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Skip to main content Skip to main content As the world marks the 30th anniversary of the Beijing Declaration and Platform for Action on Women – a landmark blueprint for gender equality – progress remains frustratingly slow. If we are to achieve the Sustainable Development Goals, we must place women at the centre of global health transformation.Well-functioning health systems are the foundation of gender equality. When health care is accessible, equitable, and responsive, women and girls in all their diversity can live healthier lives and have equal opportunities beyond health.Women have distinct and sometimes changing health needs at different stages of their lives. These include reproductive and maternal health, mental health, non-communicable diseases (NCDs), ageing, and other critical health concerns. Yet, systemic barriers continue to place women at higher health risks, particularly in low- and middle-income countries. Message by the Director-General Consider household air pollution - an issue disproportionately affecting women. Women exposed to harmful pollutants from household fuels face a 46% higher risk of developing cataracts compared to those unexposed. NCDs further exacerbate gendered health disparities: two out of three women die from NCDs such as cancer, diabetes, cardiovascular diseases, and respiratory conditions, with most deaths occurring in low- and middle-income countries. Violence against women remains a global crisis, severely impacting their health and well-being. One in three women worldwide experiences physical or sexual violence, and the health-care sector itself is not immune. Nearly a quarter of all workplace violence occurs in health and care settings, with women disproportionately affected. Additionally, social determinants such as income, education, and nutrition further widen the health gap for women and girls. Alarmingly, malnutrition among pregnant women, breastfeeding mothers, and adolescent girls has surged by 25% since 2020 in the 12 countries hardest hit by the global food and nutrition crisis, affecting 6.9 million women and girls.Message by the Regional Diretor, WHO Eastern Mediterranean RegionAgeing is another critical issue. While women generally live five years longer than men, they spend more of those years in poor health due to higher morbidity rates. This underscores the urgent need for gender-responsive health care that enhances not just longevity but overall quality of life.The biggest opportunity for change lies in the very workforce that drives healthcare forward. Women are the backbone of the global health and care workforce, yet their contributions often go unrecognized and undervalued. The world faces a projected shortfall of 11.1 million health workers by 2030. Women, making up 67% of this workforce, are set to bridge this gap, leading to advancements in care, innovation, and policy transformation. Yet, they encounter obstacles, such as earning 24 percent less than men, even after accounting for factors such as experience and education. Pay gaps are even wider for mothers and women from marginalized backgrounds. However, this is not inevitable, as there are many effective policies that support the rights, equality and empowerment of this crucial workforce.To create truly equitable and effective health systems, women must be at the forefront - not just as caregivers but as leaders and decision-makers. Their leadership can drive systemic change, from advancing gender-responsive policies to securing investments in women's health research. WHO reaffirms its commitment to championing these efforts, pushing for policies, funding, and research that ensure meaningful and lasting impact. Health is a crucial step on the road to gender equality. To achieve this, health systems must prioritize women's and girls' health needs and their full participation in the workforce. By creating opportunities for women to participate equally at every level, including in decision making, we can transform health systems, bridge gender gaps, and build a healthier, more equitable world. Now is the time to turn the commitments of the Beijing Declaration into action and ensure that both women's health needs and their advancement in the workforce drive lasting, transformative change. Skip to main content Gender inequity remains a challenge in the health workforce, with too few women making critical decisions and leading the work. WHO, the Global Health Workforce Network, and Women in Global Health today launched a report at the Commission on the Status of Women to describe the social and economic factors that determine why few women lead in global health, and make a call for action to urgently address gender inequity. These are the 10 key points to emerge from the report. 1. Women make up 70% of the health workforce but only 25% hold senior roles.This means that in reality, women deliver global health and men lead it. These gaps in gender leadership are driven by stereotypes, discrimination, and power imbalances. Some women are further disadvantaged on the basis of their race or class. 2. Gender inequity in the health workforce is indicative of a wider problem in global health.Global health is predominantly led by men: 69% of global health organizations are headed by men, and 80% of board chairs are men. Only 20% of global health organizations were found to have gender parity on their boards, and only 25% had gender parity at senior management level. 3. Often, gender norms and stereotypes of jobs can affect the roles that women occupy.Cultural labelling as either 'men's' or 'women's' roles prevent women from reaching leadership levels. 