Notice of Emergency Rule

DEPARTMENT OF HEALTH
Board of Medicine
RULE NO.: RULE TITLE:
64B8ER23-3 Sex-reassignment Prescriptions

SPECIFIC REASONS FOR FINDING AN IMMEDIATE DANGER TO THE PUBLIC HEALTH, SAFETY OR WELFARE: On May 17, 2023, Florida Governor, Ronald DeSantis, signed CSSB 254 into law creating Ch. 2023-90, Laws of Florida and section 456.52, Florida Statutes. Pursuant to section 456.52(1), F.S., sex-reassignment prescriptions are prohibited for patients younger than 18 years of age upon the effective date of the act; however, pursuant to section 456.52(1)(a), F.S., the Board of Medicine shall within 60 days after the effective date of the act, adopt emergency rules pertaining to standards of practice by which minors may continue to be treated if such treatment was commenced before, and is still active on, the effective date of the act. Section 456.52(1)(b), F.S., also provides a minor patient meeting the criteria outlined in section 456.52(1)(a), F.S., may continue to be treated by a physician with such prescriptions according to rules adopted pursuant to paragraph (1)(a).

Further, pursuant to section 456.52(2), F.S., if sex reassignment prescriptions or procedures are prescribed for or administered to patients 18 years of age or older, consent must be voluntary, informed, and in writing on forms adopted in rule by the Board of Medicine. Pursuant to section 456.52(4), F.S., the consent required for sex-reassignment prescriptions does not apply to renewals of sex-reassignment prescriptions if a physician and his or her patient have met the requirements for consent for the initial prescription. Section 456.52(6)(a), F.S., states "[t]he Board of Medicine and the Board of Osteopathic Medicine shall adopt emergency rules to implement this section."

Accordingly, the Board of Medicine, by emergency rule, hereby allows a patient's prescribing physician to renew a prior lawfully issued sex-reassignment prescription that was initially prescribed prior to May 17, 2023, up and until six months from the effective date of the Board's emergency rule that formally adopts the required consent forms pursuant to section 456.52(1) and (2), F.S.

*** This emergency rule does not apply to Susan Doe, Gavin Goe, or Lisa Loe, or their parents or healthcare providers (see Jane Doe et al., v. Joseph A. Ladapo, et al, Preliminary Injunction, Filed June 6, 2023, Case No. 4:23cv114-RH-MAF, United States District Court for the Northern District of Florida). ***

REASON FOR CONCLUDING THAT THE PROCEDURE IS FAIR UNDER THE CIRCUMSTANCES: The procedure used for the promulgation of this emergency rule is fair under the circumstances. CSSB 254 was signed into law on May 17, 2023. The Board of Medicine was contacted by multiple licensed physicians and physician groups seeking clarification regarding the exception contained in section 465.52(4), F.S., and a timeframe for the required emergency rules shortly thereafter. In response, the Board of Medicine and the Board of Osteopathic Medicine held a Joint Rules/Legislative Committee (Joint Committee) meeting on June 1, 2023, to discuss the emergency rule. On May 19, 2023, the Board of Medicine published notice of the Joint Committee meeting both on its website and in the Florida Administrative Register. On June 2, 2023, the Board of Medicine discussed the report of the Joint Committee and voted upon emergency rule language. The Board of Medicine published notice of its June 2, 2023, meeting in the Florida Administrative Register on May 5, 2023, and on its website on May 12, 2023. Each meeting was held in person in a public forum and was able to be attended by any interested parties. Accordingly, all notice requirements contained in Rule 28-102.001, F.A.C., were properly complied with and interested parties were given ample opportunity to participate in this rulemaking process.

SUMMARY: The proposed emergency rule allows a patient's prescribing physician to renew a prior lawfully issued sex-reassignment prescription that was prescribed prior to the effective date of section 465.52, F.S., up and until six months from the effective date of the Board of Medicine's emergency rule formally adopting a consent form per sections 456.52(1) and (2), Florida Statutes.

THE PERSON TO BE CONTACTED REGARDING THE EMERGENCY RULE IS: Paul Vazquez, Executive Director, Board of Medicine, 4052 Bald Cypress Way, Bin # C-03, Tallahassee, Florida 32399-3253.

THE FULL TEXT OF THE EMERGENCY RULE IS:

64B8ER23-3 Sex-reassignment Prescriptions.

A patient's prescribing physician may renew a prior lawfully issued sex-reassignment prescription as defined in section 456.001(9)(a), Florida Statutes, that was prescribed prior to May 17, 2023, up and until six months from the effective date of the Board's emergency rule formally adopting a consent form per sections 456.52(1) and (2), Florida Statutes.

Rulemaking Authority 456.52(1)(a), (b), 456.52(6)(a) FS. Law Implemented 456.52(1), (2) FS. History – New 6-8-23.

THIS RULE TAKES EFFECT UPON BEING FILED WITH THE DEPARTMENT OF STATE UNLESS A LATER TIME AND DATE IS SPECIFIED IN THE RULE.

EFFECTIVE DATE: June 8, 2023

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Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.-B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus

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REPORT

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Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

E. Coleman[1], A. E. Radix[2,3], W. P. Bouman[4,5], G. R. Brown[6,7], A. L. C. de Vries[8,9], M. B. Deutsch[10,11], R. Ettner[12,13], L. Fraser[14], M. Goodman[15], J. Green[16], A. B. Hancock[17], T. W. Johnson[18], D. H. Karasic[19,20], G. A. Knudson[21,22], S. F. Leibowitz[23], H. F. L. Meyer-Bahlburg[24,25], S. J. Monstrey[26], J. Motmans[27,28], L. Nahata[29,30], T. O. Nieder[31], S. L. Reisner[32,33], C. Richards[34,35], L. S. Schechter[36], V. Tangpricha[37,38], A. C. Tishelman[39], M. A. A. Van Trotsenburg[40,41], S. Winter[42], K. Ducheny[43], N. J. Adams[44,45], T. M. Adrián[46,47], L. R. Allen[48], D. Azul[49], H. Bagga[50,51], K. Başar[52], D. S. Bathory[53], J. J. Belinky[54], D. R. Berg[55], J. U. Berli[56], R. O. Bluebond-Langner[57,58], M.-B. Bouman[9,59], M. L. Bowers[60,61], P. J. Brassard[62,63], J. Byrne[64], L. Capitán[65], C. J. Cargill[66], J. M. Carswell[32,67], S. C. Chang[68], G. Chelvakumar[69,70], T. Corneil[71], K. B. Dalke[72,73], G. De Cuypere[74], E. de Vries[75,76], M. Den Heijer[9,77], A. H. Devor[78], C. Dhejne[79,80], A. D'Marco[81,82], E. K. Edmiston[83], L. Edwards-Leeper[84,85], R. Ehrbar[86,87], D. Ehrensaft[19], J. Eisfeld[88], E. Elaut[74,89], L. Erickson-Schroth[90,91], J. L. Feldman[92], A. D. Fisher[93], M. M. Garcia[94,95], L. Gijs[96], S. E. Green[97], B. P. Hall[98,99], T. L. D. Hardy[100,101], M. S. Irwig[32,102], L. A. Jacobs[103], A. C. Janssen[23,104], K. Johnson[105,106], D. T. Klink[107,108], B. P. C. Kreukels[9,109], L. E. Kuper[110,111], E. J. Kvach[112,113], M. A. Malouf[114], R. Massey[115,116], T. Mazur[117,118], C. McLachlan[119,120], S. D. Morrison[121,122], S. W. Mosser[123,124], P. M. Neira[125,126], U. Nygren[127,128], J. M. Oates[129,130], J. Obedin-Maliver[131,132], G. Pagkalos[133,134], J. Patton[135,136], N. Phanuphak[137], K. Rachlin[103], T. Reed[138†], G. N. Rider[55], J. Ristori[93], S. Robbins-Cherry[4], S. A. Roberts[32,139], K. A. Rodriguez-Wallberg[140,141], S. M. Rosenthal[142,143], K. Sabir[144], J. D. Safer[60,145], A. I. Scheim[146,147], L. J. Seal[35,148], T. J. Sehoole[149], K. Spencer[55], C. St. Amand[150,151], T. D. Steensma[9,109], J. F. Strang[152,153], G. B. Taylor[154], K. Tilleman[155], G. G. T'Sjoen[74,156], L. N. Vala[157], N. M. Van Mello[9,158], J. F. Veale[159], J. A. Vencill[160,161], B. Vincent[162], L. M. Wesp[163,164], M. A. West[165,166] and J. Arcelus[5,167]

