ (Sanger 2008: 41). Monro (2005) and Monro and Richardson (2014), as well as Van der Ros (2013b), critique the gender-binariated nature of feminist approaches to citizenship, arguing for the acknowledgement of gender diversity in terms of citizenship claims, rights and obligations.

Despite wider difficulties with feminist citizenship, some feminist approaches are relevant for gender variant citizenship debates. For example, the conceptual toolkit of ‘recognition’, ‘representation’ and ‘redistribution’, developed by feminist political scientist Fraser (1997, 2000), is useful for developing an understanding of the Norwegian situation. Fraser maintains that in order to ensure social justice, as in the just distribution of goods and services, the diversity of groups’ interests must be presented and represented in social policy decision-making (1998). In this paper, we discuss the uneven and changing ways in which Norwegian trans people’s interests and identities are represented within medical and legal policy spheres.

### **Citizenship in Norway**

The overall Norwegian approach to citizenship shapes trans citizenship in Norway. Nordic political cultures and structures build on a corporatist approach to power and influence in policy formation and decision-making processes. This corporate approach has coloured the gender regimes of the Nordic countries. Originally, these regimes consisted of the citizen worker and his family [sic] and ‘Members of the trade unions were until recently the prototypical social democratic citizen’ (Skjeie and Siim 2000: 349). The citizenship model in the Scandinavian countries developed from a male breadwinner model to dual citizenship, including women as citizen workers. Introducing the citizen father as an important agent in the private sphere includes a father’s right to be a caring father, and his obligation to attend to his child for minimum four weeks during the new-born’s first year. Thus, Norwegian state

intervention in family life is more substantial than envisaged in earlier liberal discourses on citizenship suggesting minimum state intervention (Marshall 1950). The Scandinavian model of the state infuses citizenship debates in Norway. Lesbians and gay men are peu-en-peu provided with rights and obligations similar to those of heterosexual citizens, especially when they imitate the nuclear family model; they have obtained both marriage rights and adoption rights. Thus, arguments by authors such as Cossman (2007) that hegemonic forms of heterosexuality underpin the construction of the ‘normal citizen’ are somewhat less relevant in Norway than in other countries. Women and lesbian and gay people have, overall, left the second-class citizenship status to which they were previously (dis)placed. Trans people, however, still hold second-class positions in Norway. Gender nonconforming individuals have no right to health services related to their gender incongruence; this is not based on explicit political decisions but is related to administrative practices which we will explore below. Legislation against discrimination based on gender identity and gender expression did not exist before 2014, due to the political non-recognition of gender variant people. In the hierarchy of minorities, gender variant individuals are in the lower part, while gender corrected women and men, assimilated with the cis majority, are on top (Van der Ros and Motmans 2015). This pattern may also be found elsewhere in Europe, for example Hines points to the UK’s Gender Recognition Act of 2005, arguing that ‘Normative binary understandings of gender that underpin the legislation mean that some trans people are excluded from these new citizenship rights’ (2007: 5). In part, it may be because universalist approaches (Monro 2007) to trans citizenship are in place in Norway that subsume and render less visible the specific needs of non-binary people.

Overall, Norway presents a particular case regarding trans citizenship. There is a national emphasis on modern, egalitarian and humanist political culture, specifically in respect to (cis) gender equality. However, until recently, the Norwegian state has breached the human rights of its trans citizens, of both transsexuals and those with gender variant positions.

## Methodology

The empirical basis for our article is a study of living conditions of trans people in Norway, conducted in 2012 (Van der Ros 2013a; 2017). This qualitative study used focus groups with trans individuals, in-depth interviews with stakeholders, and participatory observation with the trans communities and with policy makers and government officials. Informants were recruited through the three Norwegian trans organisations, FRI (the national Norwegian LGBT organisation) and its youth chapter, the Norwegian Trans Persons organisation (NFTP), and the HBRS who all distributed information about the project on their websites and encouraged their members to participate. Another vital recruitment channel was a low-threshold service centre for trans people, the Stensveen Resource Centre. Informants varied with regard to trans positions and gender identities, age, educational level and profession/work; they came from different regions of Norway and from both urban and rural locations.

