THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DECLARATION OF THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

RE: Safety, Effectiveness, and Professional Standards of Care for Sex-Rejecting Procedures on Children and Adolescents

Date: December 18, 2025

Declarant: Robert F. Kennedy Jr., Secretary of U.S. Department of Health and Human Services

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I, Robert F. Kennedy, Secretary of the U.S. Department of Health and Human Services (HHS), pursuant to my authority and responsibilities under federal law, and pursuant to 42 CFR § 1001.2, hereby declare as follows

I. BACKGROUND AND AUTHORITY

A. Rising Prevalence of Gender Dysphoria Diagnoses in Youth

In recent years, medical professionals have documented a substantial increase in gender dysphoria diagnoses among young people in the United States, with similar trends throughout Europe.[1] In response to this phenomenon and following the publication of the "Dutch Protocol," and subsequent endorsements by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (ES), the number of children and adolescents receiving medical interventions for gender dysphoria increased substantially.[2] These interventions, referred to in this Declaration as sex-rejecting procedures, include puberty-suppressing hormones, cross-sex hormones, and surgical procedures.

Research indicates that thousands of American children have undergone these sex-rejecting procedures.[3] Yet current medical evidence does not support a favorable risk/benefit profile for using these interventions to treat pediatric gender dysphoria. Moreover, existing clinical guidelines endorsing these procedures demonstrate significant variation in methodological rigor and quality.

To address these methodological concerns and evaluate the evidence for sex-rejecting procedures for children and adolescents, on May 1, 2025, HHS released a review of the evidence to identify best practices for treating pediatric gender dysphoria.[4] On November 19, 2025, HHS released the final, peer-reviewed report, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* ("the HHS Report").[5] The HHS Report is a comprehensive review of the evidence and literature related to sex-rejecting procedures.

B. Expansion of Medical Interventions for Gender Dysphoria

Following the 2006 publication of what became known as the "Dutch Protocol" in *The European Journal of Endocrinology*, pediatric medical interventions for gender dysphoria increased substantially.[6] During the subsequent decade, growing numbers of children and adolescents diagnosed with gender dysphoria began receiving medical procedures advocated by organizations such as the WPATH and the ES.[7]

WPATH's Standards of Care Version 8 (SOC-8) specifically acknowledged this trend, attributing the development of a dedicated adolescent chapter partly to what it characterized as exponential increases in youth referrals.[8] While earlier health system studies documented referral rates below 0.1 percent, more recent surveys identifying "transgender" youth report prevalence ranging from 1.2 to 2.7 percent, with "gender diverse" identification reaching as high as 9 percent.[9] WPATH documentation also indicates that adolescent females seek these interventions at rates between two and seven times higher than adolescent males.[10]

WPATH guidelines recommend that providers conduct thorough biopsychosocial evaluations of adolescents seeking medical transition, incorporating input from mental health specialists, medical professionals, parents or guardians, except in circumstances where parental involvement might cause harm.[11]

C. Scale of Pediatric Interventions in the United States

The number of pediatric patients seeking sex-rejecting procedures can only be roughly estimated. The decentralized and largely privatized nature of the American healthcare system has facilitated the proliferation of specialized gender clinics alongside numerous independent practitioners offering these services.[12] Conservative estimates from March 2023 identified 271 gender clinics operating across the United States, with approximately 70 rendered inactive due to state legislative restrictions.[13]

The treatment approach referenced in this declaration as sex-rejecting procedures—terminology that some refer to as “gender-affirming care”—encompasses several intervention types, when provided to minors: puberty-suppressing drugs that prevent the onset of puberty, cross-sex hormones that induce secondary sex characteristics of the opposite-sex, and surgical procedures, including breast removal and, less commonly, genital reconstruction. Thousands of American minors have undergone these interventions.[14]

Research published in 2023 estimated that from 2016 through 2020, approximately 3,700 adolescents in the U.S., aged 12 to 18 with gender dysphoria diagnoses underwent surgical interventions. This figure includes more than 3,200 youth who underwent breast or chest surgery and over 400 who had genital surgeries resulting in permanent reproductive organ alterations and compromised sexual function.[15] Separate research examining the period from 2017 to 2021 identified more than 120,000 children ages 6 through 17 diagnosed with gender dysphoria, with over 17,000 of these minors initiating either puberty blockers or hormonal therapy.[16] However, as discussed in the HHS Review, current medical evidence does not support a favorable risk/benefit profile for the use of chemical or surgical procedures in children to treat gender dysphoria.