4. This stereotyping is a significant contributor to the gender pay gap.The gender pay gap is 25% - higher than average for other sectors. Female health workers are clustered into lower-status and lower-paid (often unpaid) roles. 5. Women often face bias and discrimination, as well as sexual harassment. This can affect their careers and lead to extreme stress and a loss of morale. Many countries lack laws and social protection that are the foundation for gender equality at work – moreover, male health workers are more likely to be organized in trade unions that defend their rights than female health workers. 6. Gender inequity is threatening the delivery of health.An estimated 40 million new jobs will be needed by 2030 in the global health and social sector. Yet there is an estimated shortfall of 18 million health workers, primarily in low- and middle-income countries. 7. Leaving the gender balance to equalize on its own is not an option.Unless specific, targeted measures are taken, workplace gender equality is estimated to take 202 years. 8. Addressing gender inequities in the health and social workforce as one of the biggest employment sectors of women could have enormous impact towards achieving the Sustainable Development Goals (SDGs).There is a health dividend in filling the millions of new jobs that must be created to meet growing demand and reach universal health coverage and the health-related SDGs by 2030. There is a gender equality dividend, since investing in women and the education of girls to enter formal, paid work will increase gender equality and women's empowerment as women gain income, education and autonomy. In turn, this is likely to improve family education, nutrition, women's and children's health, and other aspects of development. Finally, there is a development dividend as new jobs are created, fuelling economic growth. 9. Countries need to adopt policies that address the underlying causes of gender inequities. This is what is called gender-transformative change. For example, adding jobs to the health workforce under current conditions will not solve the gender inequities that exacerbate the health worker shortage. Policies to date have attempted to fix women to fit into inequitable systems; now we need to fix the system and work environment to create decent work for women and close gender gaps in leadership and pay. 10. The focus of research in the global health and social workforce should be shifted. Research must prioritize low- and middle-income countries; apply a gender and intersectionality lens; include sex- and gender-disaggregated data; and include the social care workforce. Research must go beyond describing the gender inequities to also evaluate the impact of gender-transformative interventions. The earth's climate is changing rapidly, mainly due to human activities. Increasing temperatures, sea-level rises, changing patterns of precipitation, and more frequent and severe extreme events are expected to have largely adverse effects on key determinants of human health, including clean air and water, sufficient food and adequate shelter.The effects of climate on human society, and our ability to mitigate and adapt to them, are mediated by social factors, including gender. This report provides a first review of the interactions between climate change, gender and health. It documents evidence for gender differences in health risks that are likely to be exacerbated by climate change, and in adaptation and mitigation measures that can help to protect and promote health.The aim of this publication is to provide a framework to strengthen WHO support to Member States in developing health risk assessments and climate policy interventions that are beneficial to both women and men. Skip to main content Millions of people around the world do not have their health needs met because of inequalities, discrimination and human rights violations. We envision a world where all people attain the highest possible standard of health and well-being; where diversity of all kinds is celebrated; human rights are promoted, protected, and fulfilled; gender equality and health equity are the norm; and barriers to health and well-being are addressed. Our work is articulated around three areas: 1) Health inequities are systematically identified, monitored and addressed; 2) Gender-specific and gender-transformative approaches to health are implemented at scale; and 3) The human right to health and health-related human rights are respected, protected and fulfilled. The department leverages and contributes to WHO's leadership, technical expertise and country presence to accelerate progress on gender equality, human rights and health equity. It also leads capacity building efforts for mainstreaming gender, equity and human rights in all WHO programmes, working closely with a growing organization-wide network of Gender Equality, Human Rights and Health Equity focal points.The department supports WHO's commitment to "leaving no one behind" as essential to achieving the Sustainable Development Goals (SDGs). Our work contributes to SDG 3: to ensure healthy lives and promote well-being for all at all ages; SDG 5: to achieve gender equality and empower all women and girls; SDG 8: to promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all; and SDG 10: to reduce inequality within and among countries. Skip to main content Gender norms, roles and relations, and gender inequality and inequity, affect people's health all around the world. This Q&A examines the links between gender and health, highlighting WHO's ongoing work to address gender-related barriers to healthcare, advance gender equality and the empowerment of women and girls in all their diversity, and achieve health for all. Gender refers to socially constructed characteristics of women and men – such as norms, roles and relations of and between groups of women and men[1]. Gender norms, roles and relations vary from society to society and evolve over time. They are often upheld and reproduced in the values, legislation, education systems, religion, media and other institutions of the society in which they exist. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health. Gender is also hierarchical and often reflects unequal relations of power, producing inequalities that intersect with other social and economic inequalities. What is the difference between gender and sex? Gender interacts with but is different from sex. The two terms are distinct and should not be used interchangeably. It can be helpful to think of sex as a biological characteristic and gender as a social construct. Sex refers to a set of biological attributes in humans and animals. Sex is mainly associated with physical and physiological features including chromosomes, gene expression, hormone level and function, and reproductive and sexual anatomy.Sex is often categorized as females and males, but there are variations of sex characteristics called intersex. The term 'intersex' is used as an umbrella term for individuals born with natural variations in biological or physiological characteristics (including sexual anatomy, reproductive organs and/or chromosomal patterns) that do not fit traditional definitions of male or female[1]. Infants are generally assigned the sex of male or female at birth based on the appearance of their external anatomy/genitalia. Gender identity refers to a person's innate, deeply felt internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth. Gender expression refers to how an individual expresses their gender identity, including dress and speech[1]. Gender expression is not always indicative of gender identity. 'Transgender' is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender or otherwise gender non-conforming[2].Sexual orientation refers to a person's physical, romantic and/or emotional attraction (or lack thereof) towards other people[3]. It encompasses hetero-, homo- and bisexuality and a wide range of other expressions of sexual orientation[4]. Sexual orientation cannot be assumed from one's assigned sex at birth, gender identity or gender expression. How do sex and gender influence health? Sex and gender interact in complex ways to affect health outcomes. Sex can affect disease risk, progression and outcomes through genetic (e.g. function of X and Y chromosomes), cellular and physiological, including hormonal, pathways. These pathways can produce differences in susceptibility to disease, progression of disease, treatment and health outcomes, and are likely to vary over the life-course. For example, data shows that men experience more severe COVID-19 outcomes in terms of hospitalizations and deaths than women. This is, in part, explained by higher quantities of angiotensin-converting enzyme found in men, which binds to the SARS-COV2 virus. Gender norms, socialization, roles, differentials in power relations and in access to and control over resources contribute to differences in vulnerabilities and susceptibilities to illness, how illness is experienced, health behaviours (including health-seeking), access to and uptake of health services, treatment responses and health outcomes. For example, gender can determine health risks faced and taken. Data show that men's increased risk of acquiring SARS-COV2, is also linked to their lower rates of handwashing, higher rates of smoking and alcohol misuse and, related to that – higher comorbidities for severe COVID-19 symptoms as compared to women. How else does gender link with health? Gender has implications for health across the course of every person's life. Gender can influence a person's experiences of crises and emergency situations, their exposure to diseases and their access to healthcare, water, hygiene and sanitation.Gender inequality disproportionately affects women and girls. In most societies, they have lower status and have less control over decision-making about their bodies, in their intimate relationships, families and communities, exposing them to violence, coercion and harmful practices. Women and girls face high risks of unintended pregnancies, sexually transmitted infections including HIV, cervical cancer, malnutrition and depression, amongst others. Gender inequality also poses barriers for women and girls to access health information and critical services, including restrictions on mobility, lack of decision-making autonomy, limited access to finances, lower literacy rates and discriminatory attitudes of healthcare providers.Gender diverse people are more likely to experience violence and coercion, stigma and discrimination, including from health workers. Data suggests that transgender individuals experience high levels of mental health illness – linked to the discrimination and stigma they face from societies and in healthcare settings[1].