



Principles for Collecting, Coding, and Reporting Identity Data SEX AND GENDER GUIDELINES

Purpose

To promote accuracy, transparency and consistency, so that the San Francisco Department of Public Health's (SFDPH) data collection and reporting on health by sex and gender reflect the spectrum of gender categories that are meaningful for identifying differences in health outcomes, conditions that impact health, and delivery of health services.

Background

The World Health Organization stipulates that "sex" refers to the biological and physiological characteristics that define men and women. "Gender" refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women.¹ The CDC recently referred to "gender identity" [as] an individual's internal understanding of one's own gender, or the gender with which one identifies."² The importance of collecting gender identity information was recognized in a 2011 Institute of Medicine report recommending that the US Dept. of Health and Human Services should collect gender identity and sexual orientation information on health and related surveys.³ Many SFDPH programs already collect data on sex and gender identity to reflect different health conditions, outcomes, practices, and needs in the populations they serve.

Sex and gender are complex concepts that are influenced by biology but also by cultural, social-historical, and political contexts and practices. Some of the new gender theories have moved us beyond an earlier dichotomous explanation of gender identity to include multi-dimensional and multi-layered concepts.⁴ Still, many funders, health departments, and government agencies do not allow for the identification or reporting of transgender people as clients and patients, and currently there is no standardized method for capturing sex and gender identity data that accurately reflects their complexities.

Data collection of sex (male and female) demographics is standardized and the health differences between males and females are well-studied. However, the prevalence of the various gender identities and their health differences, along with their health-related impacts, have been much less studied and understood.

Confusion, assumptions, and/or discomfort among health professionals around asking gender identity questions have resulted in inaccurate surveillance of transgender populations. For example, transgender women are often counted under the behavioral risk category of MSM (men-who-have-sex-with-men). This is incorrect. Transgender women may or may not have sex with men. Moreover, transgender women may have a variety of sexual orientation identities including lesbian, gay, and bisexual (to name a few). Although in public health we often examine the intersections of these constructs to identify at-risk populations, behavioral risk categories, sexual orientation, and gender identity are independent constructs.

For a variety of reasons, many people with trans-lived histories do not identify as "transgender." Some feel that "trans" is part of their past and is not a present identification; others do not use the word transgender due to cultural beliefs, social networks, and/or linguistic norms in



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geographic locations. Therefore, it is important to collect information about both birth sex and gender identity.

Provider and community experience, and increasingly research, indicate that being transgender has important implications for health. It is associated with differences in (1) access to and use of health care treatment, (2) health-related behavior and experiences, and (3) health outcomes. A recent large national survey of transgender people showed high rates of postponed health care, refused care, inappropriate provider knowledge, and harassment and violence in care settings. Survey results also showed high rates of HIV infection, attempted suicides, and drug and alcohol misuse. In some cases prevalence was greater for those with ethnic co-minority status.⁵ These findings suggest that from the perspectives of both clinical health care and public health monitoring, it is important to identify those with transgender identities in the populations we reach and do not reach.

These guidelines were developed by SFDPH epidemiologists, researchers, and analysts, in consultation with the Center of Excellence for Transgender Health at UCSF to promote consistency and quality in the collection, coding, reporting, interpretation, and use of social identity indicators. They are meant to address the following key issues concerning sex and gender identity data:

1. Desire for consistency in grouping or categorizing of sex and gender data across time, data systems, and the profusion of terms used for sex and gender identity.
2. Need for flexibility to accommodate many different existing data collection practices.
3. Need for a concise, feasible method that could be widely applied.
4. Lack of clarity in the meaning and use of terms defining sex and gender.
5. Enable people see themselves in the response options in order to produce more reliable, accurate and useful data.

