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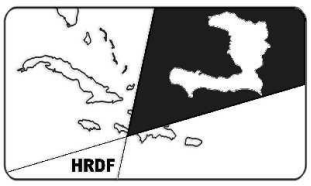

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THE MASSIMADI SPIRITS AMONG US

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I. HAITI'S MASSIMADI

Late last September, forward-thinking Haitians planned a "MassiMadi" [homosexual] Afro-Caribbean cultural festival in Port-au-Prince. Their goal was to recognize and celebrate the diversity of gender identification and sexual preferences in Haiti, in the tradition of similar festivals held in other parts of the world, beginning in Canada in 2009.

But the well-laid plans soon became a hot topic in the capital city and across the country. Even peasants from Aquin's far away third communal section rose in opposition. And when Port-au-Prince local commissioner Jean Danton Léger decided to block the festival on a complaint from Senator Jean Renel Senatus, claiming that the event would undermine morals and public order, the American embassy fired back a terse retort and reminder:

"The U.S. Embassy in Port-au-Prince deeply regrets the circumstances leading to the postponement of the MASSIMADI Festival and condemns discrimination, intimidation and threats of violence in any form. Haiti has a long tradition of tolerance and has undertaken international commitments to respect the rights of all individuals. The United States supports the human rights and fundamental freedoms of all people, allowing them to live peacefully and lawfully without fear of oppression, violence or penalty regardless of their race, color, gender or sexual orientation.

The embassies of Canada and France echoed the American reaction, but ultimately the organizers cancelled their four-day film, art and performance festival, citing threats of violence and government opposition. News of this culture clash quickly reached international media and spread across the world.

I was in Haiti while this was happening and then returned home to Weston, Florida on the 30th of September, thinking I'd have a breather from this hullabaloo. Then, Flash! From the frying pan into the fire! My television blared, "Alabama Supreme Court Chief Justice Roy Moore has

been suspended for defying the rule of the Supreme Court of the United States that gay marriage is legal." Apparently, the spirits of sexual attraction and sex identification had seats on my flight back to the States. Or they may have already resided in Alabama before my arrival.

II. DEFINITIONS

Before proceeding, some definition of terms.

1. Today, there is a worldwide movement to acknowledge and respect equal rights of those who are of lesbian, gay, bisexual, transsexual [transgender] and indeterminate sexual status. The basis for this is the guarantee of nondiscrimination and universal rights for all humans, including the minority who may not sexually prefer the opposite gender or who may not psychologically identify with the physical gender of their birth. From the recent uproar in Haiti, it is clear that the majority does not yet afford such rights to everyone. This majority will even threaten violence to maintain its prejudice and to reject and fear the fact of human diversity.

2. Further, in Haiti, transsexual [transgender] and gay [homosexual] are considered synonymous.

3. Strictly speaking, however, transsexual and gay are not synonymous because they have distinctly different frames or reference. The first refers to how one regards oneself, while the second refers to how one regards someone else. This should not be confused. Further, because of the different frame of reference, one can be transgender without being gay, and one can be gay without being transgender.

4. Gay [homosexual] is a matter of predominant sexual attraction to others of the same gender. Gay men predominantly prefer sex with other men, and gay women [lesbians] predominantly prefer sex with other women.

5. On the other hand, transgender is a matter of sexual self-regard. Transgender persons regard themselves as opposite in gender to how they were physically born. Transgender females regard themselves as women despite being born physically as male, and transgender males regard themselves as men despite being born physically as female.

6. Modern medicine and psychology have made it possible for transgendered persons to become the gender of their self-regard.

III. RECOGNITION OF TRANSGENDER

To continue with my story, I am a gynecologist who has had transgendered patients during my professional career. I would like to share and clarify what I have learned about them and from them over the years, and how this has shaped my attitudes and advice about gender diversity, sexual attraction and self-regard. Some of what follows is excerpted from a continuing education course for physicians, "Clinical Care of the Transgender Patient." I recommend this course to health providers to improve their cultural competency. An online version is at http://www.netce.com/coursecontent.php?courseid=1227

Transsexualism, also known as transgenerism, transgenderism, transgenre and "variance of genre," has been recognized and recorded since antiquity. In the late 1800s, the psychiatrist Richard von Krafft-Ebing was the first to write about what he called "gender nonconformity" in his book, Psychopathia Sexualis [Sexual Psychopathy: A Clinical-Forensic Study] See

https://ia601408.us.archive.org/26/items/psychopathiasexu00krafuoft/psychopathiasexu00krafuoft.pdf Based on more than two hundred case studies of human sexual practices, it was one of the first books to include the subjects of homosexuality and bisexuality. According to the Wikipedia summary, https://en.wikipedia.org/wiki/Richard_von_Krafft-Ebing Krafft

"Ebing considered procreation the purpose of sexual desire and that any form of recreational sex was a perversion of the sex drive... Hence, he concluded that homosexuals suffered a degree of sexual perversion because homosexual practices could not result in procreation. Krafft-Ebing's conclusions about homosexuality are now largely forgotten..."