[1]Institute for Sexual and Gender Health, Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA; [2]Callen-Lorde Community Health Center, New York, NY, USA; [3]Department of Medicine, NYU Grossman School of Medicine, New York, NY, USA; [4]Nottingham Centre for Transgender Health, Nottingham, UK; [5]School of Medicine, University of Nottingham, Nottingham, UK; [6]James H. Quillen College of Medicine, East Tennessee State University, Johnson City, TN, USA; [7]James H. Quillen VAMC, Johnson City, TN, USA; [8]Department of Child and Adolescent Psychiatry, Amsterdam UMC Location Vrije Universiteit Amsterdam, Amsterdam, Netherlands; [9]Center of Expertise on Gender Dysphoria, Amsterdam UMC Location Vrije Universiteit Amsterdam, Amsterdam, The Netherlands; [10]Department of Family & Community Medicine, University of California—San Francisco, San Francisco, CA, USA; [11]UCSF Gender Affirming Health Program, San Francisco, CA, USA; [12]New Health Foundation Worldwide, Evanston, IL, USA; [13]Weiss Memorial Hospital, Chicago, IL, USA; [14]Independent Practice, San Francisco, CA, USA; [15]Emory University Rollins School of Public Health, Atlanta, GA, USA; [16]Independent Scholar, Vancouver, WA, USA; [17]The George Washington University, Washington, DC, USA; [18]Department of Anthropology, California State University, Chico, CA, USA; [19]University of California San Francisco, San Francisco, CA, USA; [20]Independent Practice at dankarasic.com; [21]University of British Columbia, Vancouver, Canada; [22]Vancouver Coastal Health, Vancouver, Canada; [23]Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, IL, USA; [24]New York State Psychiatric Institute, New York, NY, USA; [25]Department of Psychiatry, Columbia University, New York, NY, USA; [26]Ghent University Hospital, Gent, Belgium; [27]Transgender Infopunt, Ghent University Hospital, Gent, Belgium; [28]Centre for Research on Culture and Gender, Ghent University, Gent, Belgium; [29]Department of Pediatrics, The Ohio State University College of Medicine, Columbus, OH, USA; [30]Endocrinology and Center for Biobehavioral Health, The Abigail Wexner Research Institute at Nationwide Children's Hospital, Columbus, OH, USA; [31]University Medical Center Hamburg-Eppendorf, Interdisciplinary Transgender Health Care Center Hamburg, Institute for Sex Research, Sexual Medicine and Forensic Psychiatry, Hamburg, Germany; [32]Harvard Medical School, Boston, MA, USA; [33]Harvard T. H. Chan School of Public Health, Boston, MA, USA; [34]Regents University London, UK; [35]Tavistock and Portman NHS Foundation Trust, London, UK; [36]Rush University Medical Center, Chicago, IL, USA; [37]Division of Endocrinology, Metabolism & Lipids, Department of Medicine, Emory University School of Medicine, Atlanta, GA, USA; [38]Atlanta VA Medical Center, Decatur, GA, USA; [39]Boston College, Department of Psychology and Neuroscience, Chestnut Hill, MA, USA; [40]Bureau GenderPRO, Vienna, Austria; [41]University Hospital Lilienfeld—St. Pölten, St. Pölten, Austria; [42]School of Population Health, Curtin University, Perth, WA, Australia; [43]Howard Brown Health, Chicago, IL, USA; [44]University of Toronto, Ontario Institute for Studies in Education, Toronto, Canada; [45]Transgender Professional Association for Transgender Health (TPATH); [46]Asamblea Nacional de Venezuela, Caracas, Venezuela; [47]Diverlex Diversidad e Igualdad a Través de la Ley, Caracas, Venezuela;

CONTACT Dr Eli Coleman, PhD Institute for Sexual and Gender Health, Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA
†Deceased.

[48]University of Nevada, Las Vegas, NV, USA; [49]La Trobe Rural Health School, La Trobe University, Bendigo, Australia; [50]Monash Health Gender Clinic, Melbourne, Victoria, Australia; [51]Monash University, Melbourne, Victoria, Australia; [52]Department of Psychiatry, Hacettepe University, Ankara, Turkey; [53]Independent Practice at Bathory International PLLC, Winston-Salem, NC, USA; [54]Durand Hospital, Guemes Clinic and Urological Center, Buenos Aires, Argentina; [55]National Center for Gender Spectrum Health, Institute for Sexual and Gender Health, Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA; [56]Oregon Health & Science University, Portland, OR, USA; [57]NYU Langone Health, New York, NY, USA; [58]Hansjörg Wyss Department of Plastic Surgery, New York, NY, USA; [59]Department of Plastic Surgery, Amsterdam UMC Location Vrije Universiteit Amsterdam, , Amsterdam, Netherlands; [60]Icahn School of Medicine at Mount Sinai, New York, NY, USA; [61]Mills-Peninsula Medical Center, Burlingame, CA, USA; [62]GrS Montreal, Complexe CMC, Montreal, Quebec, Canada; [63]Université de Montreal, Quebec, Canada; [64]University of Waikato/Te Whare Wānanga o Waikato, Hamilton/Kirikiriroa, New Zealand/Aotearoa; [65]The Facialteam Group, Marbella International Hospital, Marbella, Spain; [66]Independent Scholar; [67]Boston's Children's Hospital, Boston, MA, USA; [68]Independent Practice, Oakland, CA, USA; [69]Nationwide Children's Hospital, Columbus, OH, USA; [70]The Ohio State University, College of Medicine, Columbus, OH, USA; [71]School of Population & Public Health, University of British Columbia, Vancouver, BC, Canada; [72]Penn State Health, PA, USA; [73]Penn State College of Medicine, Hershey, PA, USA; [74]Center for Sexology and Gender, Ghent University Hospital, Gent, Belgium; [75]Nelson Mandela University, Gqeberha, South Africa; [76]University of Cape Town, Cape Town, South Africa; [77]Department of Endocrinology, Amsterdam UMC Location Vrije Universiteit Amsterdam, , Amsterdam, Netherlands; [78]University of Victoria, Victoria, BC, Canada; [79]ANOVA, Karolinska University Hospital, Stockholm, Sweden; [80]Department of Medicine Huddinge, Karolinska Institutet, Stockholm, Sweden; [81]UCTRANS—United Caribbean Trans Network, Nassau, The Bahamas; [82]D M A R C O Organization, Nassau, The Bahamas; [83]University of Pittsburgh School of Medicine, Pittsburgh, PA, USA; [84]Pacific University, Hillsboro, OR, USA; [85]Independent Practice, Beaverton, OR, USA; [86]Whitman Walker Health, Washington, DC, USA; [87]Independent Practice, Maryland, USA; [88]Transvisie, Utrecht, The Netherlands; [89]Department of Clinical Experimental and Health Psychology, Ghent University, Gent, Belgium; [90]The Jed Foundation, New York, NY, USA; [91]Hetrick-Martin Institute, New York, NY, USA; [92]Institute for Sexual and Gender Health, Institute for Sexual and Gender Health, Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA; [93]Andrology, Women Endocrinology and Gender Incongruence, Careggi University Hospital, Florence, Italy; [94]Department of Urology, Cedars-Sinai Medical Center, Los Angeles, CA, USA; [95]Departments of Urology and Anatomy, University of California San Francisco, San Francisco, CA, USA; [96]Institute of Family and Sexuality Studies, Department of Neurosciences, KU Leuven, Leuven, Belgium; [97]Mermaids, London/Leeds, UK; [98]Duke University Medical Center, Durham, NC, USA; [99]Duke Adult Gender Medicine Clinic, Durham, NC, USA; [100]Alberta Health Services, Edmonton, Alberta, Canada; [101]MacEwan University, Edmonton, Alberta, Canada; [102]Beth Israel Deaconess Medical Center, Boston, MA, USA; [103]Independent Practice, New York, NY, USA; [104]Northwestern Feinberg School of Medicine, Chicago, IL, USA; [105]RMIT University, Melbourne, Australia; [106]University of Brighton, Brighton, UK; [107]Department of Pediatrics, Division of Pediatric Endocrinology, Ghent University Hospital, Gent, Belgium; [108]Division of Pediatric Endocrinology and Diabetes, ZNA Queen Paola Children's Hospital, Antwerp, Belgium; [109]Department of Medical Psychology, Amsterdam UMC Location Vrije Universiteit Amsterdam, , Amsterdam, Netherlands; [110]Department of Psychiatry, Southwestern Medical Center, University of Texas, Dallas, TX, USA; [111]Department of Endocrinology, Children's Health, Dallas, TX, USA; [112]Denver Health, Denver, CO, USA; [113]University of Colorado School of Medicine, Aurora, CO, USA; [114]Malouf Counseling and Consulting, Baltimore, MD, USA; [115]WPATH Global Education Institute; [116]Department of Psychiatry & Behavioral Sciences, Emory University School of Medicine, Atlanta, GA, USA; [117]Jacobs School of Medicine and Biomedical Sciences, University at Buffalo, Buffalo, NY, USA; [118]John R. Oishei Children's Hospital, Buffalo, NY, USA; [119]Professional Association for Transgender Health, South Africa; [120]Gender DynamiX, Cape Town, South Africa; [121]Division of Plastic Surgery, Seattle Children's Hospital, Seattle, WA, USA; [122]Division of Plastic Surgery, Department of Surgery, University of Washington Medical Center, Seattle, WA, USA; [123]Gender Confirmation Center, San Francisco, CA, USA; [124]Saint Francis Memorial Hospital, San Francisco, CA, USA; [125]Johns Hopkins Center for Transgender Health, Baltimore, MD, USA; [126]Johns Hopkins Medicine Office of Diversity, Inclusion and Health Equity, Baltimore, MD, USA; [127]Division of Speech and Language Pathology, Department of Clinical Science, Intervention and Technology, Karolinska Institutet, Stockholm, Sweden; [128]Speech and Language Pathology, Medical Unit, Karolinska University Hospital, Stockholm, Sweden; [129]La Trobe University, Melbourne, Australia; [130]Melbourne Voice Analysis Centre, East Melbourne, Australia; [131]Stanford University School of Medicine, Department of Obstetrics and Gynecology, Palo Alto, CA, USA; [132]Department of Epidemiology and Population Health, Stanford, CA, USA; [133]Independent PracticeThessaloniki, Greece; [134]Military Community Mental Health Center, 424 General Military Training Hospital, Thessaloniki, Greece; [135]Talkspace, New York, NY, USA; [136]CytiPsychological LLC, San Diego, CA, USA; [137]Institute of HIV Research and Innovation, Bangkok, Thailand; [138]Gender Identity Research and Education Society, Leatherhead, UK; [139]Division of Endocrinology, Boston's Children's Hospital, Boston, MA, USA; [140]Department of Reproductive Medicine, Karolinska University Hospital, Stockholm, Sweden; [141]Department of Oncology-Pathology, Karolinska Institute, Stockholm, Sweden; [142]Division of Pediatric Endocrinology, UCSF, San Francisco, CA, USA; [143]UCSF Child and Adolescent Gender Center; [144]FtM Phoenix Group, Krasnodar Krai, Russia; [145]Mount Sinai Center for Transgender Medicine and Surgery, New York, NY, USA; [146]Epidemiology and Biostatistics, Dornsife School of Public Health, Drexel University, Philadelphia, PA, USA; [147]Epidemiology and Biostatistics, Schulich School of Medicine and Dentistry, Western University, Ontario, Canada; [148]St George's University Hospitals NHS Foundation Trust, London, UK; [149]Iranti, Johannesburg, South Africa; [150]University of Houston, Houston, TX, USA; [151]Mayo Clinic, Rochester, MN, USA; [152]Children's National Hospital, Washington, DC, USA; [153]George Washington University School of Medicine, Washington, DC, USA; [154]Atrium Health Department of Obstetrics and Gynecology, Division of Female Pelvic Medicine and Reconstructive Surgery, Charlotte, NC, USA; [155]Department for Reproductive Medicine, Ghent University Hospital, Gent, Belgium; [156]Department of Endocrinology, Ghent University Hospital, Gent, Belgium; [157]Independent Practice, Campbell, CA, USA; [158]Department of Obstetrics and Gynaecology, Amsterdam UMC Location Vrije Universiteit Amsterdam, Amsterdam, Netherlands; [159]School of Psychology, University of Waikato/Te Whare Wānanga o Waikato, Hamilton/Kirikiriroa, New Zealand/Aotearoa; [160]Department of Psychiatry & Psychology, Mayo Clinic, Rochester, MN, USA; [161]Division of General Internal Medicine, Mayo Clinic, Rochester, MN, USA; [162]Trans Learning Partnership at https://spectra-london.org.uk/trans-learning-partnership, UK; [163]College of Nursing, University of Wisconsin MilwaukeeMilwaukee, WI, USA; [164]Health Connections Inc., Glendale, WI, USA; [165]North Memorial Health Hospital, Robbinsdale, MN, USA; [166]University of Minnesota, Minneapolis, MN, USA; [167]Bellvitge Biomedical Research Institute (IDIBELL), L'Hospitalet de Llobregat, Barcelona, Spain.