The Center of Excellence (CoE) for Transgender Health at the University of California San Francisco developed an approach in accordance with the CDC to collect these data.⁶ References provided by the CoE⁷ were reviewed, and a similar two-part approach to sex and gender coding, collecting, and reporting is presented in these guidelines:

1. What is your gender?
2. What was your sex at birth?

The two-question approach recommended here has also been used in prior research throughout the last decade and has yielded increased accuracy in sex and gender information about patients and clients.⁸ A version of the approach recommended here is currently being used or discussed in various aspects of CDC research, training, and evaluation projects, and the CDC guidelines for data collection for HIV surveillance have contributed to these guidelines.⁹

Gathering these data is consistent with key recommendations in Healthy People 2020, the 2011 Institute of Medicine report on LGBT health issues and research gaps, the recent California Department of Mental Health “Reducing LGBTQ Disparities Population Report,”¹⁰ and the



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federal government's implementation of the Patient Protection and Affordable Care Act.¹¹ Healthy People 2020 explicitly identify the data collection as a priority.^{12 A}

These guidelines recommend that gender identity information be routinely collected by DPH, and a method for doing so. They systematically address the need to improve data collection in order to improve information, data consistency and understanding of our populations' sex and gender identity. They were developed in consultation with groups focused on transgender health issues in order to ensure that the wording of questions and response options encompass the gender identities and birth sex of transgender individuals. Our recommended language in the questions reflect the Department of Public Health's multiple needs to (1) enable transgender people to see and identify themselves, (2) minimize confusion by the large non-transgender population, and (3) obtain answers readily and accurately from all populations in all programs.

These guidelines are meant to be used for individuals who are 15 years of age and older.¹³ Children and adolescents under the age of 15 have unique developmental processes with understanding gender identity and identification. With its expert partners, SFDPH will continue to research and explore appropriate methods and models for capturing sex and gender identity for the children and adolescents under the age of 15.

SFDPH Policy

All new data collection systems purchased or designed for or by the Department of Public Health that will be used to track the sex and gender of patients, clients, participants, or other cohorts ages 15 and over must have the ability to track sex and gender in accordance with these guidelines. Additionally, reporting of collected data should also adhere to these guidelines whenever possible, recognizing third party reporting requirements may be in conflict.

General Guiding Principles

1. To the extent that sex and gender identity are markers of health or risk differences, they should be identified as well as possible in SFDPH data collection and reporting.

Sex and gender identity markers are important for identifying and addressing health differences, treatment or prevention needs, or health-related practices. The lack of accurate and consistent sex and gender data and data collection methods can have important implications for public health, identifying emerging health trends and health disparities, allocating resources, improving health care services, addressing service gaps, targeting outreach efforts to at-risk groups, and advising programs and services.

2. Biological, social, and personal history aspects of sex and gender identity may matter for understanding health differences, so data collection protocols should allow for concise collection of the most key aspects of these factors.

^A Health People 2020: Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify transgender populations



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Most federal, state, and local agencies collect data about individuals' sex and gender with one question, stated either "What is your sex?" or "What is your gender?" with two possible answers: male or female.

This approach fails to capture key categories of sex and gender identity that affect the health of the populations who do not fall into this assumed binary of being only and always male or female. This holds true even when data collection tools are provided to identify transgender individuals, with options such as "Transgender" or "Male-to-Female (MTF)" and "Female-to-Male (FTM)". For example, a person may identify as "female" and also "transgender." (Definitions of sex and gender options may be found at the end of these guidelines.¹⁴)

A concise, feasible method for identifying a person's sex and gender identity involves asking these two questions:

1. What is your gender?
 2. What was your sex at birth?
3. Naming of Sex and Gender identity should allow for both consistency and relevancy.

Sex and gender are dynamic concepts, the meaning of which changes based on the ways individuals, communities and institutions identify themselves and others, and actions taken based on those identifications. The Department of Public Health's approach to naming and categorizing sex and gender should maintain consistency across programs and over time, so that data are as comparable and interpretable as possible, while also striving to reflect the way people and communities construct and experience their own sex and gender identities. Individuals cannot be expected to provide accurate information if they cannot identify themselves and/or their communities in the questions and response options presented.

4. Categorization should allow for both compliance and comparability.
- a. Programs need to meet their specific reporting and funding requirements for data
 - b. Comparability should be maintained with federal, state, and local data requirements across agencies of the City and County of San Francisco and DPH programs
5. Sexual orientation, behavior, and practice data should be gathered through other specific questions and not inferred from sex and gender identity. These guidelines only refer to collecting sex/gender identity information. Regardless of their sexual orientation, a transgender (trans) person is someone who has a different sex, gender identity, and/or gender expression than the one assigned to them at birth.¹⁵

Data Collection Principles

6. Sex and gender should be self-identified.

Sex and gender should be self-identified and allow for a minimum set of categories as shown in response categories given in principle 7 below. If self-identification is not possible, declaration by next of kin or other close informant should be used. Sex and



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gender should not be ascribed by others based on physical appearance or other assumptions.

