THE LEGAL POSITION REGARDING THE BEST INTERESTS OF THE CHILD IN GENDER REASSIGNMENT DECISIONS IN SOUTH AFRICA

by

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The legal position regarding the best interests of the child in gender reassignment decisions in South Africa

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ABSTRACT

Although the recent concepts 'gender dysphoria' (according to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, 2022) and 'gender incongruence' (as defined in the World Health Organization's 2022 International Classification of Diseases, ICD-11) may seem to refer to recent phenomena, research has shown that gender diversity has affected individuals since the earliest times. Recent years have seen a rapid increase in the number of adolescents and children diagnosed with gender dysphoria. The prevalence of gender dysphoria is also reflected in growing public attention and fierce debates regarding gender reassignment procedures. Despite opposition to the procedures, an increased acceptance of gender diversity in some parts of the world has been noted, accompanied by the emergence of adolescent gender affirming health care and the establishment of gender responsive health services. Not all adolescents affected by gender dysphoria are able to express their gender incongruence from an early stage, often leading to feelings of social alienation, anxiety and depression. Past medical practices, as this thesis shows, have created unintended barriers to care for gender-diverse adolescents. Adolescents and children were initially not incorporated in clinical practice guidelines and standards of care issued by the World Professional Association for Transgender Health (WPATH), an international body that sets the standards of care for transgender medicine. In recent years, WPATH has recommended medical interventions for adolescents and children with gender incongruence. This is because delaying or minimising such medical interventions may prolong the manifestation of gender dysphoria in adolescents and children. Early intervention has been found to have a positive effect on the psychological well-being and social functioning of these children, as well as establishing an external physical appearance more closely aligned with their gender identity. Despite the recommendation of early medical intervention, the optimal age of introducing gender-affirming therapies remains a contested issue in this sensitive field of medicine and law.

The thesis identifies several legal challenges obstructing adolescents' access to gender affirming health care in South Africa. Drawing on a comparative legal overview of both proactive and restrictive approaches regarding the provision of gender affirming care in Australia, the United Kingdom, New Zealand, Canada and Denmark, the thesis postulates that the current South African legal framework governing gender affirming health care fails to meet the bests interests of children and adolescents suffering from gender dysphoria. In order to address this, the thesis first explores, through the lens of the best interests of children, different perspectives regarding children and adolescents' informed consent to gender affirming health care. Secondly, the thesis concludes with sound recommendations informed by the legal comparative analysis, which provides a firm foundation for the consideration of children and adolescents' access to gender affirming health care. This foundation will promote ongoing civil discourse and deliberative dialogue toward better shared decision-making in adolescent gender affirming health care and beyond. In the final instance, the thesis demonstrates how access to gender affirming health care services must be grounded in a human rights discourse, strengthened by the application of the yardstick of the best interests of the child.

KAKARETSO

Dikgopolotaba tsa moraorao e leng ‘masisapelo a tliswang ke bong ba tlhaho le bong bo fapaneng le bong ba motho ba boitsebiso’ (ho ya ka 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders, 2022) le ‘bong ba tlhaho bo sa dumellaneng le bong ba motho ba boitsebiso’ (jwalo ka ha ho hlaloswa ke World Health Organisation’s 2022 International Classification of Diseases, ICD-11) eka di bua ka diketsahalo tsa matsatsing a jwale, feela diphuputso di bontsha ha phapano ya bong e le tlhobaboroko ho batho ho tloha sethathong. Sesosa sa bokudi, e leng masisapelo a tliswang ke bong ba tlhaho le bong bo fapaneng ba motho ba boitsebiso, se atile ka sekgahla dilemong tsa jwale dipalong tsa bana le batjha. Ketsahalo ena e hlalositsweng ka hodimo e iponahatsa ka tsela eo setjhaba se tsepamisitseng maikutlo le dingangisano tse matla mabapi le oporeishene tse fetolang bong. Ho hlokometswe ho eketseha ha mafatshe a amohelang bong bo fapaneng, mme ho tsamaya mmoho le ho ropoha ha ditshebeletso tsa bophelo tse tshehetsang batjha le ho thehwa hwa ditshebeletso tsa bophelo tse arabelang bong ba motho, le ha ba bang ba le kgahlanong le tsona. Ha se batjha bohle ba anngwang ke masisapelo a tliswang ke bong ba tlhaho le bong bo fapaneng ba motho ba boitsebiso, ba kgonang ho hlalosa bong ba tlhaho bo sa dumellaneng le bong ba motho ba boitsebiso ba sa le banyane, mme sena se lebisa ho maikutlo a ho kgetholleha setjhabeng, ngongoreho le kgatello ya maikutlo. Ditlwaelo tsa bophelo tsa kgale, jwalo ka ha thesese ena e bontsha, di bakile dithibella tsa tlhokomelo tseo e seng tsa ka boomo ho hlokomeleng batjha ba bong bo fapaneng. Ho tloha sethatong, batjha le bana ba ne ba sa kenyelletswa ditataisong tsa ditshebeletso tsa bongaka le boemong ba tlhokomelo bo nehelanweng ke World Professional Association for Transgender Health (WPATH), e leng mokgatlo wa matjhabatjhaba o thehang boemo ba tlhokomelo bitsong la meriana ho ba fetolang bong. WPATH e kgothalleditse bonamodi ba bongaka bitsong la batjha le bana ba nang le bong ba tlhaho bo sa dumellaneng le bong ba motho ba boitsebiso dilemong tsa jwale. Lebaka ke hore tiehiso kapa ho nyenyefatsa ha bonamodi bona ba bongaka bo ka atolosa boiponahatso ba bong ba tlhaho bo sa dumellaneng le bong ba motho ba boitsebiso ho batjha le bana. Ho ile ha fumaneha hore bonamodi bo nakong bo na le ditlamorao tse ntle maemong a bana bana a kelello le tshebetsong ya phedisano, le hona ho thehweng ha tjhebeho e kantle ya sebopeho sa mmele e tshwanang le bong ba bona ba boitsebiso. Ntle le dikgothalletso tsa bonamodi ba bongaka bo

