The rights of transgender children in South Africa to gender-affirming care in the form of puberty blockers

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Abstract

The provision of gender-affirming care to transgender children has sparked significant discourse within medical, ethical, and legal realms. This contribution examines the evolving conceptualisations of children's autonomy and decision-making capacity within the context of paediatric health care, with particular attention devoted to the unique challenges posed by gender dysphoria. It also investigates the legal landscape surrounding the rights of transgender children to access gender-affirming care. This contribution advocates for a rights-based approach that prioritises the autonomy and well-being of transgender children in the provision of gender-affirming care, while also acknowledging the complexities and ethical dilemmas inherent in navigating this terrain.

Keywords: Medical decision-making; transgender children; puberty blockers; best interests of the child

1. Introduction

According to the World Health Organisation (WHO), "gender-affirmative health care" can "include any single or combination of several social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity". [1] The most widely discussed treatment is the use of puberty blockers. Puberty blockers primarily cause puberty suppression with gonadotropin-releasing hormone analogues (GnRHa), which essentially delay puberty and the onset of developing sex characteristics that are incongruent with the person's gender identity. [2] The provision of gender-affirming care to

transgender children, particularly in the form of puberty blockers, has sparked significant discourse within medical, ethical, and legal realms.

South Africa's gender-affirming standard of care is a patchwork application of several intersecting pieces of legislation, non-binding policies, protocols, and international and regional instruments adapted to the local health care context. Although South Africa has made strides in aligning its approach with global standards, it struggles with the consistent implementation of these global standards due to a lack of trained professionals and systemic inefficiencies. [3] There are significant disparities in health care access due to, inter alia, socioeconomic inequality and, thus, intersectional and local context-specific standards of gender-affirming care for minors are necessary. This means recognising the reality of the lack of medical infrastructure, such as the lack of specialist medical personnel, the lack of care facilities specifically devoted to providing gender-affirming care, and the socioeconomic challenges, such as the urban/rural divide. [4] This is in conjunction with the somewhat controversial nature of discussions on health care for minors.

Against this background, this contribution will examine the evolving conceptualisations of autonomy and decision-making capacity within the context of paediatric health care, paying particular attention to the unique challenges posed by gender dysphoria. Furthermore, the contribution will investigate the legal landscape surrounding the rights of transgender children to access gender-affirming care, legislative developments, and policy initiatives. Since this contribution advocates for a rights-based approach that prioritises the autonomy and wellbeing of transgender children in the provision of gender-affirming care, the next part will focus on a theory of children's rights.

2. A theory of children's rights

A fundamental precondition for rights is the social perception that an individual or class of individuals has certain interests. [5] These interests must also be capable of isolation from the interests of others. [6] According to Eekelaar, there is a theory of children's rights in which the most important identified interests can be categorised into three groups: basic interests; developmental interests; and autonomy interests. Briefly, basic interests encompass claims

to the physical, emotional, and intellectual care of the child. [7] Developmental interests are those that can be enforced by the child against not only the parent, but also against the wider community. [8] It essentially means that children should have equal opportunities to access the resources available to them so that they can minimise the degree to which they enter adult life affected by harm that could have been avoided during childhood. The fulfilment of these interests will depend not only on the family dynamic, but also on the socioeconomic factors prevalent in a particular community.

Regarding the issue of the autonomy interests of the child, autonomy has been described as

> "at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan . . . . A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans". [9]

In other words, while the child certainly should have self-rule and control over their physiological and psychological interests, these are also matters that include their parents or guardians. Respecting bodily autonomy is a fundamental principle that recognises an individual's right to make decisions about their own body. [10] However, the diminished capacity of a child to make medical decisions, for example, means that they must rely on decisions being made for them by or in conjunction with their parents or guardians. It is from this vantage point that the possibility of a potential clash of rights of the child versus those of their caregivers becomes clear.

