Submission: Consultation on safety measures for the use of puberty blockers in young people with gender-related health needs
Ani O'Brien | January 2025

My contribution to the consultation on safety measures for the use of puberty blockers is simple: ban the use of puberty blockers to 'treat' gender-related health issues in New Zealand.

My background is in women's and children's rights. I am the former spokeswoman for Speak Up For Women and have a public profile as a women's rights advocate.

I am not a doctor, nor am I a parent (yet). However, nor are many of the people who have had disproportionate influence on policy and guidelines regarding gender-related medicine in New Zealand. The 'stakeholders' and 'experts' who have been treated as the authority on these matters are frankly often no more than activists.

Because of this, my *opinions* are centred on the politics that has distracted policy makers and politicians from the most important thing; the safety and wellbeing of children in New Zealand. Any medical evidence and analysis is backed up by those with the relevant medical expertise.

The activist-driven medicalisation of children deemed to be suffering from gender-related issues in New Zealand has led to doctors prescribing puberty blockers to young people at rates vastly higher than countries we compare ourselves to. The New Zealand Herald reports this rate is up to "seven times higher" than comparable countries.[1]

Many of these countries have now ceased prescribing puberty blockers completely. Great Britain, for example, placed a temporary ban on prescription of the drugs under the previous Conservative Government. Then, when the new Labour Government formed, they made this ban indefinite.[2] Both political parties cited the *Cass Review* as a thorough and valuable piece of research.

It is heartening to know that sometimes, when an issue is serious enough, politics can be set aside to protect the wellbeing of children. Unfortunately, we have not seen the same bipartisan commitment to child safety and wellbeing in New Zealand. Here, anyone who remotely challenges gender ideology and its associated medical practices is met with controversy, hostility, and aggression. Politics is put well above what is good for our children and that is very wrong.

It is my contention that the question of whether it is safe to prescribe puberty blockers to children with gender-related health needs is not a difficult one to answer. It is obvious. There is quality research, like the *Cass Review*, to refer to.[3] Countries like Great Britain, France, Sweden, and Finland have banned puberty blockers already.[4] There are law suits and malpractice cases cropping up all over the developed world relating to gender-related treatments including puberty blockers.[5] And, crucially, there is a void of credible research proving that puberty blockers make any material difference to a young person's wellbeing.

The risks simply outweigh a severe lack of benefits.

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[1] www.nzherald.co.nz/nz/puberty-blocker-use-in-new-zealand-far-higher-than-similar-countries-study/
[2] www.gov.uk/government/news/ban-on-puberty-blockers-to-be-made-indefinite-on-experts-advice
[3] www.cass.independent-review.uk/home/publications/final-report/
[4] www.forbes.com/sites/joshuacohen/2023/06/06/increasing-number-of-european-nations-adopt-a-more-cautious-approach-to-gender-affirming-care-among-minors
[5] www.thehill.com/opinion/4284777-matthews-here-come-the-gender-detransitioner-lawsuits/

The reason that this issue has been so contentious in New Zealand is not because it is a challenging medical equation. It is because of politicisation and the aggressive tactics of activists whose ideological messages have been amplified by a media who have refused to report fairly and accurately on the topic. Politicians are afraid to incur the wrath of the rainbow groups and to get bad media coverage. Public servants are aware that if they question the sacred cows connected to gender identity they will face social ostracism or even disciplinary action.

An example of how politicisation has played out internationally is the paper *An Evidence-Based Critique of the Cass Review* which came out of Yale law school.[6] The paper was co-authored by some heavy weights of the online trans-activism world who called the *Cass Review* "coercive and unethical".[7] It attacked everything from the application of scientific method to data analysis and their rebuke drew a lot of attention.