**Table 1: Sample characteristics**

	Female to Male FtM	Male to Female MtF	Gender queer, androgynous
Diagnosed F64.0, post-ops and non-ops	4	1	
Not diagnosed (not accepted by GIC and/or not willing to undergo GICs gender treatment regime)	1	8	2
Cross dressing, no treatment needs		3	

We used semi-structured interview guides, and recorded and transcribed the data. The research had a participative element, as research informants were invited to comment on both the transcriptions and

the primary draft of the report. An advisory group, with representatives from the trans organisations, supported the research project, together with members of the funding institution (the LGBT knowledge centre, whose aim is to inform civil servants in regional and local authorities about the challenges the LGBT community face in everyday life).

The research in which this article is based utilised a Participative Action methodology (Reason and Bradbury 2001, Jason et al 2004), as conducted by Van der Ros. This research contributed to renewed public and political attention to trans issues. The launch of the project report (in January 2013) was covered by leading national newspapers as well as national and regional radio stations, and was discussed by the Undersecretary of the Ministry of Health. A few months later, because of the research, the Ministry appointed an Expert Committee to explore provisions of public health services for gender incongruent people and propose alternative organisation models. In addition, the Expert Committee was mandated to recommend changes in the legal gender recognition process, which hitherto requires diagnosis F64.0, surgery and forced sterilisation (Helsedirektoratet 2015). Van der Ros was a member of this committee as expert on trans policy and activism, together with representatives from all three trans organisations as well as Queer Youth, and a number of medical and legal experts. Van der Ros's main task was to highlight the diversity of trans positions and gender identities, the diverse living conditions and serious lack of health services for those falling outside of the GIC's responsibility. The Ministry of Health and Social Care followed up the Committee's recommendations regarding legal gender recognition. In March 2016, a legislative proposal to permit unconditional legal gender change from the age of 16, and from the age of six if one of the parents requests so, was sent to Parliament (Prop. 74 L (2015)). Eventually, Norway got legislation to support legal gender change (Council of Europe 2016). This legislation has been in force from 1 July 2016, and during the first few months 490 trans persons required a change of legal gender.

### **Gender variance in Norway: The medico-legal situation**

As we already have indicated, state medical and legal institutions play a key role regarding trans citizenship in Norway. In this section, we examine the Gender Identity Clinic (GIC)'s role as the central actor in framing and implementing trans policies with regards to access to trans related health care and to legal gender recognition. We discuss areas of human rights concerns for gender corrected women and men, and outline discriminatory practices against gender variant people. For both groups, adherence to gender binarism is a core factor fuelling the lack of citizenship rights.

Access to gender reassignment is controlled by an institutionalised monopoly in Norway. In 2000, the government centralised medical treatment of the rare (defined as under 200 incidents per year in Norway) 'illness' of transsexualism (F64.0/2) to one single hospital in Norway, the University Hospital of Oslo, establishing an expert centre for transsexualism, the GIC. The GIC is the only institution authorised to perform the (rigorous) psychiatric examinations that they deem necessary before the provision of gender reassignment treatment. Roughly, only a quarter of those referred to the GIC yearly obtain status as patients, starting the 8-10 year long transformation towards gender confirmation (compared to clinics in other countries, this is an extremely long process. At the GIC clinic in Amsterdam the process takes 3-5 years). Those dismissed as 'unsuitable' for gender reassignment treatment have neither the option of a second opinion, nor access to health care related to their gender incongruence elsewhere in the public health system. The GIC consolidates its monopolistic power by not acknowledging any external clinician's competence on gender incongruence, arguing that no other medical doctor, sexologist or psychiatrist should have authorisation to prescribe publicly funded treatment or to refer patients to a public health centre for top surgery reconstruction (Helsedirektoratet 2011: 12-13). In effect, the GIC overrules patients' legal rights to a second opinion. It has reported other medics who have advised trans people about gender reassignment to the National Supervising Health Board, which then admonished these doctors to stop practice in this area. The University Hospital doctors are reported to refuse to provide genital reconstruction surgery based on other practitioners' diagnoses. Norwegian Health authorities have permitted the GIC to continue this monopoly, despite evidence of poor practice towards patients, as indicated by quotes from research participants:

*Even when I come in my female [gender] expression, they call me up by my male name. As if they won't acknowledge my gender identity (trans woman in her 30s).*

*I was referred to the clinic in 2003, and it took to 2007 to get the message that I was a gender-disturbed man, not a woman. In the meantime, I was discriminated [against], subjugated, made invisible... I did not exist as a woman for them (trans woman in her mid-40s).*

Another factor relevant to the issue of transsexual citizenship includes age discrimination. The GIC considers age a valid ground for denying treatment: 'early onset' patients (those who experience (and voice) gender incongruence early in life) are prioritised, while 'late onset' ('late' defined by GIC as over 35) is a contra-indication for treatment. Since the GIC rejects three quarters of the referrals, several of those dismissed travel abroad to buy surgical reconstructions (10-15 annually) (Helsedirektoratet 2015).

*I do not want to undergo examinations by the GIC people and be treated badly. I save money and will have my surgeries in Thailand. Besides, I am sure they [the GIC] would tell me I am too old for treatment anyway (trans woman in her late 40s).*

The role of the GIC in Norway is crucial to trans citizenship, because this clinic gate-keeps access to gender reassignment surgery, and surgery and sterilisation have been prerequisites to legal gender recognition. As mentioned earlier, the National Registry demanded (until July 2016) proof of irreversible sterilisation, to be certified by the GIC, in order to process legal gender recognition. Here again, the state sustained the GIC's monopoly position. The GIC guaranteed that people who went abroad for surgical interventions adhered to the sterilisation requirement for legal gender recognition. When, in 2013, the GIC abruptly decided to stop certifying other patients than their own, declaring it was too resource intensive, these citizens were left without access to legal recognition. This affected their citizenship rights profoundly, as the following quote from a research participant demonstrates:

*It was really a hopeless situation. I could not rent a car, or get into my bank account; I had to wait with insurance, and could not go on vacation. I was really afraid of breaking a leg or being hospitalised during that time. I had no legal papers (trans women in her mid-40s).*

The requirement of irreversible sterilisation in order to gain legal recognition has been a severe breach of transsexual people's fundamental rights, and must be understood as adherence to the gender binary system, where only people identifying as female are allowed to give birth, and only those identifying as male are permitted to become fathers. The Norwegian Health authorities were advised by the gender identity team to require irreversible sterilisation as a condition for legal gender recognition in the late 1980s. The argument: '... to avoid the potential calamity of a menstruating man, or even worse, a pregnant man, which would bring the hospital in disgrace' (Helsedirektoratet 2015: 65, our translation). This requirement was institutionalised, without ever being brought to debate in Parliament or tried legally in the Court of Justice (Sørli 2013).

It is troubling, and illustrative of the GIC's use of power, that GIC continued the practice of irreversible sterilisation practice right up until new legislation permitting individuals to 'autonomously decide one's legal gender' was in force since July 1 2016, despite the Health Directorate's order to stop the practice whilst awaiting the new legislation. Norway brought in anti-discrimination legislation concerning gender identity and expression in 2014, and since then several trans activists refusing to undergo irreversible sterilisation pursued a claim of discrimination on the part of the state. The Ombudsperson for gender equality supported their case.<sup>2</sup> However the Ministry of Justice did not, until legal gender recognition was legislated for, support this. The Commissioner of Human Rights of the Council of Europe had earlier warned the Norwegian government that Norway's requirement of irreversible sterilisation constituted a breach of human rights (Hammarberg 2009, 2011).

