THE COUNTESS

A chairde,

As an organisation promoting the rights of women and children in Ireland, with a particular focus on issues relating to gender ideology and its impact, we note with interest the announcement of your guideline development panel (https://www.who.int/news/item/18-12-2023-who-announces-the-development-of-a-guideline-on-the-health-of-trans-and-gender-diverse-people).

The Countess has a number of different pillars of concern and working groups addressing these pillars. Our working group on child transition (under 18) has reviewed the panel make up and identified a number of concerns. In addition, we have major concerns about the focus of the guideline. We outline both below.

Panel Membership

The panel demonstrates clear conflict of interests, and unbalanced views, with no clinicians or activists from organisations opposing the adoption of gender-affirming care. The panel has many current and former WPATH members, some of whom oversaw the development of care pathways that are not evidence based, and who demonstrate no willingness to examine research and opinion which does not support their position.

In addition, many panel members appear to be lobbyists and activists who have little or no expertise in analysing evidence or research findings and who pose a risk of being extremely biased when what is required is a dispassionate review of all available studies and information in this rapidly changing field.

The panel does not include any person from any organisation that favours a more cautious and therapy-based model of care for gender dysphoria and related issues. There is also a predominant representation of panellists who appear to favour the immediate affirmation/no exploratory therapy model advocated by WPATH. Given the lack of evidence of benefit for this model of care, it is a gross oversight not to include anyone who would challenge this and force a deeper evaluation of the

evidence. We recommend that Genspect should be invited to supply a panel member, as should clinicians who favour the exploratory and medical model of care (for example Dr O'Shea in Ireland).

It is noted that there are no experts in youth transition included in the panel and, given the exponential increases in children identifying as transgender and experiencing gender dysphoria, this is an area that must be represented (suggestion: Dr Riittakerttu Kaltiala, Finland).

The omission of people who have been harmed (desisters and detransitioners) by the adoption of a trans identity is notable, given the panel includes those who have had, one assumes, a more positive outcome. There are a number of adults now speaking in public about their experiences and it would be prudent to listen to their voices.

The public have a right to expect a prestigious organisation like the World Health Organisation to be impartial in their approach to all guidelines developed in their name. It is imperative that the panel make up be changed to reflect this or there is a risk of far-reaching reputational damage to the organisation.

Guideline Focus

Our concerns about the wording and content of the guideline are outlined for each of the five focus areas as given in the announcement article.

1. Provision of gender-affirming care, including hormones:
    - As there is no high-level evidence of benefit, the panel should carefully consider whether the provision of such treatments should be publicly funded, especially given the WHO assertion that being transgender is not a medical condition.
    - In particular, the panel should examine the low evidence of benefit and high evidence of harm to young people, as many national health services and international groups have found considerable issues with gender-affirming care as currently offered (https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf).
2. Health workers education and training for the provision of gender-inclusive care:

- The risk of direct and indirect harm to the general population must be considered, especially for women (e.g. cervical screening and language related to women's health); children (including safeguarding and exposure to confusing messaging) and vulnerable adults. There remains a clear need for single-sex provisions in healthcare delivery, which should not be changed in order to cater to individuals who claim a transgender identity.

3. Provision of health care for trans and gender diverse people who suffered interpersonal violence based in their needs:
    - Although the phrasing of this focus area is unclear, we agree that there should be provision of care where violence has occurred. Given high rates of violence against trans-identified males who are involved in prostitution, specific attention should be paid to the needs of this group.
4. Health policies that support gender-inclusive care:
    - All policies must take into account all consequences of this care, including resource allocation, women's health, children's health, and the indirect harms resulting from the adoption of language and care that replaces sex-based care and terminology (e.g in cancer screening literature).
5. Legal recognition of self-determined gender identity:
    - The inclusion of legal recognition of transgender identities, including self-identification, is extremely concerning and represents a considerable overstepping of the health remit of WHO. If this is to be included, the panel must examine consequences to women and children of legal sex recategorisation, and especially self id, in particular in, prisons and other single-sex spaces, health care, provision of services, child safeguarding and sport and physical activities.

We urge you to reassess the panel make up, the panel focus areas and the unquestioning approach being taken. To fail to do so risks undermining the credibility of an organisation that has international significance and should be to the fore of solid, evidence-based, healthcare.

Is mise, le meas,

Laoise De Brún

Founder and CEO, The Countess