Immediately, this had an impact on the credibility of the four-year NHS-commissioned *Cass Review* and muddied the water even further for physicians trying to understand the risks for their patients. Although the paper was online-only, and not peer-reviewed, and a disclaimer was added to the paper saying that the work did not represent Yale's views, the British Medical Association council put stock in the critique and sought to publicly disavow the *Cass Review* (without consulting members).[8]

Archives of Disease in Childhood (*ADC*) (an international paediatric journal from BMJ and the Royal College of Paediatrics and Child Health (RCPCH)) then published a peer-reviewed analysis scrutinizing the claims in the Yale paper.[9] This analysis, co-authored by several of the U.K.'s leading clinicians, concluded that the Yale paper "is not a credible scientific effort, but rather, an attempt to influence U.S. litigation while masquerading as scientific critique."[10]

Children and young people presenting with gender incongruence or 'gender dysphoria' are like an increasingly worn tennis ball being smashed across the net of international gender politics. Adults in positions of power and influence are sacrificing these children's health, wellbeing, and future fertility in service of their own personal crusades and virtue signals.

In New Zealand, the Ministry of Health and the ministers must not subject young Kiwis to the toxic tennis match any longer. They must set aside everything except the evidence. This cannot be a discussion grounded in ideology and a kind of purity politics. This is about whether a medical treatment is safe for children and whether its use has a positive impact.

There is *plenty* of evidence that supports the conclusion that it is *not* safe to administer puberty blockers and its use has negligible positive impact.

I recommend reading the plethora of information the Society for Evidence Based Gender Medicine (SEGM) has on their website.[11] The New York Times described SEGM as "one of the

[6] https://segm.org/Cass_Integrity_Project_Yale
[7] Ibid.
[8] www.theguardian.com/society/article/2024/sep/07/bma-stance-on-cass-review-of-transgender-care-has-damaged-its-reputation
[9] https://adc.bmj.com/content/early/2024/10/15/archdischild-2024-327994
[10] Ibid.
[11] https://segm.org/

most reliable nonpartisan organizations dedicated to the field" and they have featured in many medical journals since their inception in 2020.[12]

SEGM say:

> *"The 2024 Cass Review — the most comprehensive evaluation of the practice of youth gender medicine — confirmed the exceptionally weak evidence base underpinning the field of youth gender medicine, and exposed growing problems with on-demand gender transitions not only for adolescents but also for young adults.*
> *Following multiple systematic reviews of evidence, and actions by several public health authorities, there is now wide acknowledgment that the practice of youth transition has not demonstrated reliable psychological benefits, and that harms can be significant."*[13]

Suppressing puberty in children via puberty blocking Gonadotropin-Releasing Hormone Agonists (GnRHa) has several known risks. One is that patients could "end with a decreased bone density, which is associated with a high risk of osteoporosis."[14] This study used data from the Tavistock Clinic. Dutch researchers found similar results.[15]

In 2024, a systemic review into interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence concluded that there is consistent evidence that bone density and height may be compromised by the use of puberty blockers.[16] In addition, it found that worsened executive cognitive functioning as observed in those treated with puberty blockers for more than one year compared to those not treated.[17]

The same review analysed the psychosocial functioning, quality of life, and peer relations of young people on puberty blockers. It found that there was no change in their quality of life and:

> *"For psychosocial functioning, both pre-post studies reported no clinically significant change at follow-up."*

Both the above review and the one quoted below express concern that there is simply not enough high quality research demonstrating the outcomes (both positive and negative) of using puberty blockers:

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[12] https://www.nytimes.com/live/2024/01/30/opinion/thepoint?searchResultPosition=2#transgender-detransitioning-numbers
[13] Ibid.
[14] Henriette A Delemarre-van de Waal, Peggy T Cohen-Kettenis, **Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects**, *European Journal of Endocrinology*, Volume 155, Issue Supplement_1, Nov 2006, Pages S131–S137, https://doi.org/10.1530/eje.1.02231
[15] Sebastian E E Schagen, Femke M Wouters, Peggy T Cohen-Kettenis, Louis J Gooren, Sabine E Hannema, **Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones**, *The Journal of Clinical Endocrinology & Metabolism*, Volume 105, Issue 12, December 2020, Pages e4252–e4263, https://doi.org/10.1210/clinem/dgaa604
[16] Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024). **Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: a systematic review**. *Archives of Disease in Childhood*. https://doi.org/10.1136/archdischild-2023-326669
[17] Ibid.