Gender binarism is extremely apparent in the practice of the Norwegian GIC more broadly, with profound impacts on transgender people not abiding by the binary system. The aim of clinicians at the GIC is congruence between gender identity and bodily features that are unmistakably male or female (Folgerø and Hellesund 2009). Exploiting its monopoly position, medics at the GIC decide the type and order of treatments, mostly applying a ‘one-size-fits-all’ treatment regime. Patients reluctant to follow the recommended treatment of both hormonal and surgical bodily reconstructions are met with suspicion. Reluctance to undergo genital surgery may cause loss of the diagnosis, which implies losing access to any further publicly funded treatment. This has made several non-binary persons back out of the GIC treatment regime. One informant explained: *‘It is not [changing] my lower body that is most important. I want to be able go out in public and go to work in my preferred gender expression.’* A central part of the examination prior to treatment is the Real Life Experience: the minimum one-year living in one’s desired gender expression. The ‘test’ is fundamentally based on the binary gender model, as the patient is expected to adopt a stereotypical male/female identity and expression. Androgynous, non-binary, gender queer or gender independent expressions are not viable options for GIC patients in Norway.

The transsexual and gender corrected community, as organised in the HBRS, has historically supported the monopoly of the GIC. The politico-administrative system has long recognised the HBRS as the only representative for gender incongruent individuals, thus rendering the large diversity of gender variant people and their various needs and interests invisible. HBRS represents only the interests of those with a transsexualism diagnosis from the GIC, and of gender corrected women and men. They declare on their website that: ‘We are not trans or transgender’ and ‘...we do not want to destabilise the gender binary.’ For the HBRS, lobbying practices ensured generous public funding as a named recipient in the national annual budgeting processes. This funding provides the organisation with two full time posts. The organisation focuses on ‘this very small and extremely vulnerable group’ (HBRS no date) who feel ‘born in the wrong body’. It supports conventional ‘correction’ treatment at the GIC, cementing the gender binary, and disregarding the plurality of gender identity positions. HBRS does not deny the existence of non-binary and gender variant trans identities, but keeps explicit distance; they are not represented in the HBRSs’ relations with the state.

To summarise, in this section of the paper we have shown that the GIC has a monopoly on the health care of trans people in Norway, and until recently (July 1, 2016) on access to legal recognition or rejection of their gender identities of choice as endorsed by the National Registry who administers the legal status of trans individuals. This monopoly acts ‘against’ those diagnosed with other forms of gender incongruence (F64.8 or F64.9)<sup>3</sup> than ‘real’ transsexualism, and excludes those who do not want the gender correction treatment of the GIC. The gender binaried HBRS was the only organisation recognised as the legitimate representative on the political arena for persons with gender identity issues. This organisation has close cooperation, shared understandings and common interests with the GIC. The perpetration of permanent sterilisation by the GIC, in order to maintain rigid gender binaries, has been a particularly sharp demonstration of human rights breaches.

We interpret the powerful position of the medical-legal complex in Norway (see Davy 2011) in the vocabulary of the heteronormative gender binary model. The conventional medical understanding of patients with gender identity issues is based on this model, and thus the GIC dismisses gender variant persons who express their gender identity outside of the binary. Their gender identity issues do not receive attention nor treatment at the GIC, and no other public health care service has authority or competence (according to the GIC) to provide gender dysphoria/gender incongruence related health care. The following quote from a research participant illustrates this problem:

*With the F64.8 diagnosis you get nothing, you are out. They [GIC] tell you to get back to the DPS [the district psychological services]. If you do so, they [DPS] do not know how they should help you. They have no idea! (Non-binary person in their early 20s)*