7. Two questions should be used to identify sex and gender for individuals age 15 and over.

SFDPH should ask these two questions, as follows and in this order, to acquire sex and gender demographics about both the person’s present gender identity and his or her history. For children and youth under the age of 15, only the first question should be asked.

1. What is your gender^B? (Check one that best describes your current gender identity.)

- (1) Male
- (2) Female
- (3) Trans Male
- (4) Trans Female
- (5) Not listed, please specify _____

[Survey forms would include options 1-5. Coding should also allow for options 6 and 7]

- (6) Declined / Not stated
- (7) Question Not Asked

2. What was your sex at birth? (Check one)

- (1) Male
- (2) Female

[Survey forms would include options 1-2. Coding should also allow options 3 and 4]

- (3) Declined / Not stated
- (4) Question Not Asked

There are a variety of definitions today of what is “sex” and what is “gender.”¹⁶ In many cases people will mix-up or conflate these terms and, regardless of one’s personal definition, for data collection purposes it was determined to ask gender in order to differentiate between question one and question two.

^B These definitions should be considered as being fluid rather than static variables.

- (1) **Male** - the behavioral, cultural, biological, or psychological traits typically associated with males
- (2) **Female** - the behavioral, cultural, biological, or psychological traits typically associated with females
- (3) **Trans Male** – transgender men, transmasculine, or transmen, sometimes referred to as female-to-male or FTMs
- (4) **Trans Female** – transgender women, transfeminine, or transwomen, sometimes referred to ‘male-to-female or MTFs
- (5) **If not listed, please specify** _____ - this category provides options for people to state their specific transgender identity (or identities), as well as an “additional category” which will help clarify the many possible transgender identities.
- (6) **Declined Not Stated** – this category provides the individual the opportunity to opt-out from stating their sex or gender identity.
- (7) **Question Not Asked** - this category allows the provider to mark ‘Question Not Asked’ if the sex or gender question was not asked in an effort to alleviate any provider assumptions.



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In question one, we recommend providing multiple options for people to state their specific transgender identity (or identities), as well as an additional “please specify” category to help clarify which of the many transgender identities with which people may identify.¹⁷

The second question requests a person’s sex at birth. Though some people are born with a Disorder of Sex Development (DSD), currently only “male” or “female” is assigned to each newborn and only one of those two categories are placed on a birth certificate in the U.S.¹⁸ Once DSD, or “Intersex,” is assigned at birth and placed on birth certificates, these guidelines need to be revised to include the option in the second question.

In addition, SFDPH should ask and record:

1. What is the appropriate pronoun to use when addressing you?
 2. What is your chosen name?
8. Transgender data should be coded with caution and care when working with minors.

Social identity data are protected health information. However, when transgender status is identified from people younger than 18 years of age, documenting their identity should be done with sensitivity and caution knowing that legal guardians may access their child’s medical record, including demographic information and all service records (excluding services requiring minor consent).

9. Programs adopting this method should consider how to keep gender identity information up-to-date.

Since the answer to gender identity question one may change over time for some people (and probably a small number), programs should develop and adopt practices that allow for it be updated as they consider feasible and appropriate.

Coding and Reporting Principles

10. Data reports by gender should minimally present these six main categories:

1. Male
2. Female
3. Trans Male
4. Trans Female
5. Not listed (please specify) _____
6. Unspecified / Unknown

If data are not available to report reliably for any of the categories 1 through 5, that fact should be reported. For example, if insufficient data are available to report on the health of Trans Males or Trans Females in San Francisco, reports should note the reason for the lack of presentation of such data.



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11. People should be classified into these reporting categories based on the following matrix and principles.