> *"There is a lack of evidence on treatment for GD in adolescence. Although there is a growing body of literature providing data, there are limitations to the scope and quality, and prospective studies with long-term follow-up from a range of centres internationally is required. This review series has highlighted a lack of quality evidence in relation to adolescent GD in general: epidemiology, comorbidity, and treatment impact is difficult to robustly assess. Without an improvement in the scientific field, clinicians, parents, and young people are left ill-equipped to make safe and appropriate decisions."*[18]

Often trans activists attempt to distract from conversations about the fertility impacts of puberty blockers. They downplay the risks and make silly political associations between those who raise concerns about this and supposed far right ideology. Puberty blockers are prescribed in prepubescence and early puberty and the young age of these patients makes it virtually impossible for informed consent to be obtained. A twelve year old girl cannot be expected to know if she will want to have children when she is an adult, for example. Nor can a parent ethically make this decision for her. But interventions, including GnRHa puberty blockers, do affect reproductive function.[19]

Discussion of fertility preservation options has become seen as an adequate mitigation for fertility risks, but research shows that less than 5% of trans-identifying young people who received medical interventions accessed preservation services.[20] Research is unclear as to whether this is a matter of it being cost-prohibitive or because of lack of interest. It is also a false promise to posit egg freezing, for example, as a way to ensure the ability to have children later in life. Aside from the fact that utilising the frozen eggs has its own associated and substantial costs, scientists have cautioned that the process is a "lottery ticket, not a guarantee."[21]

Aside from the more well-known side effects, there have been red flags raised around lesser known downstream consequences of transition. For example, one study has found "transgender youth on a GnRHa have lower estimated insulin sensitivity and higher glycemic markers and body fat than cisgender controls with similar characteristics."[22] The authors of the paper emphasise that further longitudinal studies are required to understand the significance of these findings. Another article examining the effect of hormone therapy on insulin sensitivity and incretin response found "insulin sensitivity but also post-OGTT incretin responses tend to increase with masculinization and to decrease with feminization."[23]

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[18] Thompson, L., Sarovic, D., Wilson, P., Irwin, L., Visnitchi, D., Sämfjord, A., & Gillberg, C. (2023). **A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment**. *PLOS Global Public Health*, *3*(8), e0001478. https://doi.org/10.1371/journal.pgph.0001478

[19] Pang KC, Peri AJS, Chung HE, et al. *Rates of Fertility Preservation Use Among Transgender Adolescents*. *JAMA Pediatr.* 2020;174(9):890–891. doi:10.1001/jamapediatrics.2020.0264

[20] Pang KC, Peri AJS, Chung HE, et al. *Rates of Fertility Preservation Use Among Transgender Adolescents*. *JAMA Pediatr.* 2020;174(9):890–891. doi:10.1001/jamapediatrics.2020.0264

[21] www.theguardian.com/society/2022/nov/11/not-a-guarantee-why-freezing-your-eggs-shouldnt-be-an-insurance-policy

[22] Nokoff, N. J., Scarbro, S. L., Moreau, K. L., Zeitler, P., Nadeau, K. J., Reirden, D., Juarez-Colunga, E., & Kelsey, M. M. (2021). **Body Composition and Markers of Cardiometabolic Health in Transgender Youth on Gonadotropin-Releasing Hormone Agonists**. *Transgender Health*, *6*(2), 111–119. https://doi.org/10.1089/trgh.2020.0029

[23] Shadid, S., Abosi-Appeadu, K., De Maertelaere, A.-S., Defreyne, J., Veldeman, L., Holst, J. J., Lapauw, B., Vilsbøll, T., & T'Sjoen, G. (2020). **Effects of Gender-Affirming Hormone Therapy on Insulin Sensitivity and Incretin Responses in Transgender People**. *Diabetes Care*, *43*(2), 411–417. https://doi.org/10.2337/dc19-1061

There are also risks that are well-known in other populations treated with cross-sex hormones that are likely to also apply to the under-researched population of young people seeking gender related medicine. For example, "in hypogonadal/postmenopausal individuals, hormone therapy has been associated with an increased risk for cardiovascular events (CVEs). Although transgender individuals hypothetically have an increased risk of CVEs, there is little known about the occurrence of CVEs in this population."[24]

The impacts of puberty blockers on cognitive function, pubescent brain development, and neuropsychological function are beginning to be explored with concerning results. Again, academics and physicians are calling out for more research, but messing with kids' brains with insufficient evidence of impact and efficacy is unethical to the extreme.
Even the most basic understanding of the consequences on brain function put to bed the often cited, but completely false, notion that puberty blockers are reversible. Professor of Clinical Neuropsychology Sallie Baxendale says:

> *"1. Adolescence is a critical window of neurodevelopment and puberty plays a critical role in these neurodevelopmental processes.*
> *2. The suppression of puberty impacts brain structure and the development of social and cognitive functions in mammals, the effects are complex and often sex specific.*
> *3. No human studies have systematically explored the neuropsychological impact of pubertal suppression in transgender adolescents with an adequate baseline and follow up.*
> *4. Animal studies, single case reports and studies of the impact of puberty blockers in children with precocious puberty indicate that these treatments may be associated with reductions in IQ.*
> *5. The impact of pubertal suppression on measures of neuropsychological function should be an urgent priority for future research."*[25]

With urgent calls for research in this area, the Ministry of Health should at the very least put a temporary ban in place until questions of impact on young brains are answered. One review concluded:

> *"Critical questions remain unanswered regarding the nature, extent and permanence of any arrested development of cognitive function associated with puberty blockers. The impact of puberal suppression on measures of neuropsychological function is an urgent research priority."*[26]

It is important to note, that some of the more severe or exacerbating side effects of transition are caused by the use of cross-sex hormones rather than the puberty blockers themselves. However, employing puberty blockers should not be divorced from the subsequent prescription

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[24] Nota, N. M., Wiepjes, C. M., de Blok, C. J. M., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2019). **Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy: Results From a Large Cohort Study**. *Circulation*, *139*(11), 1461–1462. https://doi.org/10.1161/CIRCULATIONAHA.118.038584

[25] www.can-sg.org/2024/01/21/puberty-blockers-and-teenage-brain-development/

[26] Baxendale S. **The impact of suppressing puberty on neuropsychological function: A review**. Acta Paediatr. 2024 Jun;113(6):1156-1167. doi: 10.1111/apa.17150. Epub 2024 Feb 9. PMID: 38334046.

of cross-sex hormones as research demonstrates that almost all young people who take the blockers go on to take cross-sex hormones.[27]

In *Bell v Tavistock*[28], the continuity from puberty blockers to hormones was a core feature:

> *Lawyers representing the claimants said there was "a very high likelihood" children who start taking hormone blockers will later begin taking cross-sex hormones, leading potentially to infertility and impaired sexual function.*
>
> *The Tavistock argued puberty blockers and cross-sex hormones were entirely separate stages of treatment and one does not automatically lead to the other.*
>
> *The judges rejected that argument, saying "in our view this does not reflect the reality".*
>
> *"The evidence shows that the vast majority of children who take [puberty blockers] move on to take cross-sex hormones," and that these are part of "one clinical pathway".*[29]

Genspect's Stats For Gender website shares three studies that support the inevitability of the puberty blocker/hormone funnel.[30] A 2021 study from the UK found that only 1 out of 44 children placed on puberty blockers did not continue to take cross-sex hormones.[31] Similarly, a Dutch study reported that only 1.9% of adolescents who started puberty suppression treatment abandoned this course and did not take cross-sex hormones.[32] In fact, in a different Dutch study, "[n]o adolescent withdrew from puberty suppression, and all started cross-sex hormone treatment, the first step of actual gender reassignment."[33]

Any decision to place a child or young person on puberty blockers is a decision to put them on an inevitable pathway to further medicalisation and potentially surgery. It is vital therefore that the implications of cross-sex hormones and surgeries be considered as part of the risks of puberty blockers.

By continuing to allow doctors to prescribe puberty blockers to young people with gender-related issues the Ministry of Health is effectively allowing them to be treated as lab rats. While the majority consensus in academia is that there is simply not enough information for informed consent, we know enough about these drugs to be aware that they have potential for serious side effects.