etswang nako e sa le teng, dilemo tse dumellesehang tsa ho kenya tshebetsong theraphi e tshehetsang bong e ntse e le taba e lwanelwang maemong ana lekaleng la bongaka le molao.

Thesese e hlwaya dikgwehlo tse mmalwa tse thibellang batjha ho fumana tlhokomelo ya bophelo e netefatsang bong Aforika Borwa. Thesese e sisinya hore motheo wa semolao wa Aforika Borwa wa jwale o laolang tlhokomelo ya bophelo e netefatsang bong e hloleha ho ananela dikgahlehelo tse bohlokwa tsa bana le batjha ba nang le bong ba tlhaho bo sa dumellaneng le bong ba motho ba boitsebiso, ka ho bapisa tjhebeho tsa Australia, United Kingdom, New Zealand, Canada le Denmark, tsa semolao tsa katamelo e nang le dipehelo le e se nang dipehelo sepheong sa tshebeletso e netefatsang bong. Ho phenyekolleng sena, thesese e lekotse dikgahlehelo le tumello e nang le tsebo ya tshebeletso ya bophelo e netefatsang bong ba bana le batjha pele, Bobeding, thesese e phethela ka dikgothalletso tse tsepameng ho manollo le papiso ya semolao eo e leng motheo wa tshekatsheko ho ananelweng hwa bana le batjha ho fihlelleng ditshebeletso tsa bophelo. Motheo ona o tla kgothalletsa dipuisano setjhabeng le dingangisano tsa maikemisetso tse tswellang pele e le ho nka diqeto tse kopanetsweng ditabeng tsa ditshebeletso tsa bophelo tse netefatsang bong ba batjha ho ya ho ile. Qetellong, thesese e bontsha hore ho fihlella ditshebeletso tsa bophelo tse netefatsang bong di tshwanetse ho thehwa dipuisanong tsa ditokelo tsa botho mme di tshehetswe ka ho sebedisa dikgahlehelo tse bohlokwa tsa ngwana.

ISIFINGQO

Nakuba kunezimvo ezahlukene ngenxa yengcindezi yokwehluka kwemizwa nobulili (njengokwethula kwesishicilelo sesi-5 Somqulu Wamanani Okuxilongwa Kwezifo Zengqondo sezi-2022) kanye nempicabadala ngobulili (njengokuchaza Kwenhlangano Yezempilo Yomhlaba ohlelweni lwesifo lomhlaba onyakeni wezi-2022, i-ICD-11) okubukeka kuqondiswe esimweni sakamuva socwaningo esiveza ukuthi ukwehluka kobulili sekubalimaze kanjani abantu ngabodwana kulesi sikhathi. Kule minyaka esanda kudlula kube nokunyuka okukhulu kubantwana abasemabangeni okukhula abaxilongwe batholakala bekule mpicabadala yobulili. Ukukhula kwale mpicabadala ibonakala emiphakathini nasezingxoxweni ezivutha uphondo mayelana nobulili nengqubo ehambisana nabo. Noma kukhona ukungaboni ngasolinye kulezi zingqubo, ukukhula kwabemukelayo ukwehluka kwabantu ngezinhlobo zokuzikhethela ubulili kuyaqapheleka emhlabeni jikelele, kuhambisana nokuvumbuka kwabantu abaqinisekisa nanezempilo ezeseka ukwamukelwa kwezinhlobo zobulili ezahlukene emkhakheni wezempilo. Akubona bonke abantwana abasebangeni lokukhula abathintekayo kule mpicabadala yobulili, abanye basheshe babonakale besebancane ukuthi bayiluphi uhlobo lobulili, nokuthi imizwa yabo ingakuluphi uhlangothi, noma bazibona bengena ngaphansi kwamaphi amaqembu emphakathini, okumbandakanya ukukhathazeka nokucindezeleka. Ezokwelapha zesikhathi esidlule nemiqulu yocwaningo esibhalilwe isiveze imingcele edinga ukuqashelwa ngokwehluka kwezinhlobo zobulili kubantwana abasebangeni lokukhula. Abantwana abasebangeni lokukhula nabantwana nje bonke bebengafakiwe ezinhlelweni zokwelapha ezinemihlahlandlela nezimiso zokunakekela ezikhishwe Inhlangano Yezemikhakha Yomhlaba Yokuguqulwa Kobulili Yezempilo (i-WPATH), lena inhlangano yomhlaba ebeka izimiso zokunakekeleka nezokwelashwa kokuguqulwa kobulili. Eminyakeni esanda kudlula i-WPATH ilethe iziphakamiso zokungenelela kwezokwelasha kubantwana abasebangeni lokukhula nabantwana basebancane abanobulili obunesidingo sokuqondiswa. Lokhu kunonembe lokuhamba ngonyawo lonwabu noma ukuba mbalwa kwamathuba okwelashwa okwenza impicabadala yobulili iqhubekele phambili kubantwana abasebangeni lokukhula nasebantwaneni abasebancane. Ukungenelela kusesemabangeni aphansi okukhula kutholakale kunomphumela omuhle ekwelekeleleni umqondo nobuyena umntwana, nokwamukeleka kwakhe emphakathini kanjalo nokwakhekha kwezicubu zomzimba ezihambelana nobulili abuncamelayo nazizwa eyiyona umntwana. Ngaphandle kwezincomo zokungenelela kwabezokwelapha umntwana esemncane, kunebanga umntwana okufanele uma esefike kulona akwazi ukuzibona emukeleka ebulilini obuthize ngokwenziwa kwezinhlelo ezelekelelayo okugcine kuwudaba olusabhungwa futhi olubucayi emikhakheni yezomthetho neyezempilo.