The strong medico-legal influence on Norwegian trans politics can be visualised in an ‘Iron Triangle’ (Van der Ros 2016b). Earlier in the article, we mentioned the corporate culture in Norwegian politics, where state officials together with experts and affected parties contain the power of policy framing,



and for some policies, of implementation as well. The Norwegian political science literature (Egeberg et al 1978) describes access to, and tight cooperation within this corporate system as an iron triangle, indicating that not all affected parties are ensured access, and denoting the intimate relations between actors in the different corners of the triangle. In order to understand how GIC, together with HBRS, has been able to gate-keep the framing and implementation of trans related policies, and has managed to stop and distort claims and critique from patients and other doctors; we considered the iron triangle as illustrative for this policy area. In the case of trans health care policies, medical experts dominate the discourse, assisted by those who manage to be invited as ‘affected parties’, which until recently has been only the HBRS. Using Fraser’s conceptual framework (1997, 2000), other trans groups have not gained *recognition*, and have thus not been offered *representation* in the triangle; consequently, the various needs of these groups have not been not taken into account in the *distributive* policy processes such as healthcare provision.

By marginalising gender choices other than male/female, the GIC has been a central agent in maintaining the power of the conventional gender discourse and related social and political structures. The human rights issues of transgender people are discounted, including their needs for treatment other than full gender reassignment treatment. This ‘mal’-recognition (Fraser 1997, 2000) has led to lack of public health care services for gender variant individuals, and has rendered them outside of the iron triangle, and consequently outside of the remit of full citizenship.

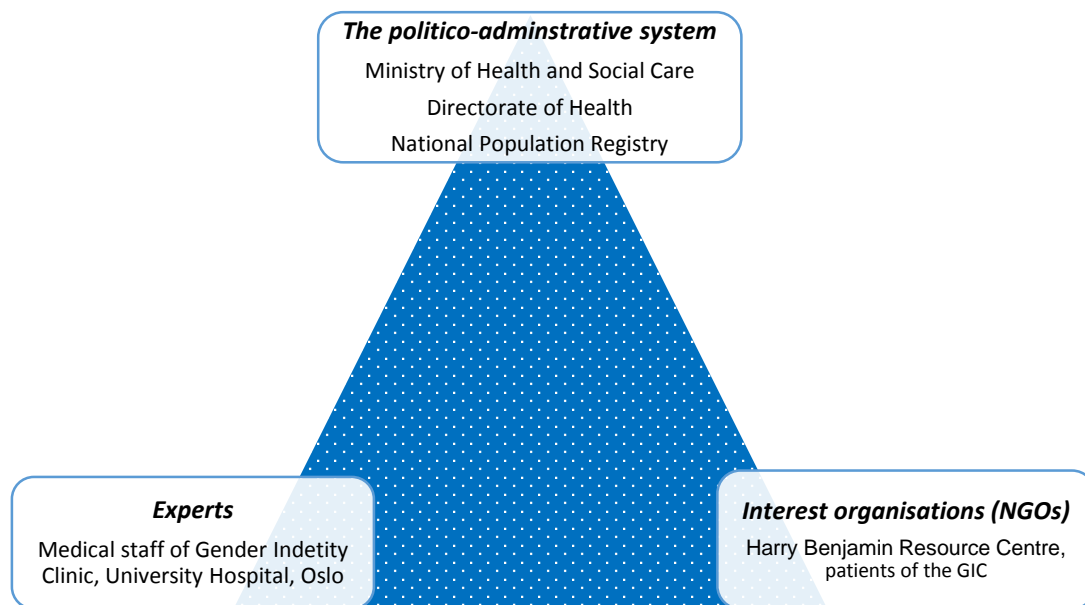


Figure 1: The medical-legal trans policy power triangle – prior to 2009.

### Towards Norwegian trans and gender variant citizenships

There have been, and continue to an extent to be, divergences between the citizenship statuses increasingly afforded to gender corrected men and women, and the exclusion from citizenship rights that gender diverse and people with non-binary identities face. As indicated above, the trans community in Norway is a divided one; with 1) those who want to ‘pass’, blending in with the cis majority, and 2) those who cannot or do not wish to pass and others who want to be ‘out and proud’ as trans, gender variant, or non-binary. The first group is acknowledged by the state, as individual (male and female) citizens who pass in society as ordinary ‘non-disturbing’ citizens, and as members of a specific trans(-sexual) community. In contrast, the lack of recognition of the gender variant communities has been detrimental, since their various interests were, until recently, kept invisible or silenced, and were thus discounted in the (re-) distribution of public funding.