ABSTRACT

Background: Transgender healthcare is a rapidly evolving interdisciplinary field. In the last decade, there has been an unprecedented increase in the number and visibility of transgender and gender diverse (TGD) people seeking support and gender-affirming medical treatment in parallel with a significant rise in the scientific literature in this area. The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. One of the main functions of WPATH is to promote the highest standards of health care for TGD people through the Standards of Care (SOC). The SOC was initially developed in 1979 and the last version (SOC-7) was published in 2012. In view of the increasing scientific evidence, WPATH commissioned a new version of the Standards of Care, the SOC-8.

Aim: The overall goal of SOC-8 is to provide health care professionals (HCPs) with clinical guidance to assist TGD people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment.

Methods: The SOC-8 is based on the best available science and expert professional consensus in transgender health. International professionals and stakeholders were selected to serve on the SOC-8 committee. Recommendation statements were developed based on data derived from independent systematic literature reviews, where available, background reviews and expert opinions. Grading of recommendations was based on the available evidence supporting interventions, a discussion of risks and harms, as well as the feasibility and acceptability within different contexts and country settings.

Results: A total of 18 chapters were developed as part of the SOC-8. They contain recommendations for health care professionals who provide care and treatment for TGD people. Each of the recommendations is followed by explanatory text with relevant references. General areas related to transgender health are covered in the chapters Terminology, Global Applicability, Population Estimates, and Education. The chapters developed for the diverse population of TGD people include Assessment of Adults, Adolescents, Children, Nonbinary, Eunuchs, and Intersex Individuals, and people living in Institutional Environments. Finally, the chapters related to gender-affirming treatment are Hormone Therapy, Surgery and Postoperative Care, Voice and Communication, Primary Care, Reproductive Health, Sexual Health, and Mental Health.

Conclusions: The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and guidance for the treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria set forth in this document for gender-affirming medical interventions are clinical guidelines; individual health care professionals and programs may modify these in consultation with the TGD person.

KEYWORDS

adolescents; assessment; children; communication; education; endocrinology; eunuch; gender diverse; health care professional; institutional settings; intersex; mental health; nonbinary; population; postoperative care; primary care; reproductive health; sexual health; SOC8; Standards of Care; surgery; terminology; transgender; voice

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INTRODUCTION

Purpose and use of the Standards of Care

The overall goal of the World Professional Association for Transgender Health's (WPATH) Standards of Care—Eighth Edition (SOC-8) is to provide clinical guidance to health care professionals to assist transgender and gender diverse (TGD) people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment. This assistance may include but is not limited to hormonal and surgical treatments, voice and communication therapy, primary care, hair removal, reproductive and sexual health, and mental health care. Healthcare systems should provide medically necessary gender-affirming health care for TGD people: See Chapter 2—Global Applicability, Statement 2.1.

WPATH is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. Founded in 1979, the organization currently has over 3,000 health care professionals, social scientists, and legal professionals, all of whom are engaged in clinical practice, research, education and advocacy that affects the lives of TGD people. WPATH envisions a world wherein people of all gender identities and gender expressions have access to evidence-based health care, social services, justice, and equality.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the Standards of Care (SOC) for the health of TGD people. The SOC-8 is based on the best available science and expert professional consensus. The SOC was initially developed in 1979, and the last version was published in 2012.

Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the SOC-8 to other parts of the world are necessary. Suggestions for approaches to cultural relativity and cultural competence are included in this version of the SOC.

WPATH recognizes that health is not only dependent upon high-quality clinical care but also relies on social and political climates that ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that advance tolerance and equity for gender diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these policy and legal changes. Thus, health care professionals who provide care to TGD people are called upon to advocate for improved access to safe and licensed gender-affirming care while respecting the autonomy of individuals.

While this is primarily a document for health care professionals, individuals, their families, and social institutions may also use the SOC-8 to understand how it can assist with promoting optimal health for members of this diverse population.

The SOC-8 has 18 chapters containing recommendations for health care professionals working with TGD people. Each of the recommendations is followed by explanatory text with relevant references. The recommendations for the initiation of gender-affirming medical and/or surgical treatments (GAMSTs) for adults and adolescents are contained in their respective chapters (see Assessment for Adults and Adolescent chapters). A summary of the recommendations and criteria for GAMST can be found in Appendix D.

Populations included in the SOC-8

In this document, we use the phrase transgender and gender diverse (TGD) to be as broad and comprehensive as possible in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. This includes people who have culturally specific and/or language-specific experiences, identities or expressions, which may or may not be based on or encompassed by Western conceptualizations of gender or the language used to describe it.

WPATH SOC-8 expands who is included under the TGD umbrella, and the settings in which these guidelines should be applied to promote equity and human rights.

Globally, TGD people encompass a diverse array of gender identities and expressions and have differing needs for gender-affirming care across their lifespan that is related to individual goals and characteristics, available health care resources, and sociocultural and political contexts. When standards of care are absent for certain groups this vacuum can result in a multiplicity of therapeutic approaches, including those that may be counterproductive or harmful. The SOC-8 includes recommendations to promote health and well-being for gender diverse groups that have often been neglected and/or marginalized, including nonbinary people, eunuch, and intersex individuals.

The SOC-8 continues to outline the appropriate care of TGD youth, which includes, when indicated, the use of puberty suppression and, when indicated, the use of gender-affirming hormones.