D. Legal Authority for This Declaration

This declaration is issued pursuant to the authority vested in the HHS Secretary, and is informed by 42 CFR § 1001.2, which provides that "when the Department has declared a treatment modality not to be safe and effective, practitioners who employ such a treatment modality will be deemed not to meet professionally recognized standards of health care." As such, this declaration supersedes

"Statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a State." For reasons explained in this Declaration, standards of care recommended by certain medical organizations are unsupported by the weight of evidence and threaten the health and safety of children with gender dysphoria.

II. COMPREHENSIVE REVIEW OF EVIDENCE

HHS issued a comprehensive evidence review and best practices assessment regarding pediatric gender dysphoria care on May 1, 2025.[17] After the publication of this preliminary report, HHS also invited peer reviews from major medical associations, including the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the ES, as well as clinical experts and evidence-based medicine methodologists. While both the AAP and the ES declined to participate, HHS received reviews from the APA and seven invited peer reviewers for consideration. The report also engaged with two unsolicited reviews that were previously published in journals. In keeping with its commitment to radical transparency, HHS published all nine peer reviews alongside its detailed responses to each one,[18] as well as a final, revised report incorporating the feedback in November 2025.[19]

Employing an evidence-based medicine approach, the HHS Review identified substantial concerns regarding outcomes from specific medical interventions—namely puberty blockers, cross-sex hormones, and surgical procedures—intended to facilitate children's and adolescents' transition away from their sex. The Review documents significant risks from these procedures, including permanent harms such as infertility, while finding markedly insufficient evidence of therapeutic benefit. Crucially, the Review determined that existing evidence cannot support effectiveness claims for medical and surgical interventions in ameliorating mental health conditions or reducing gender dysphoria symptoms. As the Review states: "Analysis of the biological plausibility of harms is necessary and suggests that some short- and long-term harms are likely (in some cases expected) sequelae of treatment."[20] The evidence examined in the HHS Review demonstrates an unfavorable risk/benefit profile for medical and surgical interventions in children and adolescents with gender dysphoria diagnoses. While the HHS Review refrains from making specific clinical, policy, or legislative recommendations, it furnishes essential insights for policymakers charged with promoting health and safety, particularly for vulnerable populations such as children and adolescents.[21]

A. HHS Review Methodology

The HHS Review conducted an "umbrella review" of existing systematic reviews, including those that informed European health authorities' policy decisions, to assess their methodological quality and the evidence regarding the benefits and harms of hormonal and surgical interventions for treating pediatric gender dysphoria. The review found that the overall quality of evidence concerning the effects of sex-rejecting procedures on psychological outcomes, quality of life, regret, or long-term health, is very low.

B. Evidence Quality Regarding Therapeutic Benefits

The HHS Review also concluded that available evidence cannot support determinations regarding the effectiveness of medical and surgical interventions for mental health or alleviating gender dysphoria symptoms.

The Review states that pediatric medical transition evidence for benefit remains highly uncertain, while harm evidence demonstrates less uncertainty.[22] The evidence compilation indicates that medical and surgical interventions for children and adolescents diagnosed with gender dysphoria present an unfavorable risk-benefit profile.

C. Evidence and Analysis of Treatment Harms

While acknowledging that systematic reviews provide limited direct evidence of harms from sex-rejecting procedures in minors, the HHS Review offers plausible rationales for why such evidence may have been inadequately sought, detected, or reported. Contributing factors include the relatively recent implementation of hormonal and surgical treatment, deficiencies in monitoring and reporting adverse effects within existing studies, and publication bias.

Despite the absence of robust evidence from large-scale population studies, the HHS Review identifies known and plausible harm risks from puberty blockers, cross-sex hormones, and surgeries based on human physiology and pharmacological agents used. The Review notes that short- and long-term adverse effects are likely, and include infertility and sterility, sexual dysfunction, impaired bone density development, adverse cognitive effects, cardiovascular and metabolic disease, psychiatric conditions, surgical complications, and regret.[23]

D. International Shift Away from Pediatric Medical Transition

The HHS Review chronicles both the weak evidentiary basis and the growing international movement away from using puberty blockers, cross-sex hormones, and surgeries for treating gender dysphoria in minors, highlighting significant harm risks.[24] The Review provides methodologically rigorous assessment of evidence underlying surgical and endocrine interventions, including puberty suppression and cross-sex hormone use, while incorporating international practice evaluations such as the United Kingdom's Cass Review.