[1] Blondeel, Karel, de Vasconcelos, Sofia, García-Moreno, Claudia, Stephenson, Rob, Temmerman, Marleen. et al. (2018). Violence motivated by perception of sexual orientation and gender identity: a systematic review. Bulletin of the World Health Organization, 96 (1), 29 - 41L. World Health Organization. What is intersectionality and why does it matter to gender and health? "Intersectionality" builds on, and extends, the understanding of how gender power dynamics interact with other power hierarchies of privilege or disadvantage, resulting in inequality and differential health outcomes for different people[1]. These factors include sex, gender, race, ethnicity, age, class, socioeconomic status, religion, language, geographical location, disability status, migration status, gender identity and sexual orientation. For example, indigenous women have worse maternal health outcomes than non-indigenous women and are less likely to benefit from health care services in Latin America and the Caribbean. Therefore, inequities in maternal health between different ethnic groups should be monitored to identify critical, modifiable, health system and community factors that could limit health care coverage, including language, religion, territory and place of residence. Monitoring health inequities is essential for designing more effective programmes and policies to reduce health risks among indigenous women[2].[1] Manandhar, Mary, Hawkes, Sarah, Buse, Kent, Nosrati, Elias & Magar, Veronica. (2018). Gender, health and the 2030 agenda for sustainable development. Bulletin of the World Health Organization, 96 (9), 644 - 653. World Health Organization. Why is gender equality also men's concern? Harmful gender norms – including those related to rigid notions of masculinity – affect the health and well-being of boys and men. For example, notions of masculinity encourage boys and men to smoke, take sexual and other health risks, misuse alcohol and not seek help or health care. Such gender norms also contribute to boys and men perpetrating violence against women and girls. They also contribute to violence perpetrated against men including homicide, youth and gang violence, which are among leading causes of morbidity and mortality among young men. Harmful masculinities also have grave implications for men's mental health. Societal expectations and norms around "manhood" lead men to engage in risk-taking behaviors; for example, being encouraged to have multiple sexual partners. In addition to affecting men's health, this also leads to negative outcomes for women and children due to increased interpersonal violence, the transmission of sexually transmitted infections (STIs) and unintended pregnancy. Men's lack of participation in domestic and care work adds to the high burden of unpaid care work often performed by women[1]. What are gender mainstreaming and gender analysis? Gender mainstreaming is the process of assessing the implications for women, men and gender diverse people of any planned action within a health system, including legislation, policies, programmes or service delivery, in all technical areas and at all levels. It is a strategy for making the concerns and experiences of diverse women and men an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all spheres so that they benefit equally and inequality is not perpetuated. Gender mainstreaming is not an end in itself but a strategy, an approach and a means to achieve the goal of gender equality. Gender analysis identifies, assesses and informs actions to address inequality and inequity[1]. It is used to systematically identify differentials between groups of women and men, whether related to sex or gender, in terms of risk factors, exposures and manifestations of ill-health, severity and frequency of diseases, health seeking behaviours, access to care and experiences in health care settings, as well as outcomes and impact of ill-health. Systematically collecting and analyzing data disaggregated by sex and additional factors such as age, ethnicity, socio-economic status and disability, is critical. Gender equality and the empowerment of women and girls are central to the 2030 Agenda for Sustainable Development and all 17 Sustainable Development Goals (SDGs). Ensuring health and well-being for all at all ages (SDG 3) cannot be achieved without addressing the specific barriers and challenges faced by women, men, girls, boys and gender diverse people. Gender equality (SDG 5) is a development goal in its own right and there are 45 targets and 54 gender-specific indicators addressing gender equality across all of the SDGs. Achieving these targets and closing gender inequalities will therefore create a multiplier effect across all of the SDGs and accelerate their achievement. WHO's work on gender is aligned with and supports the advancement of the SDGs, especially SDG3 and SDG5. The achievement of SDG3 on universal health coverage and SDG 5 on gender equality are co-dependent – without strengthening gender equality in the health workforce, across communities and across the world, universal health coverage cannot be attained. The WHO is committed to non-discrimination and to leaving no-one behind and seeks to ensure that every person, regardless of gender or sex, has the opportunity to live a healthy life. WHO's 13th General Programme of Work (2019-23) recognizes the need to promote gender equality and to mainstream gender in all of the Organization's work. WHO develops norms, standards and guidelines and delivers training on gender-responsive health service provision and delivery, and commissions research on issues focusing on gender equality, human rights and health equity.WHO also supports country-level action to strengthen health sector response to gender-based violence as well as to address gender equality in health workforce development and gender-related barriers to health services. WHO works to challenge gender stereotypes and to implement programmes, services and policies that promote gender equality in order to achieve health equity and Universal Health Coverage. WHO regularly reports on the UN System-wide Action Plan for Mainstreaming Gender Equality and the Empowerment of Women (UN-SWAP) to foster accountability and monitor progress towards gender equality. WHO is committed to increasing diversity and women's meaningful participation within the Organization at all levels. Institutional