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[27] www.bbc.com/news/uk-55282113
[28] www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf
[29] www.bbc.com/news/uk-55282113
[30] www.statsforgender.org/puberty-blockers-are-more-than-a-pause-button-roughly-98-of-children-who-take-them-go-on-to-take-cross-sex-hormones
[31] Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. (2021). **Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK**. PLOS ONE 16 (2).
[32] Wiepjes, C.M., Nota, N.M., de Blok, C.J.M., Klaver, M., de Vries, A.L.C., Wensing-Kruger, S.A., de Jongh, R.T., Bouman, M.B., Steensma, T.D., Cohen-Kettenis, P., Gooren, L.J.G., Kreukels, B.P.C. & den Heijer, M. (2018). **The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets.** Journal of Sexual Medicine 15 (4).
[33] de Vries, A.L.C., Steensma, T.D., Doreleijers, T.A. & Cohen-Kettenis, P.T. (2011). **Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study.** J Sex Med 8 (8): 2276-83.

Gonadotropin-Releasing Hormone Agonists are serious medications that are also used as part of treatments for advanced prostate cancer and hormone-responsive cancers in women.[34]

Not only are young people being treated as lab rats, but the clinical evidence shows that this risky experimentation is based on an ideological premise rather than a physically diagnosable reality. Although it is considered offensive by trans activists to describe gender incongruence or gender dysphoria as a mental illness or mental health condition, that is exactly what it is.[35] If something requires medical intervention in the form of pharmaceuticals or surgery, it must by definition be an illness, disorder, or condition. Activists cannot call puberty blockers "life-saving" on the one hand while refuting that the gender dysphoria they are purported to treat is not a medical matter.[36]

Furthermore, the existence of gender dysphoria cannot be measured, observed, or tested in the physical diagnostic sense. It can only be diagnosed via psychological assessment.[37] It is a mental illness and this should not be viewed as a pejorative statement. It is a statement of fact and those suffering from it should be treated with the same empathy and care as anyone else with mental health conditions.

Some experts have drawn a comparison between gender dysphoria and eating disorders like anorexia nervosa.[38] Their research is particularly relevant to the phenomena of vastly increased numbers of adolescent girls presenting with gender dysphoria. They warn that the complex dynamics of female adolescent development mean that trans-affirmative medical interventions should not be considered until adolescent development is complete.[39]

The paper points out a key difference between the way society and clinicians treat anorexia and gender dysphoria. That is that anorexia is not affirmed and the desire for the idealised body is not facilitated with medical treatment. On the other hand:

> "*Gender incongruence and "being trans" are currently extremely socially and politically legitimized and have been defined as a matter of human rights in recent years, which is also reflected in the planned "law of self-determination". As a result, those affected experience strong external validation and positive reinforcement in their disorder."*[40]

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[34] Farrah L. Saleh, Hugh S. Taylor, **Clinical applications of gonadotropin-releasing hormone analogues: a broad impact on reproductive medicine**, F&S Reports, Volume 4, Issue 2, Supplement, 2023, Pages 83-87. https://doi.org/10.1016/j.xfre.2023.01.008.
[35] https://www.renews.co.nz/gender-dysphoria-is-listed-as-a-disorder-some-experts-want-to-change-that/
[36] NZ Parents of Transgender and Gender Diverse Children, **Submission to Ministry of Health regarding consultation on safety measures for the use of puberty blockers in young people with gender-related health needs**, 2024. https://genderminorities.com/wp-content/uploads/2024/12/NZPOTC_submission_to_puberty_blockers_consultation.pdf
[37] www.nhs.uk/conditions/gender-dysphoria
[38] Korte, A., & Gille, G. (2023). **Wahlverwandtschaften? Trans-Identifizierung und Anorexia nervosa als maladaptive Lösungsversuche für Entwicklungskonflikte in der weiblichen Adoleszenz [Elective affinities? Trans-identification and anorexia nervosa as maladaptive attempts to resolve developmental conflicts in female adolescence].** *Sexuologie / DGSMTW*, *30 (3-4)*, 105–122. https://segm.org/gender-dysphoria-anorexia-korte-gille-elective-affinities
[39] Ibid.
[40] Ibid.

In short, we don't put young girls with anorexia on diets to help them lose weight. Rather, the approach is to treat the mental illness driving the body dysmorphia in a bid to develop healthy acceptance of their body. So why is it acceptable to employ experimental medicines to validate the plainly false belief that one is the opposite sex?