The situation regarding transgender citizenship in Norway is changing, contested, and evolving. In 2015, the Norwegian Expert Committee addressed most trans citizenship claims, recommending decentralisation of gender identity related health care services and abolishing GIC's monopolistic authority by reducing its tasks to rare endocrinological cases and genital reconstruction surgery, ending forced sterilisation, and legislating free and independent legal gender recognition. In the same year, a majority in the Norwegian Biotechnology Advisory Board proposed to equalise the rights to reproductive assistance for gender variant individuals with cis gender persons. Regarding legal gender recognition, the Ministry of Health decided against the Expert Committee's recommendation to explore a third alternative of legal gender, and Parliament supported this decision. Thus, the binary gender system stays intact, reducing trans choices for legal recognition to male and female only. '*It is not this government's policy to investigate or establish a third gender alternative*', the Minister of Health said in a comment to the LGBT movement's newspaper. He argued that such investigation would have slowed down the process of legal gender recognition and that the issue had not been high on the agenda of political parties, thereby framing it as the responsibility of party political actors (Blikk, March 10, 2016). Since this development, the Labour Party has put the issue on its political programme for 2017. Public discussions indicate ambivalence towards gender variant individuals' rights being placed on a par with conventionally gendered citizens in Norwegian society; the earlier cited medical doctor's fear of a 'pregnant man' is still present (Ytring 2015).

In Norway, there have been calls for comprehensive trans health care services to be provided elsewhere than through the GIC (Daniel and Butkus 2015, Van der Ros 2013a, 2016a, 2017). These have been underlined by the Expert Committee in Norway, and will be followed up, according to the Ministry of Health. The Health Minister has ordered the Directorate of Health to work out national standards of care and to cooperate with regional health care institutions in investigating regional competence on trans health issues. The trans community hopes for more support for trans individuals to decide for themselves the degree of bodily changes that they feel are needed to appear as the gender /non-gender /bi-gender identity they want to express. For some this will imply genital reconstruction, whilst for others hormone treatment or some slight facial changes may be sufficient. The right to different forms of health care for gender variant people is implicit.

An important aspect of developing models of trans citizenship in Norway is to acknowledge the diversity of identities, needs and interests in the trans communities. We have already pointed out some of the tensions, as well as crosscutting issues such as the damaging effects of the medically and legally imposed rigid gender binaries. One way to address these challenges is via a genuinely participative democratic turn in Norwegian trans policy making. Participatory democracy involves mechanisms for citizens to 'make a difference' in other ways, such as by taking part in policy consultations, or partnership work between the voluntary and statutory sectors (Held 1995). A participative democratic turn would, following Fraser (1998), imply recognition of the large variety of trans identities and political representation to voice the different groups' own interests. Differentiated citizenship models (Monro 2007) are relevant here, as they support the citizenship of those with a wide range of gender variations.

The institutionalisation of gender binarism can be challenged via claims for gender-diverse citizenship. Feminist institutionalist approaches (Kenny 2014) can be used to form a future basis for trans and non-binary institutionalism, including work that exposes the medical sedimentation of gender binarism. The policy implications for the Norwegian context include a need to dismantle the GIC monopoly on trans medical provisions (as discussed above), so that other qualified medics (regional, national and international) are able to have a say in the gender discourse and offer care, and state support for the establishment of trans community organisations, with representatives that include the range of gender positions (see Monro and Warren 2004). As we have indicated, this has, to some degree, started happening in Norway. For example, challenging the HBRS and its gender binaried position, the LGBT organisation, FRI: the Association for gender and sexual diversity has since 2008 included trans policy issues in its program, and claimed political space for other groups in the gender variant spectrum (Van der Ros and Motmans 2015). FRI's representation of trans issues has gradually brought political recognition of gender variant groups different from transsexuals, with other needs

and interests, although it has taken time for FRI to be acknowledged as a legitimate representative of the gender diverse community's interests by the health authorities (as well as by some trans groups). The emphasis on variable, democratically mediated approaches to trans citizenship is crucial, as the field is conflictual and under development.