The Review documents mounting concerns regarding both the scarcity of reliable benefit evidence and the presence of significant harm risks associated with this care model, identifying psychotherapy as a non-invasive alternative approach.

E. Ethical Analysis and Conclusions

The HHS Review invokes widely recognized medical ethics principles to conclude that "medical interventions pose unnecessary, disproportionate risks of harm, healthcare providers should refuse to offer them even when they are preferred, requested, or demanded by patients."[25]As the Review states, "in the domain of pediatrics, these norms limit the authority not only of patients (who in any case lack full decision-making capacity) but of parents as well."[26] The first obligation of the physician, under the Hippocratic Oath, originating in the fourth century BC, is to first do no harm, as the purpose of the practice of medicine is to heal. Sex-rejecting procedures introduce a unique set of iatrogenic harms for minors, which may include "surgeries to remove healthy and functioning organs."[27] The Review states: "To discharge their duties of nonmaleficence and beneficence, clinicians must ensure, insofar as reasonably possible, that any interventions they offer to patients have clinically favorable risk/benefit profiles relative to the set of available alternatives, which includes doing nothing."[28] As related previously in this Declaration, the risk-benefit profile of these procedures for children is extremely poor. "The best available evidence," it finds, is that pediatric sex-rejecting procedures "have not been shown to improve mental health outcomes." "At the same time," the Review notes, "there is increasing recognition of the risk and harms associated" with pediatric sex-rejecting procedures, including "possible outcomes, such as impaired cognitive function, greater susceptibility to hormone-sensitive cancers, cardiac disease, reduced bone density, sexual dysfunction, infection, and infertility [that] are objectively detrimental to health." The Review concludes that "[s]uch medical harms, or plausible risks thereof, should not be imposed on children or adolescents in the absence of a reasonable expectation of proportionate medical benefit."[29]

Though the HHS Review deliberately avoids making clinical, policy, or legislative recommendations, it supplies critical information that should guide policymakers in decisions promoting health and safety, especially for vulnerable populations such as minors.[30]

III. INADEQUACY OF CLINICAL GUIDELINE FROM MEDICAL ORGANIZATIONS

I acknowledge that guidance from prominent U.S. medical professional organizations, including the American Medical Association (AMA), AAP, and APA, has characterized sex-rejecting procedures—termed by these organizations as "gender-affirming care"—as safe and effective.[31,32,33,34] These endorsements from medical societies have encouraged widespread clinician adoption of sex-rejecting procedures throughout the United States. The most influential sources of clinical guidance for treating pediatric gender dysphoria in the United States are the WPATH and the ES clinical practice guidelines and the AAP guidance document. However, a recent systematic review of international guideline quality by researchers at the University of York found that all three documents as very low quality and should not be implemented.[35]

As the HHS Review notes regarding the role of medical organizations in the treatment of pediatric gender medicine:

> U.S. medical associations played a key role in creating a perception that there is professional consensus in support of pediatric medical transition. This apparent consensus, however, is driven primarily by a small number of specialized committees, influenced by WPATH. It is not clear that the official views of these associations are shared by the wider medical community, or even by most of their members. There is evidence that some medical and mental health associations have suppressed dissent and stifled debate about this issue among their members.[36]

A. Endocrine Society

The ES issued clinical practice guidelines in 2017 entitled “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons.” As the HHS Review notes:

> In WPATH and ES guidelines, the principal goal of CSH administration is to induce physical characteristics typical of the opposite sex. When hormone levels rise beyond the typical reference range for a person’s sex, they are considered supraphysiologic. ES guidelines suggest that the sex an individual identifies as—as opposed to their biological sex—should determine the target reference range for hormonal concentrations. Critics have argued that perceived identity does not alter physiological processes and that such a belief can result in inappropriate and potentially dangerous hormone dosing.[37]

The HHS Review states:

> The ES 2017 guideline, which used the GRADE [Grading of Recommendations Assessment, Development and Evaluation] framework, has been criticized for making strong recommendations for hormonal interventions in the setting of a weak evidence base. Notably, none of the systematic reviews that supported the ES guidelines were based on outcomes for children or adolescents. The ES recommendation to initiate puberty blockade using gonadotropin-releasing hormone agonists was derived by putting a higher value on achieving a “satisfactory physical appearance” while putting the lowest value on avoiding physical harms. The ES recommendation for the initiation of cross-sex hormones no earlier than age 16 was justified by placing a higher value on adolescent’s purported ability to meaningfully consent to

cross-sex hormones (CSH) and placing a lower value on avoiding harm from potentially prolonged pubertal suppression.