policies to promote women's career development, increase gender parity, end all-male panels, address work−life balance and prevent harassment in the workplace are being implemented in the Organization. The WHO Director General is a Gender Champion for the International Gender Champion (IGC) Parity Panel Pledge. Skip to main content Photo credit: WHO/WUN/Emilie MillsDuring the 69th Commission on the Status of Women (CSW69), held from 10–21 March 2025, countries from around the world reaffirmed their commitment to gender equality through a high-level political declaration. The declaration renewed the global commitment to women's rights, acknowledged the setbacks and called for urgent, gender-responsive policy action, including the protection of the right to the highest attainable standard of physical and mental health across the life course.A major moment for this advocacy came on 10 March with the official WHO flagship side event, "No gender equality without women's health", co-sponsored by WHO, the United Kingdom of Great Britain and Northern Ireland, United Mexican States, UN Women and the World Economic Forum. The event drew a full house and highlighted a unified call for evidence-based approaches to address gaps in women's health across the life course as a core component of advancing gender inequality and through health, particularly amid rising anti-rights rhetoric around the world.A call for holistic, life-course approachesThe event emphasized that women's health is not a niche concern, but a global issue that must be addressed across the life course. Without universal access to integrated care for all women, the goals associated with the key commitments of the Beijing Platform for Action will remain out of reach.Speakers pointed out that while women often live longer than men, they experience poorer health due to systemic barriers and lifelong disadvantage. Investing in women's health is not only critical for gender equality but could also yield major economic gains, with national health systems potentially saving billions each year.Addressing data gapsSeveral speakers at the event emphasized that limited availability, analysis and use of disaggregated sex and gender data continues to hinder progress. The lack of such data contributes to underinvestment and misdiagnosis, in conditions that specifically, differently or disproportionately affect women and particularly in conditions that remain widely underrecognized, such as endometriosis. Closing this gap and ensuring women's inclusion in clinical trials could not only improve health outcomes but also generate significant global economic savings, estimated at up to US$ 1 trillion annually.Young people at the forefront of changeLucy Fagan, WHO Youth Council member representing the UN Major Group for Children and Youth, offered a vital perspective on the role of youth in advancing gender equality and women's health. "The Beijing agenda was created before many of us were born," she said. "Progress is slowing, but youth are now part of the conversation. And we're here to carry it forward."Fagan highlighted that youth-led groups are not only active on the ground, but also resilient, continuing to drive momentum for issues such as sexual and reproductive health and rights (SRHR), gender-based violence (GBV) and mental health despite political pressures and reduced funding. As well as stressing the need for more data disaggregated by age and sex, she emphasized that "we're driving the work forward from the ground up." Lucy's remarks served as a reminder that young people are essential actors in safeguarding progress from CSW through to Beijing+30, and that their voices are especially critical to countering rising anti-rights narratives, especially in digital spaces.Working towards more intersectional solutionsPanellists emphasized the need for intersectional approaches that address systemic discrimination faced by marginalized groups: older women, women in detention, women with disabilities, those living in rural or indigenous communities and many others. It was also emphasized that women make up the majority of the global health workforce as well as taking 80% of health decisions at the household level, a massive yet underleveraged influence in shaping healthier societies.WHO at CSW69WHO's engagement at CSW69 extended beyond this flagship event. Other sessions included:Closing the gender nutrition gap: a key feminist approach to fight hunger and malnutrition, co-sponsored by Action contre la Faim, FHI360;Digital solutions for gender equality and SRHR, which explored tech-driven innovations for advancing women's health, co-sponsored by Norway, Colombia, UNFPA and WHO/HRP; Bridging the divide: men and boys as allies and agents of change, co-sponsored by MenEngage Alliance, UN Women, OHCHR, WHO, UNFPA, Government of Sweden, Government of Rwanda, Equimundo and others; andFrom potential to progress: multisectoral approaches to empower adolescents, co-sponsored by UNICEF, WHO, FCDO, Plan International and BRAC. These events reinforced WHO's commitment to a rights-based and evidence-driven agenda for gender equality and women's health. The takeaway from WHO at CSW69 is clear: investing in women's health is not optional; it is essential to achieving the 2030 Agenda and reflects our shared values. In a time of global challenges, advancing gender-responsive health systems and policies that uphold women's rights is more urgent than ever. And the voices of young people like Lucy Fagan, which are grounded in community action and solidarity, are joining the multigenerational charge and reminding us that there is no gender equality without women's health and well-being. Skip to main content 25 November to 10 December 