Anger at what activists call the "pathologisation" of gender dysphoria is so irrational that even advocacy for demedicalisation of the condition cannot be communicated without acknowledging a psychological component. American physician, and trans activist, Jack Turban describes gender dysphoria as "psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity."[41] But in the same article, Turban contradicts this saying "diverse gender expressions, much like diverse gender identities, are not indications of a mental disorder."[42]

In a New Zealand Herald article from September 2024, the journalist writes "advocates say [puberty blockers] can provide time to explore gender identity and potentially improve mental wellbeing."[43] It quotes Professor Simon Denny (a proponent of the use of puberty blockers) saying "to frame the [puberty blocker] data as alarming overlooks the reality that more individuals are actually receiving the care they need to live authentically and improve their mental well-being."[44]

If 'mental wellbeing' is a symptom that trans activists contend is improved by the use of puberty blockers, how can they deny that the issue being treated is a mental disorder? Of course, their contention is unsupported by data in any case. So their advocacy is really for a mental illness, which they deny is a mental illness, to be treated with an experimental drug that has no high quality evidence to support its efficacy.

The risks-versus-benefits-equation is further simplified by the growing body of evidence that reveals that transition does not necessarily improve mental health outcomes. In fact, complete medical and surgical transition is correlated to worsened mental health.[45] The sad and obscured reality is that "patients who have undergone gender-affirming surgery are associated with a significantly elevated risk of suicide."[46]

This is madness. It is the result of a political and social contagion that has been fed by aggressive activism of a small group of largely unqualified and self-interested people who have successfully bullied any critics into silence.

These trans activists insist that they, as the 'affected community', should have the paramount say in how their condition is defined, diagnosed, and treated. For example, political lobbying organisations like PATHA (Professional Association for Transgender Health Aotearoa) have been given privileged positions of influence by the Ministry of Health and other governmental departments.[47] This is despite their international governing body, the World Professional

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[41] www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria
[42] Ibid.
[43] www.nzherald.co.nz/nz/puberty-blocker-use-in-new-zealand-far-higher-than-similar-countries-study/
[44] Ibid.
[45] Straub J J, Paul K K, Bothwell L G, et al. (April 02, 2024) **Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery.** Cureus 16(4): e57472. doi:10.7759/cureus.57472
[46] Ibid.
[47] www.rnz.co.nz/news/national/514044/ministry-of-health-taking-the-time-to-get-it-right-on-puberty-blockers

Association for Transgender Health (WPATH), being thoroughly discredited, and abandoned as an expert source, following several scandals including evidence that came to light in *Boe v. Marshall* that WPATH was suppressing evidence reviews on hormone use.[48] The NHS in Great Britain has explicitly distanced its decision making from WPATH and it is no longer referred to in guidance.[49]

In New Zealand, PATHA President Jen Shields, who has an incomplete Bachelor of Arts degree and is not a medical professional, seeks to control the way transgenderism and gender dysphoria are defined and treated. Shields says pathologising "our identities isn't good full stop" and cites that a priority for PATHA currently is removing "burdensome" safeguards in the prescription of hormones.[50]

Writing for the Spinoff, Jen Shields asserts that PATHA should be seen as an equivalent in expertise to the New Zealand Society for Oncology on matters pertaining to cancer.[51] This is a ridiculous comparison given the President of NZSO is an actual medical oncologist.[52] Shields uses the debunked (and aforementioned) *Yale Report* in an attempt to discredit the *Cass Review* and condemns this entire public consultation process in part because Shields' own organisation, PATHA, was "excluded" from playing a role as experts.[53]

It is concerning given the lack of expertise and the high degree of personal activism from Shields and PATHA that they are currently running a "national training programme for GPs and other primary care practitioners, funded by Te Whatu Ora, to support GPs in gender diversity and gender-affirming care."[54] Re:News reports that "PATHA and Qtopia's training programme for GPs would mean patients would no longer need to see those specialists."[55]

Not only does the Ministry of Health need to issue a ban on the prescription of puberty blockers, but it also needs to claw back control of the information being taught to medical professionals, in schools, and to parents. This is a vital safeguarding issue. Unqualified activists should not be instructing GPs on how to prescribe medicines. They shouldn't be given the authority to define the parameters of diagnosis. They should not receive funding from the government to do so either.