The right of the child to act independently can vary based on age or maturity. Nevertheless, children must be seen to have agency, in terms of which they are not treated as merely passive objects of parenting, but as fully-fledged social beings. [11] As society progresses, there remains a paradigm shift to be made away from the conception of childhood solely as a journey to adulthood. [12] Childhood is a journey of navigating a multitude of complex developmental milestones and negotiating the ever-present need for autonomy and protection. Because of their vulnerable status in society,

children must simultaneously be treated as autonomous beings and in need of caregiver or state protection. This creates a complex and sometimes unequal power dynamic between the child and all the other relevant role-players in the child's life. [13]

Given this potentially unequal power dynamic, parents (and health care providers) must provide children with the information that they need to make decisions that are as autonomous as possible. [14] At the same time, they must avoid influencing children with beliefs that children cannot sufficiently validate themselves. [15] This tension reveals itself particularly in the context of gender-affirming care for transgender children. Consent to gender-affirming care tests the waters of how parents exercise their responsibilities and rights and how and when a child can exercise bodily autonomy concerning medical treatment.

3. Transgender children, the Dutch Protocol and the World Professional Association for Transgender Health ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People ("WPATH SOC") [16]

"Transgender" is an "umbrella term for persons whose gender identity, gender expression or behaviour does not conform to that typically associated with the sex to which they were assigned at birth". [17] "Sex", which is assigned

at birth, refers to "one's biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy". [18] "Gender" refers to "the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for boys and men or girls and women". [19] It is under these conditions that the gender binary exists, namely that there are only two sexes and only two genders. This binary approach incorrectly conflates sex with gender and ignores that gender exists on a spectrum. [20]

Transgender children may experience gender dysphoria at a young age. Gender dysphoria is a condition in which a child's subjectively felt identity and gender are not congruent with their biological sex. [21] A point of contention is the pathologising of transgender persons. [22] For example, the Diagnostic and Statistical Manual of Mental Disorders classifies gender dysphoria as a mental *disorder*, with the additional implication that this disorder needs to be "cured". [23]

There has been a significant amount of criticism regarding the resort to pathology as a means to access gender-affirming care. [24] One response to this criticism is the development of the gender-affirmative model which essentially allows a child to declare that they are transgender and to receive gender-affirming care. [25] However, this is not aligned with the standard of care that was developed by clinicians in the Netherlands in the 1990s [26] and which is the model upon which many countries in the West have based their own standards of care. [27] The Dutch Protocol advocates treatment involving

the administration of puberty blockers and, subsequently, gender-affirming hormones to transgender adolescents and adults. [28] However, the diagnostic procedure followed prior to the administration of treatment is both lengthy and extensive and involves an experienced and interdisciplinary team.

The administration of GnRHa drugs to suppress puberty in "juvenile transsexuals" was first proposed in print in the mid-1990s. [29] The belief was that transgender persons would experience better outcomes if they started treatment well before adulthood. [30] There were two claims made to support this position – first, that the treatment was reversible [31] and secondly, that puberty suppression was a diagnostic tool. [32] By the mid-2010s, the Dutch Protocol was established as the standard for transgender medicine. [33] However, there has recently been a wave of criticism directed at the Protocol, particularly as it pertains to a lack of longitudinal studies that would support a claim that the Protocol provides an adequate standard of care. [34]

To date, the South African standard of care does not subscribe to the Dutch Protocol. Instead, in 2019, gender-affirming hormones were approved by the South African National Essential Medicine List Committee for tertiary-level care [35] and, in October 2021, the Southern African HIV Clinicians Society Gender-Affirming Health Care Guideline for South Africa [36] ("GAHC Guideline") was introduced. [37] The GAHC Guideline is aligned with the WPATH SOC. The WPATH is an international, multidisciplinary, professional

association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. One of the main functions of the WPATH is to promote the highest standards of health care for transgender individuals. [38] While primarily a document for health professionals, the WPATH SOC may also be used by individuals, their families, and social institutions to understand how they can help promote optimal health for members of the diverse transgender population. [39]

4. The international framework regarding gender-affirming care

4.1 Introduction

There are certain factors which must be taken into account when an adolescent decides on their gender-affirming treatment, including their age, maturity, their best interests and their evolving capacities. Juxtaposed with this are the responsibilities and rights of caregivers and the role they play in the medical decision-making of their children. These concepts will be further explored within the context of the international framework regarding the rights of the child as well as the South African legal position where children can consent to their medical treatment.