B. WPATH

As explained in Chapter 9 of HHS Review, the guidelines issued by the WPATH "have been rated among the lowest in quality and have not been recommended for implementation by systematic reviews (SRs) of guidelines."[38] As the HHS Review points out: "Despite their lack of trustworthiness, for more than a decade WPATH guidelines have served as the foundation of the healthcare infrastructure for gender dysphoric (GD) youth in the United States. The WPATH Standards of Care guidelines are embedded in nearly all aspects of healthcare including clinical education, delivery of care, and reimbursement decisions by private and public insurers." In 2022, WPATH issued guidelines entitled "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" (SOC-8). These guidelines relaxed eligibility criteria for children to access sex-rejecting procedures, and ultimately recommends that adolescents wishing to undergo sex-rejecting procedures receive them. Besides the problems identified in systematic reviews of international guidelines, during recommendation development, WPATH suppressed systematic evidence reviews, failed to appropriately manage conflicts of interest, and prioritized legal and political rather than clinical considerations.[39] The HHS Review states: "In the process of developing SOC-8, WPATH suppressed systematic reviews its leaders believed would undermine its favored treatment approach. SOC-8 developers also violated conflict of interest management requirements and eliminated nearly all recommended age minimums for medical and surgical interventions in response to political pressures."[40] The HHS Review goes on to explain: "The recommendations are couched in cautious-sounding language, stating that GD should be "sustained over time," particularly before administering CSH. However, no clear standard is set; the only guidance offered is the vague and clinically meaningless phrase "several years, leaving critical decisions open to broad and subjective interpretation.""[41]

On the surface, WPATH SOC-8 might appear to recommend a cautious approach toward assessment. Mental health providers are to conduct a "comprehensive biopsychosocial assessment" prior to initiating medical interventions in order "to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care." At the same time, however, WPATH recommends that clinicians use the International Classification of Diseases 11th Revision diagnosis of "Gender Incongruence of Adolescence and Adulthood," which, unlike the DSM-5 diagnosis of "Gender Dysphoria," requires only "marked and persistent incongruence between an individual's experienced gender and the assigned sex." Because SOC-8 defines transgender in a similar way ("people whose gender identities and/or gender expressions are not what is typically expected for the sex to which they were assigned at birth") and provides no meaningful distinction between this meaning of transgender and gender non-conformity, SOC-8 effectively recognizes transgender identification as a medical condition justifying medical interventions.[42]

The HHS Review also argues: "Although WPATH's guidelines do not necessarily discourage mental healthcare, they likewise do not require it as a precondition for PMT [pediatric medical transition]. Some guideline authors opposed even minimal requirements for mental health support, arguing that such provisions were analogous to "conversion therapy."35 SOC-8's only formal recommendation is for a "comprehensive biopsychosocial assessment," although WPATH emphasizes that its guideline is "flexible," thereby leaving room for considerable variation in clinical practice."[43]
A recent systematic review evaluating international guideline quality concluded that healthcare professionals should account for the inadequate quality and independence of available guidance when utilizing WPATH and Endocrine Society international guidelines in practice.[44]

C. AMA and AAP

While the AMA and the AAP have not issued their own treatment guidelines, they support the ES and WPATH guidelines, as discussed previously in this proposed rule. AAP issued a policy statement in 2018 supporting the use of puberty blockers, cross-sex hormones, and surgeries for minors.[45] In support of sex-rejecting surgeries, AAP stated that while "current protocols [(ES, WPATH)] typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family." The AAP reaffirmed its policy statement in 2023, but also stated that it was conducting its own review of the evidence and guideline development---which still have not been released.[46]

Regarding the AAP policy statement, the HHS Review states:

> The AAP 2018 policy statement is not technically a CPG [clinical practice guideline] but has been widely cited in the U.S. as influential in establishing how pediatricians respond to children and adolescents with GD [gender dysphoria]. Because the document offers extensive clinical recommendations regarding every step of PMT—from social transition to PBs [puberty blockers], CSH [cross-sex hormones], and surgery—the York team assessed the trustworthiness of the AAP guidance using the same criteria they applied to CPGs. Using the AGREE II criteria, the AAP policy statement received the second-lowest average score among all international guidelines: 2 out of 7. As noted in Chapter 2, the AAP's policy statement's use of "gender diverse" casts a very wide net regarding which patients the organization considers eligible for medical intervention. The statement has been heavily criticized in peer-reviewed articles, which have pointed out that it is rife with referencing errors and inaccurate citations. Despite persistent advocacy among its members, who have petitioned the organization to release updated, evidence-based guidance for treating pediatric GD, the organization chose to reaffirm their policy statement in 2023.[47]

The Review comprehensively documents how SOC-8 development represented a significant departure from unbiased, evidence-driven clinical guideline development principles.[48]

The failure of professional organizations in the United States to protect children, and follow the principles of evidence-based medicine, highlights the need for this Declaration.

Global guidelines supporting care for children and adolescents experiencing gender dysphoria demonstrate variable methodological rigor and quality. The HHS Review's assessment reveals fundamental deficiencies in both the development processes and evidentiary foundations of the most frequently cited guidelines endorsing sex-rejecting procedures for minors.

IV. INTERNATIONAL EVIDENCE REVIEWS AND CONSENSUS

The HHS Review's findings align with conclusions from multiple European nations that conducted independent, rigorous systematic evidence reviews. Sweden, Finland, and the United Kingdom each commissioned independent systematic evidence reviews through their public health authorities. All three nations concluded that medicalization[49] risks may exceed benefits for children and adolescents with gender dysphoria, subsequently implementing sharp restrictions on gender transition interventions for minors.[50,51,52,53,54,55] These three countries now recommend exploratory psychotherapy as initial treatment. Sweden and Finland reserve hormonal interventions exclusively for exceptional cases, recognizing their experimental nature.[56,57,58,59]

A. United Kingdom's Cass Review

The United Kingdom's Cass Review represents the most influential evaluation to date—a four-year independent assessment of pediatric gender medicine published in April 2024. The Cass Review findings precipitated closure of the United Kingdom's Gender Identity Development Service (GIDS), which the Care Quality Commission had rated "inadequate" in 2021.

The Cass Review recommended restructuring the care delivery model away from centralized "gender clinic" approaches toward more holistic frameworks emphasizing psychosocial support delivered through regional hubs. The Review's findings also led the United Kingdom to prohibit puberty blocker use outside clinical trial settings and substantially restrict cross-sex hormone access.[60]

Though cross-sex hormones remain officially available, the National Health Service (NHS) recently disclosed that since the Cass Review's publication, no minor has satisfied eligibility criteria for receiving cross-sex hormones under updated policies.[61] Note that the United Kingdom has never provided gender dysphoria-related surgery to minors through the NHS.[62]

B. Sweden

Sweden's National Board of Health and Welfare (NBHW) reviewed and revised its guidelines for minors under age 18 in 2022. The NBHW determined that risks from puberty-suppressing treatment using GnRH-analogues (injectable medications preventing ovarian and testicular hormone production) and hormonal treatment promoting opposite-sex characteristics likely exceed potential benefits.[63,64]

The NBHW specified that mental health support and exploratory psychological care should constitute first-line treatment. Hormonal interventions may serve as last-resort measures for select youth. Sweden has elected to restrict gender transition procedures for minors to research settings exclusively, limiting eligibility to early childhood-onset gender dysphoria cases.

C. Finland

Finland's Council for Choices in Health Care, the monitoring agency for national public health services, issued guidelines in 2020 calling for psychosocial support as primary treatment, hormone therapy only after careful case-by-case consideration, and no surgical treatment for minors.[65, 66] Finland has restricted gender transition procedure eligibility to minors with early childhood-onset gender dysphoria and without mental health comorbidities.