By 1970, some universities in the United States such as Johns Hopkins and Stanford had gender identity clinics. Estimates of the occurrence of transsexualism – 1 in 2,900 males and 1 in 8,300 females - possibly comes from a retrospective study in New Zealand where, since 1995, passport holders, depending of their sexual orientations, could omit mention of their gender in their passports.

A discordance between gender identity and biological gender can occur, and can frequently cause much distress and suffering. This "gender dysphoria" can have several origins such as intrauterine hormone exposure, childhood psychological factors, anatomic differences in brain structure and activation, and subtle genetic variations.

IV. SELECTED PHYSIOLOGY

The developmental physiology of gender has been studied. For example, in the human brain, we have learned that signs of gender differences reside in the central region of the bed nucleus of the *stria terminalis,* a band of fibers running along the surface of the thalamus. See https://en.wikipedia.org/wiki/Stria_terminalis When stimulated by male hormone, this structure becomes more developed in males than in females.

Moreover, the brains of "cisgender" men (those born as physically male and who strongly regard themselves as such) have significantly more somatostatin neurons in the bed nucleus of the *stria terminalis* than the brains of "cisgender" women (those born as female and who strongly regard themselves as such). However, the size of the *stria terminalis* in male-to-female (MTF) transsexuals [i.e. transgendered females] has been found to be the same as in biological females, and the number of the somatostatin neurons in the brains of MTF transsexuals are statistically similar to that of cisgender women. And vice-versa, the numbers of somatostatin neurons in female-to-male [FTM] individuals were in the male range.

It is conjectured that these variances are the result of the developing brain during pregnancy when exposed to androgens (male hormones). Thus, a lack of exposure to androgens in a male fetus, at this critical time of development, would cause MTF transsexualism, and conversely, exposure to androgens in a female fetus would result in FTM status.

Moreover, the cerebral blood flow examination of FTM individuals with computerized tomography show a significant decrease in the regional cerebral blood flow in the left anterior *cingulate cortex* and a significant increase in regional cerebral blood flow in the right insula compared with control groups. Scientists hypothesize that the regional cerebral blood flow changes in the anterior *cingulate cortex* and in the *insula* affect the neuron networks that play a key role in human sexual behavior and consciousness, and in turn may be a biological basis of gender dysphoria.

V. MEDICAL AND HEALTH TREATMENT

The medical treatment of gender dysphoria (as well as the medical assistance available to transgendered persons who desire a "sex change") is complex and multidisciplinary. It requires and may combine a) knowledge of anatomical reassignments, b) cultural sensitivity, c) accurate diagnosis, d) psychotherapy or counseling, e) hormone therapy, f) "real-life experience" of the individual in the desired gender, g) cosmetic interventions (e.g., epilation of the beard and other unwanted hair for the male-to-female patients, and in some cases h) voice therapy and i) surgical interventions.

In the case of MTF individuals, for example, some common surgery may include breast augmentation, facial feminization surgery, tracheal shave, genital surgery such as orchiectomy (surgical removal of the testicles), penectomy (surgical removal of the penis) and clitoroplasty (surgical reduction and shaping of a penis to resemble a clitoris)

The surgical procedures commonly sought by FTM individuals include bilateral mastectomy and chest reconstruction, bilateral salpingo-oophorectomy, hysterectomy, metoidioplasty (surgical separation of the *clitoris* from the *labia minora* to lower it to where a penis would usually be), phalloplasty (plastic surgery performed to construct, repair, or enlarge the penis), scrotoplasty (surgical construction of a scrotum), testicular implants, vaginectomy (surgical removal of the vagina) and liposuction to reduce fat in the hips, thighs and buttocks.

VI. VULNERABILITY OF TRANSGENDER

In the United States, comorbidities are common among the transgender population. For example, HIV infection rates have been reported at 28%, over four times the national average. Transgendered Americans are also at high risk for sexually transmitted infections (such as syphilis, gonorrhea, chlamydia, herpes, and human papilloma virus), smoking, drug and alcohol addiction, and depression. Suicide attempts have been reported at 41%, compared to 1.6% in the general population. Prostitution among transgendered women has been reported at 11% compared to 1% in the general population. It has been reported that 717 transgendered persons have been murdered from 1970 to 2012.

When they become sick or injured, many transgendered persons fear to contact health providers and may postpone their medical care due to actual or expected discrimination against them by medical professionals and staff. Further, the difficulty in finding knowledgeable and emphatic health care providers has resulted in a) higher costs for their care, b) a lucrative market for illicit hormone suppliers and c) networking systems to identify and distinguish between compassionate versus reluctant healthcare providers.