Worldwide, TGD people commonly experience transphobia, stigmatization, ignorance, and refusal of care when seeking health care services, which contributes to significant health disparities. TGD people often report having to teach their medical providers how to care for them due to the latter's insufficient knowledge and training. Intersectional forms of discrimination, social marginalization, and hate crimes against TGD people lead to minority stress. Minority stress is associated with mental health disparities exemplified by increased rates of depression, suicidality, and non-suicidal self-injuries than rates in cisgender populations. Professionals from every discipline should consider the marked vulnerability of many TGD people. WPATH urges health care authorities, policymakers, and medical societies to discourage and combat transphobia among health care professionals and ensure every effort is made to refer TGD people to professionals with experience and willingness to provide gender-affirming care.

Flexibility in the SOC

The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and for guiding treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria put forth in this document for gender-affirming interventions are clinical guidelines; individual health care professionals and programs may modify them in consultation with the TGD person. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health care professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the SOC—to evolve.

The SOC-8 supports the role of informed decision-making and the value of harm reduction approaches. In addition, this version of the SOC recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Health care professionals can use the SOC to help patients consider the full range of health services open to them in accordance with their clinical needs for gender expression.

Diversity versus Diagnosis

The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. Unfortunately, gender nonconformity and diversity in gender identity and expression is stigmatized in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress." Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make TGD individuals more vulnerable to developing mental health concerns such as anxiety and depression. In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and

neglect in one's interpersonal relationships, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being TGD.

While Gender Dysphoria (GD) is still considered a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5-TR) of the American Psychiatric Association. Gender incongruence is no longer seen as pathological or a mental disorder in the world health community. Gender Incongruence is recognized as a condition in the International Classification of Diseases and Related Health Problems, 11th Version of the World Health Organization (ICD-11). Because of historical and current stigma, TGD people can experience distress or dysphoria that may be addressed with various gender-affirming treatment options. While nomenclature is subject to change and new terminology and classifications may be adopted by various health organizations or administrative bodies, the medical necessity of treatment and care is clearly recognized for the many people who experience dissonance between their sex assigned at birth and their gender identity.

Not all societies, countries, or health care systems require a diagnosis for treatment. However, in some countries these diagnoses may facilitate access to medically necessary health care and can guide further research into effective treatments.

Health care services

The goal of gender-affirming care is to partner with TGD people to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity. Gender-affirming care supports TGD people across the lifespan—from the very first signs of gender incongruence in childhood through adulthood and into older age—as well as people with concerns and uncertainty about their gender identity, either prior to or after transition.

Transgender health care is greater than the sum of its parts, involving holistic inter- and multidisciplinary care between endocrinology, surgery, voice and communication, primary care, reproductive health, sexual health and mental health disciplines to support gender-affirming interventions as well as preventive care and chronic disease management. Gender-affirming interventions include puberty suppression, hormone therapy, and gender-affirming surgeries among others. It should be emphasized there is no 'one-size-fits-all' approach and TGD people may need to undergo all, some, or none of these interventions to support their gender affirmation. These guidelines encourage the use of a patient-centered care model for initiation of gender- affirming interventions and update many previous requirements to reduce barriers to care.

Ideally, communication and coordination of care should occur between providers to optimize outcomes and the timing of gender-affirming interventions centered on the patient's needs and desires and to minimize harm. In well-resourced settings, multidisciplinary consultation and care coordination is often routine, but many regions worldwide lack facilities dedicated to transgender care. For these regions, if possible, it is strongly recommended that individual care providers create a network to facilitate transgender health care that is not available locally.

Worldwide, TGD people are sometime forced by family members or religious communities to undergo conversion therapy. WPATH strongly recommends against any use of reparative or conversion therapy (see statements 6.5 and 18.10).

Health care settings

The SOC-8 are guidelines rooted in the fundamental rights of TGD people that apply to all settings in which health care is provided regardless of an individual's social or medical circumstances. This includes a recommendation to apply the standards of care for TGD people who are incarcerated or living in other institutional settings.

Due to a lack of knowledgeable providers, untimely access, cost barriers and/or previous stigmatizing health care experiences, many TGD people take non-prescribed hormone therapy. This poses health risks associated with the use of unmonitored therapy in potentially supratherapeutic doses and the potential exposure to blood-borne illnesses if needles are shared for administration. However, for many individuals, it is the only means of acquiring medically necessary

gender-affirming treatment that is otherwise inaccessible. Non-prescribed hormone use should be approached with a harm-reduction lens to ensure individuals are connected with providers who can prescribe safe and monitored hormone therapy.

In some countries, the rights of TGD are increasingly being recognized, and gender clinics are being established that can serve as templates for care. In other countries, however, such facilities are lacking and care may be more fragmented and under-resourced. Nonetheless, different models of care are being pioneered, including efforts to decentralize gender-affirming care within primary care settings and establish telehealth services to reduce barriers and improve access. Regardless of the method of care delivery, the principles of gender-affirming care as outlined in the SOC-8 should be adapted to align with local sociocultural, political, and medical contexts.

Methodology

This version of the Standards of Care (SOC-8) is based upon a more rigorous and methodological evidence-based approach than previous versions. This evidence is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion. Evidence-based guidelines include recommendations intended to optimize patient care that are informed by a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility.

While evidence-based research provides the basis for sound clinical practice guidelines and recommendations, it must be balanced by the realities and feasibility of providing care in diverse settings. The process for development of the SOC-8 incorporated the recommendations on clinical practice guideline development set forth by the National Academies of Medicine and the World Health Organization, which addressed transparency, conflict-of-interest policy, committee composition, and group process.

The SOC-8 guidelines committee was multidisciplinary and consisted of subject matter experts, health care professionals, researchers, and stakeholders with diverse perspectives and geographic representation. A guideline methodologist assisted with the planning and development of questions and systematic reviews with additional input provided by an international advisory committee and during the public comment period. All committee members completed conflict of interest declarations. Recommendations in the SOC-8 are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and country settings. Consensus on the final recommendations was attained using the Delphi process that included all members of the guidelines committee and required that recommendation statements were approved by at least 75% of members. A detailed overview of the SOC-8 Methodology is included in Appendix A.

SOC-8 Chapters Summary

The SOC-8 represents a significant advancement from previous versions. Changes in this version are based upon a fundamentally different methodology, significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for TGD people beyond hormone therapy and surgery.

These updated guidelines continue the process started with the SOC-7 in 2011 to broaden in scope and move from a narrow focus on psychological requirements for "diagnosing transgenderism" and medical treatments for alleviation of gender dysphoria to gender-affirming care for the whole person. WPATH SOC-8 expands guidelines specifying who is included under the TGD umbrella, what should and should not be offered with gender-affirming care, and the settings in which these guidelines should be applied to promote equity and human rights.

The SOC-8 has several new chapters such as the Assessment of Adults, Education, Eunuchs, and a Nonbinary chapter. In addition, the chapter for children and adolescents of the SOC-7 has been divided into two different chapters. Overall, the SOC-8 is considerably longer than previous versions and provides a more in-depth introduction and recommendations for health care professionals. A summary of every chapter of the SOC-8 can be found below:

Chapter 1—Terminology

This new chapter lays the framework for language used in the SOC-8 and offers consensually agreed upon recommendations for the use of terminology. The chapter provides (1) terms and definitions, and (2) best practices for utilizing them. This document is accompanied by a glossary (see Appendix B) of common terms and language to provide a framework for use and interpretation of the SOC-8.

Chapter 2—Global Applicability

This chapter references key literature related to development and delivery of health care services, broader advocacy care for TGD people from beyond Western Europe and North America and provides recommendations for adapting and translating the SOC-8 to varied contexts.

Chapter 3—Population Estimates

This chapter updates the population estimates of TGD people in society. Based on the current evidence, this proportion may range from a fraction of a percent to several percentage points depending on the inclusion criteria, age group, and geographic location.

Chapter 4—Education

This new chapter provides a general review of the literature related to education in TGD health care. It offers recommendations at governmental, nongovernmental, institutional and provider levels to increase access to competent, compassionate health care. The intent is to lay the groundwork in the education area and invite a much broader and deeper discussion among educators and health care professionals.

Chapter 5—Assessment of Adults

This new chapter provides guidance on the assessment of TGD adults who are requesting gender-affirming medical and surgical treatments (GAMSTs). It describes and updates the assessment process as part of a patient-centered approach and the criteria that health care professionals may follow in order to recommend GAMSTs to TGD adults.

Chapter 6—Adolescents

This new chapter is dedicated to TGD adolescents, is distinct from the child chapter, and has been created for this 8th edition of the Standards of Care given (1) the exponential growth in adolescent referral rates; (2) the increase in studies available specific to adolescent gender diversity-related care; and (3) the unique developmental and gender-affirming care issues of this age group. This chapter provides recommendations regarding the assessment process of adolescents requiring GAMSTs as well as recommendations when working with TGD youth and their families.

Chapter 7—Children

This new chapter pertains to prepubescent gender diverse children and focuses on developmentally appropriate psychosocial practices and therapeutic approaches.

