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Road Works Ahead

The On-Going Discourse Regarding the Use of Puberty Blockers for Transgender Children

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Abstract

This article examines the intersection of transgender children's rights and gender-affirming care. The Dutch Protocol, renowned for its comprehensive and patient-centred approach, serves as a pivotal framework for providing gender-affirming care to transgender youth. However, amidst the growing discourse on transgender rights and ethical considerations in health care, questions arise regarding the child's right to explore their gender identity. There is an emphasis on respecting the right of the child to preserve their identity as well as the right of the child to the enjoyment of the highest attainable standard of health in terms of Articles 8 and 24 of the United Nations Convention of the Child. In the recent uptake of issues regarding gender-affirming care for transgender children, there are jurisdictions which we will explore to determine the prevailing perspectives and standard of care. Namely, the Netherlands in light of the Dutch Protocol, the United Kingdom in the wake of the Cass Report and the United States of America amidst the current political climate which has seen its "affirmative" model for gender-affirmative care being called into question. Drawing on interdisciplinary perspectives, this article explores key themes and dilemmas at the nexus of transgender children's rights and gender-affirming care.

Keywords

children – children's rights – transgender children – SOGIESC – gender identity – puberty blockers – informed consent – ethics

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1 Introduction

1.1 *Background*

Over the years it has appeared as though the rights of the child have been an internationally recognised niche of the law to a topic of much contestation in the ever-growing landscape of the healthcare considerations of transgender children. To those who are no strangers to child law, it will undoubtedly come as no surprise that this is a multifaceted, multi-disciplinary and nuanced discussion, oftentimes without any clear-cut, black-and-white solutions. In light of recent events over the years and increased visibility of people in the LGBTQI+ community, many issues that were perhaps not core principles of the envisioning of the enacting of the United Nations Convention of the Rights of the Child (CRC) have now become issues that are at the forefront of the inner sanctum of the child's being, namely in this case the child's identity. Certainly, I would be remiss not to give due regard to the drafters of the CRC at the time. However, it would appear that the concept of identity has changed in scope and taken a life of its own which is seldom explored in isolation – let alone in the context of sexual orientation, gender identity, expression and sex characteristics (SOGIESC) issues.

This article explores dissenting perspectives and ethical concerns surrounding the potential risks and uncertainties associated with puberty suppression for transgender children. Through a nuanced analysis of empirical research, clinical guidelines, and legal precedents, this article contributes to an understanding of the ethical, legal, and social implications of transgender children's rights. Ultimately, the article underscores the need for on-going dialogue, research and policy development to ensure that transgender children receive evidence-based care that respects their rights and affirms their identities.

In order to delve into the subject matter of this article, it is import to set out certain terminology. To this effect, according to the American Psychological Association, "transgender" is –

> an umbrella term for persons whose gender identity, gender expression or behavior (*sic*) does not conform to that typically associated with the sex to which they were assigned at birth.

"Gender identity" refers to –

> a person's internal sense of being male, female or something else; gender expression refers to the way a person communicates gender identity to

> others through behaviour (*sic*), clothing, hairstyles, voice or body characteristics

as per the preamble of the Yogyakarta Principles (YP)). The YP result from comprehensive and robust discussions regarding sexual orientation, gender and gender identity which took place with several human rights groups in Yogyakarta, Indonesia in 2006. We also need to examine the concepts of "sex" and "gender", as these concepts are often conflated or misunderstood (Haig, 2004; Lindsey, 2015; Hausmann, 2021; Szadvári *et al.*, 2023). Some scholars have attempted to deconstruct the terms considering a complex international human rights framework (Gilleri, 2024). Some scholars believe that the terms are conflated without a clear understanding that sex is biological and, thus, in contrast, gender is a continuum and a social construct (Abramson, 2008). "Sex" 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.
>
> BUTLER, 2006

'Gender' includes roles, behaviours, activities, and attributes that a given society considers appropriate for boys and men or girls and women" (Butler, 2006).

While pathology is often scrutinised by some transgender rights advocates (Lundberg *et al.*, 2018) as pathology invites a measure of stigma and discrimination – there is a need to pathologise this discussion as it relates to the medical decision-making of children and possibly their caregivers. "Pathologisation" can be defined as the psycho-medical, legal and cultural practice of identifying a feature, an individual, or a population as intrinsically disordered (Castro-Peraza *et al.*, 2019). In the realm of the transgender umbrella, some people have been diagnosed with gender dysphoria. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), those who are diagnosed with gender dysphoria are 'people who experience intense, persistent gender incongruence'. Additionally, the World Health Organisation (WHO) provides, in the International Classification of Diseases version 11 (ICD-11), that there is now no mention of "gender dysphoria", but rather "gender incongruence" and thus be viewed as a disorder of gender identity rather than a mental illness (Roblesa *et al.*, 2021). The rationale for the change appears to stem from substantial evidence that the current nexus of stigmatisation of transgender people and mental disorders has contributed to a rather perturbing situation for people who are transgender (Reed *et al.*, 2016). This has previously and continues to lead to difficulties in obtaining legal status, accessing health care and several human rights violations (Reed *et al.*, 2016). However, I think that regardless of the aims of de-stigmatisation efforts of the ICD-11, there is still a need for a diagnosis where the person needs gender-affirming health care. This is made not out of consideration other than the fact that medical professionals are involved. One can, however, sympathise with the plight regarding de-pathologisation as the issues regarding gender-affirming care for transgender children have in recent years become a political playground and the site of systemic violence about the treatment or lack thereof afforded to transgender children specifically.