VII. LIVES OF TRANSGENDER

A difficulty for transgenders is the discordancy between their physical gender at birth and the sex with which they identify as their life proceeds. Many transgenders often try to conform to the social gender expectations of their birth sex. Some MTF individuals marry, raise families, and generally live their lives in conformity to the expectations of the male role. Some FTM persons may conceal their gender identity by living as lesbians, thus making the gender variance among FTMs "relatively invisible" in society.

Once they disclose their transgender status, these individuals may face serious challenges. They may become victims of physical (26%) and psychological (78.1) violence. They may be sexually assaulted (10%), lose their romantic relationships, lose their jobs (26%), experience abuse, become harassed or discriminated against at work (97%). They may suffer from anxiety, depression and guilt, and have thoughts of suicide.

On the other hand, there can be positive effects in living “authentically” in their chosen gender. Expectations of positive effects may motivate many transgenders to disclose their sex identity and then integrate this gender awareness into their daily lives.

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http://lenouvelliste.com/lenouvelliste/article/164702/Avez-vous-bien-dit-Massimadi
October 26, 2016

Avez-vous bien dit « Massimadi » ⚧?

Une manifestation culturelle « massimadi » programmée à Port-au-Prince faisait la une dans l’opinion publique haïtienne, depuis les paysans de la troisième section communale d’Aquin s’opposant à une telle manifestation jusqu’à l’ambassade des États-Unis d’Amérique appelant au respect des droits des lesbiennes, gays, bisexuels, transsexuels et intersexes (LGBTI), en passant par la décision d’interdire le festival par le commissaire du gouvernement, Jean Danton Léger pour « atteinte aux mœurs et à l’ordre public ». De retour chez moi à Weston en Floride, le vendredi 30 septembre 2016, je m’apprêtais à prendre un répit de ce tollé. Flash ! Je tombe de Charybde en Scylla ! « Le président de la cour suprême d’Alabama, Roy Moore, a été, ce même vendredi, suspendu de son poste pour avoir défié la Cour Suprême des Etats-Unis sur le mariage homosexuel … ».

En tant que gynécologue, j’ai traité au cours de ma carrière professionnelle des personnes transgenres. Le terme « transgenre » se réfère à tout individu - homosexuel, lesbienne, transsexuel, troisième sexe, intersexe - qui rejette en tout ou en partie son identité de genre assignée à sa naissance ou qui ne s'identifie pas aux règles des genres masculins et féminins traditionnels.

Le transsexualisme (transgénérisme, transgendérisme, transgenre, variance de genre) a été enregistré depuis l'antiquité. En 1886, le psychiatre Richard Von Krafft-Ebing était le premier à décrire la non-conformité de ces variances de genre dans son livre, Psychopathia Sexualis. Dans les années 1970, certaines universités aux États-Unis, telles que Johns Hopkins et Stanford avaient des cliniques d'identité de genre. L'estimation la plus précise de la prévalence du transsexualisme, 1 pour 2900 hommes et 1 pour 8.300 femmes, vient d’une étude rétrospective effectuée en 1995 en Nouvelle-Zélande, où les détenteurs de passeports, dépendant de leurs orientations sexuelles, pouvaient omettre d’y mentionner leur genre.

La discordance entre l'identité du genre et le sexe biologique qui souvent provoque chez les personnes transgenres beaucoup de détresse et de souffrance (dysphorie de genre) a une étiologie multifactorielle, telle que l'exposition intra-utérine aux hormones, les facteurs

psychologiques de l'enfance, les différences anatomiques dans la structure du cerveau, l'activation du cerveau et les variations génétiques subtiles.

Par exemple, dans le cerveau humain, les différences liées au sexe se trouvent dans la région centrale du noyau de la strie terminale. Cette structure, quand elle est stimulée par les hormones masculines, est plus développée chez les hommes que chez les femmes. En plus, les cerveaux des cis-genres males (type d'identité de genre où le genre male ressenti par une personne correspond au genre male qui lui a été assigné à la naissance) avaient significativement plus de neurones de somatostatine dans le noyau de la strie terminale que dans les cerveaux de cis-genres femelles.

Néanmoins, il a été observé que la dimension de la strie terminale de l'homme-vers-femme transsexuel a la même dimension que chez les cis-genres femmes ainsi que le nombre des neurones somatostatine dans le cerveau de l'homme-vers-femme est statistiquement égal à celui des cis-genres femmes. Vice-versa, le nombre de neurones de la somatostatine d'un individu femme-vers-homme équivaut à celui des cis-genres hommes. De ce fait, on conjecture que ces variances sont les résultats de l'exposition aux androgènes (hormones masculines) dans le développement du cerveau pendant la grossesse. Ainsi, un manque d'exposition aux androgènes dans un fœtus de sexe masculin au moment critique du développement du cerveau entraînerait un homme-vers-femme transsexuel, et inversement, l'exposition aux androgènes dans un fœtus de sexe féminin se traduirait par le statut de femme-vers-homme.