Chapter 8—Nonbinary

This new chapter in the SOC-8 consists of a broad description of the term nonbinary and its usage from a biopsychosocial, cultural, and intersectional perspective. The need for access to gender-affirming care, specific gender-affirming medical interventions, as well as an appropriate level of support is discussed.

Chapter 9—Eunuchs

This new chapter describes the unique needs of eunuchs, and how the SOC can be applied to this population.

Chapter 10—Intersex

This chapter focuses on the clinical care of intersex individuals. It addresses the evolving terminology, prevalence, and diverse presentations of such individuals and provides recommendations for providing psychosocial and medical care with their evidence-based explanations.

Chapter 11—Institutional Environments

This chapter has been expanded to include both carceral and non-carceral settings and has been built upon the last 3 versions of the SOC. This chapter describes how the SOC-8 can be applied to individuals living in these settings.

Chapter 12—Hormone Therapy

This chapter describes the initiation of gender-affirming hormone therapy, the recommended regimens, screening for health concerns before and during hormone therapy, and specific considerations regarding hormone therapy prior to surgery. It includes an expanded discussion about the safety of gonadotropin releasing hormone (GnRH) agonists in youth, various hormone regimens, monitoring to include the development of potential therapy-related health concerns, and guidance on how hormone providers should collaborate with surgeons.

Chapter 13—Surgery and Postoperative Care

This chapter describes a spectrum of gender-affirming surgical procedures for the diverse and heterogeneous community of individuals who identify as TGD. It provides a discussion about the optimal surgical training in GAS procedures, post-surgical aftercare and follow-up, access to surgery by adults and adolescents, and individually customized surgeries.

Chapter 14—Voice and Communication

This chapter describes professional voice and communication support and interventions that are inclusive of and attentive to all aspects of diversity and no longer limited only to voice feminization and masculinization. Recommendations are now framed as affirming the roles and responsibilities of professionals involved in voice and communication support.

Chapter 15—Primary Care

This chapter discusses the importance of primary care for TGD individuals, including topics of cardiovascular and metabolic health, cancer screening, and primary care systems.

Chapter 16—Reproductive Health

This chapter provides recent data on fertility perspectives and parenthood goals in gender diverse youth and adults, advances in fertility preservation methods (including tissue cryopreservation), guidance regarding preconception and pregnancy care, prenatal counseling, and chest feeding. Contraceptive methods and considerations for TGD individuals are also reviewed.

Chapter 17—Sexual Health

This new chapter acknowledges the profound impact of sexual health on physical and psychological well-being for TGD people. The chapter advocates for sexual functioning, pleasure, and satisfaction to be included in TGD-related care.

Chapter 18—Mental Health

This chapter discusses principles of care for managing mental health conditions in TGD adults and the nexus of mental health care and transition care. Psychotherapy may be beneficial but should not be a requirement for gender-affirming treatment, and conversion treatment should not be offered.

CHAPTER 1 Terminology

This chapter will lay the framework for language used in the SOC-8. It offers recommendations for use of terminology. It provides (1) terms and definitions, and (2) best practices for utilizing them. This document is accompanied by a glossary of common terms and language to provide a framework for use and interpretation of the SOC-8. See Appendix B for glossary.

Terminology

In this document, we use the phrase transgender and gender diverse (TGD) to be as broad and comprehensive as possible in describing members of the many varied communities globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. This includes people who have culturally specific and/or language-specific experiences, identities or expressions, and/or that are not based on or encompassed by Western conceptualizations of gender, or the language used to describe it. TGD is used for convenience as a shorthand for transgender and gender diverse.

The decision to use transgender and gender diverse resulted from an active process and was not without controversy. Discussions centered on avoiding over-emphasis on the term transgender, integrating nonbinary gender identities and experiences, recognizing global variations in understandings of gender, avoiding the term gender nonconforming, and recognizing the changing nature of language because what is current now may not be so in coming years. Thus, the term transgender and gender diverse was chosen with the intent to be most inclusive and to highlight the many diverse gender identities, expressions, experiences, and health care needs of TGD people. A Delphi process was used wherein SOC-8 chapter authors were anonymously and iteratively surveyed over several rounds to obtain consensus on terms. The SOC-8 presents standards of care that strive to be applicable to TGD people globally, no matter how a person self-identifies or expresses their gender.

Context

The language selected in this chapter may not be (nor ever could be) comprehensive of every culture and geographic region/locale. Differences and debates over appropriate terms and specific terminologies are common, and no single term can be used without controversy. The goal of this chapter is to be as inclusive as possible and offer a shared vocabulary that is respectful and reflective of varied experiences of TGD people while remaining accessible to health practitioners and providers, and the public, for the purposes of this document. Ultimately, access to transition-related health care should be based on providing adequate information and obtaining informed consent from the individual, and not on what words TGD people, or their service providers, use to describe their identities. Using language and terminology that is respectful and culturally responsive is a basic foundation in the provision of affirming care, as is reducing the stigma and harm experienced by many TGD people seeking health care. It is vital for service providers to discuss with service users what language is most comfortable for them and to use that language whenever possible.

This chapter explains why current terms are being used in preference to others. Rather than use specific terms for medical, legal, and advocacy groups, the aim is to foster a shared language and understanding in the field of TGD health, and the many related fields (e.g., epidemiology, law), in order to optimize the health of transgender and gender diverse people.

Sex, gender, gender identity, and gender expression are used in the English language as descriptors that can apply to all people—those who are TGD, and those who are not. There are complex reasons why very specific language may be the *most* respectful, *most* inclusive, or *most* accepted by global TGD communities, including the presence or absence of words to describe these concepts in languages other than English; the structural relationship between sex and gender; legal landscapes at the local, national, and international levels; and the consequences of historical and present-day stigma that TGD people face.

Statements of Recommendations

1.1- We recommend health care professionals use culturally relevant language (including terms to describe transgender and gender diverse people) when applying the Standards of Care in different global settings.
1.2- We recommend health care professionals use language in health care settings that uphold the principles of safety, dignity, and respect.
1.3- We recommend health care professionals discuss with transgender and gender diverse people what language or terminology they prefer.

Because at present, the field of TGD health is heavily dominated by the English language, there are two specific problems that constantly arise in setting the context for terminology. The first problem is that words exist in English that do not exist in other languages (e.g., "sex" and "gender" are only represented by one word in Urdu and many other languages). The second problem is that there are words that exist outside of English that do not have a direct translation into English (e.g., *travesti*, *fa'afafine*, *hijra*, *selrata*, *muxe*, *kathoey*, *transpinoy*, *waria*, *machi*). Practically, this means the heavy influence of English in this field impacts both what terms are widely used and which people or identities are most represented or validated by those terms. The words used also shape the narratives that contribute to beliefs and perceptions. While in past versions of the Standards of Care, World Professional Association for Transgender Health (WPATH) has used only transgender as a broadly defined umbrella term, version 8 broadens this language to use TGD as the umbrella term throughout the document (see Chapter 2—Global Applicability).

Furthermore, the ever-evolving nature of language is impacted by external factors and the social, structural, and personal pressures and violence enacted on TGD people and their bodies. Many of the terms and phrases used historically have been marred by how, when, and why they were used in discussing TGD people, and have thus fallen out of use or are hotly contested among TGD people, with some individuals preferring terms others find offensive. Some wish that these Standards of Care could provide a coherent set of universally accepted terms to describe TGD people, identities, and related health services. Such a list, however, does not and cannot exist without exclusion of some people and without reinforcing structural oppressions, with regards to race, national origin, Indigenous status, socioeconomic status, religion, language(s) spoken, and ethnicity, among other intersectionalities. It is very likely that at least some of the terminology used in SOC-8 will be outdated by the time version 9 is developed. Some people will be frustrated by this reality, but it is hoped it will be seen instead as an opportunity for individuals and communities to develop and refine their own lexicons and for people to develop a still more nuanced understanding of the lives and needs of TGD people, including TGD people's resilience and resistance to oppression.

Finally, law and the work of legal professionals are within the remit of these Standards of Care. As such, language used most widely in international law is included here to help with the development of the functional definitions of these terms and encourage their usage in legal contexts in lieu of more antiquated and/or offensive terms. The currently most thorough document in international human rights law uses the term "gender diverse."[1]

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

Statement 1.1

We recommend health care professionals use culturally relevant language (including terms to describe transgender and gender diverse people) when applying the Standards of Care in different global settings.

Culturally relevant language is used to describe TGD people in different global settings. For example, the concepts of sex, gender, and gender diversity differ across contexts, as does the language used to describe them. Thus, the language used when caring

for TGD people in Thailand is not going to be the same as that used for TGD care in Nigeria. When applying the Standards of Care globally, we recommend health care professionals (HCPs) utilize local language and terms to deliver care in their specific cultural and/or geographical locale.

Gender affirmation refers to the process of recognizing or affirming TGD people in their gender identity—whether socially, medically, legally, behaviorally, or some combination of these (Reisner, Poteat et al., 2016). Health care that is gender-affirming or trans-competent utilizes culturally specific language in caring for TGD people. Gender-affirming care is not synonymous with transition-related care. Provision of transition-related care, such as medical gender affirmation via hormones or surgery, does not alone ensure provision of gender-affirming care, nor does it indicate the quality or safety of the health care provided.

Consultation and partnerships with TGD communities can help to ensure relevancy and inclusivity of the language used in providing health care locally in a particular context and setting.

Statement 1.2

We recommend health care professionals use language in health care settings that upholds the principles of safety, dignity, and respect.

Safety, dignity, and respect are basic human rights (International Commission of Jurists, 2007). We recommend HCPs utilize language and terminology that uphold these human rights when providing care for TGD people. Many TGD people have experienced stigma, discrimination, and mistreatment in health care settings, resulting in suboptimal care and poor health outcomes (Reisner, Poteat et al., 2016; Safer et al., 2016; Winter, Settle et al., 2016). Such experiences include misgendering, being refused care or denied services when sick or injured and having to educate HCPs to be able to receive adequate care (James et al., 2016). Consequently, many TGD people feel unsafe accessing health care. They may avoid health care systems and seek other means of getting health-related needs met, such as taking hormones without a medical prescription or monitoring and relying on peers for medical advice. Furthermore, previous negative experiences in health care settings are associated with future avoidance of care among TGD people.

Many TGD people have been treated unjustly, with prejudice, and without dignity or respect by HCPs, and lack of trust is often a barrier to care. Using language grounded in the principles of safety, dignity, and respect in health care settings is paramount to ensure the health, well-being, and rights of TGD people globally. Language is a significant component of gender-affirming care, but language alone does not resolve or mitigate the systematic abuse and sometimes violence TGD people face globally in care settings. Language is but one important step toward patient/client-centered and equitable health care among TGD people. Other concrete actions HCPs can take include obtaining informed consent and refraining from making assumptions about a person's needs based on their gender or TGD status.

Statement 1.3

We recommend health care professionals discuss with transgender and gender diverse people what language or terminology they prefer.

In providing health care to TGD people, we recommend HCPs discuss with their patients what language or terminology they prefer be used when referring to them. This discussion includes asking TGD people how they would like to be addressed in terms of name and pronouns, how they self-identify their gender, and about the language that should be used to describe their body parts. Utilizing affirming language or terminology is a key component of TGD-affirming care (Lightfoot et al., 2021; Vermeir et al., 2018). Furthermore, these discussions and communications can serve to build rapport and reduce the mistrust many TGD people feel toward HCPs and experience within health care systems. Discussions and usage of language or terminology can also facilitate engagement and retention in care that is not specifically TGD-related, such as uptake of routine preventive screenings and any necessary medical follow-up of findings. In electronic health records, organ/anatomical inventories can be standardly used to inform appropriate clinical care, rather than relying solely on assigned sex at birth and/or gender identity designations.

HCPs and health care settings can implement standardized procedures to facilitate these conversations such as: using intake forms that include chosen pronouns and name, inviting

all staff (regardless of gender, i.e., cisgender, TGD) to use pronouns in introductions, having pronouns accompany names on a document for all patients, and not using gendered honorifics (e.g., Ms., Mr.). Policies for HCPs and health care settings can be put in place to ensure a TGD person's privacy and right to confidentiality, including when they disclose being a TGD person, and if/how to appropriately document. For example, a clinic policy may be to record this information as private and confidential between HCPs and patients/clients, and that it should only be disclosed on a "need to know" basis.

Note

1. A/73/152, Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity

CHAPTER 2 Global Applicability

People who defy cultural boundaries of sex and gender have existed in cultures worldwide since ancient times, sometimes acknowledged in local language terms (Feinberg, 1996). In contrast to the more recent pathologization of gender diversity as an illness, some cultures traditionally celebrated and welcomed this diversity (e.g., Nanda, 2014; Peletz, 2009). Today, the English language umbrella term transgender and gender diverse (TGD) describes a huge variety of gender identities and expressions, and therefore a population with diverse health care experiences and needs. Together, TGD people represent important aspects of human diversity the World Professional Association for Transgender Health (WPATH) asserts should be valued and celebrated. TGD people continue to make vital contributions to the societies in which they live, although often these are unrecognized.

Disturbingly, many TGD people in the modern world experience stigma, prejudice, discrimination, harassment, abuse and violence, resulting in social, economic and legal marginalization, poor mental and physical health, and even death—a process that has been characterized as a stigma-sickness slope (Winter, Diamond et al., 2016). Experiences such as these (and the anticipation or fear of encountering such experiences) leads to what Meyer has described as minority stress (Meyer, 2003; see also Bockting et al., 2013 writing specifically about TGD people), and are associated with poor physical (e.g. Rich et al, 2020) and psychological (e.g., Bränström et al., 2022; Scandurra et al., 2017; Shipherd et al., 2019, Tan et al., 2021) health outcomes.

Violence against TGD people is a particular problem. Seen from a global perspective, it is widespread, diverse in nature (emotional, sexual and physical, e.g., see Mujugira et al., 2021), and involves a range of perpetrators (including State actors). Statistics on murder, the form of violence most extreme in its consequences, are alarming. Worldwide, there were over 4,000 documented killings between January 2008 and September 2021; a statistic widely regarded as flawed by under-reporting (TGEU, 2020).

Since the publication of the Standards of Care Version 7 (SOC-7), there have been dramatic changes in perspectives on TGD people and their health care. Mainstream global medicine no longer classifies TGD identities as a mental disorder. In the Diagnostic and Statistical Manual Version 5 (DSM-5) from the American Psychiatric Association (APA, 2013), the diagnosis of *Gender Dysphoria* focuses on any distress and discomfort that accompanies being TGD, rather than on the gender identity itself. A text revision (DSM-5-TR) was published in 2022. In the International Classification of Diseases, Version 11 (ICD-11), the diagnostic manual of the World Health Organization (WHO, 2019b), the *Gender Incongruence* diagnosis is placed in a chapter on sexual health and focuses on the person's experienced identity and any need for gender-affirming treatment that might stem from that identity. Such developments, involving a depathologization (or more precisely a de-psychopathologization) of transgender identities, are fundamentally important on a number of grounds. In the field of health care, they may have helped support a care model that emphasizes patients' active participation in decision-making about their own health care, supported by primary health care professionals (HCPs) (Baleige et al., 2021). It is reasonable to suppose these developments may also promote more socially inclusive policies such as legislative reform regarding gender recognition that facilitates a rights-based approach, without imposing requirements for diagnosis, hormone therapy and/or surgery. TGD people who have changed gender markers on key documents enjoy better mental health (e.g., Bauer et al., 2015; Scheim et al., 2020). A more rights-based approach in this area may contribute greatly to the overall health and well-being of TGD people (Arístegui et al., 2017).

Previous editions of the SOC have revealed much of the recorded clinical experience and knowledge in this area is derived from North American and Western European sources. They have focused on gender-affirming health care in high income countries that enjoy relatively well-resourced health care systems (including those with trained mental health providers, endocrinologists, surgeons and other specialists) and where services are often funded publicly or (at least for some patients) through private insurance.

For many countries, health care provision for TGD people is aspirational; with resourcing in this area limited or non-existent, and services often unavailable, inappropriate, difficult to access and/or unaffordable. Few if any HCPs (primary or specialist) may exist. Funding for gender-affirming health care may be absent, with patients often bearing the full costs of whatever health care they access. Health care providers often lack clinical and/or cultural competence in this area. Training for work with these patients may be limited (e.g., Martins et al., 2020). For all these reasons and because of mainstream "Western" medicine's historical view of TGD people as mentally disordered (a perspective that has only recently changed), TGD people have commonly found themselves disempowered as health care consumers.

Health care providers have found the relevant literature is largely North American and European, which present particular challenges for persons working in health care systems that are especially poorly resourced. Recent initiatives that often involve TGD stakeholders as partners are changing this situation somewhat by providing a body of knowledge about good practice in other regions, including how to provide effective, culturally-competent TGD health care in low- and middle-income countries outside the global north.

Within the field, a wide range of valuable health care resources have been developed in recent years. Dahlen et al (2021) review twelve international clinical practice guidelines; over half those reviewed originate from professional bodies based in North America (e.g., Hembree et al., 2017) or Europe (e.g., T'Sjoen et al., 2020). Three are from WHO (the most recent being WHO, 2016). Nowadays, there are numerous other resources, not on Dahlen et al.'s list, that explicitly draw on expertise from regions outside North America and Europe. Examples can be found in Asia and the Pacific (APTN, 2022; Health Policy Project et al., 2015), the Caribbean (PAHO, 2014), Thailand, Australia (Telfer et al., 2020), Aotearoa New Zealand (Oliphant et al., 2018), and South Africa (Tomson et al., 2021) (see also TRANSIT (UNDP et al., 2016)). These resources have commonly been created through the initiatives of or in partnership with TGD communities locally or internationally. This partnership approach, focused on meeting local needs in culturally safe and competent ways, can also have broad international relevance. Some of these publications may be of particular value to those planning, organizing and delivering services in low-income, low-resource countries. There are likely to be other resources published in languages other than English of which we are unaware.

Globally, TGD identities may be associated with differing conceptual frameworks of sex, gender, and sexuality and exist in widely diverse cultural (and sometimes spiritual) contexts and histories. Considering the complex relationships between social and cultural factors, the law, and the demand for and provisions of gender-affirming health care, the SOC-8 should be interpreted through a lens that is appropriate for and within the context of each HCP's individual practice while maintaining alignment to the core principles that underscore it (APTN and UNDP, 2012; Health Policy Project et al., 2015; PAHO, 2014).

It is within this context and by drawing broadly on the experiences of TGD people and health care providers internationally that we consider the global applicability of SOC-8 within this chapter. We set out key considerations for HCPs and conclude by recommending core principles and practices fundamental to contemporary health care for TGD people, regardless of where they live or whether there are resources available to those who seek to provide such health care.

Statement 2.1

We recommend health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people.

Medical necessity is a term common to health care coverage and insurance policies globally. A common definition of medical necessity as used by insurers or insurance companies is "Health care services that a physician and/or health care professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically

Statements of Recommendations

2.1- We recommend health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people.
2.2- We recommend health care professionals and other users of the Standards of Care, Version 8 (SOC-8) apply the recommendations in ways that meet the needs of local transgender and gender diverse communities, by providing culturally sensitive care that recognizes the realities of the countries they are practicing in.
2.3- We recommend health care providers understand the impact of social attitudes, laws, economic circumstances, and health systems on the lived experiences of transgender and gender diverse people worldwide.
2.4- We recommend translations of the SOC focus on cross-cultural, conceptual, and literal equivalence to ensure alignment with the core principles that underpin the SOC-8.
2.5- We recommend health care professionals and policymakers always apply the SOC-8 core principles to their work with transgender and gender diverse people to ensure respect for human rights and access to appropriate and competent health care, including:

General principles
- Be empowering and inclusive. Work to reduce stigma and facilitate access to appropriate health care for all who seek it;
- Respect diversity. Respect all clients and all gender identities. Do not pathologize differences in gender identity or expression;
- Respect universal human rights including the right to bodily and mental integrity, autonomy and self-determination; freedom from discrimination, and the right to the highest attainable standard of health.

Principles around developing and implementing appropriate services and accessible health care
- Involve transgender and gender diverse people in the development and implementation of services;
- Become aware of social, cultural, economic, and legal factors that might impact the health (and health care needs) of transgender and gender diverse people, as well as the willingness and the capacity of the person to access services;
- Provide health care (or refer to knowledgeable colleagues) that affirms gender identities and expressions, including health care that reduces the distress associated with gender dysphoria (if this is present);
- Reject approaches that have the goal or effect of conversion and avoid providing any direct or indirect support for such approaches or services.

Principles around delivering competent services
- Become knowledgeable (get training, where possible) about the health care needs of transgender and gender diverse people, including the benefits and risks of gender-affirming care;
- Match the treatment approach to the specific needs of clients, particularly their goals for gender identity and expression;
- Focus on promoting health and well-being rather than solely the reduction of gender dysphoria, which may or may not be present;
- Commit to harm reduction approaches where appropriate;
- Enable the full and ongoing informed participation of transgender and gender diverse people in decisions about their health and well-being;
- Improve experiences of health services including those related to administrative systems and continuity of care.

Principles around working towards improved health through wider community approaches
- Put people in touch with communities and peer support networks;
- Support and advocate for clients within their families and communities (schools, workplaces, and other settings) where appropriate.

appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease." The treating HCP asserts and documents that a proposed treatment is medically necessary for treatment of the condition (American Medical Association, 2016).

Generally, "accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, designated Medical Specialty Societies and/or legitimate Medical Colleges' recommendations, and the views of physicians and/or HCPs practicing in relevant clinical areas.

Medical necessity is central to payment, subsidy, and/or reimbursement for health care in parts of the world. The treating HCP may assert and document that a given treatment is medically necessary for the prevention or treatment of the condition. If health policies and practices challenge the medical necessity of a treatment, there may be an opportunity to appeal to a governmental agency or other entity for an independent medical review.

It should be recognized gender diversity is common to all human beings and is not pathological. However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical

interventions. In many countries, medically necessary gender-affirming care is documented by the treating health professional as treatment for Gender Incongruence (HA60 in ICD-11; WHO, 2019b) and/or as treatment for Gender Dysphoria (F64.0 in DSM-5-TR; APA, 2022).

There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in TGD people in need of these treatments (e.g., Ainsworth & Spiegel, 2010; Aires et al., 2020; Aldridge et al., 2020; Almazan & Keuroghlian, 2021; Al-Tamimi et al., 2019; Balakrishnan et al., 2020; Baker et al., 2021; Buncamper et al., 2016; Cardoso da Silva et al., 2016; Eftekhar Ardebili, 2020; Javier et al., 2022; Lindqvist et al., 2017; Mullins et al., 2021; Nobili et al., 2018; Owen-Smith et al., 2018; Özkan et al., 2018; T'Sjoen et al., 2019; van de Grift, Elaut et al., 2018; White Hughto & Reisner, Poteat et al., 2016; Wierckx, van Caenegem et al., 2014; Yang, Zhao et al., 2016). Gender-affirming interventions may also include hair removal/transplant procedures, voice therapy/surgery, counseling, and other medical procedures required to effectively affirm an individual's gender identity and reduce gender incongruence and dysphoria. Additionally, legal name and sex or gender change on identity documents can also be beneficial and, in some jurisdictions, are contingent on medical documentation that patients may call on practitioners to produce.

Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria (e.g., Aires et al., 2020; Aldridge et al., 2020; Al-Tamimi et al., 2019; Balakrishnan et al., 2020; Baker et al., 2021; Bertrand et al., 2017; Buncamper et al., 2016; Claes et al., 2018; Eftekhar Ardebili, 2020; Esmonde et al., 2019; Javier et al., 2022; Lindqvist et al., 2017; Lo Russo et al., 2017; Marinkovic & Newfield, 2017; Mullins et al., 2021; Nobili et al., 2018; Olson-Kennedy, Rosenthal et al., 2018; Özkan et al., 2018; Poudrier et al., 2019; T'Sjoen et al., 2019; van de Grift, Elaut et al., 2018; White Hughto & Reisner, Poteat et al., 2016; Wierckx, van Caenegem et al., 2014; Wolter et al., 2015; Wolter et al., 2018).

Consequently, WPATH urges health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude coverage for any medically necessary procedures or treatments for the health and well-being of TGD individuals. In other words, governments should ensure health care services for TGD people are established, extended or enhanced (as appropriate) as elements in any Universal Health Care, public health, government-subsidized systems, or government-regulated private systems that may exist. Health care systems should ensure ongoing health care, both routine and specialized, is readily accessible and affordable to all citizens on an equitable basis.

Medically necessary gender-affirming interventions are discussed in SOC-8. These include but are not limited to hysterectomy +/- bilateral salpingo-oophorectomy; bilateral mastectomy, chest reconstruction or feminizing mammoplasty, nipple resizing or placement of breast prostheses; genital reconstruction, for example, phalloplasty and metoidioplasty, scrotoplasty, and penile and testicular prostheses, penectomy, orchiectomy, vaginoplasty, and vulvoplasty; hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process; gender-affirming facial surgery and body contouring; voice therapy and/or surgery; as well as puberty blocking medication and gender-affirming hormones; counseling or psychotherapeutic treatment as appropriate for the patient and based on a review of the patient's individual circumstances and needs.

Statement 2.2

We recommend health care professionals and other users of the Standards of Care, Version 8 (SOC-8) apply the recommendations in ways that meet the needs of local transgender and gender diverse communities, by providing culturally sensitive care that recognizes the realities of the countries they are practicing in.

TGD people identify in many different ways worldwide, and those identities exist within a cultural context. In English speaking countries, TGD people variously identify as *transsexual,*

trans, gender nonconforming, gender queer or diverse, nonbinary, or indeed *transgender and/or gender diverse,* as well as by other identities; including (for many identifying inside the gender binary) *male* or *female.* (e.g., James et al., 2016; Strauss et al., 2017; Veale et al., 2019).

Elsewhere, identities include but are not limited to *travesti* (across much of Latin America), *hijra* (across much of South Asia), *khwaja sira* (in Pakistan), *achout* (in Myanmar), *maknyah, paknyah* (in Malaysia), *waria* (Indonesia) *kathoey, phuying kham phet, sao praphet song* (Thailand), *bakla, transpinay, transpinoy* (Philippines), *fa'afafine* (Samoa), *mahu* (French Polynesia, Hawai'i), *leiti* (Tonga), *fakafifine* (Niue), *pinapinaaine* (Tuvalu and Kiribati), *vakasalewalewa* (Fiji), *palopa* (Papua Niugini), *brotherboys* and *sistergirls* (Aboriginal and Torres Strait Islander people in Australia), and *akava'ine* (Cook Islands) (e.g., APTN and UNDP, 2012; Health Policy Project et al., 2015; Kerry, 2014). There are also a large number of *two spirit* identities across North America (e.g., *nadleehi* in Navajo (Diné) culture) (Sheppard & Mayo, 2013). The identities to which each of these terms refer are often culturally complex and may exist in a spiritual or religious context. Depending on the cultures and the identities concerned, some may be regarded as so-called "third genders" lying beyond the gender binary (e.g., Graham, 2010; Nanda, 2014; Peletz, 2009). Some TGD identities are less firmly established than others. In many places worldwide, the visibility of transgender men and nonbinary trans masculine identities is relatively recent, with few or no applicable traditional terms in local languages (Health Policy Project et al., 2015). Regardless of where or with whom HCPs work (including those working with ethnic minority persons, migrants and refugees), they need to be aware of the cultural context in which people have grown up and live as well as the consequences for health care.