In order to affirm their gender identity, transgender children often undergo gender-affirming care in the form of hormone treatment such as puberty blockers (puberty suppression with gonadotropin-releasing hormone analogues (GnRHa)) which essentially delays puberty and the outset of developing sex characteristics that are incongruent with the person's gender identity (Giordano and Holm, 2020).

In this regard, The Netherlands pioneered the development of medical treatment for adolescents diagnosed with gender dysphoria (van der Loos *et al.*, 2023). The so-called Dutch Protocol as it is now known is essentially an approach of diagnostic treatment developed over years with the combined treatment of GnRHa and subsequent gender-affirming hormone being administered to a transgender adolescent and adult under specific circumstances to treat gender dysphoria (van der Loos *et al.*, 2023). The Dutch Protocol spread throughout the West and became the international standard upon which many countries implemented gender-affirming health care for transgender children. However, this was not implemented as per the visions of those who pioneered the treatment. This is illustrated by the sentiments of Dutch physician Steensma who is quoted as saying:

> We conduct structural research in the Netherlands. But the rest of the world isblindly adopting our research. Every doctor or psychologist who engages intransgender health care should feel the obligation to do a proper assessmentbefore and after intervention.
>
> WILLIAMS, 2021

There has been a fundamental misunderstanding by those who adopted the Dutch Protocol without heeding its cautionary nature that the research was not extensive at that point and the health care needs of transgender children should be an area of on-going research. The Dutch have always been more careful in their use of interventions like puberty blockers, taking care to conduct thorough assessments before proceeding (Cohen-Kettenis and van Goozen, 1998). Many Dutch clinicians have practised what has been characterised as "watchful waiting" (Cohen-Kettenis and van Goozen, 1998). This is in stark contrast to the "affirmation approach" promoted by the most prominent gender clinicians in the United States of America (USA) (Williams, 2021). This model does not support the "wait and see" approach as espoused in the Dutch Protocol. Instead, it seeks to provide gender-affirming care on the basis of self-determination of the child regarding their gender identity (Keo-Meier and Ehrensaft, 2018). The "adoption without research to supplement" approach has now turned the world upside down, as it were, in several countries. There are even States within the USA and even litigation in England that has led to the questioning of the standard of health care (SOC) for transgender children in its entirety. I am at pains to postulate that the Dutch Protocol was probably not established with the sole intention of creating a SOC for the entire world. There are also international guidelines in the form of the Standards of Care for the Health of Transsexual (*sic*), Transgender, and Gender Nonconforming People by the World Professional Association for Transgender Health and the Endocrine Society (WPATH) which one can investigate (this will be explored later in this article). However, as far back as 2015, Dutch researchers noted that there was no actual consensus in practice as to whether to use these early medical interventions on transgender children (Vrouenraets, *et al.* 2015).

It is also interesting to note that there are even those who have critiqued the Dutch Protocol over the years, which I view as a testament to its own self-awareness of its short-comings. Some of the critiques levelled against the Dutch Protocol is that the methodology of the Protocol may be flawed, including issues of selection bias and inadequate follow-up periods (Biggs, 2023). Furthermore, even one of the pioneers of the Protocol, psychologist Peggy Cohen-Kettenis (founder of the Utrecht Children's Clinic in the Netherlands), has acknowledged that a proper evaluation of the Protocol's outcomes would require at least 20 years of follow-up – far longer than what was originally conducted (Bakker, 2021).

1.2 *Changing Tide*

On 12 March 2024, The National Health Service (NHS) England issued its puberty blockers clinical policy (Puberty Suppressing Hormones Policy), thus banning the use of puberty blockers as a treatment for children with gender dysphoria through the NHS. Back in January 2020, a Policy Working Group (PWG) was established by NHS England to undertake a review of SOC *vis-à-vis* transgender children. A review was commissioned by the National Institute for Health and Care Excellence that concluded, *inter alia*, that there is 'not enough evidence to support the safety or clinical effectiveness of puberty-suppressing hormones to make the treatment routinely available at this time'. While this appears to impose a complete and unequivocal ban on the use of puberty blockers by transgender children in England, this is not entirely the case. According to the Independent Review of Gender Identity Services for Children and Young People: Final Report (the Cass Report), there is not enough known about the longer-term impacts of puberty blockers for children and young people with gender incongruence to know whether they are safe or not, nor which children might benefit from their use. The report essentially reviews and evaluates the clinical approach for children in the NHS regarding gender-affirming care in order to ensure evidence-based, safe and effective care.

Litigation to this extent may have also (purely speculative) played a role in the about-face concerning the SOC for gender-affirming health care for transgender children. In *Bell v. Tavistock* (*Bell v. The Tavistock and Portman NHS Foundation Trust* [2020] EWGC 3274) the applicant, Quincy Bell (born female), was put on a course of puberty-blocking medication at the age of 16 years-old. Bell then transitioned through hormone treatment and surgery (double mastectomy aged 20 years old). This was facilitated by the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. The claimants' primary case is that children or young persons under the age of 18 are not capable of giving consent to the administration of puberty blockers. The argument is that a child cannot give informed consent to undergo this treatment. Bell expressed a great amount of regret for having proceeded with the use of puberty blockers and has since "detransitioned". In contrast, GIDS stated in their defence that they will only refer a young person for puberty blockers if they determine that person is competent to give consent, i.e. is *Gillick* competent within the meaning of competence identified in the decision in (*Gillick v. West Norfolk and Wisbech Health Authority* [1986] AC 112). Furthermore, GIDS stated that they had taken all the necessary measures in terms of a multi-disciplinary approach to gender-affirming care that is extensive and requires several assessments before the puberty blockers are prescribed (*Bell v. The Tavistock and Portman NHS Foundation Trust* [2020] EWGC 3274). By way of brevity, a *Gillick* competent child can provide informed consent to their medical treatment. The Court in Bell concluded, *inter alia*, that it is highly unlikely that a child aged 13 or under would ever be *Gillick* competent to give consent to being treated with puberty blockers. Furthermore, the court was also doubtful that children aged 14 and 15 years of age could give informed consent to the extent that they would be able to understand the long-term risks and consequences of treatment. The court also called the treatment experimental and that there was currently limited evidence of the efficacy or long-term effects of the treatment.

On appeal it was determined that the court *a quo* had erred and overturned the decision on several grounds, including that children are capable of giving informed consent to treatment for gender dysphoria, and court authorisation would not be routinely required before children could access such treatment. For this research, I will focus on the court in the *Bell Appeal*, stating that the high court was incorrect in their conclusion that puberty blockers for gender dysphoria were experimental. The court in the *Bell Appeal* noted that clinical disagreements about issues such as the efficacy of puberty blockers were for the NHS and other relevant bodies to determine as a matter of policy, and not for the courts.

It is thus interesting that following this case the NHS issued its Puberty Suppressing Hormones Policy. Perhaps the further threat of litigation has had a deterrent effect as there is much to be said in discourse that there has been an uptake in the number of children seeking gender-affirming care on one hand and the attention to the possibility of childhood gender dysphoria desisting in adolescence or adulthood on the other (Vrouenraets *et al.*, 2015; Chua, 2023). This could also be a logical fallacy as the numbers of those seeking treatment will rise with increasing visibility, knowledge, representation and access to health care for the diagnosis of gender dysphoria. In a study conducted with child and adolescent psychiatrists, psychologists and endocrinologists from diverse treatment teams in European and North American countries, two Dutch ethicists, who are not directly related to a treatment team, were also interviewed (Vrouenraets *et al.*, 2015). Some of those interviewed wondered in what way the increasing media attention affects the way gender-variant behaviour is perceived by the child or adolescent with gender dysphoria and by the society in which they exist (Vrouenraets *et al.*, 2015). As far as the studies and/or commentary that touch on “detransition” after childhood and adolescence are concerned, there are calls to exercise caution in prescribing early treatment for gender dysphoria because some case histories illustrate the complexities that may be associated with later-presenting transgender adolescents and describe that some eventually “detransition” (de Vries, 2020). There are also arguments to be made regarding the existence of comorbidities and the gender dysphoria diagnosis. Because various studies show that transgender youth may present with psychosocial problems, a clinical approach that includes both medical and mental health support treatment when necessary is deemed most appropriate (Grossman and D’Augelli, 2006). In the literature, no single cause has been found so far as to the cause of gender dysphoria. Genetic, hormonal, neurodevelopmental and psychosocial factors have been suggested to play a role (de Vries and Cohen-Kettenis, 2012).

Proponents of puberty suppression emphasise the beneficial effects of puberty suppression on adolescents' mental health, quality of life and having their physical appearance align with their gender identity (Kreukelsand Cohen-Kettenis, 2011). However, some studies demonstrate that some children have one or more diagnoses of a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria (Littman, 2018). I am then left to ponder whether the existence of comorbidities exacerbates the feelings of dysphoria or whether there is a perception by the child that gender dysphoria is the cause of psychiatric disorders or neurodevelopmental disabilities. Furthermore, is the child then convinced that the comorbidities will subside once they are on puberty blockers as the perceived underlying cause of their psychiatric distress is their gender incongruence? For clinicians, it is important to realise how one condition may increase the risk for another condition (Zucker, 2005). This is by no means a manner in which to diminish the existence of gender dysphoria – but rather to be critical and ask whether the child is experiencing a crisis regarding their gender identity and must thus be placed on puberty blockers to stop the psychiatric distress or whether the child has another psychiatric disorder that has nothing to do with their gender identity. As previously stated, the Dutch Protocol for gender-affirming care, with a specific focus on the use of puberty blockers, is complex. The diagnosis of gender dysphoria and the dispensing of puberty blockers are done on a case-by-case basis and with a multidisciplinary team with a cautious approach (Williams, 2021). Those countries who blindly adopted an "affirming model" (mostly the US) without conducting their research resulting in proponents and detractors of gender-affirming care for transgender children, are only now starting to roll back, review, research and ask questions. This is possibly why negative sentiments, such as that of a Professor of health care ethics and health law interviewed in a study, have been adopted (*vis-à-vis* gender-affirming care):

> The fact that somebody wants something badly does not mean that a healthcare provider should do it for that reason; a medical doctor is not a candy seller.
>
> VROUENRAETS *ET AL.*, 2015

Questions have arisen regarding the child's right to explore their gender identity and whether puberty blockers always align with the best interests of the child. An increasing number of European states are now adopting a more cautious approach to gender-affirming care among minors. With the position in England having already been discussed, in 2023 the Norwegian Healthcare Investigation Board (NHIB/UKOM) decided that transgender surgeries, hormones and puberty blockers were experimental (Block, 2023). According to UKOM:

> UKOM recommends:
>
> 1. that the Ministry of Health and Care commissions the Directorate of Health to revise the national professional guideline, Gender congruence. The revision must, among other things, be based on a systematic summary of knowledge. We point to several elements that should be included in the audit.
> 2. that puberty-delaying treatment (puberty blockers) and hormonal and surgical gender confirmation treatment for children and young people are defined as experimental treatment. This is particularly important for teenagers with gender dysphoria.
> 3. that the Ministry of Health and Care is considering whether a national medical quality register should be established for the treatment of children and young people with gender incongruity and gender dysphoria. Necessary measures must be implemented so that such a national quality register can be established, operated and financed to contribute to an overview, better quality and reduce unjustified variation in patient treatment.

The difference with the Norwegian position is that they do not call for a ban, but rather a revision of existing research and guidelines. In 2020, the Finnish Health Authority (PALKO/COHERE) issued new guidelines that stated that psychotherapy, rather than puberty blockers, should be the first consideration in treating transgender children with gender dysphoria. Again, I stress that this was the approach taken by the Dutch from the beginning in stating that research was ongoing; treatment was patient-centred and approach-measured.

1.3 *Problems with the "Affirmative Model" of Care for Transgender Children*

The US presents an interesting anomaly in the scope of gender-affirming care. As of April 2023, at least 12 States had passed legislation to limit or ban gender-affirming care for transgender children, adding to several other countries that had done so prior (Ferguson *et al.*, 2023). Countries such as Norway (Block, 2023), Finland and the United Kingdom all base their revision of guidelines on a lack of longitudinal studies about the use of puberty blockers to treat gender dysphoria. One of the claims found in the recent literature is that the use of

GnRHa for puberty delay is experimental because it has not been tested in a randomised controlled trial (RCT) (Giordano and Holm, 2020). These types of trials are normally taken as providing the highest level of medical and scientific evidence that can be obtained from a single study (Elamin and Montori, 2012) and are, in cases where they are possible, usually a requirement for the licensing of a pharmaceutical product (Elamin and Montori, 2012). In the case of GnRHa, it is, however, practically impossible to conduct an RCT, and there may be ethical concerns in trying to conduct such trials because of, amongst other things, the unknown long-term side effects of GnRHa (Giordano and Holm, 2020).

The US, however, adopted a very "affirmative model" of care for transgender children (Keo-Meier and Ehrensaft, 2018). Most European countries use a clinically determined gender-affirming process rather than a self-determined process (Breckenkamp *et al.*, 2022). The European Academy of Paediatrics even released a statement which advocates a child-centred individual rights-based analytical approach (Brierley *et al.*, 2024).

The problem in the US and perhaps why it has become such a polarising, political battle could be explained by way of a critique of the work of Milrod and Karasic (Milrod and Karasic, 2017). The authors start well enough by acknowledging that performing surgery on minors is in contravention of the standard of care as set out in WPATH. However, the article seems to condone the usage of surgery and provides that there should be a change to the WPATH to accommodate surgery. A study was conducted by the authors comprising 20 surgeons of which 11 had admitted to performing surgery on minors on transgender children. They had done so on the behest of the children and two letters from experts with qualifications in transgender issues. The authors do not clarify who these experts are and the qualifications they must possess. They merely state that it can be a "therapist". Several practices cause one to raise an eyebrow. None of the 11 surgeons have published their work or findings. Furthermore, legal frameworks surrounding parental consent for gender-affirming care for adolescents vary across States, leading to inconsistencies in access to care. Some States require parental consent for medical interventions such as hormone therapy or surgery, while others allow minors to access care without parental involvement under certain circumstances. This provides a loophole and a measure of unethical practices that go against the WPATH provisions. The problem with the reliance on the SOC of WPATH that leads to an overreliance on US medical professionals is the vague nature of its provisions. Esses postulates that the guidelines feature language based on ideology, rather than medicine or biology, throughout (Esses, 2022). WPATH has a history of being funded and pressured by transgender activists and transgender organisations (Esses, 2022). While the work of activists and transgender organisations is important in shaping the social context in which transgender children exist, it must be embedded in the work of science and long-term studies regarding the standard of care and the lack of conclusive evidence as to its efficacy. WPATH is critiqued for being a hybrid professional and activist organisation, where activists have become voting members and have served as president (Esses, 2022).

Furthermore, as it pertains to the affirmative model in the US, the surgeons interviewed in the Milrod and Karasic study seemed to base their SOC on perceived maturity, stating that age is also arbitrary. This is in complete contravention of bioethical standards that point to autonomy being based on maturity and age (Liefaard *et al.*, 2017). Both criteria must be present. This could easily be rectified by employing Articles 3 and 12 of the CRC. However, the USA remains the only state that has not ratified the CRC – therein lies part of the problem.

There are many reasons that the US has not ratified the Convention. There is a debate within the US regarding the impact of ratifying the CRC because of sovereignty and the implications for domestic law. Some opponents of ratification argue that it could lead to external influences on US law and policy, particularly in areas related to parental rights and state versus federal jurisdiction over children's issues. This lack of engagement can also hinder international cooperation and support in addressing issues affecting children impacting on children's rights and well-being. The CRC emphasises the principle that the best interests of the child should be a primary consideration in all actions concerning children. Failing to ratify the CRC raises concerns about the US commitment to this principle and to ensuring that children's rights are protected and promoted in line with international standards. There are concerns regarding whether the best interests of the child standard are upheld in the issuing of puberty blockers. Some of the issues raised in the Milrod and Karasic study were training and professionalism in the field of gender-affirming care. It appears that the surgeons interviewed were concerned about the lack of training regarding performing surgeries on transgender minors and fellowship programs were suggested. However, this does not justify nor quell justified critique over the ethical considerations of performing surgeries on transgender minors in the first place.

2 Does the Right to Identity Encompass "Gender Identity"?

2.1 *Examining Article 8 of the CRC*

Article 8 of the CRC states:

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized (*sic*) by law without unlawful interference.
2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 8 of the CRC recognises the importance of preserving a child's identity; encompassing aspects such as nationality, name and family relations. This provision aligns with the broader principles of the CRC, emphasising the dignity of the child. Article 8 obligates states to enact and enforce laws that recognise and protect children's identities and prohibits unlawful interference with a child's identity, emphasising the need to prevent actions that could harm or infringe upon a child's identity rights. This provision therefore serves as a safeguard against arbitrary actions by individuals or authorities that could disrupt a child's sense of identity.

The second paragraph of Article 8 highlights the responsibility of states to provide appropriate assistance and protection to children who are illegally deprived of elements of their identity. This includes measures to swiftly re-establish the child's identity, ensuring their rights and well-being are upheld.

Article 8 is 'the vehicle through which a biological entity transforms into a legal being, confirming the "existence of a specific legal personality capable of bearing rights and duties"' (van Bueren, 1998; Tobin and Todres, 2019). Article 8 is the first human rights law provision recognising the right to the preservation of the child's identity explicitly (Arkadas-Thibert, 2022). Strictly speaking, Article 8 does not relate to aspects such as gender identity. It is,rather, a provision that deals with cases of enforced disappearances of children (Hodgkin and Newell, 2020). While one can and should look at the right to identity in conjunction with the other rights in the CRC, I argue that by the very nature of the word "identity", one can shoe-horn gender identity into this specific right by way of a creative interpretation of Article 8(2) of the CRC. This sub-section, read in isolation, provides a protective layer upon which state parties must comply where a child is deprived of some or all of the elements of their identity, and provide appropriate assistance and protection, with a view to re-establishing that identity. The phrase, "some or all of the elements of identity", suggests the existence of more than the facets of one's identity that extend beyond the confines of the listed grounds in subsection 1 of Article 8. According to the Merriam-Webster dictionary, definition of "identity" is 'the distinguishing character or personality of an individual'. According to the American Psychological Association, "gender identity" is a person's psychological sense of self about their gender. Gender is one aspect of the sanctity of which a person is – their individuality and their very being.

While there is no CRC General Comment on the right to identity specifically – however, one can rely on others as a measure of interpretation. General Comment No. 20 (2016) of the CRC pertains to the implementation of the rights of the child during adolescence. As per paragraph 2: 'Adolescence is a life stage characterized (*sic*) by growing opportunities, capacities, aspirations, energy and creativity, but also significant vulnerability'. This acknowledgement by the UN Committee on the Rights of the Child touches on several factors. Children in this period are subject to some changes in line with their evolving capacities. While that may be a source of strength, it is also a potential weakness. Children may be exposed to puberty blockers at a time that is inappropriate and not in their best interests. As has been emphasised above, there is a paucity of longitudinal studies on the efficacy of puberty blockers as a treatment for gender dysphoria. The lack of research may place a child in harm's way if not treated on a case-by-case basis and with a multidisciplinary team. The child, in exercising their changing capacity, must also contend with the negotiation of the concept of informed consent to medical treatment – this means assessing the benefits, risks and all the relevant information regarding the use of the treatment and the potential long-term effects thereof. While interpreting General Comment No. 20, one is confronted with other rights in the CRC which are relevant to this discussion, namely the best interests of the child and the right to be heard and to participate. Article 3 of the CRC provides that the best interests of the child are a primary consideration in all actions concerning the child. The concept is further explored in General Comment No. 14 (2013). What is in the best interests of the child is not a general standard, but rather one that considers every child on an individual basis. What may be in the best interests of one child may differ from another child.

2.2 *The Best Interests of the Child – the Dichotomy Tested*

As per General Comment No. 14 of the CRC, what is in the best interests of the child is an exercise in flexibility with the awareness that one must assess the particular circumstances of a specific child or group of children on a case-by-case basis.

Treating transgender children with puberty blockers raises ethical concerns regarding the best interests of the child, particularly in light of Article 3 of the CRC. While the intention may be to alleviate gender dysphoria and provide a window for the exploration of gender identity, the practice is contentious due to the lack of comprehensive research on its long-term effects. However, over the years it is now part of the clinical management guidelines for gender dysphoria (De Vries *et al.*, 2014). Article 3 emphasises that the best interests of the child should be a primary consideration in all actions concerning children. However, the use of puberty blockers in transgender children may present a problem because it involves medical intervention with uncertain long-term consequences. Several factors must be considered. First, puberty blockers disrupt the developmental process, potentially impacting physical, psychological, and social aspects of the child's life. Without sufficient evidence on the long-term effects, there is a risk of unintended consequences such as compromised bone health (although this is contested using a singular follow-up 22-year-old study (Cohen-Kettenis *et al.*, 2011)), the use of GnRHa *may* result in fertility issues as it also pauses the maturation of germ cells (Finlayson *et al.*, 2016; Cheng *et al.*, 2019) and concerns relating to bone density The counter to this argument is the research that GnRHa is putatively fully reversible (Thornton *et al.*, 2014). Secondly, the decision to administer puberty blockers to children is often made in a complex social and cultural context, influenced by parental, medical and societal perspectives on gender identity. In some cases, societal pressure or parental preferences may overshadow the child's agency and autonomy in making informed decisions about their body and identity. Concerning gender-affirming care, a child's autonomy refers to their ability to make informed and voluntary decisions regarding their gender identity and medical interventions, considering their capacity to understand the risks and benefits thereof, while balancing parental and medical guidance and expertise (Marino *et al.*, 2024).

In a study conducted (30 parents were interviewed from across England, Scotland and Wales), 100 per cent of interviewees were cisgender, 90 per cent were white, 93 per cent were female and 23 per cent were disabled). Regarding parental decision-making concerning gender-affirming care the study revealed an overwhelming number of parents that were distressed regarding the mental health of their children and happiness compared to the lack of longitudinal studies regarding the use of puberty blockers (Horton, 2022). This study can, however, be criticised for its lack of diversity and small sample size. Moreover, the efficacy of puberty blockers in alleviating gender dysphoria and improving overall well-being remains debated. While some studies suggest positive outcomes in reducing psychological distress associated with incongruent gender identity, the evidence is not conclusive, and long-term studies are lacking (De Vries *et al.*, 2014). Given these uncertainties, it is crucial to prioritise the child's well-being by ensuring that decisions about medical interventions align with their best interests. This necessitates thorough assessment, informed consent processes, and ongoing monitoring of the child's physical and psychological health. Additionally, further research into the efficacy and long-term effects of puberty blockers in transgender children is essential to inform evidence-based practice and uphold the principles of the CRC. One must also be cognisant at this time that there is misinformation regarding the efficacy of gender-affirming care in the form of research on "detransitioners" (Ammaturo and Moscati, 2021). Those who detransition may or may not account for a small portion of the transgender community, but there is also a paucity of studies on the actual figure and occurrence thereof (Danker *et al.*, 2018). Arguments regarding detransition are also usually used nefariously to diminish the research on gender-affirming care. However, as the actual figure is unknown, we lean on the Dutch Protocol's "watch and wait" approach. An ideal study should consist of the following elements (Cohn, 2023): (a) 'wait long enough to observe regret', (b) 'have a small loss to follow up' (c) 'use an appropriate measure instrument' and (d) 'study a relevant sample'. There are also a range of reasons that transgender persons detransition even after having taken puberty blockers. It is important not to look at the situation as a monolith of regret, but rather to analyse deeply on a case-by-case basis why the person detransitioned. It does not necessarily mean that the treatment prescribed was incorrect (Cohn, 2023). However, one could also argue that one detransition is one too many and may point to the conclusion that perhaps prescribing puberty blockers is not in the best interests of every child.

On the other hand, an argument can be made that treating transgender children with puberty blockers is in the best interests of the child, even amidst ongoing research with no agreed-upon consensus when considered within the framework of Article 3 of the CRC. There are several arguments supporting their potential benefits for transgender children. Puberty blockers can provide transgender children with relief from distressing experiences associated with the development of secondary sexual characteristics incongruent with their gender identity. By delaying puberty, these children have more time to explore their gender identity. According to the YP, gender identity is integral to every person's dignity and humanity and must not be the basis for discrimination or abuse. The YP also reinforce the tenets of Article 3 of the CRC that children (including those with diverse gender identities) must be placed in a position where their best interests are a primary consideration in the advancement of human rights. It is important that the principle of the best interests of the child is understood critically in conjunction with the social and cultural starting point of both childhood and gender and thus a dynamic interpretation of the best interests principle should take into account the impact of both the social constructs of childhood and gender (Ammaturo and Moscati, 2021). In understanding that the best interests of the child are also dependent on the child in question, what may be strengthened, in light of evolving capacities and maturity, may be the interplay of Article 3 and Article 12 of the CRC. In other words, given the maturity of the child and their ability to communicate their desires, a child can actively participate in giving informed consent to using puberty blockers with the comprehension of its possible outcomes, risks, benefits and possible long-term effects. The intertwining of Articles 3 and 12 of the CRC must be viewed in the context of strengthening the autonomy rights of the child – even if this interferes with the rights of the parents or caregivers. Access to puberty blockers empowers transgender children and their families to make decisions that align with the child's gender identity and well-being. By respecting the child's self-identified gender and providing them with the means to affirm their identity, providing puberty blockers can promote autonomy and self-determination, consistent with the principles of the CRC and promote a less paternalistic approach to children's rights (Ammaturo and Moscati, 2021).

In terms of their psychological well-being, for many transgender children, the onset of puberty can exacerbate feelings of minority stress. Transgender persons are at an extremely high risk for minority stress (Walters *et al.*, 2024). Minority stress stems from experiences of stigma and discrimination and creates a higher risk of negative physical and mental health outcomes (McConnell *et al.*, 2018). This may lead to increased rates of depression, anxiety and suicidal ideation. By delaying puberty, puberty blockers may mitigate these negative mental health outcomes, allowing the child to experience a more positive and affirming transition process.

3 The Right to the Highest Attainable Standard of Healthcare

Could one argue that receiving puberty blockers for gender dysphoria amounts to the protection of the child's right to the highest attainment of health care? According to Article 24(1) of the CRC, an argument could be made in this regard. Article 24(1) provides:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and 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.