Category		Q1: Gender Identity					
		1. Male	2. Female	3. Trans Male	4. Trans Female	5. Not listed, specify	6. Unspecified
Q2: Birth Sex	1. Male	M	TF	TM	TF	O	M
	2. Female	TM	F	TM	TF	O	F
	Unspecified	M	F	TM	TF	O	U

M = Male; F = Female; T = Transgender; O = Other; U = Unspecified

Individuals would be identified as “Trans” when they choose:

- a) “Trans Male” or “Trans Female” for question #1, “What is your gender?”
and
- b) A “Birth Sex” option in question #2 that is different from their chosen current gender identity

Individuals would be identified as “Other” when they choose:

- a) “Not Listed, please specify ____” for question #1, “What is your gender?”
and/or
- b) If both question #1 and question #2 are unspecified

Individuals would be identified as “Unknown” when they:

- a) Do not specify a gender identity
and
- b) Do not specify a sex at birth

When programs develop categories to meet specific needs in their populations or to allow for changes in community norms of self-identification, they should maintain explanatory documentation and a coding crosswalk to allow for consistency and comprehensibility in reporting over time and across programs using these minimum reporting categories. It is important to remember that regardless of data coding rubrics for internal reporting, direct service staff should maintain every effort to recognize clients by their chosen name and by their asserted pronoun preference.

12. A single set of core sex and gender categories that are aligned with state and federal minimum reporting requirements (Male and Female) are needed and should be developed.

Current best practice recommendation is to use the response to question one (gender identity) and count transgender males with males and transgender females with females to report numbers of males and females. We recommend further research and reporting of program experiences on this issue.



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Implementation Recommendations

1. SFDPH’s Minor Consent Policy should to be reviewed to integrate the recommendations of these guidelines in such a way that will protect children and youth while also allow for collecting of this important health-relevant data.
2. SFDPH should continually evaluate these guidelines by gathering input and feedback from community members, providers, and stakeholders on the proposed two-question model for collecting sex and gender variables. Experiences should be reviewed periodically by cross-program analytic teams to modify these guidelines as needed. DPH programs, units, and sections should incorporate these principles into their current data collection tools and reporting as useful and feasible, and try to apply them further in any citywide systems, data collection, and reporting (re)designs. As they do so, they should produce brief documentation summarizing their experience and lessons that were learned, which should be made available to other programs by posting on the intranet or by other means, preferably with implementation contact person identified.
3. Assess training and technical assistance implementation needs of SFDPH, agencies, community service providers.

Since the model will be new to most community service providers and programs, it will need an implementation plan, with technical assistance if possible. All staff and public health practitioners should receive transgender cultural competency training and should be able to ask questions about gender identity correctly and consistently.

The technical assistance needs of health professionals, programs and departmental units should be assessed to ensure that the policy is clear, that these sex and gender questions are asked, and that they identity sex and gender correctly and consistently. The Center of Excellence for Transgender Health provide interactive and educational training to help health professionals understand the update and learn how to effectively and accurately ask and record information about sex and gender identity¹⁹. Any training materials developed for implementation of these guidelines should also be made widely available via the intranet or through other means. Suggestions on how to ask and training guidelines for staff have been developed by the National Resource Center on LGBT Aging and can be found in their 2013 report, “Inclusive Questions for Older Adults - A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity.”²⁰

Endnotes

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- ¹ *What do we mean by sex and gender?* (2010). Retrieved June 29, 2010, from World Health Organization: <http://www.who.int/gender/whatisgender/en/index.html>
 - ² Clark, Hollie, et. Al., “Guidance for HIV Surveillance Programs: Working with Transgender-Specific Data” , CDC Div. of HIV/AIDS Prevention, downloaded February 14, 2013.
 - ³ Institute of Medicine (IOM), *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Washington, DC. National Academies Press, March 2011. http://books.nap.edu/catalog.php?record_id=13128