D. Denmark

Denmark experienced increased sex-rejecting procedure referrals from 97 individuals in 2016 to 352 in 2022, with biological females aged 11-18 constituting 70 percent.[67] Concerned about rising referrals and reports of treatment regret or attempts to reverse hormone-induced bodily changes, Denmark adopted an approach emphasizing assessment and psychosocial support for minors while postponing hormone therapy decisions, including puberty blockers and cross-sex hormones, particularly when gender incongruence has been brief or when questions exist regarding gender identity stability.[68]

E. Norway

Norway's Norwegian Commission for the Investigation of Health Care Services (UKOM), an independent state agency, issued 2023 recommendations regarding treatment for children and young people with gender incongruence.[69] Recommendations included classifying puberty blockers and surgical treatment for children as experimental, revising national guidelines based on systematic

knowledge synthesis, and establishing a national registry to enhance quality and reduce treatment variation. Norway's public health authority has indicated intentions to adjust current treatment guidelines in response to UKOM concerns.[70]

F. Additional Countries

Italy,[71] Brazil,[72] and Australia[73] represent additional countries that have restricted or contemplated restricting various sex-rejecting procedures for minors.

G. International Developments Summary

Growing international concern exists regarding hormonal and surgical interventions for pediatric gender dysphoria among countries conducting rigorous, independent, evidence-based evaluations. While certain medical associations have endorsed sex-rejecting procedures, the HHS Review emphasizes that these endorsements lack grounding in evidence-based medicine and often reflect suppression of opposing ideas.

V. DECLARATION

Based on the comprehensive evidence review published by the Department of Health and Human Services, documented risks of significant harm, markedly weak evidence of benefit, unfavorable risk-benefit profiles, inadequate existing clinical guidelines, growing international consensus among countries conducting rigorous evidence reviews, and applicable medical ethics principles, I hereby declare:

Sex-rejecting procedures for children and adolescents are neither safe nor effective as a treatment modality for gender dysphoria, gender incongruence, or other related disorders in minors, and therefore, fail to meet professional recognized standards of health care. For the purposes of this declaration, "sex-rejecting procedures" means pharmaceutical or surgical interventions, including puberty blockers, cross-sex hormones, and surgeries such as mastectomies, vaginoplasties, and other procedures, that attempt to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

This Declaration does not apply (1) To treatment of an individual with a medically verifiable disorder of sexual development; (2) For purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex; or (3) To treat complications, including any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of a sex-rejecting procedure. 42 CFR § 1001.2 allows the Secretary to declare a "treatment modality *not* to be safe and effective," (emphasis added), and accordingly nothing in this declaration recommends a particular treatment for gender dysphoria or any other condition. However, the HHS Review points to psychotherapy (talk therapy) as a noninvasive alternative to sex-rejecting procedures. As Sweden's national health authority has recommended, "[p]sychosocial support that helps adolescents deal with natal puberty without medication needs to be the first option when choosing care measures."[74]

Under 42 U.S.C. § 1320a-7(b)(6)(B), the Secretary "may" exclude individuals or entities from participation in any Federal health care program if the Secretary determines the individual or entity has furnished or caused to be furnished items or services to patients of a quality which fails to meet professionally recognized standards of health care. This declaration does not constitute a determination that any individual or entity should be excluded from participation in any Federal health care program. Any such determination could only be made after a separate determination under 42 C.F.R. § 1001.701, which is subject to further administrative and judicial review under 42 C.F.R. §§ 1001.2007,

1005.21. Before making any such determination, HHS will ensure compliance with applicable laws, regulations, court orders, and any required procedures.

This declaration rests upon the best available scientific evidence and aims to promote the health, safety, and well-being of children and adolescents, who constitute an especially vulnerable population deserving the highest standards of care.

DECLARED this 18th day of December, 2025.

Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services

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[6] Henriette A. Delemarre-van de Waal and Peggy T. Cohen-Kettenis, "Clinical management of gender identity disorder in adolescents: A protocol on psychological and pediatric endocrinology aspects," *European Journal of Endocrinology* 155, Supp 1 (2006): S131-S137, https://doi.org/10.1530/eje.1.02231.

[7] E. Coleman et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8,"*International Journal of Transgender Health* 23, Supp 1 (2022): S1-S258, https://doi.org/10.1080/26895269.2022.2100644; Wylie C. Hembree et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism* 102, no. 11 (2017): 3869--3903, https://doi.org/10.1210/jc.2017-01658.

[8] Jennifer Block, "US transgender health guidelines leave age of treatment initiation open to clinical judgment," *BMJ* 378 (2022), https://doi.org/10.1136/bmj.o2303.

[9] Ibid.

[10] Ibid.

[11] Block, "US transgender health guidelines leave age of treatment initiation open to clinical judgment."

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[22] Ibid.
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[25] Ibid., 15.
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[37] HHS Review. Pg. 124
[38] HHS Review, pg. 157
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