The changes that Norway has seen during the last four-five years indicate a more inclusive trans citizenship and the institutionalisation of trans policy. This, we argue, is one of the effects of new actors accessing the political system, and the inclusion of other experts in trans policy framing processes. The original iron power triangle on trans policy (figure 1) has been dismantled, and changed into what we may call a 'velvet triangle' (Woodward 2003). This is visualised in figure 2. Legal experts and other medical doctors in addition to GIC were included in the Expert Committee; since 2014 all trans organisations have been invited to participate in policy framing, voicing other concerns than the ones presented by HBRS. The LGBT Knowledge Centre, an official institution with explicit aims to recognise and include all gender and sexual variant groups, has entered the politico-administrative system in the top corner of the triangle. In all three corners earlier unrecognised and unrepresented voices and knowledge have obtained access and voice (Van der Ros 2016b).

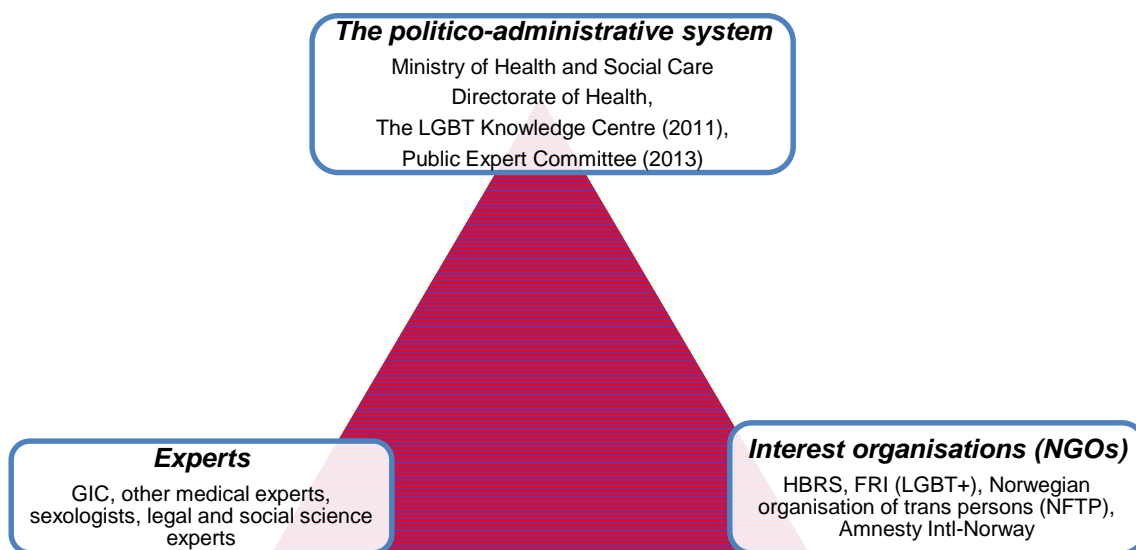


Figure 2: The velvet trans policies power triangle, post 2009.

