

'Gender affirming healthcare' is not what the family physician needs to know



Authors:

Janet Giddy¹ 
Allan Donkin¹ 
Reitze Rodseth^{1,2} 

Affiliations:

¹First Do No Harm Southern Africa, Cape Town, South Africa

²Department of Anesthesiology, School of Clinical Medicine, University of KwaZulu-Natal, Pietermaritzburg, South Africa

Corresponding author:
Janet Giddy,
janetgiddy@gmail.com

Dates:
Received: 15 Oct. 2024
Accepted: 17 Oct. 2024
Published: 13 Jan. 2025

How to cite this article:
Giddy J, Donkin A, Rodseth R. 'Gender affirming healthcare' is not what the family physician needs to know. *S Afr Fam Pract*. 2025;67(1), a6061. <https://doi.org/10.4102/safp.v67i1.6061>

Copyright:
© 2025. The Authors.
Licensee: AOSIS. This work is licensed under the Creative Commons Attribution License.

Read online:



Scan this QR code with your smart phone or mobile device to read online.

In July 2023, the *South African Family Practice* (SAFP) journal published *An introduction to gender affirming healthcare: What the family physician needs to know*.¹ In this article, Muller et al. promote the Southern African HIV Clinicians Society Gender-Affirming Healthcare Guideline for South Africa (SAHCS GAHG)² which they co-authored. The article recommends that family physicians give cross-sex hormones to 'Transgender and gender diverse' (TGD) people and that this should happen at 'primary care level'.

The terms 'transgender' and 'gender diverse' are neither in the International Classification of Diseases (ICD-11)-11³ nor in the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, Text Revision (DSM-5-TR).⁴ ICD-11 uses the codes HA60 (Gender incongruence of adolescence or adulthood), HA61 (Gender incongruence of childhood) and HA6Z (Gender incongruence, unspecified). The World Health Organization's (WHO) rationale (through ICD-11) is that 'TGD people' do not have conditions of mental ill-health, and that a mental ill-health classification can cause stigma, an unevidenced claim.⁵ The DSM-5-TR has gender dysphoria as a *diagnosis* using the codes 302.6 ('Gender Dysphoria in Children') and 302.85 ('Gender Dysphoria in Adolescents and Adults').

Notwithstanding this confusing terminology, there is a global exponential increase in people presenting with gender confusion, gender distress and transgender ideation. The complex aetiology and epidemiology of this phenomenon are poorly understood. It is not explained by the 'left-handed' analogy used by Muller et al.

'Gender affirming healthcare' (GAHC) has its historical origins in transsexualism and 'intersex', and experimentation with body alteration using hormones and surgery. Historical accounts make for disturbing reading.⁶ The lead developer of GAHC is the World Professional Association of Transgender Health (WPATH). The 8th edition of WPATH's Standards of Care (SOC8)⁷ is their most recent version of their 'care' construct. For SOC8, WPATH commissioned a systematic review of cross-sex hormone use. Their own review showed no evidence for efficacy and safety.⁸ Nevertheless, SOC8 goes on to recommend the use of cross-sex hormones.

The World Professional Association of Transgender Health has many affiliates, including the Professional Association of Transgender Health South Africa (PATHSA). The Professional Association of Transgender Health South Africa and Muller et al. promote 'GAHC' for 'TGD people', who by their own determination, have no pathology. At the 'TGD' client's request, GAHC should be initiated to 'affirm' their transgender ideation. Gender affirming healthcare consists of:

- *Social transition* at any age of presentation, including young children.
- *Puberty suppression* in prepubertal children and adolescents.
- *Cross-sex hormones*, including in adolescents and young adults.
- *Body altering surgery*, such as breast and penis amputations, including in adolescents and young adults.

These core interventions, detailed in the SAHCS GAHG and promoted in Muller et al.'s article, create a lifetime dependency on the health system in people with previously healthy bodies.

The SAHCS GAHG draws heavily on WPATH's SOC7 (SOC8's predecessor), published in 2012. Neither was compiled using global best practice for guideline development, nor are they based on high-quality evidence. There is much circular referencing. An independent review of the SAHCS GAHG performed by epidemiologists at York University as part of the Cass Review⁹ concluded that the SAHCS GAHG and its recommendations should not be followed.¹⁰ The Cass Review further concluded that 'gender affirming' medical treatments were based on 'wholly inadequate

evidence' and noticed that young adults between 18 years and 25 years in adult gender clinics are also vulnerable and need safeguarding.⁹

The practice of medicine is a discipline, the cornerstones of which are that for each patient, clinicians need to take a careful history, do a thorough examination, interpret findings into a careful assessment, and then make a considered treatment plan, *guided by good evidence*. This is equally important for people experiencing gender distress. Muller et al. regard this as 'gatekeeping'.

Thus, GAHC is neither healthcare nor is it a 'new medical field' as Muller et al. declare. It is a 'care' construct arising out of an ideology that believes that a human can be 'born in the wrong body'.

The National Department of Health has no policies on providing GAHC at any level. No South African professional medical body no academic institution recognises GAHC as a 'new field of medicine'. Gender affirming healthcare places children, adolescents and young adults at risk of serious harm. Medical societies, practitioners and scientific journals should foster proper evidence-based clinical practice and health system development. Any training in and practice of GAHC, as formulated and promoted by PATHSA and Muller et al., should *not* happen in mainstream medical care at any level, let alone in the 'primary health care setting'.

With GAHC not being a 'new field in medicine', and not fitting the family medicine paradigm, clinicians should strongly refute the assertion that GAHC is much needed. What is needed, is a careful and evidence-based approach to understanding the complex aetiology, epidemiology, and possible treatment options for people with gender confusion, much of which is still to be established. In the meantime, clinicians need to follow standard and accepted medical and psychological approaches for children, and vulnerable adolescents and adults with gender distress.

Acknowledgements

The authors acknowledge First Do No Harm Southern Africa.

Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

J.G., A.D., and R.R. contributed to writing, reviewing and editing.

Funding information

The only funding received was from the University of KwaZulu-Natal for publication.

Data availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Disclaimer

The views and opinions expressed in this article are those of the authors and are the product of professional research. It does not necessarily reflect the official policy or position of any affiliated institution, funder, agency, or that of the publisher. The authors are responsible for this article's results, findings, and content.

References

1. Muller M, De Vries E, Tomson A. An introduction to gender affirming healthcare: What the family physician needs to know. *S Afr Fam Pract.* 2023;65(4):a5770. <https://doi.org/10.4102/safp.v65i1.5770>
2. Tomson A, McLachlan C, Watrus C, et al. Southern African HIV clinicians society gender-affirming healthcare guideline for South Africa – Expanded version [homepage on the Internet]. 2021 [cited 2024 Oct 1]. Available from: <https://sahivsoc.org/Subheader/Index/sahcs-guidelines>.
3. World Health Organization. HA60, HA61, HA62 Gender incongruence. In: International classification of diseases for mortality and morbidity statistics (11th revision). Geneva: World Health Organization; 2019 [cited 2024 Oct 1]. Available from: <https://icd.who.int/browse/2024-01/mms/en#411470068>
4. American Psychiatric Association. Gender dysphoria 302.6, 302.85. In: Diagnostic and statistical manual of mental disorders. 5th ed., Text Revision (DSM-5-TR). Washington: American Psychiatric Association; 2022; p. 511–20.
5. Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: Revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatr.* 2016;15(3):205–221. <https://doi.org/10.1002/wps.20354>
6. Hughes M. The WPATH files pseudoscientific surgical and hormonal experiments on children, adolescents, and vulnerable adults [homepage on the Internet]. 2024; p. 6–9. [cited 2024 Oct 1]. Available from: <https://environmentalprogress.org/big-news/wpath-files>.
7. Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, version 8. *Int J Transgend Health.* 2022;23(sup1):S1–S259. <https://doi.org/10.1080/26895269.2022.2125695>
8. Baker KE, Wilson LM, Sharma R, Dukhanin V, McArthur K, Robinson KA. Hormone therapy, mental health, and quality of life among transgender people: A systematic review. *J Endocr Soc.* 2021;5(4):bvab011. <https://doi.org/10.1210/jendso/bvab011>
9. Cass H. Independent review of gender identity services for children and young people: final report. London: NHS England; 2024.
10. Taylor J, Hall R, Heathcote C, Hewitt CE, Langton T, Fraser L. Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: A systematic review of guideline quality (part 1). *Arch Dis Child.* 2024;109(Suppl 2):s65–s72.