4.2 The United Nations Convention on the Rights of the Child ("CRC") [40]

There are several CRC provisions that are relevant to the topic of this contribution, many of them interrelated. However, for the sake of brevity, only a few will be discussed here.

According to Article 3(1):

> "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."

The standard of the best interests of the child, which is one of the general principles of the CRC, is a fixture in the interpretation of many of the provisions of the CRC. The United Nations Committee on the Rights of the Child ("UN CRC") views the child's best interests as a three-fold concept: a substantive right; a fundamental, interpretative legal principle; and a rule of procedure. [41] According to *General Comment No 14*, which provides

a comprehensive interpretation of Article 3 and guidance on how states should implement this Article, the best interests of the child is a "dynamic concept that requires an assessment appropriate to the specific context". [42] This standard does not attempt to prescribe what is best for the child in any given situation at any point in time; rather the child must be viewed in their particular context, taking into account the specific circumstances that make the child unique. [43] Thus, Article 3(1) of the CRC prescribes a holistic approach that informs, supports, and ensures the implementation of all of the rights of the child, as well as the overall development of the child, taking into account the vulnerability of children in general. [44] The fact that the best interests of the child is usually a primary consideration means that it will not always trump other rights. [45] Potential conflicts between the best interests of the child and the rights of other persons with whom they interact must be carefully balanced to find a suitable compromise where this is possible. [46]

In all matters, including medical matters, the other rights contained in the CRC inform what should be considered to be in the best interests of the child. [47] The UN CRC states that:

> "It is through the interpretation and implementation of Article 3, paragraph 1, in line with the other provisions of the [CRC], that the legislator, judge, administrative, social or educational authority will be able to clarify the [best interests of the child] and make concrete use thereof." [48]

Since Article 12(1) (the right of the child to express their views freely) is one of the other guiding principles of the CRC, the Committee explicitly states that an "[a]ssessment of a child's best interests must include respect for the child's right to express his or her views freely". [49] In terms of matters such as medical treatment, Article 12(1) would be a prominent right to bear in mind in the investigation of what is in a child's best interests. According to Article 12(2):

> "[To give effect to a child's right to express their views freely], the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law."

The exercise of the child's or children's right to be heard is a crucial element of participation. This allows for an exchange between children and adults on the development of policies, programmes and measures in all relevant contexts of children's lives. [50] One of the main issues that affects the realisation of this right is the power dynamic between a child, their parents or other caregivers, and society at large. This power dynamic must be taken into consideration when decisions are made regarding the medical well-being of a child, particularly in the context of children from minority groups like transgender children. This is where Article 12 and Article 5 of the CRC intersect. According to Article 5 of the CRC:

> "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention."

In interpreting this Article, the UN CRC explains that

> "[t]he more the child himself or herself knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for the child have to transform direction and guidance into reminders and advice and later to exchange on an equal footing. This transformation will not take place at a fixed point in a child's development, but will steadily increase as the child is encouraged to contribute her or his views". [51]

The "evolving capacities" of the child is loosely understood to mean that children move progressively from a situation in which their rights primarily protect their interests to one in which their rights primarily protect their choices. [52] There is a gradual shift in the child's development over the years which is not merely informed by the child's age, but also by their maturity and ability to engage with their lived environment and reality. The concept of the "evolving capacities" of the child provides room for guidance from adults, but also respect for the child's autonomy. [53]

The final Article which will be discussed here is Article 24, which states the following:

> "1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
>
> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
>
> (a) . . . ;
>
> (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
>
> (c) . . . ;
>
> (d) . . . ;
>
> (e) . . . ;
>
> (f) . . . .
>
> 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
>
> 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries."

