GATE

Reaffirming Autonomy of Trans and Gender Diverse Children and Adolescents

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About GATE

GATE is an international advocacy organization working towards justice and equality for trans, gender diverse and intersex communities. Rooted in our movements, we work collaboratively with strategic partners at the global level to provide knowledge, resources, and access to international institutions and processes. Our vision is a world free from human rights violations based on gender identity, gender expression, and sex characteristics. Our strategy is to transform the landscape of global advocacy, knowledge creation and resource distribution through critical inclusion of trans, gender diverse and intersex movements at all levels of political, legal and socio-economic processes.

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Introduction

The purpose of this document is to reaffirm the decision-making autonomy and the physical and bodily integrity of trans and gender diverse children and adolescents, demonstrating their full compatibility with the international human rights framework and, therefore, the obligation of States to protect them and guarantee their access to rights.

This paper develops the debate surrounding the importance of the safety of trans youth. It stresses the role that States play in ensuring trans youth's access to bodily autonomy, gender-affirming healthcare and legal gender recognition.

The necessity for respecting autonomy and its application within the human rights framework is presented through different approaches and situations. On the one hand, we are facing a moment of intersection between the visibility of trans children and adolescents, both in the media and on social networks, cultivated by their parents, guardians, and professional support systems. On the other hand, attacks from conservative/traditional and radical/critical anti-gender groups are also prevalent. It is essential to note the significant financing and politicization of anti-gender campaigns targeting children and adolescents.

This paper analyzes and characterizes how trans youth's access to autonomy and mental and physical integrity are compromised. It also discusses how freedom of gender expression and access to legal recognition of gender identity and gender-affirming procedures has been endangered. This paper will cover research based on the framework and premise of depathologization and human rights.

In 2007, the Yogyakarta Principles (YP) stated that international human rights law affirms the entitlement of all persons, regardless of sexual orientation or gender identity, to the full enjoyment of all human rights and that the application of existing human rights entitlements should take into account the specific situations and experiences of people of diverse sexual orientations and gender identities. In all matters concerning children, the best interests of the child shall be the primary consideration, and a child who is capable of forming personal views has the right to express those views freely, with such views being given due weight in accordance with the age and maturity of the child.[1]

1 Yogyakarta principles on the application of international human rights law in relation to sexual orientation and gender identity. (2009). *Asia-Pacific Journal on Human Rights and the Law*, 9(2), 86–113. https://doi.org/10.1163/157181509789025200

Trans and Gender Diverse[2] Children and Adolescents[3]

Trans and gender diverse are terms used to describe a wide range of identities for people whose gender identity differs from the gender identity typically associated with the sex assigned at birth. Gender exists as a spectrum, and people may or may not identify as male or female; some may identify as gender diverse. Across cultures, in addition to non-binary gender expressions and identities, many other terms are used to describe gender identities and expressions that differ from the sex assigned at birth.

> "Cultures and countries from all over the globe recognize in cultural traditions, and occasionally in law, gender identities that do not correspond with the male/female binary. Examples include Argentina, Australia, Bangladesh, Canada, Fiji, India, Indonesia, Mexico, Nepal, New Zealand, Pakistan, the Philippines, Samoa, Thailand, Tonga, and the United States of America - these examples alone already comprise more than a third of the world's population. The prevalence of the gender binary and the repression of gender diversity are also directly linked to the history of colonialism and oppression. Some pre-colonial cultures were more open to the idea of gender plurality before the establishment of colonial and postcolonial legal systems. Recently, the scientific community has also collected evidence to support the conclusion that gender identity is not strictly a binary phenomenon."[4]

2 GATE uses the term 'trans and gender diverse' to refer to people whose gender identity, gender expression or behavior does not conform to that typically associated with the sex they were assigned at birth. This includes binary gender identities and expressions (trans men, trans women), gender identities and expressions that fall outside the male/female binary, and culturally-specific gender identities that do not conform to the Western- and Colonialist-imposed gender binary, such as hijra, two-spirit, fa'afāfine (non-exhaustive).

3 It is important to clarify that, in this paper, the words child or children refers to a child who has not reached puberty, and the words young person or adolescent refers to a person who has reached puberty.

4 United Nations Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity - IESOGI. *Reports on Gender: The Law of Inclusion & Practices of Exclusion*. Reports presented in 2021 at the 47th UN Human Rights Council and 76th UN General Assembly (2021) available from https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Reports_on_Gender_Final_Summary.pdf

The number of young people who identify as trans has nearly doubled in recent years, according to a new report that captures a stark generational shift and emerging societal embrace of the diversity of gender[5].

This trend can be attributed to increasing societal acceptance and availability of relevant information, facilitating a more enabling environment where people can identify as trans.

The analysis, relying on the U.S. government health surveys conducted from 2017 to 2020, estimated that 1.4% of 13- to 17-year-olds and 1.3% of 18- to 24-year-olds were transgender, compared with about 0.5% of all adults.

These figures illustrated a significant rise since the researchers' previous report in 2017, though the analysis used different methods. In the previous report, an estimated 0.7% of children and adolescents under 18 identified as trans or gender diverse, with more recent estimates observing up to 1.8% of high school students identifying as trans[6].

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5 Herman, J. L., Flores, A. R., & O'Neill, K. K. (2022). *How many adults and youth identify as transgender in the United States?* The Williams Institute. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf
This study finds that:

- Over 1.6 million adults (ages 18 and older) and youth (ages 13 to 17) identify as transgender in the United States, or 0.6% of those aged 13 and older.
- Among U.S. adults, 0.5% (about 1.3 million adults) identify as transgender. Among youth aged 13 to 17 in the U.S., 1.4% (about 300,000 youth) identify as transgender.
- Of the 1.3 million adults who identify as transgender, 38.5% (515,200) are transgender women, 35.9% (480,000) are transgender men, and 25.6% (341,800) reported they are gender nonconforming.

Research shows transgender individuals are younger on average than the average age of the U.S. population. We find that youth ages 13 to 17 are significantly more likely to identify as transgender (1.4%) than adults ages 65 or older (0.3%).
The racial/ethnic distribution of youth and adults who identify as transgender appears generally similar to the U.S. population, although our estimates mirror prior research that found transgender youth and adults are more likely to report being Latinx and less likely to report being White compared to the general U.S. population.
Our estimates of the percent of residents in U.S. regions who identify as transgender range from 1.8% in the Northeast to 1.2% in the Midwest for youth ages 13 to 17 and range from 0.6% in the Northeast to 0.4% in the Midwest for adults. At the state level, our estimates range from 3.0% of youth aged 13 to 17 identifying as transgender in New York to 0.6% in Wyoming. Our estimates for the percentage of adults who identify as transgender range from 0.9% in North Carolina to 0.2% in Missouri.

6 Herman, J.L., Flores, A.R., Brown, T.N.T., Wilson, B.D.M., & Conron, K.J. (2017). *Age of Individuals who Identify as Transgender in the United States*. Los Angeles, CA: The Williams Institute
Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., ... & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students—19 states and large urban school districts, 2017. *Morbidity and Mortality Weekly Report*, 68(3), 67.

Although there is no reliable estimate of the worldwide population of trans youth, population surveys in six countries have generated estimates that between 0.4% and 1.3% of the population may be trans and gender diverse[7].

As a result of their marginalized status and the widespread transphobia experienced in all aspects of everyday life, trans and gender diverse (TGD) youth are more likely than their non-TGD peers to experience several trauma-related risk factors associated with poor physical and mental health outcomes, including poverty, homelessness, and violence. Even with access to gender-affirming healthcare, TGD youth may be at an elevated risk of harm[8].

However, recent data showed that trans youth who were able to use their chosen name (rather than their name assigned at birth) reported fewer depressive symptoms and less suicidal ideation and behavior, suggesting that psychosocial burdens may also be alleviated by social, non-medical interventions.[9]

7 Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., & Wylie, K. (2016). Transgender people: health at the margins of society. *The Lancet*, 388(10042), 390-400.
Spizzirri, G., Eufrásio, R., Lima, M. C. P., de Carvalho Nunes, H. R., Kreukels, B. P., Steensma, T. D., & Abdo, C. H. N. (2021). Proportion of people identified as transgender and non-binary gender in Brazil. *Scientific reports*, 11(1), 1-7.

8 Bochicchio, L., Reeder, K., Aronson, L., McTavish, C., & Stefancic, A. (2021). Understanding factors associated with suicidality among transgender and gender-diverse identified youth. LGBT health, 8(4), 245-253.
Witcomb, G. L., Claes, L., Bouman, W. P., Nixon, E., Motmans, J., & Arcelus, J. (2019). Experiences and psychological wellbeing outcomes associated with bullying in treatment-seeking transgender and gender-diverse youth. LGBT health, 6(5), 216-226.
Lillemoe, J., Holmstrom, S. E., & Sojar, S. H. (2023). Emergency care considerations for transgender and gender diverse youth: a review to improve health trajectories. Current opinion in pediatrics, 35(3), 331-336.

9 Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. *Journal of adolescent Health,* 63(4), 503-505.

Research published in the U.S. indicates that trans children who receive support from their community and family are less likely to experience mental anguish, as such symptoms are the result of social factors such as discrimination, rejection, and harassment, and rather than the process of transition itself[10]. Current research suggests that instead of focusing on who a child might become, valuing them for who they are now–even at a young age–fosters secure attachment and resilience for the whole family[11].

States must protect trans and gender diverse youth from discrimination and violence based on gender identity. When States deny children the agency to consent to legal gender recognition, they exclude them –often de jure and de facto– from gender recognition, with a corresponding heightened risk of persecution, abuse, violence, and discrimination. In its General Comment No. 20, the Committee on the Rights of the Child emphasized

> "the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy."

It concluded that

> "States should also take effective action to protect ... transgender ... adolescents from all forms of violence, discrimination or bullying by raising public awareness and implementing safety and support measures[12]."

10 Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. Pediatrics, 137(3), e20153223. https://doi.org/10.1542/peds.2015-3223

11 Ehrensaft, D., Giammattei, S. V., Storck, K., Tishelman, A. C., & St. Amand, C. (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. International Journal of Transgenderism, 19(2), 251–268. https://doi.org/10.1080/15532739.2017.1414649
Olson, K. R., Key, A. C., & Eaton, N. R. (2015). Gender cognition in transgender children. Psychological Science, 26(4), 467–474. https://doi.org/10.1177/0956797614568156
Olson, K. R. (2016). Prepubescent transgender children: What we do and do not know. Journal of the American Academy of Child & Adolescent Psychiatry, 55(3), 155-156.e3. https://doi.org/10.1016/j.jaac.2015.11.015
Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. Pediatrics, 137(3), e20153223. https://doi.org/10.1542/peds.2015-3223
Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. Family Process, 50(4), 453–470. https://doi.org/10.1111/j.1545-5300.2011.01371.x

12 Committee on the Rights of the Child, General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence, paras. 33 and 34

Human Rights Framework

Key human rights principles essential for the effective protection of LGBT people can be found in existing international instruments, including the Convention on the Rights of the Child (CRC). Regional instruments applicable to violations based on sexual orientation and gender identity include the African Commission on Human and Peoples' Rights (ACHPR), the European Court of Human Rights (ECHR), and the American Convention on Human Rights (ACHR).[13]

In March 2007, a panel of international experts published the 'Yogyakarta Principles' on applying international human rights law in relation to sexual orientation and gender identity. The Principles affirm binding international legal standards with which all States must comply. The Principles affirm the primary obligation of States to implement human rights but also emphasize that all actors have responsibilities to promote and protect human rights. Recommendations are therefore addressed to State and non-State actors alike, including the UN, National Human Rights Institutions (NHRIs), and NGOs.[14]

Following on from this, in 2017, the 'Yogyakarta Principles plus 10' (YP+10) were published, updating and complementing the previous document.[15]

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13 *Lesbian, gay, bisexual and transgender persons*. (n.d.). Icelandic Human Rights Centre. Retrieved 27 October 2022, from https://www.humanrights.is/en/human-rights-education-project/human-rights-concepts-ideas-and-fora/the-human-rights-protection-of-vulnerable-groups/lesbian-gay-bisexual-and-transgender-persons

14 Ibid.

15 In relation to children, the YP states in Principle 13, relating to the right to social security and to other social protection measures, that States must:
"B. Ensure that children are not subject to any form of discriminatory treatment within the social security system or in the provision of social or welfare benefits on the basis of their sexual orientation or gender identity, or that of any member of their family."
Regarding Principle 24 relating to the right to found a family, the YP promotes that States
"C. Take all necessary legislative, administrative and other measures to ensure that in all actions or decisions 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, and that the sexual orientation or gender identity of the child or of any family member or other person may not be considered incompatible with such best interests;"
"D. In all actions or decisions concerning children, ensure that a child who is capable of forming personal views can exercise the right to express those views freely, and that such views are given due weight in accordance with the age and maturity of the child;"
The YP+10 indicate the following additional State obligations: Relating to the right to education (Principle 16), States shall:
"I. Ensure inclusion of comprehensive, affirmative and accurate material on sexual, biological, physical and psychological diversity, and the human rights of people of diverse sexual orientations, gender identities, gender expressions and sex characteristics, in curricula, taking into consideration the evolving capacity of the child."
Relating to the right to found a family (Principle 24), States shall:
"H. Protect children from discrimination, violence or other harm due to the sexual orientation, gender identity, gender expression or sex characteristics of their parents, guardians, or other family members;"
"I. Issue birth certificates for children upon birth that reflect the self-defined gender identity of the parents;"
Lastly, the YP+10 recognized Principle 32, the right to bodily and mental integrity, establishing that
"Everyone has the right to bodily and mental integrity, autonomy and self- determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to be free from torture and cruel, inhuman and degrading treatment or punishment on the basis of sexual orientation, gender identity, gender expression and sex characteristics. No one shall be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person."

The consideration of sexual orientation and gender identity within the human rights framework has evolved considerably since the 1980s. Despite the absence of explicit reference to sexual orientation and gender identity in the existing international human rights treaties, the treaty bodies have gradually incorporated this aspect of rights within the scope of their work. The development of this sexual orientation and gender identity-related human rights doctrine has focused on non-discrimination, protecting privacy rights, and ensuring the enjoyment of human rights regardless of sexual orientation or gender identity.

According to the Convention on the Rights of the Child (the Convention or CRC), States are obliged to create legislation allowing children and adolescents to self-determine their gender identity and ensure, among other things, that their rights under the CRC to education (Article 28), health (Article 24), identity (Article 8), protection against discrimination (Article 2), an adequate standard of living and ultimately their right to life, survival and development (Article 6) are protected.

It is worth noting, as a principle, that the CRC did not directly contemplate issues associated with gender identity. However, it did recognize the right to identity, to a name (art. 8), to be heard (art. 12), the principle of progressive autonomy, and the prohibition of discrimination within this age group (art. 2), all of which are rights closely related to the subject. However, treaties are subject to an evolving and dynamic interpretation, which is why, in 2016, the Committee on the Rights of the Child in General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence states that

"Adolescents who are lesbian, gay, bisexual, trans and intersex commonly face persecution, including abuse and violence, stigmatization, discrimination, bullying, exclusion from education and training, as well as a lack of family and social support, or access to sexual and reproductive health services and information. In extreme cases, they face sexual assault, rape and even death. These experiences have been linked to low self-esteem, higher rates of depression, suicide, and homelessness."

The Committee emphasizes the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity, and emerging autonomy. It condemns the imposition of procedures to change sexual orientation and forced surgeries or treatments on intersex adolescents. It urges States to eliminate such practices, repeal all laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation, gender identity, or intersex status, and adopt laws prohibiting discrimination on those grounds. States should also take effective action to protect all lesbian, gay, bisexual, trans, and intersex adolescents from all forms of violence, discrimination, or bullying by raising public awareness and implementing safety and support measures. It states that

> "There should be no barriers to commodities, information and counseling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization. In addition, particular efforts need to be made to overcome barriers of stigma and fear experienced by, for example, adolescent girls, girls with disabilities and lesbian, gay, bisexual, trans and intersex adolescents, in gaining access to such services."

Previously, the Committee, in the General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), held that

> "States parties have an obligation to ensure that children's health is not undermined as a result of discrimination, which is a significant factor contributing to vulnerability."

In particular, it emphasized that

> "A number of grounds on which discrimination is proscribed are outlined in article 2 of the Convention, including the child's, parent's or legal guardian's race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."

These also include sexual orientation, gender identity, and health status, such as HIV status and mental health.[16] Attention should also be given to any other forms of discrimination that might undermine children's health, and the implications of multiple forms of discrimination should also be addressed.

In 2011, General Observation No. 13, on the right of the child not to be subjected to any form of violence, highlighted trans children as

> "Children in situations of potential vulnerability."

Furthermore, at the international level, the Inter-American Court of Human Rights issued an Advisory Opinion (OC- 24/12) in November 2017. This was requested by Costa Rica on the topic of gender identity and equality and non-discrimination against same-sex couples. The advisory opinion (OC24) mentions that

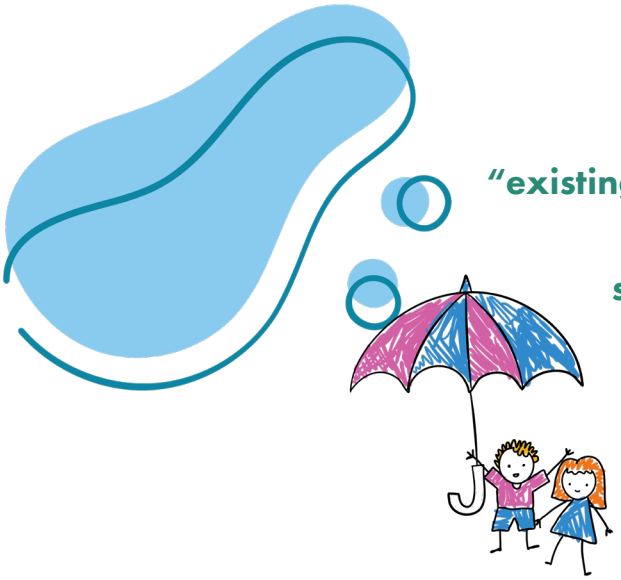
> "children are entitled to the same rights as adults and all the rights recognized in the American Convention, in addition to having the special protection measures contemplated in art. 19 of the Convention... and that the rights contained in the general human rights instruments must be interpreted taking into consideration the corpus iuris on childhood" (Paragraph 149).

It provides that, in the measures taken for their protection, in addition to progressive autonomy, the principles of non-discrimination, superior interest, respect for the right to life, survival and development, and respect for the child's opinion must be taken into account in any procedure that affects them, so that their participation is guaranteed.

The OC24 expressly recognizes that the considerations related to the right to gender identity apply to children who wish to present requests for their gender identity to be recognized in documents and records. Finally, it highlights that any restriction imposed on the full exercise of this right through provisions that aim to protect children can only be justified in accordance with these principles, and it must not be disproportionate.

16 Committee on the Rights of the Child. General Comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child.

The UNHCR Independent Expert on sexual orientation and gender identity (IE SOGI) mandate, under the guidance of its special rapporteur, Victor Madrigal Borloz, has amplified the umbrella by saying that



"existing data already supports the concept that gender identity is not strictly a binary phenomenon."

More fundamentally, presenting diverse gender identities as a mental health disorder is a form of pathologization inconsistent with the 11th revision of the International Classification of Diseases published by the World Health Organization in 2019. Recent medical evidence has concluded that

> "those who received treatment with pubertal suppression, when compared with those who wanted pubertal suppression but did not receive it, had lower odds of lifetime suicidal ideation."[17]

According to the SOGI Independent Expert, when States deny children the agency to consent to gender recognition treatments, they heighten the risk of persecution, abuse, violence, and discrimination. States must always take the best interests of the child as a primary consideration and respect the child's right to express views in accordance with age and maturity, recognizing their autonomy and decisional power.[18]

17 Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics,* 145(2), e20191725. https://doi.org/10.1542/peds.2019-1725

18 United Nations Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity - IESOGI. Reports on Gender: *The Law of Inclusion & Practices of Exclusion. Reports presented in 2021 at the 47th UN Human Rights Council and 76th UN General Assembly (2016)* available from https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Reports_on_Gender_Final_Summary.pdf

The Right to Autonomy of Children and Adolescents

Personal autonomy has been a vital issue for centuries in the psychosocial field and medicine, where it has been considered an essential ethical principle. Autonomy derives from a Greek word combining the words 'self' and 'law.' It means giving a law or regulation to oneself. Autonomy is the basis for decision-making. This area has become even more relevant in recent years with the development of new technologies, which can make considerable changes to the body and its functions and other areas of human endeavors.[19]

In medicine, autonomy is the basis for decision-making and is necessary to give informed consent to any form of treatment and participation in research projects.[20] International human rights norms call for protecting and promoting adolescents' right to access confidential and comprehensive sexual and reproductive health services. The Convention on the Rights of the Child, adopted by the UN General Assembly in 1989, requires States

> "to ensure that no child is deprived of his or her right of access to… healthcare services,"

including preventive healthcare and family planning education and services. Moreover, the Convention recognizes 'the evolving capacities of the child' when considering the role of parents in guiding a child's exercise of their rights. According to the International Planned Parenthood Federation, 'the evolving capacities of the child' standard requires a balance between recognizing children as active agents in their own lives, as people and as rights-bearers with increasing autonomy, and as being entitled to protection in accordance with their vulnerability.[21]

19 Di Ceglie, D. (2018). Autonomy and Decision-Making in Children and Adolescents with Gender Dysphoria. In M. Shaw & S. Bailey (Eds.), *Justice for Children and Families: A Developmental Perspective* (pp. 145-153). Cambridge: Cambridge University Press. https://doi.org/10.1017/9781108619554.018

20 Ibid.

21 International Planned Parenthood Federation. (2009). Sexual rights: an IPPF Declaration, 2008

According to General Comment 20 of the CRC, Article 5 of the CRC requires that parental direction and guidance be provided in a manner consistent with the evolving capacities of the child. The Committee defines evolving capacities as an enabling principle that addresses the process of maturation and learning through which children progressively acquire competencies, understanding, and increasing levels of agency to take responsibility and exercise their rights. The Committee has argued that the more a child knows and understands, the more their parents will have to evolve their direction and guidance into a gradual equal exchange on decision making.

The Committee emphasizes that the right to exercise increasing levels of responsibility does not preclude States' obligations to guarantee protection. Gradual emergence from the protection of the family or another care environment, together with relative inexperience and lack of power, can render adolescents vulnerable to violations of their rights. The Committee stresses that engaging adolescents in identifying potential risks and developing and implementing programs to mitigate them will lead to more effective protection. By being guaranteed the right to be heard, challenge rights violations, and seek redress, adolescents can progressively exercise agency in their protection.

In seeking to provide an appropriate balance between respect for the evolving capacities of adolescents and appropriate levels of protection, consideration should be given to various factors affecting decision-making. These include the level of risk involved, the potential for exploitation, understanding of adolescent development, recognition that competence and understanding do not necessarily develop equally across all fields simultaneously, and recognition of individual experience and capacity.

The Hastings Center, a non-partisan, non-profit bioethics research institute, defines decision-making capacity as existing when a patient can

(a) comprehend information relevant to the decision

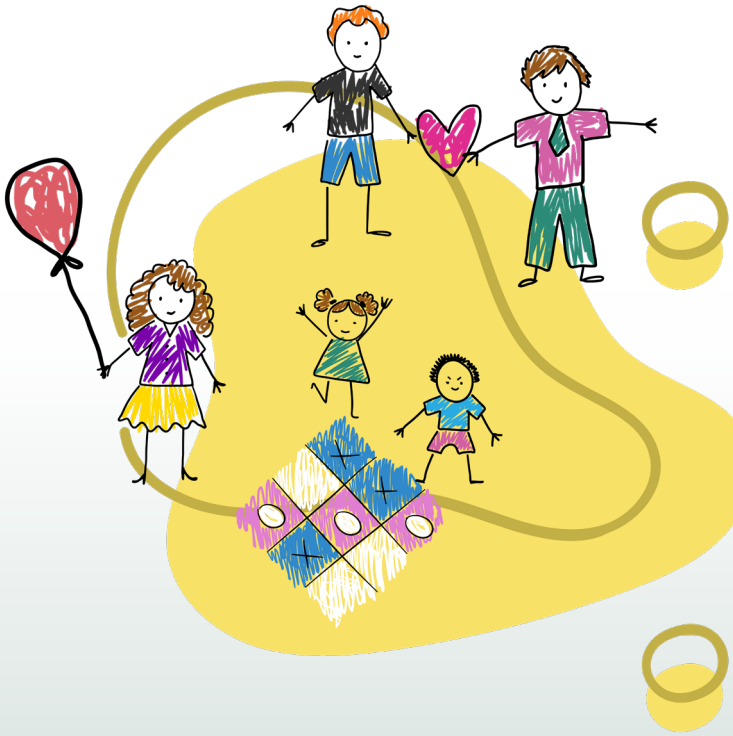
(b) deliberate about choices in accordance with personal values and goals, and

(c) communicate verbally or nonverbally with caregivers.[22]

22 Cohen, C. B. (Ed.). (1988). *Casebook on the termination of life-sustaining treatment and the care of the dying.* Indiana University Press; Hastings Center.

Decision-making capacity also requires the ability to provide consent beyond merely acquiescing or deferring to authority. Accordingly, a health care provider should ultimately base an evaluation of an adolescent's decision-making capacity upon the adolescent's

"ability to understand and communicate relevant information, ability to think and choose with some degree of independence, ability to assess the potential for benefit, risks, or harms, as well as to consider the consequences and multiple options."[23]



To develop the right to autonomy in children and adolescents, we should start by analyzing the principle of evolving capacities.

23 Mutcherson, K. M. (2004). Whose body is it anyway-an updated model of healthcare decision-making rights for adolescents. *Cornell JL & Pub. Pol'y*, 14, 25

Evolving Capacities

In contrast to chronological age and emancipation-based rules, the international law concept of the 'evolving capacity of the child' is a standard that allows for discretionary assessments of decisional competency. The benefit of standards is that they allow contextual factors to be weighed individually. The downside is that the outcome is more uncertain and subject to the biases of the service provider or adjudicator (e.g., the court). For some youth, discretion in the hands of gatekeepers will undermine their care; for others, it will provide an opening to receive care.

Many common law jurisdictions recognize some version of the evolving capacities standard. According to this doctrine, children who exhibit sufficient maturity to understand the nature, consequences, and potential risks of treatment can provide informed consent. The level of requisite maturity may differ according to the kind of treatment. An adolescent or younger child capable of consenting to dental treatment or treatment for a sports injury may nevertheless lack the capacity to refuse life-sustaining care.[24]

The 'evolving capacities of the child' is articulated in Article 5 of the CRC:

> "States Parties shall respect the responsibilities, rights and duties of parents (...) 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."

This provision limits the degree to which States must respect parental or community rights vis-à-vis children, including in the healthcare context. The CRC provides that States do not have to respect parental or community rights or duties when these are exercised in a manner inconsistent with the evolving capacities of the child.

This concept of 'evolving capacities' should be read in conjunction with children's right to express their views under Article 12 of the CRC. Article 12 of the CRC provides:

> "1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

24 Kelly, L. (2012). Why is it important to develop capacities for autonomous decision-making. *International Planned Parenthood Federation,* 1-12.

> 2. For this purpose, the child shall 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."

Article 12 considers children and adolescents to be active subjects rather than passive objects of State or parental authority. The Article reflects a compromise between using age as a proxy for competency and requiring an individualized maturity analysis. Article 12(1) states that "due weight" should be given to the child's views "in accordance with the age and maturity of the child." According to the Convention, neither the child's age nor maturity is determinative of the appropriate weight to be accorded their views; both are necessary and valid considerations.

The CRC Committee has emphasized the importance of children and adolescents' views in the healthcare context. In its General Comment on 'the Right of the Child to be heard,' the Committee stated:

> "The realization of the provisions of the Convention requires respect for the child's right to express his or her views and to participate in promoting the healthy development and well-being of children. This applies to individual health-care decisions, as well as to children's involvement in the development of health policy and services."[25]

The views of young people are relevant not only for individual access but also for program design. It is essential that young people are key participants in programs made for them.

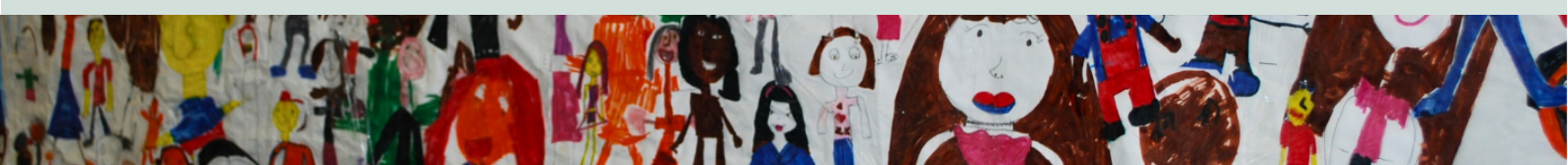
The doctrine states that adolescents deemed mature have the capacity to consent.[26] Despite the highly varied nature of legal support for the international law concept of the 'evolving capacity of the child' across State jurisdictions, as an ethical concept, it is highly relevant to trans healthcare. In situations where trans healthcare is deemed low risk and aligns with current guidelines, we believe the international law concept of the 'evolving capacity of the child' can and should be applied to children and adolescents.[27]

Providing exhaustive information and an appropriate informed consent process is also important.

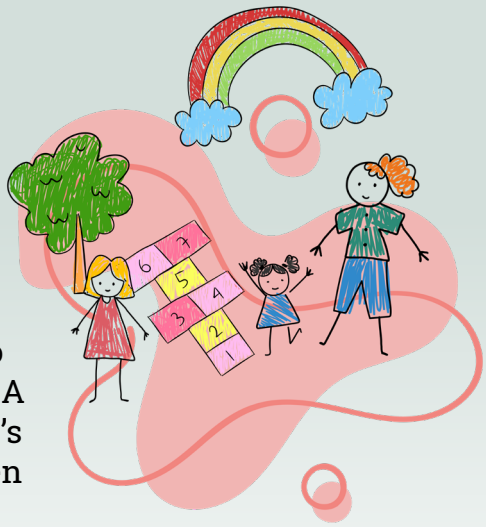
25 Committee on the Rights of the Child, *General Comment No. 12: The right of the child to be heard,* UN Doc. CRC/C/ GC/12 (2009) at para. 98.

26 Holder, A. R. (1987). Minors' rights to consent to medical care. *JAMA: The Journal of the American Medical Association,* 257(24), 3400. https://doi.org/10.1001/jama.1987.03390240106033

27 Dubin, S., Lane, M., Morrison, S., Radix, A., Belkind, U., Vercler, C., & Inwards-Breland, D. (2020). Medically assisted gender affirmation: when children and parents disagree. *Journal of Medical Ethics,* 46(5), 295-299.



The Best Interests of the Child



The best interests of the child should be a primary consideration in legal procedures, and the child's view should be given proper weight, taking into account their individual maturity and development. A child's best interests must include respect for the child's right to express their views freely and due weight given to said views in all matters affecting the child.[28]

The best interest principle is one of the most analyzed and discussed CRC Articles in academic literature.[29] Determining what is in the best interest of the child is difficult in practice, especially when the subject concerns gender-affirming healthcare, such as may be the case for trans children and adolescents.[30] However, the use of the word 'shall' in Article 3 CRC reflects the mandatory nature of the obligation, while the term 'consideration' makes clear that the child's interests must be taken into account. The decision maker must also undertake a careful, considerate, and informed assessment of the child's best interest. In General Comment 14, the Committee on the Rights of the Child reiterates 'the best interest principle' as a dynamic, threefold concept[31] that requires an assessment appropriate to the specific context and which ensures the holistic development of the child.[32]

28 Committee on the Rights of the Child, General Comment No. 14 on the right of the child to have his or her best interests taken as primary consideration, 23 May 2013, CRC/C/GC/14, para 43.

29 Mieke Verheyde, A Commentary on the United Nations Convention on the Rights of the Child, Article 28: The Right to Education (Martinus Nijhoff 2006) 38.

30 Houston, C. (2020). Respecting and Protecting Transgender and Gender-Nonconforming Children in Family Courts. *Can. J. Fam. L.*, 33, 103.

31 The Committee underlines that the child's best interests is (1) a substantive right which takes the best interest of the child as primary consideration when different interests are being considered in order to reach a decision on the issue at stake and guarantees that this right will be implemented whenever a decision is to be made concerning a child, a group of identified or unidentified children or children in general. Article 3, paragraph 1, creates an intrinsic obligation for States, is directly applicable and can be invoked before a court; (2) a fundamental, interpretative legal principle which means that when a legal provision is open to more than one interpretation, the interpretation which most effectively serves the child's best interests should be chosen; and (3) a rule of procedure that stipulates that the decision-making process must include an evaluation of the possible impact (positive or negative) of the decision on the child or children concerned. See UN CRC 'General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)' (May 2013) UN Doc CRC/C/GC/14, para 6.

32 Bucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review*, 3(1), 59-81.

Taken together with Article 12 CRC, which in 12(1) recognizes the right of children capable of forming views to express those views in all matters affecting them, and directs that due weight be accorded to those views, depending on the age and maturity of the child as well as the matter at issue, it is clear that the CRC brings together a procedural link between providing for a child's best interests and participation and progressing or securing other rights of the child set out in the CRC.[33]

Thus, participation in decision-making should be consistent with a child's best interests while at the same time, children's participation in identifying and/or securing their best interests must be secured.[34]

To assess the best interests of a child, those involved in decision-making must fully consider the child's view on the subject. Such consideration must be kept under constant review and take account of changing circumstances and evolving capacity of the child.[35]

To summarize, States should take the best interests of the child as a primary consideration and respect the child's right to express views in accordance with the age and maturity of the child, in line with the CRC and, in particular, in keeping with the safeguards established under Article 19 of the Convention, which must not be excessive or discriminatory in relation to other safeguards that give recognition to the autonomy and decisional power of children of a certain age in other areas. States should also fulfill their obligation to ensure, to the maximum extent possible, the survival and development of the child[36] and the creation of an environment that respects human dignity.[37]

33 Zermatten, J. (2010). The best interests of the child principle: literal analysis and function. *The International Journal of Children's Rights*, 18(4), 483-499.

34 ibid.

35 Bucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review*, 3(1), 59-81.

36 Convention on the Rights of the Child, art. 6. See also Committee on the Rights of the Child, General Comment No. 5 (2003) on general measures of implementation of the Convention.

37 Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz. Protection against violence and discrimination based on sexual orientation and gender identity. A/76/152. 15 July 2021.

Access to Legal Gender Recognition

The right to recognition of gender identity necessarily includes the right that the personal information in records and on identity documents should correspond to the sexual and gender identity assumed by trans persons. Thus, the Yogyakarta Principles establish the obligation of States

> "to take all necessary legislative, administrative and other measures to fully respect and legally recognize each person's self-defined gender identity,"

and to ensure that

> "procedures exist whereby all State-issued identity papers which indicate a person's gender/sex – including birth certificates, passports, electoral records and other documents – reflect the person's profound self-defined gender identity."[38]

Furthermore, the United Nations High Commissioner for Human Rights has recommended that States

> "issue legal identity documents, upon request, that reflect the preferred gender of the person concerned and facilitate legal recognition of the preferred gender of trans and gender diverse persons and establish arrangements to permit relevant identity documents to be reissued reflecting the preferred gender and name, without infringing other human rights."[39]

38 The YP recognize the right to recognition before the law, under principle 3 which states that

> "Everyone has the right to recognition everywhere as a person before the law (...) and no one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilization or hormonal therapy, as a requirement for legal recognition of their gender identity. No status, such as marriage or parenthood, may be invoked as such to prevent the legal recognition of a person's gender identity. No one shall be subjected to pressure to conceal, suppress or deny their sexual orientation or gender identity."

YP+10 recognize the right to legal recognition under principle 31 which states that

> "Everyone has the right to legal recognition without reference to, or requiring assignment or disclosure of, sex, gender, sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to obtain identity documents, including birth certificates, regardless of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to change gendered information in such documents while gendered information is included in them."

39 Office of the United Nations High Commissioner for Human Rights. (2015). *Discrimination and violence against individuals based on their sexual orientation and gender identity.* para. 79.i.

To ensure that any person can amend public documents and identity documents so that these correspond to their gender identity, the procedures should be regulated and implemented in accordance with certain basic characteristics so that this right is truly protected, and the procedures do not violate human rights. The regulation and implementation of the procedure should be based solely on the free and informed consent of the person involved. This is consistent with the fact that procedures for recognizing gender identity are founded on the possibility for self-determination and of freely choosing the options and circumstances that give meaning to a person's existence, in keeping with their own choices and convictions, as well as the right to dignity and privacy.[40] Consequently, the procedure should be based on the mere expression of the person's intention[41] even if the person is a child or adolescent.

Also, although, in principle, States may determine, based on their internal social and judicial circumstances, the most appropriate procedure to comply with the requirements for procedures to rectify the name and the reference to the sex/gender and the photograph in the corresponding records and identity documents, it is also true that the procedure best suited to the human right standards and requirements is one of an administrative or notarial nature, because, in some States, a judicial proceeding may incur excessive formalities and delays characteristic of the proceedings of judicial nature.[42]

40 OC 24/17, par. 117

41 OC 24/17, par. 129

42 OC 24/17 par. 159.

Gender Identity and the Right to Identity under CRC[43]

Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the gender typically associated with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, gender-affirming healthcare) and other expressions of gender, including dress, speech, and mannerisms. Gender identity is a broad concept that creates space for self-identification and reflects a deeply felt and experienced sense of one's gender. Thus, gender identity and its expression also take many forms; some people do not identify themselves as either male or female or identify themselves as both.[44]

Under Article 2 CRC, States have the duty to respect and ensure the rights set forth in the Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's

> "(...) race, color, sex, language, religion, political or other opinion, national, ethnic, or social origin, property, disability, birth or other status."

The interpretation of 'or other status' in the light of the *ejusdem generis*[45] doctrine indicates that gender identity is included in the protection of Article 2 of the CRC, as it is of 'the same kind' as the other grounds mentioned in the Article. This interpretation coincides with the aim of the Convention to ensure that States fulfill their obligation of empowering and protecting children and ensuring their healthy development at all times and under all circumstances.[46] The same interpretation is also supported by the Committee on Economic, Social and Cultural Rights' General Comment (GC20) underlining that the expression 'other status' in Article 2(2) of the International Covenant on Economic, Social and Cultural Rights[47] (ICESCR) paves the way for adding further grounds of discrimination, such as disability, age, nationality, marital and family status, sexual orientation and gender identity, health status, place of residence, and economic and social situation.[48]

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43 ABucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review*, 3(1), 59-81.

44 Inter-American Commission on Human Rights, Rapporteurship on the Rights of LGTBI Persons. *Basic concepts*. At October 31, 2017, available at: http://www.oea.org/en/iachr/multimedia/2015/lgbti-violence/lgbti-terminology.html
UNHCR, *Guidelines on international protection No. 9: Claims to Refugee Status based on Sexual Orientation and/or Gender Identity with the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees*, HCR/IP/12/09, 23 October 2012, para. 8;
UNHCR (United Nations Refugee Agency). (2015). Protecting Persons with Diverse Sexual Orientations and Gender Identities: A Global Report on UNHCR's Efforts to Protect Lesbian, Gay, Bisexual, Transgender and Intersex Asylum seekers and Refugees.

45 *Ejusdem generis* is Latin for "of the same kind." When a law lists classes of persons or things, this concept is used to clarify such a list.

46 Verhellen, E. (2015). The Convention on the Rights of the Child: Reflections from a historical, social policy and educational perspective. *In Routledge international handbook of children's rights studies* (pp. 43-59). Routledge.

47 International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR)

48 UN CESCR, (2009) 27. 'General Comment No. 20 on Non-discrimination in economic, social and cultural rights (art. 2, para. 2 of the International Covenant on Economic, Social and Cultural Rights)' UN Doc E/C.12/GC/20

Article 8 CRC can also be interpreted as including a child's right to legal gender recognition.[49] Article 8(2) CRC requires that whenever a child is illegally deprived of elements of their identity, the State must provide protection and assistance to reestablish that child's identity speedily.

The right to identity was first introduced as a result of the horrifying events in Argentina, where children were abducted from their families, being deprived of their true identity and family ties.[50] Including a non-exhaustive reference to the term identity and not underpinning any specific terminology like 'family identity' in the law allows for a broader interpretation of the word.

Furthermore, refusing to acknowledge gender identity as a ground for protection against any kind of discrimination or abuse may not align with the evolving character of today's society and the purpose of the CRC. Children and adolescents' right to identity does not only entail the aspects of name, nationality, and family origin. Identity is the human right condition of being identified as a separate and unique person. Essentially, identity comprises the entire personal history of a person from birth until death or even after. As noted by the Inter-American Court of Human Rights:

> **"Personal identity is closely related to the person in his or her specific individuality and private life, both supported by a historical and biological experience, and also by the way in which the said individual relates to others, by developing social and family ties. This is why, although identity is not a right that is exclusive to children, it has special importance during childhood."[51]**

A broad interpretation of Article 8 CRC not only coincides with the purpose of the CRC, but also with other international documents, which analyze the right to identity and non-discrimination in relation to legal recognition of gender and sexual orientation and of human rights as an "alive" framework.[52]

49 Ombudsman for Children's Office, (2013). Advice of the Ombudsman for Children on the General Scheme of the Gender Recognition Bill 2013.

50 Doek, J. E. (2006). *Article 8: the right to preservation of identity; Article 9: the right not to be separated from his or her parents.* Martinus Nijhoff Publishers.

51 Inter-American Court of Human Rights Series C No 242 (2012). *Case of Forneron and daughter vs. Argentina (Merits Reparations and Costs).*

52 Organization of American States, 'Human Rights, Sexual Orientation and Gender Identity Expression' (June 2013) AG/RES. 2807 (XLIII-O/13); UNHRC 'Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity' (November 2011) A/HRC/19/41; UN HRC, 'Human rights, sexual orientation and gender identity' (July 2011) A/HRC/RES/17/19; Ombudsman for Children's Office, (n 21) 5.

Age Of Consent for the Change of Gender Markers

It is important to distinguish between the age of consent for the change of gender markers and the actual starting point of medical treatment, which is divided into psychological support, hormone blockers, gender-affirming hormones and/or gender-affirming surgeries, the latter three known collectively as gender-affirming healthcare. Some trans children or adolescents may be content with only changing gender markers legally without pursuing any access to gender-affirming healthcare. Authorities should keep in mind that children are free to determine if they want to undergo any gender-affirming healthcare or not and that they may not want to categorize themselves as either male or female but non-binary and still wish to be legally recognized as such.[53]

Due to the fact that trans children and adolescents face severe discrimination, legal gender recognition may facilitate access to several fundamental rights and should not be dependent on whether the person has undergone any hormonal or surgical treatment prior to the application for a gender marker change.[54] Thus, legal gender recognition should be separated from the actual bodily transition period. As previously mentioned, accessibility of the means to change gender markers should be based on the mere expression of the child or adolescent's intention.

Recognizing the fluidity of gender identity means acknowledging that every person has the right to choose their gender and consequently rely on documentation that permits them to identify with this choice.[55] As such, it is important that gender recognition laws allow gender markers to be changed more than once in a person's life, particularly in the case of children.

Legal recognition allows trans individuals to change their gender markers and may therefore help to reduce stigmatization and discrimination against trans individuals significantly within society.[56] This step may also benefit the psychological stability of individuals and ensure they have access to proper education, healthcare, and other human rights and similar services.[57]

53 Bucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review,* 3(1), 59-81.

54 Ibid.

55 Ibid.

56 Commissioner for Human Rights (n 12).

57 Bucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review*, 3(1), 59-81.

The next question to be addressed is how registry officials and/or authorities determine at what age a child is mature enough to self-determine their gender identity[58], considering that the procedure should be administrative.

The age at which legal gender recognition may be granted should depend on the evolving capacities of the child or adolescent and their wish to change their gender identity. It is essential to recognize that all newborns receive gender markers; in other words, every person is assigned a sex at birth based on sexual characteristics. This assignment is independent of identity or gender, characterizations unrelated to biology. Thus, every child should be allowed to change their gender markers if they want to. Refusing the change is even more of a denial of autonomy than allowing choices by those who don't have full capacity.

Having said so, to establish certain principles or bases, it could be stated that

- if a person is an adolescent, the request could be made by themselves. For a teenager, their ability to consent to this type of act should be presumed.

- If it is a child, the request should be made by them, with the consent of one of their legal representatives, and if there are no parents, it would be enough to be accompanied by an effective reference. In these cases, their ability to consent is not presumed, but their consent and the assent of a supporting person are required.

Therefore, depending on their ability to understand what the change of legal name means, they could exercise it by themselves, without the need for the consent of their representative(s), which would be discarded but would be maintained for those children who do require such consent.

58 Ibid.

Access to Gender-Affirming Healthcare

The relationship between bodily autonomy and the right to have one's physical and mental integrity respected, and their inextricable connection with legal notions of agency, has been documented by the United Nations Population Fund (UNFPA) as being fundamental to the enjoyment of all other human rights, including the right to health as described by the Committee on Economic, Social and Cultural Rights:

> "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation."[59]

The YP+10 recognizes the right to bodily and mental integrity, establishing that

> "Everyone has the right to bodily and mental integrity, autonomy and self-determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to be free from torture and cruel, inhuman and degrading treatment or punishment on the basis of sexual orientation, gender identity, gender expression and sex characteristics."

Accordingly, States shall guarantee and protect the rights of everyone, including all children, to bodily and mental integrity, autonomy, and self-determination.[60]

Medical and psychosocial care designed to affirm individuals' gender identities have been demonstrated to mitigate much of the distress that frequently accompanies a discrepancy between one's assigned sex at birth and one's gender identity. Such care appears to satisfy the principles of beneficence (the obligation to provide benefit to patients) and nonmaleficence (the avoidance of unnecessary harm). Emerging evidence suggests that a lack of access to gender-affirming care may lead to TGD youth being at greater risk of harm, including violence, sexually transmitted infections (such as HIV), depression, anxiety, and suicide.[61]

59 Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), para. 8.

60 Yogyakarta Principles "+10"

61 Kimberly, L. L., Folkers, K. M., Friesen, P., Sultan, D., Quinn, G. P., Bateman-House, A., ... & Salas-Humara, C. (2018). Ethical issues in gender-affirming care for youth. *Pediatrics*, 142(6).

Young adults who begin gender-affirming hormones following puberty blockers also report improved quality of life.[62] Following puberty, many healthcare users choose to take gender-affirming hormone therapy in the form of testosterone or estrogen, which have well-documented positive psychosocial outcomes.[63] Despite the lack of long-term data on specific clinical interventions, a recent ethical discussion concludes that "the risks of not treating trans and gender non-conforming youth are evident."[64] For TGD youth, the risks associated with the absence of gender-affirming hormones are far greater than any potential risk associated with the provision of such treatments.

A recently published study has concluded that trans adults who had access to puberty blockers had a lower risk of suicidal ideation compared to those trans adults who did not have access to puberty blockers.[65] Research consistently demonstrates that gender diverse youth who are encouraged to live and/or explore the gender role that is consistent with their gender identity have better mental health outcomes than those who are not.[66]

Alternatively, for example, the persistence of a prepubescent body habitus due to puberty suppression has been linked to decreased social inclusion for trans youth whose physical development is asynchronous to their cisgender peers.[67]

Steensma and Cohen-Kettenis report from a clinical-based sample that between 2000 and 2004, out of 121 pre-pubertal children, 3.3% had "completely transitioned" (clothing, hairstyle, change of name, and use of pronouns) when they were referred, and 19% were living in the preferred gender role in clothing style and hairstyle, but did not announce that they wanted a change in name and pronoun. Between 2005 and 2009, these percentages increased to 8.9% and 33.3%, respectively.[68]

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62 de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696–704. https://doi.org/10.1542/peds.2013-2958
Gorin Lazard, A., Baumstarck, K., Boyer, L., Maquigneau, A., Gebleux, S., Penochet, J., Pringuey, D., Albarel, F., Morange, I., Loundou, A., Berbis, J., Auquier, P., Lançon, C., & Bonierbale, M. (2012). Is hormonal therapy associated with better quality of life in transsexuals? A cross-sectional study. *The Journal of Sexual Medicine*, 9(2), 531–541. https://doi.org/10.1111/j.1743-6109.2011.02564.x

63 de Vries ALC, Ibid.

64 Kimberly, L. L., Folkers, K. M., Friesen, P., Sultan, D., Quinn, G. P., Bateman-House, A., ... & Salas-Humara, C. (2018). Ethical issues in gender-affirming care for youth. *Pediatrics*, 142(6).

65 Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics, 145(2), e20191725. https://doi.org/10.1542/peds.2019-1725

66 Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137(3).
Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of child and adolescent psychiatric nursing*, 23(4), 205-213.

67 Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "gender management service" (Gems) in a major pediatric center. Journal of Homosexuality, 59(3), 321–336. https://doi.org/10.1080/00918369.2012.653302
Shumer, D. E., Nokoff, N. J., & Spack, N. P. (2016). Advances in the care of transgender children and adolescents. *Advances in Pediatrics*, 63(1), 79–102. https://doi.org/10.1016/j.yapd.2016.04.018
Leibowitz, S. F., & Telingator, C. (2012). Assessing gender identity concerns in children and adolescents: Evaluation, treatments, and outcomes.*Current Psychiatry Reports*, 14(2), 111–120. https://doi.org/10.1007/s11920-012-0259-x

68 Cohen-Kettenis, P. T., Steensma, T. D., & de Vries, A. L. (2011). Treatment of adolescents with gender dysphoria in the Netherlands. *Child and adolescent psychiatric clinics of North America*, 20(4)

In the Dutch long-term evaluation study, it has been found that the psychological functioning of selected trans adolescents tends to improve after a staged program of puberty suppression, gender-affirming hormones, and gender reassignment surgery.[69] In this series of studies, 55 adolescents were followed up at three points in time: i) at intake, before the start of puberty suppression (mean age 13.6); ii) when gender-affirming hormones were introduced (mean age 16.7); and iii) at least one year after gender reassignment surgery (mean age 20.7). No adolescent withdrew from puberty suppression, and all started gender-affirming hormones. Their psychological functioning improved steadily over time, resulting in rates of clinical problems that were indistinguishable from general population samples (e.g., numbers in the 'clinical' range dropped from 30% to 7% on the Youth Self Report (YSR) and 38% to 5% on the Child Behavior Checklist (CBCL). Quality of life, satisfaction with life, and subjective happiness were comparable to same-age peers.

Any exploration of gender expressions and trajectories other than gender related to sex assigned at birth is not necessarily related to an experience of suffering or conceptualized as a disease, disorder, or condition in need of medical attention. Although, in some cases, children with gender expressions, trajectories, and identities that differ from the gender assigned at birth may require psychological and social counseling about the process of exploring gender expressions or experiences of discrimination, as do their parents and other people who belong to their close social environment, the truth is that for this type of support, a specific category in the ICD would not be necessary, but rather the availability of professionals with a non-pathologizing approach that is open to gender diversity.

It is argued that

> "diagnosing children with diverse genders only because of who they are and how they express themselves reinforces and institutionalizes cissexism and transphobia in psycho-medical matters and in society as a whole."[70]

69 de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics,* 134(4), 696–704. https://doi.org/10.1542/peds.2013-2958

70 Cabral, M., Suess, A., Ehrt, J., Seehole, T. J., & Wong, J. (2016). Removal of gender incongruence of childhood diagnostic category: A human rights perspective. *The Lancet Psychiatry*, 3(5), 405–406. https://doi.org/10.1016/S2215-0366(16)30043-8

Different scientific evidence shows high rates of anxiety and depression in children diagnosed with "gender dysphoria."[71] On the other hand, normative levels of depression and only minimal elevations in anxiety are found in children who can transition socially.[72]

Many reputable professional organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Pediatrics, and the Endocrine Society, which represent tens of thousands of professionals across the United States, have published clinical guidance that promotes non-discriminatory, supportive interventions for gender diverse youth based on the current evidence base. These interventions may include, and are not limited to, social gender transition, hormone-blocking agents, hormone treatment, and affirmative psychotherapeutic modalities.

For example, the American Academy of Pediatrics (AAP)[73] works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. According to the AAP, any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends the following:

1. that youth who identify as transgender and gender diverse (TGD) have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space;

2. that family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD;

71 Winter, S., Ehrensaft, D., Pickstone-Taylor, S., De Cuypere, G., & Tando, D. (2016). The psycho-medical case against a gender incongruence of childhood diagnosis. *The Lancet Psychiatry*, 3(5), 404-405.
Cabral, M., Suess, A., Ehrt, J., Seehole, T. J., & Wong, J. (2016). Removal of gender incongruence of childhood diagnostic category: A human rights perspective. *The Lancet Psychiatry*, 3(5), 405–406. https://doi.org/10.1016/S2215-0366(16)30043-8
Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., & Wylie, K. (2016). Transgender people: Health at the margins of society. *The Lancet*, 388(10042), 390–400. https://doi.org/10.1016/S0140-6736(16)00683-8
Winter, S., Settle, E., Wylie, K., Reisner, S., Cabral, M., Knudson, G., & Baral, S. (2016). Synergies in health and human rights: a call to action to improve transgender health. *The Lancet*, 388(10042), 318-321.
Winter, S., Riley, E., Pickstone-Taylor, S., Suess, A., Winters, K., Griffin, L., ... & De Cuypere, G. (2019). The "gender incongruence of childhood" diagnosis revisited: a statement from clinicians and researchers. 2016.

72 Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics,* 137(3).

73 Rafferty, J., COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON ADOLESCENCE, SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS, Yogman, M., Baum, R., Gambon, T. B., Lavin, A., Mattson, G., Wissow, L. S., Breuner, C., Alderman, E. M., Grubb, L. K., Powers, M. E., Upadhya, K., Wallace, S. B., Hunt, L., Gearhart, A. T., Harris, C., ... Sherer, I. M. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, 142(4), e20182162. https://doi.org/10.1542/peds.2018-2162

3. that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts;

4. that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions;

5. that provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families

6. that pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression;

7. that pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence;

8. that the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression; and

9. that the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD.

To sum up, if one considers that forcing children to live in circumstances in which they have decided they do not wish to live is cruel and inhuman, then not allowing trans children and adolescents to undergo gender-affirming healthcare to live the life they wish should be classified similarly. If not providing care for gender-variant adults is unacceptable, the same should apply to children and adolescents. Thus, they should be allowed access to gender-affirming healthcare if they wish, as is in their best interest. Children who are not able to undergo gender-affirming healthcare may feel even more mentally distressed once they reach puberty and experience body changes that they don't desire and are incongruent with their gender expression.[74]

74 Bucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review,* 3(1), 59-81.

Access to Health

Trans youth must have access to healthcare and be able to attain the highest standard of health as a state of "complete physical, mental and social well-being and not only the absence of disease or infirmity."[75]

Article 24 CRC does not ask State parties to ensure the right to health but the highest attainable standard of health. In this context, health is more than not having an illness; it is the best possible mental or physical condition a person can have. According to the Declaration of Alma-Ata 1978, health is a state of "complete physical, mental and social wellbeing" that should permit individuals to lead socially and economically productive lives. Many groups of children are overlooked in the development of healthcare programs. One of these groups is trans children and adolescents. According to the Council of Europe, trans children and adolescents face obstacles when they try to access trans-specific healthcare and support services before they reach the age of majority.[76]

The obligation of Article 24 of the CRC, which recognizes the right of children to the highest attainable standard of health, must be read in conjunction with Article 2 on non-discrimination, prohibiting States from offering children a health service less adequate than other children because of their sexual orientation, gender identity/expression or sex characteristics. In General Comment No. 15,[77] concerning the right to health, the Children's Committee states that to fully realize the right to health for all children, State parties

75 World Health Organization. (1946). Preamble to the Constitution of WHO

76 Commissioner for Human Rights of the Council of Europe, 'LGBT children have the right to safety and equality', Human Rights Comment (October 2014) http://www.coe.int/hu/web/commissioner/blog/-/asset_publisher/xZ32OPEoxOkq/content/lgbti- children-have-the-right-to-safety-and- equality?_101_INSTANCE_xZ32OPEoxOkq_languageId=en_GB accessed 3 March 2017.

77 Committee on the Rights of the Child (2013).

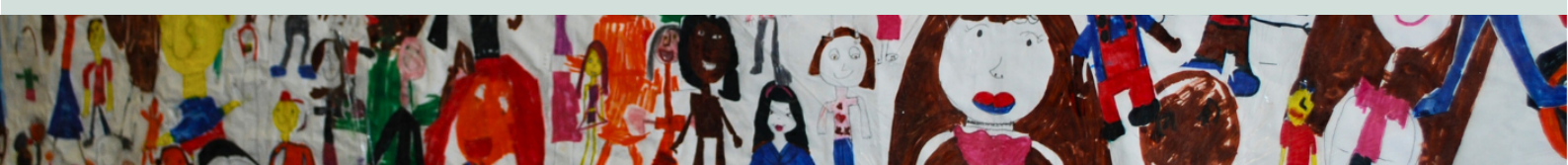
have an obligation to ensure that children's health is not undermined as a result of discrimination, which contributes to vulnerability. The Committee explicitly mentions discrimination based on sexual orientation and gender identity. This understanding is also in line with Yogyakarta Principle 17, which in relation to trans rights, provides that States shall facilitate access to competent, non-discriminatory treatment, care, and support for those seeking gender-affirming healthcare.

The following must all be taken into consideration in all decisions concerning the health of the child: CRC Article 3 concerning the best interest of the child, Article 16 concerning the child's right to private life, and Article 12 concerning the obligation to respect the view of the child. For health questions concerning gender identity and intersex children, the right to health must also be read in conjunction with Article 8 about the right of the child to develop its identity.

When discussing what obligation the State has under Article 24, it is vital to take into consideration that Article 4 of the CRC permits States the opportunity to fulfill the obligation progressively and that the resources of the State should be taken into consideration.

That being so, states should take measures to ensure that everyone can enjoy the highest attainable standard of health without discrimination on the grounds of gender identity. A way to achieve this is by including the needs of trans children and adolescents in the development of national healthcare plans. States should take further appropriate measures to ensure that trans children and adolescents have adequate access to appropriate trans health care, provided that the public health insurance covers all expenses.[78]

78 Eide and Barth Eide (n 38) 27, 28.



Age Of Consent for Gender-Affirming Healthcare

Defining the ability of children and adolescents to consent to medical treatment has raised a contentious debate among scholars.[79] In England and Wales, adolescents aged 16 and over are deemed by law to be competent to consent to any medical or surgical treatment.[80] For children and adolescents aged under 16, the standard approach of determining when their control over their own body begins is by looking at the case of Gillick v West Norfolk and Wisbech Area Health Authority, in which it was held that competence to consent is for children task- and not age-specific.[81] According to the Gillick competence test, once children and adolescents under 16 years of age have "sufficient understanding and intelligence" to enable them to fully understand the nature and consequences of the proposed treatment, then the decision to undergo treatment should lie within their power and not that of their parents. The Gillick test has been mostly adopted internationally as the standard by which children and adolescents can be determined competent to consent to their medical treatment. The standard adopted fits with the evolving character of the CRC.[82]

From a legal standpoint, competence to make medical decisions is typically recognized as a multifactorial and fluid construct; in the absence of a reliable approach to applying the construct in practice, many countries still default to age-based thresholds.[83] The World Health Organization defines adolescents as individuals between the ages of 10 and 19 years.[84] However, most countries recognize 18 years as the threshold for full decision-making rights, and thresholds for involvement in decision-making for younger adolescents and children vary greatly. Groups such as the International Committee on the Rights of the Child have sought to focus instead on the capacity for understanding as a condition of consent, referring to evolving capacities for self-determination to describe one's ability to participate in medical decision-making during adolescence.[85]

79 See in this matter Van Bueren (n 46), Melinda Jones, (n 102) 129, 132.

80 Family Law Reform Act, 1969 s 8(1).

81 Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 para 189.

82 Bucataru, A. (2016). Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition. *Queen Mary Human Rights Review*, 3(1), 59-81.

83 Hein, I. M., De Vries, M. C., Troost, P. W., Meynen, G., Van Goudoever, J. B., & Lindauer, R. J. (2015). Informed consent instead of assent is appropriate in children from the age of twelve: Policy implications of new findings on children's competence to consent to clinical research. *BMC medical ethics,* 16(1), 1-7.

84 World Health Organization. (n.d). Health topics: adolescent health. 2018. Adolescent health. https://www.who.int/health-topics/adolescent-health

85 Dickens, B. M., & Cook, R. J. (2005). Adolescents and consent to treatment. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics,* 89(2), 179–184. https://doi.org/10.1016/j.ijgo.2005.01.038

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood.[86] Multiple developmental processes occur simultaneously, including pubertal-signaled changes. Cognitive, emotional, and social systems mature, and physical changes associated with puberty progress. These processes do not all begin and end at the same time for a given individual, nor do they occur at the same age for all persons. Therefore, the lower and upper borders of adolescence are imprecise and cannot be defined exclusively by age. For example, physical pubertal changes may begin in late childhood and executive control neural systems continue to develop well into the mid-20s.[87] There is a lack of uniformity in how countries and governments define the age of majority (i.e., legal decision-making status).

While many specify the age of majority as 18 years of age, in some countries it is as young as 15 years (e.g., Indonesia and Myanmar), and in others as high as 21 years (e.g., the U.S. state of Mississippi and Singapore).[88]

It should be noted that the age of consent to medical treatments without parental consent varies across the European Union, with roughly 35% of members requiring the age of majority (18 years old), 40% ranging from 14 to 16 years old, and the remaining considering maturity rather than a strict age cut-off.[89]

In clinical practice, a wide variance exists in an individual child's or adolescent's capacity to understand the risks, benefits, and consequences of a particular medical treatment or procedure. WPATH and AAP guidelines suggest that an adolescent's decision-making capacity should be honored unless there are concerns surrounding the ability to do so.[90] These include the adolescent's lack of ability to understand the ramifications of medically assisted gender transition such as potential side effects and irreversible effects of treatment, or having unrealistic expectations surrounding the medication's effect.[91]

86 Sanders, R. A. (2013). Adolescent psychosocial, social, and cognitive development. *Pediatrics In Review,* 34(8), 354–359. https://doi.org/10.1542/pir.34.8.354

87 Ferguson, H. J., Brunsdon, V. E. A., & Bradford, E. E. F. (2021). The developmental trajectories of executive function from adolescence to old age. *Scientific Reports*, 11(1), 1382. https://doi.org/10.1038/s41598-020-80866-1

88 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health,* 23(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

89 Data and maps. (n.d.). European Union Agency for Fundamental Rights. Retrieved 27 October 2022, from https://fra.europa.eu/en/publications-and-resources/data-and-maps

90 Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., … Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13(4), 165–232. https://doi.org/10.1080/15532739.2011.700873

91 Ibid.

Importantly, a diagnosis of "gender dysphoria" is not considered a legitimate reason to doubt an adolescent's decision-making capacity.[92]

WPATH, EPATH,[93] USPATH, AsiaPATH, CPATH, AusPATH, and PATHA recommend that capacity to consent is evaluated on a case-by-case basis by the treating clinician.[94] The Australian Standards of Care and Treatment Guidelines (ASOCTG)[95] aim to maximize quality care provision to trans and gender diverse children and adolescents across Australia, whilst recognizing the unique circumstances of providing such care to this population.

To sum up and to provide some bases, considering the constitutional principles *pro persona and pro minoris*, the rule should be that adolescents who are mature enough, and according to their evolving capacities are considered "adults for decisions regarding their own body," should be able to consent to gender-affirming healthcare.

Although, according to the type of intervention, the rule must be adjusted: practices such as surgeries or cross-hormonal treatments can be requested by the adolescent with the assistance of people who exercise care roles and accompany the process.

The reproductive rights of people accessing gender-affirming healthcare must be respected. For this reason, it is essential that they receive complete information on the effects that such interventions can produce concerning fertility to guarantee freedom of decision-making regarding both sexual and reproductive rights. Then fertility preservation information and counseling should be provided to all children or adolescents prior to the commencement of puberty suppression or gender-affirming hormones.[96] This will need to be tailored to the developmental stage of the children or adolescents[97], especially for those who are in the early stages of puberty and have a limited understanding of reproductive biology.

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92 Dubin, S., Lane, M., Morrison, S., Radix, A., Belkind, U., Vercler, C., & Inwards-Breland, D. (2020). Medically assisted gender affirmation: when children and parents disagree. *Journal of Medical Ethics,* 46(5), 295-299.

93 EPATH. (2020). Joint statement regarding medical affirming treatment including puberty blockers for transgender adolescents. https://epath.eu/joint-statement-regarding-medical-affirming-treatment-including-puberty-blockers-for-transgender-adolescents/

94 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health,* 23(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

95 Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *Medical Journal of Australia,* 209(3), 132-136.

96 Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., … & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869-3903.

97 Finlayson, C., Johnson, E. K., Chen, D., Dabrowski, E., Gosiengfiao, Y., Campo-Engelstein, L., … & Woodruff, T. K. (2016). Proceedings of the working group session on fertility preservation for individuals with gender and sex diversity. *Transgender Health,* 1(1), 99-107.

In general, no matter the age at which people have their capacities to produce gametes altered, it is presumptively desirable to preserve the option of having genetically related children later unless that option is specifically waived.[98]

Thus, it is important for Artificial Reproductive Techniques laws to regulate healthcare coverage of the cryopreservation of gametes or tissues for trans people. This requirement was explicitly recognized by the Yogyakarta Principles, which stated that States shall: "take all necessary measures to ensure the right to found a family, including through access to adoption or assisted procreation (including donor insemination), without discrimination on the basis of sexual orientation or gender identity."

More recently, to the right to found a family, the YP+10 added the State obligation to:

> "Enable access to methods to preserve fertility, such as the preservation of gametes and tissues for any person without discrimination on grounds of sexual orientation, gender identity, gender expression, or sex characteristics, including before hormonal treatment or surgeries."

Despite its importance, there are no definite practice guidelines for fertility preservation for trans persons.[99]

Lastly, trans health care implicates privacy and adolescent well-being concerns in similar ways as contraceptive access, STI testing, mental healthcare, and substance abuse care. The existence of legal carve-outs to parental consent for these latter forms of care supports the need for legislatures to adopt similar legislation creating carve-outs for trans health care.[100]

98 Murphy, T. F. (2019). Adolescents and body modification for gender identity expression. *Medical Law Review,* 27(4), 623–639. https://doi.org/10.1093/medlaw/fwz006

99 Rothenberg, S. S., Witchel, S. F., & Menke, M. N. (2019). Oocyte cryopreservation in a transgender male adolescent. *New England Journal of Medicine*, 380(9), 886–887. https://doi.org/10.1056/NEJMc1813275

100 Dubin, S., Lane, M., Morrison, S., Radix, A., Belkind, U., Vercler, C., & Inwards-Breland, D. (2020). Medically assisted gender affirmation: when children and parents disagree. *Journal of Medical Ethics,* 46(5), 295-299.

Conclusions

Respect for the human rights of trans and gender diverse youth in all aspects of their life must be assured. The States' duty should be to provide legal access to legal gender recognition and gender-affirming healthcare.

The best interest of the child, the principle of evolving capacities, the right to health, and the depathologization of trans childhood must be considered fundamentally in deciding when to allow children and adolescents to access change of gender markers and gender affirming healthcare.

The increasing numbers of young people seeking assessment for issues related to gender identity indicate that increased knowledge in this area is essential.

States must take all appropriate legislative, administrative, and other measures to realize and monitor the human rights of trans and gender diverse children and adolescents. To this end, States parties should notably fulfill the following obligations:

"(a) To ensure a holistic approach within the education system so that educational workers and students are aware of what sex, gender, gender identity and expression, and trans and gender diverse identities are and to ensure that trans youth can learn in an environment free of discrimination and verbal abuse.

(b) To create a safe and supportive environment for trans and gender diverse children and adolescents, including within their family, in schools, in all types of institutions in which they may live, and in society at large;

(c) To renounce the requirement of sex on identity documentation. If gender markers are to remain a requirement, future legislation should allow TGD youth to change them by the provision of consent. The procedure should be administrative, requiring only an expression of intent, judged on the individual's evolving capacities.

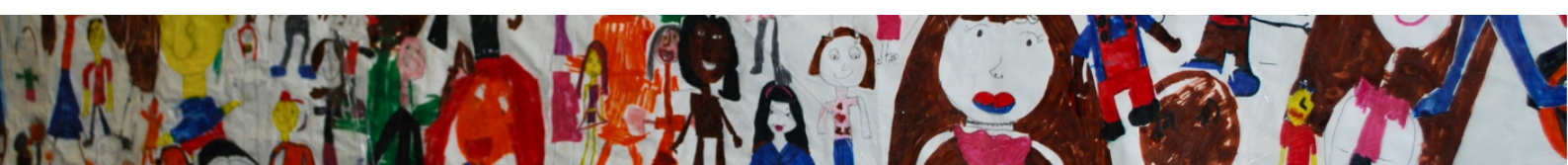
(d) To ensure that trans and gender diverse children and adolescents have access to the information essential for their access to change gender markers and gender-affirming healthcare and receive an appropriate informed consent process.

(e) To improve future legislation by allowing more freedoms to children and adolescents to change gender identity and undergo gender-affirming healthcare.

(f) To ensure that trans and gender diverse children and adolescents participate and decide according to their evolving capacities their access to gender-affirming healthcare (notably through informed consent and the right of confidentiality)

(g) To ensure that trans and gender diverse children and adolescents have access to health and development, to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behavior choices; Furthermore, trans children and adolescents should have free access to psychological and legal counseling, when required, as well as other health-care facilities.

(h) To ensure that trans and gender diverse children and adolescents have access to sexual and reproductive health, including the right to conserve gametes and tissues."



Under Articles 24, 39 and other related provisions of the CRC, State parties should provide health services that are sensitive to the particular needs and human rights of trans and gender diverse children and adolescents, paying attention to the following characteristics:

> ***"(a) Accessibility. Identity documentation, body modifications, health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all trans and gender diverse children and adolescents, without discrimination.***
>
> ***(b) Acceptability. Identity documentation, body modifications, all health facilities, goods and services should be gender sensitive, be respectful of medical ethics and be acceptable to trans and gender diverse children and adolescents.***
>
> ***(c) Quality. Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for trans and gender diverse children and adolescents, adequate facilities and scientifically accepted methods."***

In closing, trans children should be afforded more than just protection; trans and gender diverse youth should have access to trustworthy treatment, autonomy, and responsibility. The transition period in a trans child's life is when it is crucial that their agency be respected, and their autonomy honored.

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