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- ⁴ Vade, D. (2005). Expanding gender and expanding the law: Toward a social and legal conceptualization of gender that is more inclusive of transgender people. *Michigan Journal of Gender and Law*, 11, 253-316.
- ⁵ Grant JM, Mottet LA, & Tanis J. “National Transgender Discrimination Survey Report on Health and Health Care.” National Center for Transgender Equality, October 2010.
- ⁶ <http://www.transhealth.ucsf.edu/>
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- ⁷ References
- a. Adams, A., Lundie, M., Marshall, Z., Pires, R., Scanlon, K., Scheim, A. I. M., & Smith, T. (2008, June). Getting Primed: Informing HIV Prevention with Gay/Bi/Queer Trans Men in Ontario. A project of the: Gay/Bisexual/Queer Trans Men’s Working Group; Ontario Gay Men’s HIV Prevention Strategy; and AIDS Bureau, Ontario Ministry of Health and Long-Term Care. Retrieved October 8, 2008 at: <http://www.queertransmen.org/images/gettingprimed.pdf>
 - b. Brown, N.C. (2002). Special Concerns Populations: Transgender Needs Assessment. Chicago: Chicago Department of Public Health Office of Gay and Lesbian Health.
 - c. Devor, H. (2002). Who are “we”? Where sexual orientation meets gender identity. *Journal of Gay and Lesbian Psychotherapy*, 6(2), 5-21.
 - d. Kenagy, G. (2005). Transgender health: findings from two needs assessment studies in Philadelphia. *Health and Social Work*, 30 (1): 19-26.
 - e. Maine HIV Prevention Community Planning Group (2003) HIV Risk Among Transgender People in Maine: A Statewide Needs Assessment of Behavioral Risk. Retrieved October 8, 2008 at: <http://mehivcpg.org/Trans%20rprt%20finl.pdf>
 - f. McGowan, C.K. (1999). Transgender Needs Assessment. New York: The HIV Prevention Planning Unit of the New York City Department of Health.
 - g. Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay and Lesbian Issues in Education*, 3(1), 15-28.
 - h. Sausa, L. A., Sevelius, J., Keatley, J., Iñiguez, J. R., & Reyes, M. (2008). Policy Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services. Center of Excellence for Transgender HIV Prevention: University of California, San Francisco. Available online at: www.transhealth.ucsf.edu
 - i. Vade, D. (2005). Expanding gender and expanding the law: Toward a social and legal conceptualization of gender that is more inclusive of transgender people. *Michigan Journal of Gender and Law*, 11, 253-316.
 - j. Xavier, J., Bobbin, M., Singer, B. & Budd, E. (2005). A Needs Assessment of Transgendered People of Color Living in Washington, DC *International Journal of Transgenderism*, 8 (2/3), 31-47
 - k. Xavier, J., Honnold, J., and Bradford, J. (2007) The Health, Health-related Needs, and Lifecourse Experiences of Transgender Virginians. Virginia HIV Community Planning Committee and Virginia Department of Health. Retrieved October 8, 2008 at: <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf>
- ⁸ Adams et al., 2008; Brown, 2002; Kenagy, 2005; Kenagy & Bostwick, 2005; Maine HIV Prevention Community Planning Group, 2003; McGowan, 1999; Xavier, Bobbin, Singer, & Budd, 2005; and Xavier, Honnold, & Bradford, 2007). Additionally, the California Department of Public Health, State Office of AIDS’ HIV Prevention Research and Evaluation Section is updating its California statewide online system for tracking



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information about funded HIV education and prevention programs, including counseling and testing services, to include a 2-question system about gender identity.

⁹ See Endnote 2.

¹⁰ Mikalson, P.; Pardo, S.; Green, J. “First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California.” Office of Health Equity, California Department of Public Health, 2012. <http://www.eqcai.org/atf/cf/%7B8cca0e2f-faec-46c1-8727-cb02a7d1b3cc%7D/first_do_no_harm-LGBTQ_report.pdf>

¹¹ Bradford, J.; Cahill, S.; Grasso, C.; and Makadon, H. “Policy Focus: Why gather data on sexual orientation and gender identity in clinical settings.” The Fenway Institute, 2012.

¹² http://www.fenwayhealth.org/site/DocServer/Policy_Brief_WhyGather..._v6_01.09.12.pdf?docID=9141
Healthy People 2020. “Lesbian, Gay, Bisexual, and Transgender Health: Objectives.” U.S. Department of Health and Human Services, 2012.

¹³ <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=25>

Journal of LGBT Health Research, Vol. 4(1) 2008, The Haworth Press. doi: 10.1080/15574090802412572
Efforts to monitor the health of transgender youth, a small but high-risk population, are hindered by a lack of knowledge about how to accurately measure gender identity. Adolescents (n = 30) participated in semistructured qualitative interviews after completing a close-ended transgender-inclusive measure of gender. Interviews explored item comprehension and respondent burden. Participants, who were diverse in age (range = 15–21), gender identity, sexual orientation, and race–ethnicity, were accurately classified as male, female, or transgender. All youth understood transgender as a difference between the physical body and a person’s internal sense of self. Nontransgender youth frequently used an example (a woman in a man’s body) in their explanations and were largely supportive of the transgender options. Most transgender youth found a response option that they felt was appropriate. Transgender response options were added to a gender measure without impacting the accuracy of nontransgender responses or burdening the nontransgender adolescents in our sample. A modified measure (Gender: male; female; transgender male-to-female; transgender female-to-male; transgender, do not identify as exclusively male or female) is recommended for testing in samples that vary by age, race–ethnicity, socioeconomic status, language, and geography. Additional suggestions for research in this area are provided.

¹⁴ Sex /Gender Definitions:

“Transgender” is an umbrella term used to describe people with gender identities and/or gender expressions not traditionally associated with the sex they were assigned at birth. More recently, the term “trans” has been replacing “transgender” because it is considered to be more all-inclusive of the many identities under the umbrella (San Francisco Transgender Advisory Group, 2010). The SF TAG acknowledges that gender identity is not static and that there are cultural, social, and regional variations within trans communities with regard to preferred language and terminology.

¹⁵ A. Cabral, M. (2007). Transgender people and violence against women. In P. Currah, G. G. Guevara, & R. M. Juang (Eds.), *Transgender Justice*. New York, NY: The Center for Lesbian and Gay Studies.

B. Sausa, L. A., Keatley, J. & Operario, D. (2007). Perceived risks and benefits of sex work among transgender women of color in San Francisco. *Archives of Sexual Behavior*, 36(6):768-777.

¹⁶ See Devor, 2002; Sausa, 2006; Vade, 2005

Some define “sex” as only “male” or “female” and as strictly biological condition that can never be changed. Some believe one’s sex can be changed but only through hormone therapy and genital surgeries. Yet, others believe that the definition of sex goes beyond medical definitions of genitalia, chromosomes, hormone levels, and reproductive abilities and encompasses legal, policy, cultural and social issues; i.e., a person need not undergo surgeries to reassign the sex they were given at birth. This has major implications for document changes (such as birth certificates, passports, driver’s licenses, etc.) and U.S. state and national laws (for example, the United Kingdom (2004), Spain (2006), and the state of Iowa (2006) allows transgender people to change their legal sex on their birth certificate without undergoing any surgeries).

The definition of the term “gender” or “gender identity” often referring to “man” or “woman” also varies. Some believe that sex is one’s biology and gender is socially and culturally constructed (thus you can change your gender but not your sex). Others recognize that one’s gender identity includes one’s social status, self-identification, legal status, and biology, noting that it is more complex than originally assumed. New gender



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theories have moved us beyond an antiquated dichotomous explanation of gender identity to include multi-dimensional and multi-layered concepts.

- ¹⁷ There are many more transgender identities than MTF or FTM. Some believe that only having the categories male, female, MTF, and FTM is reductionary and recreates a narrow binary thinking about sex and gender. For example today “transgender men” may identify as: transguys, trannyfags, studs, men, males, genderqueers, two-spirit, gender outlaws, gender fluid, bois, FTMs, transsexual men, MSM, TMSM, gay men, among others.
- ¹⁸ See Emi Koyama’s article at www.ipdx.org/articles/letter-outsidein.html In 2006, a consensus for a new paradigm of care for people diagnosed with "intersex" conditions was developed by 50 international experts and patient advocates. Accompanied by a change in nomenclature referring collectively to these conditions as Disorders of Sex Development, or DSD, a new standard of care was proposed focusing on improved quality of life through a patient-centered model of care with an emphasis on an interdisciplinary team approach to health care delivery (www.accordalliance.org). It is important to note that some people born with DSD may also identify as transgender, through most do not. It is important to not conflate the issues of transgender people and people with DSD by placing them both within the transgender umbrella. In addition, the inclusion of “Intersex” or “DSD” as a gender or sex category is not recommended for a variety of reasons including the fact that most people with DSD identify as male or female, as highlighted by Emi Koyama from the Intersex Initiative Portland.
- ¹⁹ The Center of Excellence for Transgender Health provide interactive and educational training to help health professionals understand the update and learn how to effectively and accurately ask and record information about sex and gender identity . This is available at: www.transghealth.ucsf.edu
- ²⁰ National Resource Center on LGBT Aging. “Inclusive Questions for Older Adults - A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity,” 2013. This is available at: http://www.lgbtagingcenter.org/resources/pdfs/InclusiveQuestionsOlder%20Adults_Guidebook.pdf