Using this line of argument is complex and controversial. According to Principle 18 of the YP, the danger lies in treating gender identity as a medical condition that can be treated, cured or suppressed. However, the very nature of gender dysphoria is pathologised; as it appears both in the DSM-5 and the ICD-11. Whether that should be the case is not within the scope of this research. However, one can argue that there is no health care without a diagnosis. A condition where an individual's gender identity differs from the sex they were assigned at birth, can lead to significant distress and mental health challenges. Access to appropriate medical care, including puberty blockers, can alleviate some of this distress and contribute to the child's overall well-being (Skagerberg *et al*, 2013; Day *et al*, 2019). The question is then whether the prescription of puberty blockers amounts to appropriate care and whether the denial of providing puberty blockers amounts to a denial of the right to health care. General Comment No. 14 (2000) to the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides for a framework for the normative content of the right to health. It affirms each individual's agency to make decisions about their health (O'Connor *et al.*, 2022). O'Connor *et al.* make an argument for the non-pathologising of transgender persons – but in the same vein make the argument that transgender health care amounts to health care. It is a difficult line of reasoning to follow, especially as gender-affirming care cannot be dispensed without the assistance of a health care professional and in a multidisciplinary environment. It would thus follow that gender-affirming care is health care and by that reasoning, there must certainly be a degree of pathology. One can understand where the advocates for the depathologising of gender identity stems. It reinforces the societal stigma attached to the transgender community. However, what is important to get across is that when we discuss the health care puberty blockers, when prescribed by qualified medical professionals, are considered a reversible intervention that can delay the onset of puberty according to limited research. For transgender and gender-nonconforming children experiencing distress due to their physical development not aligning with their gender identity, puberty blockers can be a crucial intervention to prevent the exacerbation of gender dysphoria and associated mental health issues (Turban *et al.*, 2023). Therefore the moral question of whether the pathologising of transgender persons is justified juxtaposed with actually receiving treatment seems like a moot argument in so far as it relates to the child receiving the treatment at the end of the day. This is especially true as one of the aims of providing gender-affirming care is to protect the child from undue harm. Gender dysphoria can have severe consequences for a child's mental health and by providing puberty blockers, healthcare providers aim to mitigate these risks and protect the child from harm, consistent with Article 6 of the CRC, which stipulates that children have the right to survival and development.

4 Conclusion and Recommendations

In cases where the child's gender identity is clear and persistent, withholding access to puberty blockers may be seen as denying them a medically necessary intervention that aligns with their fundamental identity. Failing to provide this treatment could perpetuate feelings of dysphoria and contribute to the child's distress and suffering. While the research on the long-term effects of puberty blockers in transgender children is on-going, these potential benefits suggest that their use can be justified within the framework of the CRC's principle of prioritising the best interests of the child. However, decisions about the use of puberty blockers must be made on a case-by-case basis, with careful consideration of the child's circumstances, in collaboration with qualified healthcare professionals and with informed consent from the child and their guardians. Additionally, continued research into the safety and efficacy of puberty blockers in this population is necessary to ensure that interventions are evidence-based and ethically sound.

The debate over the use of puberty blockers for children experiencing gender dysphoria is complex and deeply nuanced, touching on medical, ethical, psychological and social considerations. Concluding whether puberty blockers can or cannot be in the best interest of the child involves balancing these multifaceted issues to consider the best outcomes for the child's overall well-being. In favour of prescribing puberty blockers to minors is viewed by healthcare professionals and advocates as a critical intervention for children experiencing intense gender dysphoria. They argue that these medications can be in the best interest of the child for several reasons such as alleviating psychological distress associated with their gender identity and the research conducted that puberty blockers are reversible. Some research suggests that if a child decides not to proceed with further gender-affirming treatments, puberty can resume its course, providing a safeguard that allows for the exploration of gender identity without permanent changes.

Conversely, there are arguments against the use of puberty blockers in children, centred on concerns regarding consent, long-term outcomes, and the nature of gender dysphoria. Some detractors argue that the long-term effects of puberty blockers are not fully understood, raising concerns about potential impacts on bone density, brain development and fertility. They contend that children are unable to comprehend these long-term risks fully, making it difficult to ensure informed consent. There is also a viewpoint that gender dysphoria in children might stem from or be intertwined with other psychological issues. Critics of puberty blockers argue for a more cautious approach that prioritises psychological interventions over medical treatments.

Therefore, the question of whether puberty blockers are in the best interest of a child experiencing gender dysphoria depends on a careful, individualised consideration of the child's psychological well-being and on-going research on the use of puberty blockers. It necessitates a holistic approach that involves medical professionals, the child and their family. Any decision must be made with the utmost care, guided by the principle of doing what is best for the well-being and future of the child.

It is thus important to emphasise the words of Steensma in that states and medical professionals do not blindly follow the Dutch Protocol without understanding the tenets thereof and the ever-so-cautious approach that Dutch researchers have always taken. It is incumbent on researchers to conduct their research to enhance the quality for the benefit of all transgender children across the globe. The affirmative model of health care for transgender children poses a real and imminent threat that is currently being masked by the assumption that banning and limiting puberty blockers for children is strictly a political agenda. That would constitute a mischaracterisation of the entire picture. Politics is a consideration as every state must consider the health care of its citizens; however, purely to paint the issue with a single brush would be irresponsible and disingenuous to the plight of researchers who desperately want to understand how best to treat children with gender dysphoria.

Furthermore, a discussion must be had regarding whether Article 8 of the CRC can be utilised in such a manner that takes into account gender identity as being a facet of a child's identity in order further to entrench the importance of the general principles of the CRC. This will mean that there should be further clarification by the Committee on the Rights of the Child on what constitutes "identity" in the primal sense of the word.

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