Worldwide the availability, accessibility, acceptability and quality of health care vary greatly, with resulting inequities within and across countries (OECD, 2019). In some countries, formal health care systems exist alongside established traditional and folk health care systems, with indigenous models of health underpinning the importance of holistic health care (WHO, 2019a). HCPs should be aware of the traditions and realities within which health care is available and provide support that is sensitive to the local needs and identities of TGD people and provide them with culturally competent and safe care.

Statement 2.3

We recommend health care providers understand the impact of social attitudes, laws, economic circumstances, and health systems on the lived experiences of transgender and gender diverse people worldwide.

TGD people's lived experiences vary greatly, depending on a range of factors, including social, cultural (including spiritual), legal, economic and geographic. When TGD people live in environments that affirm their gender and/or cultural identities, then these experiences can be very positive. Families are particularly important in this regard (e.g., Pariseau et al., 2019; Yadegarfard et al., 2014; Zhou et al., 2021). However, when viewed from a global perspective, the circumstances in which TGD people live are often challenging. They are commonly denied widely accepted rights in international human rights law. These include rights to education, health and protection from medical abuses, work and an adequate standard of living, housing, freedom of movement and expression, privacy, security, life, family, freedom from arbitrary deprivation of liberty, fair trial, treatment with humanity while in detention, and freedom from torture, inhuman or degrading treatment or punishment (International Commission of Jurists, 2007, 2017).

It is widely accepted that denial of rights can impact sexual and gender minority health and well-being (e.g., OHCHR et al., 2016; WHO, 2015). We therefore reaffirm here the importance of the rights listed above for TGD people and note WPATH's previous rights advocacy, including through numerous policy documents (e.g., WPATH, 2016, 2017, 2019). HCPs can play an important role in rights advocacy, including the right to quality gender-affirming health care that is appropriate, affordable, and accessible.

Across the world, a large number of studies detail the challenges TGD people face in their lives, and the impact on their health and well-being (e.g., Aurat Foundation, 2016;

Bhattacharya & Ghosh, 2020; Chumakov et al., 2021; Coleman et al., 2018; Heylens, Elaut et al., 2014; Human Rights Watch, 2014; James et al, 2016; Lee, Operario et al., 2020; Luz et al., 2022; McNeil et al., 2012, 2013; Motmans et al., 2017; Muller et al., 2019; Scandurra et al., 2017; Strauss et al., 2019; Suen et al., 2017; Valashany & Janghorbani, 2019; Veale et al., 2019; Wu et al., 2017). The research shows TGD people often experience stigma and prejudice as well as discrimination and harassment, abuse and violence, or they live in anticipation and fear of such actions. Social values and attitudes hostile to TGD people, often communicated to young people in school curricula (e.g., Olivier & Thurasukam, 2018), are also expressed in family rejection (e.g., Yadegarfard et al., 2014), and perpetuated in laws, policies and practices that limit freedom to express one's gender identity and sexuality and hinder access to housing, public spaces, education, employment and services (including health care). The end result is TGD people are commonly deprived of a wide range of opportunities available to their cisgender counterparts and are pushed to the margins of society, without family supports. To make matters worse, across much of the world TGD people's access to legal gender recognition is restricted or non-existent (e.g., ILGA World, 2020a; TGEU, 2021; UNDP and APTN, 2017). In some countries, such barriers nowadays draw on support from "gender-critical theorists" (as critiqued by e.g., Madrigal-Borloz, 2021; Zanghellini, 2020).

Gender identity change efforts (gender reparative or gender conversion programs aimed at making the person cisgender) are widespread, cause harm to TGD people (e.g., APTN, 2020a, 2020b, 2020c, 2021; Bishop, 2019; GIRES et al., 2020; Turban, Beckwith et al., 2020), and (like efforts targeting sexual orientation) are considered unethical (e.g., APS, 2021; Trispiotis and Purshouse, 2021; Various, 2019, 2021). These efforts may be viewed as a form of violence. The UN independent expert on protection against violence and discrimination based on sexual orientation and gender identity has called for a global ban on such practices (Madrigal-Borloz, 2020). An increasing number of jurisdictions are outlawing such work (ILGA World, 2020b).

Inequities arise from a range of factors, including economic considerations and values underpinning the provision of health care systems, particularly with regard to the emphasis placed on public-, private- and self-funding of health care. Lack of access to appropriate and affordable health care can lead to a greater reliance on informal knowledge systems. This includes information about self-administration of hormones, which, in many cases, is undertaken without necessary medical monitoring or supervision (e.g., Do et al., 2018; Liu et al., 2020; Rashid et al., 2022; Reisner et al., 2021; Winter & Doussantousse, 2009).

In some parts of the world, large numbers of transgender women employ silicone as a means of modifying their bodies, drawing on the services of silicone "pumpers" and/or attending pumping "parties", often within their communities. The immediate results of silicone pumping contrast with significant downstream health risks (e.g., Aguayo-Romero et al., 2015; Bertin et al., 2019; Regmi et al., 2021), particularly where industrial silicone or other injectable substances have been used and where surgical removal may be difficult.

Finally, sexual health outcomes for TGD people are poor. HIV prevalence for transgender women reporting to clinical organizations in metropolitan areas is approximately 19% worldwide, which is 49 times higher than the background prevalence rate in the general population (Baral et al., 2013). Sexual health outcomes for transgender men are also problematic (e.g., Mujugira et al., 2021).

Statement 2.4

We recommend translations of the SOC focus on cross-cultural, conceptual and literal equivalence to ensure alignment with the core principles that underpin the SOC-8.

Much of the research literature on TGD people is produced in high-income and English-speaking countries. global northern perspectives about TGD people (including those related to health care needs and provision) dominate this literature. A May 2021 Scopus database search undertaken by the current authors shows 99% of the literature on transgender health care comes out of Europe, North America, Australia, or New Zealand. Overall, 96% of the literature is in the English language. TGD people of the Global

South have received relatively little attention in the English language literature, and the work of those HCPs who interact with them has often gone unrecognized and unpublished or has not been translated into English. Applying resources produced in the global north risks overlooking the relevance and nuance of local knowledge, cultural frameworks and practices, and missed opportunities to learn from the work of others.

When translating the principles set out in the SOC, we recommend following best practice guidelines for language translation to ensure high quality written resources are produced that are culturally and linguistically appropriate to the local situation. It is important translators have knowledge about TGD identities and cultures to check that literal translations are culturally competent and safe for local TGD people. It is also important translation should follow established processes for quality assurance (Centers for Medicare & Medicaid Services, 2010; Sprager & Martinez, 2015)

Statement 2.5

We recommend health care professionals and policymakers always apply the SOC-8 core principles to their work with transgender and gender diverse people to ensure respect for human rights and access to appropriate and competent health care, including:

General principles

- Be empowering and inclusive. Work to reduce stigma and facilitate access to appropriate health care, for all who seek it;
- Respect diversity. Respect all clients and all gender identities. Do not pathologize differences in gender identity or expression;
- Respect universal human rights, including the right to bodily and mental integrity, autonomy, and self-determination; freedom from discrimination and the right to the highest attainable standard of health.

Principles around developing and implementing appropriate services and accessible health care

- Involve TGD people in the development and implementation of services;
- Become aware of social, cultural, economic, and legal factors that might impact the health (and health care needs) of transgender and gender diverse people, as well as the willingness and capacity of the person to access services;
- Provide health care (or refer to knowledgeable colleagues) that affirms gender identities and expressions, including health care that reduces the distress associated with gender dysphoria (if this is present);
- Reject approaches that have the goal or effect of conversion, and avoid providing any direct or indirect support for such approaches or services

Principles around delivering competent services

- Become knowledgeable (get training, where possible) about the health care needs of transgender and gender diverse people, including the benefits and risks of gender-affirming care;
- Match the treatment approach to the specific needs of clients, particularly their goals for gender identity and expression;
- Focus on promoting health and well-being rather than solely the reduction of gender dysphoria, which may or may not be present;
- Commit to harm reduction approaches where appropriate;
- Enable the full and ongoing informed participation of transgender and gender diverse people in decisions about their health and well-being;
- Improve experiences of health services, including those associated with administrative systems and continuity of care.

Principles around working towards improved health through wider community approaches

- Put people in touch with communities and peer support networks;
- Support and advocate for clients within their families and communities (schools, workplaces, and other settings) where appropriate.