There is a trend in medical academia to prioritise 'patient-centred care' which "encourages the active collaboration and shared decision-making between patients, families, and providers".[56] However, this does not extend to patients with heart disease, cancer, or schizophrenia being allowed to define the diagnostic parameters of their conditions and dictate to physicians the exact pharmaceuticals and surgical treatments. And so neither should trans activist groups be setting the guidelines for diagnosis and prescription for gender-related medicine.

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[48] www.segm.org/wpath-evidence-manipulation-risks-discrediting-WHO-transgender-guidelines
[49] www.theguardian.com/commentisfree/2024/mar/09/disturbing-leaks-from-us-gender-group-wpath-ring-alarm-bells-in-nhs
[50] www.renews.co.nz/gender-dysphoria-is-listed-as-a-disorder-some-experts-want-to-change-that
[51] www.thespinoff.co.nz/politics/04-12-2024/gender-affirming-care-affects-a-small-minority-so-why-the-public-consultation
[52] www.nzsoncology.org.nz/nzso25/leadership-team
[53] www.thespinoff.co.nz/politics/04-12-2024/gender-affirming-care-affects-a-small-minority-so-why-the-public-consultation
[54] www.renews.co.nz/gender-dysphoria-is-listed-as-a-disorder-some-experts-want-to-change-that
[55] Ibid.
[56] https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

It is my recommendation that in order to better assess the risks and benefits of the use of puberty blockers for gender-related health issues the Ministry of Health needs to create significantly more distance between themselves and trans activist organisations like PATHA, InsideOUT, Rainbow Youth, and more. There certainly should not be activists embedded in the ministry influencing policy.

The UK Government was able to better assess their own situation regarding the treatment of children and young people with gender dysphoria once they established distance from trans activist groups.[57] Both Conservative and Labour governments relied on medical experts rather than the demands of highly emotionally-engaged but unqualified activists.

Current UK Health and Social Care Secretary Wes Streeting concluded:

> *"Children's healthcare must always be evidence-led. The independent expert Commission on Human Medicines found that the current prescribing and care pathway for gender dysphoria and incongruence presents an unacceptable safety risk for children and young people."*[58]

And, James Palmer, NHS Medical Director for Specialised Services, responded:

> *"We welcome the government's decision to further ban access through private prescribers, which closes a loophole that posed a risk to the safety of children and young people."*[59]

Dr Hilary Cass, the author of the independent review of gender identity services for children and young people, commented also, saying:

> *"Puberty blockers are powerful drugs with unproven benefits and significant risks, and that is why I recommended that they should only be prescribed following a multi-disciplinary assessment and within a research protocol.*
> *I support the government's decision to continue restrictions on the dispensing of puberty blockers for gender dysphoria outside the NHS where these essential safeguards are not being provided."*[60]

I urge the Ministry of Health, Minister Dr Shane Reti, and other ministers to take their lead from the sombre and sensible measures taken in the UK. Activists will make a lot of noise, but they cannot be allowed to undermine the Government's obligations to the children and young people of this country.

The risks of puberty blockers are too high and the benefits are negligible at best.

Summary of recommendations:

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[57] www.theguardian.com/world/2023/aug/15/health-minister-says-stonewall-should-not-write-gender-policies-for-nhs-bodies
[58] www.gov.uk/government/news/ban-on-puberty-blockers-to-be-made-indefinite-on-experts-advice
[59] Ibid.
[60] Ibid.

1. Ban the prescription of puberty blockers for gender dysphoria and gender-related disorders via changes to the Medicines Act. *Note, the appropriateness of puberty blockers for other conditions is another matter and not one I am commenting on.*
2. Regulate medical 'education' programmes so that only medically qualified and appropriate organisations can instruct clinicians on how to diagnose and treat gender-related disorders.
3. Regulate gender-related 'education' programmes in schools, and for parents, so that only medically qualified and appropriate organisations can deliver information to students and parents.
4. Create distance (formally and informally) between the Ministry of Health and trans activist organisations. These relationships should be no more than consultative and equivalent to any other special interest group's access to decision makers.
5. Create penalties for doctors who prescribe puberty blockers off-label for gender-related conditions or seek to use loopholes to do the same.
6. Create penalties for organisations who undermine MOH clinical policy on banning puberty blockers by providing information on loopholes.