En plus, l'examen du flux sanguin cérébral chez les individus femmes-vers-hommes par la tomographie assistée par ordinateur a montré une diminution significative du débit sanguin cérébral régional du côté gauche du cortex cingulaire antérieur et une augmentation significative du débit sanguin cérébral régional dans l'insula droit par rapport aux groupes témoins. On suppose que les changements régionaux de flux sanguin cérébral dans le cortex cingulaire antérieur et l'insula non seulement affectent les réseaux de neurones actifs dans le comportement sexuel humain mais aussi peuvent contribuer à une base biologique de la dysphorie de genre.

La prise en charge médicale des personnes transgenres nécessite une approche multidisciplinaire complexe qui comprend une connaissance de la modification des structures anatomiques, la sensibilité culturelle, un diagnostic précis, la psychothérapie ou le counseling, la thérapie hormonale, une expérience de vie réelle de l'individu dans le genre désiré, des interventions cosmétiques (par exemple, l'épilation de la barbe et autres poils non-désirés pour le patient homme-vers-femme) et dans certains cas, le traitement de la voix et les interventions chirurgicales.

Dans les cas de patients hommes-vers-femmes, certaines interventions chirurgicales courantes comprennent l'augmentation mammaire, la chirurgie de féminisation du visage, le rasage de la trachée, la chirurgie génitale y compris l'orchidectomie (ablation chirurgicale des testicules), la pénectomie (l'ablation chirurgicale du pénis) et la clitoroplastie (réduction chirurgicale de la taille du pénis afin de simuler un clitoris).

Les interventions chirurgicales couramment recherchées par les patientes femmes-vers-hommes comprennent la mastectomie bilatérale (ablation des seins), la reconstruction de la poitrine, la salpingo-ovariectomie bilatérale, l'hystérectomie, la métaoidioplastie (séparation chirurgicale du clitoris des petites lèvres afin de le ramener à la position approximative de pénis), la phalloplastie (fabrication chirurgicale d'un pénis), la scrotoplastie (construction

chirurgicale du scrotum), les implants testiculaires, la vaginectomie (l'ablation chirurgicale du vagin) et la liposuccion pour réduire la graisse dans les hanches, les cuisses et les fesses. Des comorbidités sont habituelles parmi la population transgenre aux Etats-Unis: taux d'infection au VIH de 28%, plus de quatre fois la moyenne nationale - risque élevé pour les infections sexuellement transmissibles, telles que la syphilis, la gonorrhée, la chlamydia, l'herpès et le virus du papillome humain – tabagisme, consommation de drogues et d'alcool et dépression - tentatives de suicide de 41% par rapport à 1,6% de la population générale - 11% des femmes se livrent à la prostitution contre 1% de la population générale - 717 meurtres documentés entre 1970 et 2012.

Beaucoup de transgenres craignent de contacter les prestataires de la santé lorsqu'ils sont malades et diffèrent leurs soins médicaux en raison de discrimination. La difficulté à trouver des professionnels de la santé empathiques et bien informés a entraîné une augmentation appréciable du coût de leurs soins médicaux, un marché pour les fournisseurs d'hormones illicites et des systèmes en réseau pour identifier les professionnels de la santé qui les acceptent ou les rejettent.

La difficulté pour les transgenres est qu'il existe une incompatibilité entre leur identité de genre et leur sexe de naissance. Beaucoup de transgenres tentent souvent de se conformer aux attentes de genre social de leur sexe de naissance. Certains individus hommes-vers-femme se marient, ont une famille et mènent généralement une vie en conformité aux attentes de leur rôle masculin. Les individus femmes-vers-hommes peuvent dissimuler leur identité de genre en menant une vie de lesbiennes, ce qui rend la variance de genre parmi elles relativement invisible dans la société.

Une fois leur statut transgenre divulgué, ces individus peuvent confronter des défis graves : devenir des victimes de violence physique (26%) et psychologique (78.1 de%) - être agressés sexuellement (10%) - perdre leurs relations sentimentales - perdre leur emploi (26%) - subir de mauvais traitements, du harcèlement ou de la discrimination au travail (97%) - souffrir d'anxiété, de dépression et de sentiment de culpabilité - ruminer des idées suicidaires. Cependant, les effets positifs potentiels de mener une vie authentiquement désirée motivent beaucoup de transgenres à divulguer leur choix et intégrer dans leur vie quotidienne des comportements de genre mâle ou femelle différent de leur sexe de naissance.

Cet article est une récapitulation du cours de formation médicale continue sur les soins cliniques du patient transgenre. Ce cours est fortement recommandé aux prestataires de la santé pour parfaire leur compétence culturelle.

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