2024 16 Days of Activism against Gender-Based Violence is a key international moment to call for an end to violence against women and girls (VAWG). It runs from 25th November (the International Day for the Elimination of Violence Against Women) until 10th December, Human Rights Day. Violence against women happens in every country and culture, causing harm to millions of women and girls. Risks and challenges to access care increase even more for women and girls living in humanitarian emergencies. Around the world today, prolonged and intense conflicts have resulted in a continuous rise in of all forms of gender-based violence. WHO plays an active role in strengthening health systems and local health partner capacity to prevent and respond to VAWG in humanitarian emergencies. In addition, WHO is calling for all parties to respect their obligations under international humanitarian and human rights law to protect women and girls from gender-based violence and ensure access to essential health services. Prolonged and intense conflicts around the world, alongside major displacements, are increasing risks of violence for millions of women and girls. Gender-based violence prevention and support for survivors are essential in every humanitarian response. During emergencies, all forms of gender-based violence can spike, including sexual and intimate partner violence. 1 in 5 refugee or displaced women and girls living in complex emergencies is estimated to have experienced sexual violence. Trafficking, abduction, and harmful practices such as female genital mutilation and child marriage also often increase during times of crisis. Many survivors of gender-based violence in humanitarian emergencies face immense hurdles to access essential health care and support services – whether because of destruction of infrastructure, dangers of moving through conflict zones, or fear of stigma or reprisals. Violence against women and girls is preventable. There is an urgent need to ensure prevention is addressed and funded in emergencies from the outset, including through engagement of health workers and front-line responders. All parties to a conflict have a responsibility to prevent and end violence against women and girls, while peace and development processes must explicitly address gender-based violence impacts and prevention. Ensure gender-based violence prevention and response measures are integrated and funded as an essential standard in humanitarian responses. Raise visibility of the heightened risks of gender-based violence in emergencies, and the long-term health impacts. Call on all parties to meet their obligations to prevent violence against women and girls during emergencies, and protect access to essential services that meet the needs of survivors. Online courses: Clinical Management of Rape and Intimate Partner Violence Survivors in humanitarian settings Learn more, visit the WHO violence against women health topic page and accompanying factsheet, or use the interactive database to learn more about prevalence across countries, regions, and age groups.On social media, share WHO's infographics and videos to encourage awareness and help people seek appropriate help. You can tag @WHO & @HRPresearch and use hashtags: #OrangeTheWorld, #16Days, #EndViolence The International Classification serves to record and report health and health-related conditions globally. ICD ensures interoperability of digital health data, and their comparability. The ICD contains diseases, disorders, health conditions and much more. The inclusion of a specific category into ICD depends on utility to the different uses of ICD and sufficient evidence that a health condition exists. ICD-11 and Gender IncongruenceThe 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11). The newly revised ICD-11 codes includes new changes to reflect modern understanding of sexual health and gender identity.What does the ICD revision aim to do for transgender health?ICD-11 has redefined gender identity-related health, replacing outdated diagnostic categories like ICD-10's "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood" respectively. Gender incongruence has been moved out of the "Mental and behavioural disorders" chapter and into the new "Conditions related to sexual health" chapter. This reflects current knowledge that trans-related and gender diverse identities are not conditions of mental ill-health, and that classifying them as such can cause enormous stigma. Inclusion of gender incongruence in the ICD-11 should ensure transgender people's access to gender-affirming health care, as well as adequate health insurance coverage for such services. Recognition in the ICD also acknowledges the links between gender identity, sexual behaviour, exposure to violence and sexually transmitted infections.What is Gender Incongruence?Gender incongruence of adolescence or adulthood : Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.Gender incongruence of childhood : Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.What is transgender and what are the main health concerns of transgender people?Transgender people share many of the same health needs as the general population, but may have other specialist health-care needs, such as gender-affirming hormone therapy and surgery. However, evidence suggests that transgender people often experience a disproportionately high burden of disease, including in the domains of mental, sexual and reproductive health. Some transgender people seek medical or surgical transition, others do not.What is gender-affirmative health care?Gender-affirmative health care can include any single or combination of a number of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity.