Consultation questions

The Action Plan has six main themes: Human Rights and Recognition; Safety; Home and Communities; Health and Social Care; Education; and the Workplace. We would like your thoughts on the proposed actions within each theme. You may want to comment on one or all of these areas.

Please use the following questions as the basis of your response. You are welcome to add additional comments or information if you wish.

Question 1

Do you think the Action Plan will increase equality for LGBTQ+ people and what do you think the priorities should be?

Yes

Key priority:

Promote and resource research into the normal development of sexual and gender identity, and the contributions made by genetic, neurodevelopmental, and environmental influences. The ‘inclusive’ agenda has dictated that diversity be celebrated and not investigated. Being ‘born in the wrong body’ has entered common parlance as if the notion was based on firm evidence. Nobody wants to see a continuation of prejudice or discrimination, but unbiased research is urgently needed. For example, how are we to understand the enormous increase in rapid-onset gender dysphoria among young people, particularly girls, in recent years?

The Welsh government commissioned Stonewall Cymru as its primary partner in preparing the Action Plan. Their beliefs and ideology undergird the Plan. Surveys they have undertaken typically draw upon the views, often strongly held, of those in the LGBTQ+ community. The results inevitably reflect those views. They are no less valid for that, but they could not be called unbiased, nor truly representative of the population of Wales.

Ideological agendas must not be allowed to prevent good quality research. Legislation, as well as guidance for professionals in healthcare and education, must be evidence-based and we regret that the government in Wales has not drawn evidence from more representative sources.

Question 2

Do you agree with the overarching aims? What would you add or take away in relation the overarching aims?

We welcome this commitment, especially as it pertains to refugees and asylum-seekers. We suggest that the rights of LGBTQ+ people not to be discriminated against on the basis of their sexual orientation or gender identity are adequately covered by existing legislation (2010 Equality Act). But we do recognise the importance of awareness and welcome the commitment to equalities training for all public service workers.

Question 3

Do you agree with the proposed actions? What would you add or take away in relation the actions?

Human Rights and Recognition

Action 9 – devolving powers relating to Gender Recognition

a) A change to gender self-declaration would be unsafe.

CMF is opposed to gender self-declaration, though we agree that the present process is complex, cumbersome and costly, and in need of reform. However, replacing the current assessment procedure with what would be, in effect, an online self-registration, we believe would not be in the best interests of the trans community in Wales. To make it simpler for someone to make a life-changing decision that, evidence suggests, they might later regret, is not beneficial. The current law's delays are often seen as too onerous, but their purpose is to allow people time to explore their new identity before making far-reaching decisions. The Welsh Government's aim, and its responsibility, should be to develop policies and processes that are evidence-based, not ideologically driven. A process of

legal gender recognition based on self-identification would appear to reinforce the notion that an individual's subjective sense of their gender identity defines reality, regardless of their biology, as if it were proven fact.

A change to self-declaration would be unsafe. Gender dysphoria often co-exists with mental health disorders like anxiety and depression, and sometimes with autism. It is important to distinguish distress relating to one of these other conditions from dysphoria related to gender incongruence. This requires the skills of appropriately qualified healthcare professionals. Self-declaration would deprive people of contact with these professionals at the very time when their assessment and advice could be crucial.

There is a real risk that individuals who require psychological support and psychiatric treatment will not receive it. Young people, whose dysphoria could have been alleviated by treating co-existent mental health disorders or by giving appropriate support where family breakdown/social isolation are factors, will instead pursue transgender recognition (and possibly reassignment for which evidence of effectiveness is lacking).

b) A change to gender self-declaration would remove helpful barriers to overly easy transition

Until recent years, gender dysphoria was viewed as a mental health disorder and required specialist expertise to make a correct diagnosis. Many in the medical profession believe that the change from disorder to dysphoria was ideologically driven, not evidence based. Removing the need for medical diagnosis would remove a sensible 'barrier' to overly easy transition that would result in more people embarking on early medical transition with insufficient thought, more people living to regret irreversible changes to their bodies, and/or wanting to de-transition later, and an overall increase in co-morbid mental health issues including suicidality.

c) A change to gender self-recognition would create a trans-affirming environment that would constrain support for other protected characteristics

Relaxing the requirements of the Gender Recognition Act (GRA) would mean that more people apply for and receive Gender Recognition Certificates. Presumably, the gender reassignment protected characteristic of the Equality Act would apply to all with a GRC. In settings where the rights of trans people compete with those of other groups, the point of

balance would shift in favour of the trans community. Incremental extension of those rights through subsequent case law would likely follow. The ability of the Act to support those with other protected characteristics would be progressively constrained in a trans-affirming environment. In seeking to correct one imbalance it is clearly important not to create another that is open to exploitation, whether by ideologues or predators.

d) A change to gender self-declaration would put biological women at a disadvantage in the realm of sport and at danger in women-only protected spaces and prisons

There would be an impact in the realm of sport, where it would become more difficult to maintain the fairness of a contest. It is obvious that trans women have an advantage over other women in many sporting activities. It would become harder to protect single-sex and separate-sex exceptions under the Equality Act.

Making the acquisition of a GRC easier would make it easier for men, including some with a history of physical or sexual abuse of women, to identify as women and thus gain access to 'safe spaces' for women, for example in hospitals, prisons and women's refuges.

e) A change to gender self-declaration would undermine medical research and public health

Such changes to the GRA would also impact on areas of law and public services other than the Equality Act. For example, accurate record-keeping and statistical analysis provide the basis for much medical research and health-programming. Increasing the number of people whose biology does not match their registered gender will distort those data. In the long term, this is not in the best interests of the transgender community.

Action 10 – Banning all aspects of conversion therapy

CMF is wholly in agreement with banning harmful and coercive practices. Legislation should be evidence based. Legislation to ban harmful practices must be based on reliable research that clearly demonstrates such harm is occurring.

a) A decision to ban all forms of conversion therapy lacks a sufficient evidence base.

No evidence has been supplied that historic abhorrent practices such as chemical castration, corrective rape, electric shock therapy and forced marriage are commonly taking place in the UK today, and in any case, legislation already exists that bans such practices.

There is a lack of good quality research data to guide legislators. Such research as has been done generally takes the form of voluntary surveys with small sample sizes and with respondents recruited through the social media channels of the LGBTQ+ charities. Inevitably, these channels tend to attract respondents with strong views on the subject. In these circumstances, bias in the results is hard to avoid. In addition, the methodology uses retrospective self-reporting, which is not a reliable measure.

One such report is the 2020 Conversion Therapy and Gender Identity Survey[1] undertaken by Stonewall. The cohort surveyed was small. Out of a total 1504 responses to the survey, only 51 respondents had undergone 'gender identity conversion therapy' (p. 10). Of these, 8 (15 per cent) 'felt it worked completely' (p. 14). Therefore, the survey identified only 43 (2.8 per cent) people who reported negative experiences. This number is surely too slender a basis on which to propose new legislation.

The analysis excluded 28 per cent of the survey responses (p. 7). Many of these were omitted for being 'transphobic' (p. 18). No criteria are provided to define transphobia; it is hard to avoid the conclusion that the label serves primarily to exclude responses that contradicted the legislative agenda of the organisations funding the research, notably Stonewall. Yet the government in Wales chose Stonewall Cymru as its primary partner in drawing up its LGBTQ+ Action Plan. We question the wisdom of this decision.

The point is this: the ideological agenda behind the proposal to ban all forms of conversion therapy not only lacks an evidence base to support it

[1] https://www.stonewall.org.uk/about-us/news/new-research-gender-diverse-people-severely-harmed-conversion-therapy

but ignores a growing body of evidence that reveals its assumptions to be false.

b) The decision to ban all forms of conversion therapy ignores all voices and perspectives other than those of ideological activists

We recommend that the Committee gather perspectives from a wider range of opinion and expertise, including healthcare professionals. GPs are often best placed to understand the social settings of their patients and be able to contextualise their stories. Many of our (CMF) members work in general practice and are concerned that the current 'affirmative' approach is fast-tracking gender-confused children to social transitioning and puberty blockade. They are also worried that emerging gay and lesbian young people who experience homophobic bullying at school are identifying as trans to escape the homophobia and find themselves being encouraged towards puberty blockers and trans-sex hormone therapy. In effect, the strongly affirmative trans agenda is imposing a form of conversion therapy on gay and lesbian young people.

We believe the voices of parents also need to be heard where children are concerned. Transgender Trend[2] is an organisation of parents, professionals and academics who are concerned about the current trend to diagnose children as transgender, and about legislation which places transgender rights above the right to safety for girls and young women in public places and to fairness in sport. They are not a faith-based organisation. We commend them as an organisation to speak with.

LGBTQ+ activists are calling for a far-reaching ban that must include pastoral support, prayer and counsel provided by faith communities. We recommend that the Committee invite the perspective of the Evangelical Alliance,[3] founded in 1846 and now representing thousands of UK churches. Their aim is to serve and strengthen the work of the church in communities and to promote evangelical Christian beliefs in government, media and society.

We would also commend the work of Living Out[4] whose aims include 'to provide pastoral support and advice in relation to biblical teachings on

[2] https://www.transgendertrend.com/
[3] https://www.eauk.org/
[4] https://www.livingout.org/

human sexuality, assisting same-sex attracted Christians to reconcile their sexuality with the teachings of the Bible.' They represent people who would be profoundly affected by the proposed legislation and, as such, merit the opportunity to contribute to the listening exercise.

c) The decision to ban all forms of conversion therapy ignores the experiences and voices of de-transitioners

The steadily increasing number of people requesting help to de-transition is a constituency that also deserves to have its voice heard. The insights they can offer into how the current treatment of gender incongruent people could be made better would help to prevent an escalation in the number of stories like that of Keira Bell[5] from arising.

We strongly request that the Welsh Government sponsor a programme of independent research and review, to produce reliable data that will inform legislation, and not to proceed on the basis of biased reporting and flawed methodology.

d) The decision to ban all forms of conversion therapy unhelpfully conflates sexual orientation with gender identity, and ties the hands of therapists

We believe it would be essential for any legislation to distinguish clearly between sexual orientation and gender identity. The Memorandum of Understanding (MoU) on Conversion Therapy, published in 2015, and signed by most of the therapeutic bodies, the Royal College of GPs and NHS England, was a practice guide for therapists to protect gay, lesbian and bi patients from therapists who attempted to convert them to heterosexuality.

In 2017, following pressure from trans rights activists, it was revised to include 'gender identity.' The conflation of sexual orientation and gender identity effectively prevents a therapist from carrying out a neutral investigation into a client's gender dysphoria, whatever their age. For young people and children with gender dysphoria this means therapists must affirm a young person's belief that they are the opposite sex. It has been shown conclusively[6] that around 80 per cent of children will outgrow a trans identity during puberty if a watchful waiting approach is taken. But

[5] https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf
[6] Adolesc Health Med Ther. 2018; 9: 31–41. Published online 2018 Mar 2. doi: 10.2147/AHMT.S135432

even trying to discuss this possibility with a young person could lay a therapist open to charges of conversion therapy. As Shelley Charlesworth has pointed out: *'The NHS is now committed to contradictory guidance; on the one hand it has signed the MoU mandating an affirmation only approach to gender dysphoria and on the other it has revised its advice on treatment, stating that little is known about the long-term effects of puberty blockers or cross-sex hormones… Whatever the government proposes in relation to a legal ban, the MoU 2017 will remain a block to an open exploratory therapeutic approach for young people who struggle with their sense of self and identity.'*[7]

The article concludes that there is no evidence in any of the reports of documented conversion therapy taking place in professional healthcare settings in the UK. It further concluded that there is some evidence that gay conversion therapy, but not gender identity conversion therapy (GICT), is happening in some faith settings. Our contention is that the 2017 version of the MoU needs further revision lest it represent a barrier to helping children wrestling with their gender identity.

In summary, evidence suggests that most accounts of coercive and harmful conversion therapy relate to historic acts. That these have sometimes occurred in faith settings we deeply regret. That some attempts to 'minister' to people with unwanted same sex attraction today might be seen by some as overly zealous, we do not dispute. But there are cultural factors to take into account, as well as the personal stories of those people who clearly have been helped by such ministry. If there is evidence that harm has been suffered by others through this kind of ministry, this too we would regret. We agree that appropriate legislation to ban clearly harmful practices is needed.

But, as stated above, changing the law does not change attitudes. Education, discussion, and inspirational examples are needed. A 'total' ban that aims to shut down the work of responsible churches and other supportive organisations will rob many of the very information, support and counsel that they are seeking. Fearful of transgressing the law, churches will cease to engage with people who are seeking to express their sexuality and gender identity in ways consistent with their Christian faith but who experience same sex attraction or gender dysphoria. The very people who

[7] https://www.transgendertrend.com/gender-identity-conversion-therapy-uk/

currently offer acceptance, community, help and support will be paralysed, fearful of being reported and prosecuted. (This much is recognised in the Equality Impact Assessment, p. 8).

We urge the Welsh Government to pause, review evidence, listen to a broad range of stakeholders and produce good legislation as a result.

Action 11 – Removal of gender markers from documentation

As stated above, under action 9, accurate record-keeping and statistical analysis provide the basis for much medical research and health-programming. If sex and gender markers are removed from health records, some trans men will miss out on calls for routine cervical smears or mammograms, and trans women on assessment of the health of their prostates. We recommend that consideration be given to retaining markers for biological sex on all health records.

Safety Considerations

Action 15 – Hate Crimes

We applaud the intention to work with the tech companies and media platforms to tackle hate crime and misinformation. Hatred and hostility expressed towards any personal characteristic should be a crime, and the law should set and test the thresholds of evidence of harm to guide sentencing.

In many settings, offense has been weaponised and equated with harm, but we contend that there is a world of difference between the two. The claim to be offended by the opinion of another, whether spoken or written, is given as reason enough to ‘cancel’ that opinion – to silence it or, at the very least, to hold it up to ridicule. In this situation, offense is not an index of harm done to the one claiming to be offended; instead, it has become a weapon with which to inflict damage the credibility of another.

Many times, offense is not harm – it is a choice, something ‘taken’ not ‘given.’ One is free not to take offense. Granted, if a person takes offense, they may be ‘harmed’ in the sense that they may experience negative emotions such as rejection, anger, resentment, and the like. But it is the

choice to take offense, and not the opinion at which the offense is taken, that is the cause of the ‘harm’ to the offended person.

Clearly, online and verbal abuse and harassment are significant issues in our day, and we commend the intention to limit them. We simply ask that the law continues to protect the freedom courteously to express an opinion, even one that is repugnant to others, without being accused of committing a hate crime and being found guilty of a criminal offence. Seeking to discredit another, whose opinion one does not like, by crying ‘foul’ and claiming to have been harmed by their ‘hateful’ opinion, is rife in our society, particularly around the issues of sexuality and gender. What is needed here is more light and less heat.

Home and Communities

Action 20 – Raising awareness

We understand and appreciate the enthusiastic tone of this section and simply appeal for the same level of support and sponsorship to be given by the Welsh government to other communities with protected characteristics under the Equality Act, such as the disabled community, that are many times more numerous in the population than the LGBTQ+ community, albeit less vocal.

Action 25 – Participation: Culture and Sport

In our opinion it is impossible for biological men and biological women to compete against each other fairly on the sports field. Biological men (including trans women) clearly have an unfair advantage. The review Transgender Inclusion in Domestic Sport[8] found that ‘*there are retained differences in strength, stamina and physique between the average woman compared with the average transgender woman or non-binary person registered male at birth, with or without testosterone suppression*.’ In the light of this review, we hope that the Welsh Government will provide clear and unambiguous legislation, that respects individual choices of gender identity but does not ignore biological realities. Wales has long ‘punched above its weight’ in its sporting achievements, and we urge the Welsh

[8] https://www.uksport.gov.uk/news/2021/09/30/transgender-inclusion-in-domestic-sport p3.

government not to undermine its proud history by bowing to ideological imperatives at the expense of biological realities.

Health Outcomes

Action 42 - Tele-medicine for sexual health

We are very concerned about plans to make permanent the temporary measure to permit home use of both pills for early medical abortion (EMA) up to 10 weeks' gestation.

The absence of a face-to-face consultation:

1) removes the physical examination and routine scanning that would confirm gestation dates

The 'pills by post' process relies on the woman being able to recall the first day of her last period. Studies report that approximately one half of women do not accurately recall their LMP.[9] Evidence from the DHSC[10] confirms that pregnancies that are well past 9 weeks and 6 days are being terminated at home, with increased safety risks, particularly haemorrhage, as a consequence.

2) removes examination and scanning that would reveal if a pregnancy were ectopic

A ruptured ectopic pregnancy is a surgical emergency. For all women this is of serious concern, but for those living remotely it can be a matter of life and death.

3) removes the opportunity to clarify and supervise the timing and method of taking the two medicines

For example, one of the pills (Misoprostol) is designed to be absorbed from the mouth by keeping the pill between the cheek and gum for a full 30 minutes. Swallowing the pill whole converts it to an oral dose, which is associated with reduced efficacy and increased failure rates.[11]

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[9] https://www.healthcare.uiowa.edu/familymedicine/fpinfo/OB/OB2017/ACOG%20redating%20gestational%20age.pdf page 2

[10] https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-tojune-2020

[11] Scottish Abortion Care Providers Network. Abortion − improvement to existing services − approval for misoprostol to be taken at home. Scottish Government Health and Social Care Directorates 26 October 2017.

4) removes a safe place for a woman under coercion to speak freely
5) allows impersonation – is the woman requesting abortion the same woman that will take the medicines?

A nationwide undercover investigation, commissioned by Christian Concern, showed that 'home abortion schemes are wide open to abuse' and are 'leading to dangerous and illegal 'DIY' abortions.' Kevin Duffy, a former Global Director of Clinics Development at Marie Stopes International, who led the investigation, said: *'The investigation clearly demonstrates that abortion at home, by pills-by-post, is not safe and on many occasions oversteps legal boundaries without any proper scrutiny... It is deeply concerning that the abortion industry has been allowed to take this service this far during an already highly vulnerable time for pregnant women. The process of wholly relying on telemedicine must be withdrawn urgently.'*[12]

6) removes the opportunity to check that the patient has another adult present who will raise the alarm if things go wrong, and that emergency medical support is at hand

Manufacturers clearly understand these risks: the data sheet supplied with Medabon's 'Combipack' of Mifepristone with Misoprostol states: '*Because it is important to have access to appropriate medical care if an emergency develops, the treatment procedure should only be performed where the patient has access to medical facilities equipped to provide surgical treatment for incomplete abortion, or emergency blood transfusion or resuscitation during the period from the first visit until discharged by the administering qualified medical professional.'*[13]

A Swedish study which looked at all abortions from one hospital from 2008 to 2015 reported an overall complication rate of 7.3 per cent in medical abortions under 12 weeks. The commonest complication was incomplete abortion.[14] A significant finding was that the rate of complications associated with medical abortions increased from 4.2 per cent in 2008 to

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https://bit.ly/2DFZi7y; Raymond EG et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. Contraception 2013; 87:26-37 https://bit.ly/2S10BRF; Winikoff B et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. Obstetrics and Gynecology December 2008;112(6):1303-10

[12] https://christianconcern.com/news/undercover-investigation-exposes-diy-abortion-service-breaking-thelaw

[13] Electronic Medicines Compendium (accessed 10.02.2021). 2020 [cited; Available from: https://www.medicines.org.uk/emc/product/3380/smpc

[14] Carlsson I, Breding K, Larsson PG. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. BMC Womens Health 2018;18(1):158.

8.2 per cent in 2015, possibly associated with a shift from hospital to home medical abortions.

7) removes an opportunity for reflection – time to consider options in a non-pressurising context

The BBC has reported[15] concerns over the negative impact on women's health of not being able to access in-person abortion counselling.

A study of women from Sweden who had home abortions in 2016 noted that 'one-third of the women stated that they lacked information in different areas like bleeding, pain, the abortion process, expulsion of the embryo, and the opportunity to see a counsellor. Lack of or insufficient information about bleeding was most frequently mentioned.'[16]

Home abortion instructions given by phone or video are more likely to be misunderstood and therefore carry greater potential for harm. This would be especially true if the woman did not have English as a first language.

8. increases the risk of psychological trauma

The American Psychological Association's report[17] identified fifteen risk factors for post abortion psychological injury, including suicidal ideation. Reardon notes that the list is one of the shortest that has been developed,[18] emphasising how unlikely it is that consultations done by phone or video link will be able to fully assess the risk of an abortion to a woman's psychological health. About half the women who have abortions in England and Wales each year have had at least one abortion previously. The incidence of repeat abortion is therefore high. Sullins found a compounding effect of repeat abortion on suicidal ideation and substance misuse.[19]

9. prevents screening for sexually transmitted diseases

The Royal College of Obstetricians and Gynaecologists (RCOG) recommends screening for Chlamydia and other STDs in all women having abortion.[20] This cannot be done other than by a face-to-face appointment.

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[15] https://www.bbc.co.uk/news/uk-wales-54423710

[16] Hedqvist M, Brolin L, Tyden T, Larsson M. Women's experiences of having an early medical abortion at home. *Sex Reprod Healthc* 2016;9:48-54

[17] Report of the APA Task Force on Mental Health and Abortion. Washington DC: American Psychological Association; 2008

[18] Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *SAGE Open Med* 2018;6:2050312118807624

[19] Sullins DP. Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States. *SAGE Open Med* 2016;4:2050312116665997

[20] The care of Women Requesting Induced Abortion London: Royal College of Obstetricians and

The lack of provision for this under the emergency provisions therefore increases further the risk of personal injury to the woman.

10. entrusts safety into the hands of those whose practices have been found unsafe

The Care Quality Commission found examples of malpractice at Marie Stopes centres in 2016. In answer to a Parliamentary question in February 2020, it was reported that 121 facilities performing abortions (59% of the total) required improvement for safety.[21] The proposal to make permanent the emergency regulations will lower safety standards. If abortion providers were already compromising on safety standards, then lowering those standards will likely result in further compromises.

11. increases the risk of under-reporting of complications

In response to an FOI request, the Government reported that 'Between April and June 2020, there were 23,061 medical abortions performed on residents of England and Wales where both medicines (antiprogesterone and prostaglandin) were administered at home. Of the 23,061 abortion notification forms received, one form reported a complication.'

Commenting on this report, Sally-Ann Hart MP pointed out: 'This would mean that the average rate of complication for medical abortions at a similar gestation over the past five years was over seventeen times higher than the complication rate for home abortions earlier this year. 'This is not only highly unlikely – that complications would radically reduce in a home setting versus a medical setting – but, some may say, ridiculous. 'There is either a serious problem when medical abortions are provided in a clinical environment with direct medical supervision – leading to vastly more complications in clinics than in homes – or a substantial issue with the overall quality of reporting and recording the real impact of 'at-home' medical abortions on women's health.'[22]

12. prevents accurate assessment of outcomes and hinders research

Abortion providers are not obliged to record NHS numbers and women are not required to report adverse outcomes to their abortion provider. So systematic, objective analysis of the outcomes for women post abortion is prevented by the absence of full records linking women's health to prior abortion. Accurate records, systematic review and robust audit are essential to safe practise. How is the effectiveness of the present system,

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Gynaecologists; 2011

[21] https://questions-statements.parliament.uk/written-questions/detail/2020-02-27/21971

[22] https://www.politics.co.uk/comment/2021/01/06/home-abortions-a-disservice-to-women/

were it to be made permanent, to be assessed? How will we learn from mistakes if longitudinal analysis is impossible? It is essential that there be a record of EMAs at home, and a mandatory consultation and assessment would facilitate this.

13. threatens the validity of consent

Even at the best of times, the decision to terminate a pregnancy is a profoundly significant one. From the earliest days of her pregnancy, a woman's intuition is to provide a welcome and a safe place in her womb for her baby. The choice to abort is costly and may lead to later regret.

But these are not the best of times. The pressures of isolation, and fears and anxieties around jobs, vulnerable family members, education etc have had a profound effect on the mental health of many. These are not good times for people to be making far-reaching decisions. To have to do so without the opportunity to talk things over in person with trusted medical carers is to make an already difficult situation intolerable.

Evidence[23] confirms that women requesting EMA at home are less likely to be given clear and comprehensive information and advice. As a result, consent to the procedure is not fully informed and therefore not valid.

We believe that the initial consultation should be with the patient’s doctor and that that doctor should routinely have to account for his or her decision to another doctor, who may affirm or resist their colleague's decision. We believe that this level of care and involvement is essential to the patient's best interests in providing a confidential setting where any coercive factors can be safely discussed, and fears and anxieties gently explored. Only in this way can informed and free consent be assured. We believe this is sufficiently important to justify the very small risk of Covid transmission when undertaken in a Covid secure environment with appropriate PPE and distancing measures.

A temporary measure to deal with an unforeseen national emergency should not become the norm. It is putting lives at risk. There has been no review by an independent body of the safety of remote consultations.

The UK government has no systematic, objective data analysis of the outcomes for women post ‘abortion at home’, no evidence base for the safety of the process, no comparison with outcomes prior to the sanctioning of home abortion. Even if such an analysis existed,

helpful as it would be, in such a short timeframe it would not cover longer term psychological consequences.

Abortion providers should not be relied upon to provide unbiased data – remote consultations are clearly easier for them and cut costs. To press ahead with plans to make the emergency provisions permanent, without supportive evidence, appears driven more by ideology than science or public health concerns.

Education

Action 47 – LGBTQ+ inclusive RSE curriculum for all learners (age 3-16)

We would like to place on record our concerns that the 'expert panel' relied so heavily on Stonewall Cymru's survey which, for reasons already stated, cannot be said to be free of bias.

Whilst opposed to discriminatory attitudes and practices, we do not support the strongly affirmative stance towards early social transitioning and referral for puberty-blocking treatment for primary school aged, gender-confused children. We regard such treatment as experimental, without a sufficient evidence base for its use. Given that around 98 per cent of children who receive puberty blockers will progress to cross-sex hormone treatment that carries with it significant risks, not least the likelihood of sterility, we call for a moratorium on this affirmative action.

Notwithstanding the recent ruling by the Appeal Court, in Bell v Tavistock and Portman NHS Trust, we agree with the earlier High Court ruling that children under 16 are not able to give valid legal consent to such procedures. In respect of young persons aged 16 and over, given the long-term consequences of the clinical interventions at issue, and that the treatment is as yet innovative and experimental, the High Court recognised that clinicians 'may well regard these as cases where the authorisation of the court should be sought before starting treatment with puberty blocking drugs.'[24]

The LGBTQ+ Action Plan for education strongly promotes diversity in sexuality and gender identity in schools to counter what it sees as 'an unduly heteronormative provision.' We believe that a great deal more research and data are needed before such a stance can be justified

[24] https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Clinic-and-ors-Summary.pdf

through evidence. The growing number of ‘detransitioners’ who claim that hormone therapy and gender reassignment surgery have not ‘fixed’ their dysphoria should at least give us reason to pause. We would argue for a more cautious approach than that recommended in the Action Plan.

Question 4

What are the key challenges that could stop the aims and actions being achieved?

In our view, the most obvious challenge to the successful accomplishment of the aims and actions of the Plan is that the Welsh Government has relied so heavily on data supplied by Stonewall. The resulting bias is clear to every fair-minded reader and we do not think the Plan will be supported by the population as a whole, who for the most part will not share the ideological stance of Stonewall.

Question 5

What resources (this could include funding, staff time, training, access to support or advocacy services among other things) do you think will be necessary in achieving the aims and actions outlined?

Question 6

Do you feel the LGBTQ+ Action Plan adequately covers the intersection of LGBTQ+ with other protected characteristics, such as race, religion or belief, disability, age, sex, and marriage and civil partnership? If not, how can we improve this?

The LGBTQ+ community in Wales is relatively small in size. What it lacks in terms of numbers it makes up for in terms of the stridency with which is promotes its message and underlying assumptions. The recommendations in the Plan reflect a disproportionate ‘weighting’ in favour of the LGBTQ+

community over the interests of other protected characteristics, where there is ‘intersection.’

This is most obviously so in the case of religion and belief. Many Welsh communities were impacted and transformed by a revival of Christian religion in the early 20th century. Though church attendance has since declined, we believe it would be a mistake to conclude that traditional Christian belief and intuitions have evaporated. That cultural legacy will endure long after the chapel buildings crumble. Traditional Christian views about marriage, sexuality and gender, for example, are at odds with the values and beliefs espoused in the Plan, which is heavily weighted against those traditional views. This disproportionate emphasis invites pushback rather than acceptance; it appears to strike at the very equality that the 2010 Equality Act was created to safeguard.

As for what could be done to level that playing field, we have recommended above that the Welsh government sit down with representatives of a broader constituency of opinions, to include faith communities, and commission studies by, and gather data from, organisations that do not reflect the ideological stance of Stonewall.

Question 7

We would like to know your views on the effects that these proposals would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.

What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Question 8

Please also explain how you believe the proposed policy approach could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Question 9

This plan has been developed in co-construction, and discussions around language and identity have shown that the acronym LGBTQ+ should be used. This stands for lesbian, gay, bisexual, transgender and queer/questioning people, with the + representing other sexual identities. As a result we refer to LGBTQ+ people in the Plan.

What are your views on this term and is there an alternative you would prefer? Welsh speakers may wish to consider suitable terminology in both languages.

Question 10

We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

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Organisation (if applicable)

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Responses to consultations may be made public. To keep your response anonymous (including email addresses) tick the box.

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