According to *General Comment No 15*, [54] Article 24 also intersects with, *inter alia*, the general principles of the CRC. The UN CRC further recognises that the evolving capacities of the child play a role in their ability to make decisions about issues relating to their health, and that there are often discrepancies in this ability, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. [55]

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has not explicitly addressed gender-affirming care as a standalone issue. However, the broader discussions of discrimination, [56] informed consent, [57] and structural equity [58] have indirectly shaped the discourse. [59] These discussions provide a robust

framework for advocating for gender-affirming care. This connection underscores the need for health care systems to move beyond a binary understanding of gender and towards an inclusive, rights-based approach to health. By interpreting the principle of non-discrimination in health care broadly, the Special Rapporteur has advocated for health care systems to address the unique needs of marginalised communities, including LGBTQI+ [60] individuals. This inclusive framework can be applied to transgender individuals, particularly in the context of accessing gender-affirming care.

4.3 The United Nations' Sustainable Development Goals

The United Nations Department of Economic and Social Affairs has stated that:

> "The 2030 Agenda for Sustainable Development, adopted by all United Nations Member States in 2015, provides a shared blueprint for peace and prosperity for people and the planet, now and into the future. At its heart are the 17 Sustainable Development Goals ["SDGs"], which are an urgent call for action by all countries – developed and developing – in a global partnership. They recognize that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests." [61]

Goal 3 of the SDGs aspires to ensure health and well-being for all. Arguably, SDG 3 provides a valuable framework for advocating for transgender children by promoting equitable access to health care, mental health support, and the elimination of inequalities. Target 3.8, for example, provides that there is an aim to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". [62] One could, therefore, argue that gender-affirming care, including counselling, puberty blockers, and other medical interventions, falls under essential health care for transgender children to ensure their physical and mental wellbeing. There is literature that evidences the mental health struggles of transgender

children, particularly adolescents. [63] Transgender youth are found to have a disproportionate share in negative mental health outcomes when compared to cisgender youth. [64]

It must also be acknowledged that transgender persons (and the greater SOGIESC [65] community) are at high risk for minority stress. [66] Experiences of stigma and discrimination create a higher risk of negative physical and mental health prognoses. [67] Puberty blockers may

therefore mitigate these negative mental health outcomes, allowing the child to experience a positive and affirming transition process. [68]

As gender identity refers to a person's internal sense of self, [69] there are undoubtedly transgender persons who question where they belong within the world of the predominant gender binary. To question one's gender is to question human nature itself. This can cause mental distress and trauma. Access to gender-affirming care could significantly improve mental health outcomes for transgender children, which may, in turn, reduce risks of depression, anxiety, and suicidal ideation linked to gender dysphoria. [70] There have been several studies outlining the benefits of attaining such health care. [71] These studies demonstrate significantly lower rates of depression, suicidal

thoughts, and suicide attempts among transgender youth who have access to this health care. They also indicate the need for transgender children to have access to necessary health care to promote Goal 3 of the SDGs which aims to promote positive mental health and well-being outcomes.

SDG 3 provides a valuable framework for advocating for gender-affirming care for children by promoting equitable access to health care, mental health support, and the elimination of inequalities. However, realising this goal requires integrating SDG 3 with broader human rights principles, ensuring that health care systems are inclusive, non-discriminatory, and responsive to the specific needs of all children.

5. The South African position

5.1 Introduction

There has not yet been a decision by the courts regarding gender-affirming care in the form of puberty blockers for transgender children in South Africa. However, there is case law concerning children consenting to medical treatment which may be helpful to the discussion.

Christian Lawyers Association v Minister of Health [72] is significant because it deals with the right of minor girls to consent to medical procedures without parental consent, specifically in the context of termination of pregnancy. The court upheld provisions of the Choice on Termination of Pregnancy Act 92 of 1996, which allows girls of any age to undergo a termination of pregnancy without the consent of a caregiver. This case demonstrates the importance of the autonomy of minors in making decisions about their health care, particularly in the context of sensitive or potentially life-altering decisions. The court found that the fundamental right to individual self-determination "lies at the very heart and base of the constitutional right" to terminate a pregnancy and that sections 10 (dignity), 12(2) (the right to bodily and psychological integrity), 14 (the right to privacy), and 27(1)(a) (the right to have access to health care services) of the Constitution of the Republic of South Africa, 1996 ("the Constitution") provide the foundation for the right to terminate a pregnancy. The important *caveat*, however, is that the minor girl's consent must be informed consent. In other words, the child must understand the consequences of her actions and understand the details of the procedure as explained by the medical professional. [73]

5.2 The legislative context

According to section 39(1)(b) of the Constitution, when interpreting the Bill of Rights, a court, tribunal or forum must consider international law. Similarly, section 233 of the Constitution states that "when interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law". South Africa has ratified the CRC. [74] Many of the provisions of the Constitution that are relevant to children reflect the same values and principles of the CRC; the same can be said of the provisions of the Children's Act 38 of 2005. Section 28(2) of the Constitution is probably the most integral provision as it pertains to children, and it echoes Article 3 of the CRC: "[a] child's best interests are of paramount importance in every matter concerning the child". Article 3 of the CRC is also given effect to in sections 7 and 9 in the Children's Act. One would, however, be remiss in not noting the difference in the terminology that is used: the CRC refers to the best interests' principle as being "a primary consideration", whereas the Children's Act and the Constitution refer to it as being of "paramount importance". It must be stated once again that the advantage of applying the standard is that the determination of what precisely is in the best interests of the child is a factual question that must be determined in the light of the circumstances of each case. This flexibility should be viewed as a strength rather than as a weakness. [75] It must also be borne in mind that, when using the best interests' standard, the approach is child-centred in nature. However, there may be several intersecting constitutional values and interests involved in a matter concerning a child that may compete and overlap. There is no hierarchy of fundamental rights and the fact that the best interests' standard is afforded the status of paramountcy does not mean that it supersedes other provisions of the Bill of Rights. [76] The right is still subject to limitation in terms of section 36 of the Constitution.

Section 129 of the Children's Act provides for the circumstances in which children can consent to medical treatment and surgical operations. Section 129(2) stipulates that children aged twelve and older can consent independently to medical treatment if they have the maturity to understand the benefits, risks, and social implications of the treatment. Section 129(3) regulates the position in terms of consent by children over the age of 12 years to their surgical treatment. Sections 129(4) and 129(5) regulate the

position in respect of medical and surgical treatment of children younger than 12 years. These statutory provisions emphasise a combination of respect for the evolving capacities of the child, the importance of considering the child's best interests, and a focus on individual maturity when assessing a child's ability to consent to medical treatment. They illustrate a nuanced approach to child autonomy in health care decisions within the South African legal landscape. In this contribution, the focus will be on children who do not require parental consent because they fulfil the requirements of section 129(2) of the Children's Act. Regarding the decisions of a children to take puberty blockers and who fall within the ambit of section129(2), two aspects need to be considered: first, what does informed consent to such treatment entail, and secondly, does the administration of puberty blockers constitute medical treatment?

In respect of consent to medical treatment, one must examine the National Health Act 61 of 2003 and the GAHC Guideline. Section 7 of the National Health Act stipulates that a health service may not be provided to a user without that user's informed consent. Section 6 sets out the parameters of *informed* consent:

> "6(1) Every health care provider must inform a user of—
>
> (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
>
> (b) the range of diagnostic procedures and treatment options generally available to the user;
>
> (c) the benefits, risks, costs and consequences generally associated with each option; and
>
> (d) the user's right to refuse health services and explain the implications, risks, and obligations of such refusal.
>
> (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a
>
> manner which takes into account the user's level of literacy."

Sections 6 and 7, therefore, reveal that it is not enough for a person merely to consent to medical treatment; they must be fully aware of what it is that they are consenting to. Therefore, section 129(2) of the Children's Act must be read with sections 6 and 7 of the National Health Act to determine what informed consent by a child aged 12 years or older to the administration of medical treatment encompasses. [77] The GHAC Guideline builds upon this framework when it comes to the informed consent of children to the administration of puberty blockers and other related interventions:

> "If an adolescent desires puberty blocking medication, [hormone therapy] or surgery, the [informed consent] process requires involvement of a

multidisciplinary team, including both mental health and medical or surgical providers. It is recommended that both parents and legal guardians be included in this process wherever possible, as improved family support is associated with better mental health outcomes in [transgender and gender diverse] adolescents." [78]

The second aspect that must be considered is whether the administration of puberty blockers amounts to medical treatment. There is no definition of "medical treatment" in the Children's Act, the National Health Act, the Mental Health Care Act 17 of 2002, the Prevention and Treatment of Substance Abuse Act 70 of 2008 or any other related legislation or policy. [79] Furthermore, there is no clear guidance provided by a South African standard of care for transgender children specifically.

One way to approach this aspect is to examine the GAHC Guideline. In terms of the Guideline, the term "medical treatment" is understood "to be a manifestation of the right to health as provided for in section 27 of the Constitution, and includes access to psychosocial and mental health care services". [80] While this definition is quite vague, one could argue that its broad scope would include all treatments associated with gender-affirming care. However, it may be necessary to develop a definition that is inclusive of this reality while providing clarity on what "medical treatment" actually entails. While a broadly defined concept may be beneficial, it does come with challenges in interpretation and precision. It leaves too much room for "bad faith" actors (such as some right-wing organisations) to draw their own conclusions regarding the interpretation of certain terms. This is an especially pertinent issue in the rise of the anti-gender movements that have taken a hard stance on so-called "gender ideology", which they claim is harming rather than helping children. [81] Conservative anti-gender actors insist on heterosexuality, strict gender roles and so-called "traditional family" models. [82] The anti-gender movement falls outside of the scope of this contribution, but it is worth noting when one considers the criticism of the administration of puberty blockers to transgender children.

A cautious approach to gender-affirming care is endorsed by the GAHC Guideline. This is a good starting point. As previously mentioned, one of the purposes of the GAHC Guideline is to provide evidence-based best practice recommendations to enable South African health care providers to offer quality, affirming services to transgender persons, which includes the administration of puberty blockers to minors. However, I am of the opinion that there should be a policy document solely dedicated to outlining the gender-affirming care of children, in particular, and which does not combine this issue with issues relevant to transgender adults and other issues such as HIV. Such a combined approach dilutes the specific policy considerations underlying gender-affirming care afforded to transgender children.

6. Developments in foreign jurisdictions

In the case of *Bell v Tavistock and Portman NHS Foundation Trust*, [83] it was ruled that children (in this case transgender adolescents younger than sixteen) are highly unlikely to be able to make an informed decision about taking puberty blockers and, as a result, all applicants for gender-affirming medical intervention in the United Kingdom under the age of sixteen must first seek authorisation from a court of law to obtain gender-affirming medical care. This was later overturned in *Bell v Tavistock and Portman NHS Foundation Trust* [84] because it placed a burden on courts that should rather be placed on medical professionals. Furthermore, the court found that if a child is *Gillick* competent, [85] then they should be able to consent to the use of puberty blockers. On 12 March 2024, England's National Health Service ("NHS") released a statement regarding gender-affirming care for minors. The NHS concluded that there was not enough evidence to support the safety or clinical effectiveness of puberty blockers to make the treatment routinely available to children. [86] The Cass Report came to the same conclusion. It observed that there was insufficient evidence about the longer-term impact of puberty blockers on children and young people with gender incongruence to

know whether these puberty blockers are safe, as well as insufficient evidence about which children might benefit from their use. [87] The position in England is similar to that in Norway [88] and Finland [89], where the relevant guidelines on the use of puberty blockers have been revised due to a lack of longitudinal studies about the use of puberty blockers to treat gender dysphoria.

By contrast, the United States of America has adopted a gender-affirmative model of health care for transgender children. [90] This model does not support the "watchful waiting" approach [91] as espoused in the Dutch Protocol. Instead, it seeks to provide gender-affirming care based on the self-determination of the child regarding their gender identity. It is a standard of care that stems from research which has indicated that the social support of children in their gender development is directly correlated with mental health outcomes for children. [92] While the motives underlying this model are commendable, the approach lacks a scientific basis, particularly because it is not supported by comprehensive, longitudinal research. [93] An affirmative model essentially rejects the approach advocated by the Cass Report (the need for further research on the effects of puberty blockers and cross-gender hormone treatment) based on the possibility that a failure to provide puberty blockers will result in psychological harm to a child. [94]

7. Conclusion

South Africa has made strides in aligning with global standards like WPATH SOC when it comes to the provision of gender-affirming care to transgender children. However, I support the argument that there should be a cautious approach to the standard of care of transgender children in South Africa until

more research has been conducted on the effects of gender-affirming care and there is a general international consensus on the scientifically supported standard of care for transgender children.

Children aged 12 years and older can consent independently to medical treatment if they have the maturity to understand the benefits, risks, and social implications of the treatment. This respects the autonomy, evolving capacities, and participation of the child and, ultimately, the child's best interests. In the context of gender-affirming care in particular, the process of informed consent should involve a multidisciplinary team, including both mental health and medical (or surgical where relevant) providers. Parents or other caregivers and children should be provided with comprehensive and unbiased information about the implications and potential consequences of gender-affirming care, allowing them to make informed decisions that prioritise the well-being and long-term health of the child given the circumstances of each case.

While it is of some comfort to know that the Children's Act and the National Health Act provide mechanisms by which a child of a certain age and maturity can access health care, it is concerning that there is a lack of comprehensive guidelines or legislation specifically addressing gender-affirming care for minors. Together with the absence of a clear indication that gender-affirming care qualifies as "medical treatment" in terms of the Children's Act or other legislation, this lack of guidance means that transgender children will continue to be vulnerable to inconsistent healthcare practices, discrimination, and other potential rights violations. This does not align with the Constitution's commitment to protecting the rights to dignity, equality, and bodily integrity of all people, including transgender children.

1 World Health Organisation ("WHO") "Gender Incongruence and Transgender Health in the ICD" (n.d.) *World Health Organisation* <https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd> (accessed 01-03-2025).

2 G Simona & S Holm "Is Puberty Delaying Treatment 'Experimental Treatment'?" (2020) 21 *International Journal of Transgender Health* 113.

3 See eg J DeBeer-Proctor & P Brouard "Why Affirming Treatment for Gender Questioning Youth Matters in SA" (13-06-2024) *Spotlight* <https://www.spotlightnsp.co.za/2024/06/13/why-affirming-treatment-for-gender-questioning-youth-matters-in-sa/> (accessed 01-03-2025).

4 See n 3.

5 J Eekelaar "The Emergence of Children's Rights" (1986) 6 *OJLS* 161 170.

6 M Jones & LAB Marks "The Dynamic Developmental Model of the Rights of the Child: A Feminist Approach to Rights and Sterilisation" (1994) 2 *The International Journal of Children's Rights* 265 271–272.

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