Given the continued marginalisation of Norwegian trans people who do not fit neatly into gender binaried norms, we contend that there is a need for a revised model of citizenship using a gender pluralist (spectrum) ontological framework (Monro 2005). This will be '... based on the principles of equality, diversity and the right to self-determination' (Monro 2000: 439). Key aspects of Norwegian non-binary trans citizenship claims will include the provision of third/other options on forms (where gender identification is deemed necessary) and support for non-binary pronouns such as 'ze', which Sweden already has brought into its vocabulary with 'hen'. We observe indications that gender-variant citizenship models are emerging, for example, a national committee investigating a new national identity system (suggesting a new social security number system) in Norway has suggested genderless identification numbers in the future. One of its arguments concerns gender variant people and problems related to legal gender change. The committee has also pointed to the other European countries which use or are considering genderless identity numbers, for example Germany in relation to intersex babies (see Konseptvalgutredning 2014: 24). It is worth noting that some Asian and south pacific countries, including Nepal, Pakistan, India, Bangladesh, New Zealand and Australia have introduced a third, gender neutral and non-specific gender. Overall, Norwegian people with gender variant and non-binary identities require reproductive rights in line with the rest of the population, in line with broader international developments. Norwegian trans citizenship will diversify family forms and include the possibilities of pregnant men, androgynes, and non-binary people in Norway. In addition, the ability to be 'out' and publicly visible is '...crucial to the ability to claim rights'

(Richardson 2000a: 120), so that robust policy interventions are necessary to ensure safety and freedom from discrimination.

### **Concluding remarks on trans and gender variant citizenships**

The Norwegian trans and gender variant situation raises some broader issues about citizenship and diversity. Gender pluralism need not pose any threat to people with conventional gender identities, nor to the institutions of family and heterosexuality. It simply implies the broadening of social options to include non-binary people (see Monro 2005). However, gender pluralism does destabilise the hegemonic position of gender binarism, potentially presenting a site of resistance to the Norwegian gender-binaried model of citizenship and the organisation and ideology of the welfare state. A complementary position (Monro 2005), concerns degendering; this would entail policy interventions to remove gender identifiers from legal, bureaucratic and other systems. We question the necessity of gender identification, specifically in countries such as Norway, where same-sex relations are equal to heterosexual marriages, and seek clarity concerning the circumstances under which gender identification is necessary as a basis for gaining citizenship rights.

Citizenship rights are relevant to gender corrected women and men, transsexual and gender variant people, albeit with possibly different implications. Some forms of citizenship rights that are sensitive to gender variance can be seen as universal (Monro 2007). Monro and Warren's baseline concerns the rights to freedom from psychiatric diagnosis concerning gender identity and to 'appropriate medical care, the right to equality of employment, the right to freedom from harassment and abuse, the right to self-expression and rights to relationships and parenthood' (2004: 350). In terms of personal autonomy, citizenship requirements include legal recognition as the gender of choice, which is broader than two options of male and female, and which does not have requirements of gender reassignment surgery or a medical diagnosis. These citizenship claims will need to be further developed. Following Fraser (2000), political recognition of the diversity of gender identities is required, followed by political representation, such as the establishment of mechanisms to ensure that divergences and conflicts regarding rights claims are played out within the democratic political sphere, to ensure just and equal (re-)distributions of public resources.

As this article has indicated, differentiated citizenship rights are important for non-binary and other gender diverse citizenship claims. Differentiated trans citizenship could develop into a form of gender super-diversity, mirroring the super-diversity discussed by Phillimore (2010) in relation to immigration and welfare provision. A central issue with regard to differentiated rights, for gender variant persons and other groups, is that such rights not impede other people's autonomy, self-expression and self-determination (Human Rights Watch 2016). As Monro and Richardson argue, 'The balancing of the needs of diverse groups against the good of the whole is an important theme for transgender citizenship' (2004: 358).

### **Endnotes**

1. As defined in WHO's International Code of Diseases (ICD 10) under the chapter of mental health diseases as F64.0 for adolescents and adults and F64.02 for children. ICDData.com <http://www.icd10data.com/ICD10CM/Codes/F01-F99/F60-F69/F64-> (last accessed 18.7.17).
2. Case nr. 14/840 Discrimination based on gender identity <http://www.ldo.no/nyheiter-og-Afag/klagesaker/2014/18840-diskriminering-pa-grunn-av-kjonnsidentitet/> (last accessed 18.7.17).
3. F64.8 is defined as other gender identity disorder (than transsexualism) and F64.9 as an unspecified gender identity disorder. In the US these are billable/specific ICD-10-CM codes that can be used to indicate a diagnosis for reimbursement purposes.

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