Lo mqulu wocwaningo uhlonze izinselelo ezimbalwa zezomthetho ezigqashula izibopho zokufinyelela kubantwana abasebangeni lokukhula abadinga ukwelekelelwa ukuze baqiniseke ubulili babo ngokwezempilo eNingizimu Afrikha. Ukuhogela imikhondo ekuqhathanisweni kwesendlalelo somthetho nalokho kokubili, ukulungiselela kusenesikhathi nezimiso ezinqabayo mayelana nokuhlelelwa kokuqinisekisa ubulili ngokuqaphela e- Australia, eNgilandi, e-New Zealand, e-Canada naseDenmark, lo mqulu wocwaningo unikeza imibandela yezivumelwano zokuthi ezomthetho zaseNingizimu Afrikha zibe nesisekelo esilawula ukuqinisekisa kobulili ngokwezokwelashwa nokunakekela okuhambisana nezifiso zabantwana abasebangeni lokukhula abanenselelo yale mpicabadala yobulili. Ukuze kuzanywe isixazululo, lo mqulu wocwaningo uqala ngokuhlola usebenzisa izinjulakuhlola ezihambisana nezifiso zabasemabangeni okukhula, ubheka nezimvume nokwelashwa nokunakekelwa. Okunye lo mqulu wocwaningo uphetha ngokwethula iziphakamiso eziya emkhakheni wezomthetho oqhathanisa ukuhlaziya okuyikona okunikeza isisekelo esinzulu ngokulandelwa kwendlela yokufinyelela kubantwana abasebangeni lokukhula ukufinyelela ekwelashweni okumayelana nokuqinisekisa kobulili nokwelashwa. Lesi sisekelo sizophumelelisa izingxoxo ezinohlonze nemibono eqhubezela phambili ukwabelana ngezimvo nokuthatha izinqumo ngabantwana abasemabangeni okukhula ukufinyelela ekwelashweni okumayelana nokuqinisekisa ubulili, ukwelashwa nokuqhubekela phambili. Ngasekuphethweni lo mqulu wethula ukuthi kungafinyelelwa kanjani ekwelashweni okumayelana nokuqinisekiswa kobulili nokwelashwa okuhambisana nezinsizakusebenza okumele zesekwe ngamalungelo abantu, kuqiniswe nangokwethulwa kwenkombandlela ebeka izidingo zabantwana phambili.

Acronyms/ abbreviations

ACRWC	African Charter on the Rights and Welfare of the Child
Alteration Act	Alteration of Sex Description and Sex Status Act 49 of 2003
ANC	African National Congress
AU	African Union
Australian guidelines	Australian Standards of Care and Treatment Guidelines
CBO	Community-based organisations
CESCR	United Nations Committee on Economic, Social and Cultural Rights
Children's Act	Children's Act 38 of 2005
CODESA	Convention for a Democratic South Africa
Constitution	Constitution of the Republic of South Africa, 1996
CPATH	Canadian Association for Transgender Health
CTPA	Choice on Termination of Pregnancy Act
DHSS	Department of Health and Social Security
DSD	Disorder of sex development
DSM	Diagnostic and Statistical Manual of Mental Disorders
GASA	Gay Association of South Africa
GAHC	Gender Affirming Health Care
Geneva Declaration	Geneva Declaration on The Rights of the Child
GIDS	Gender Identity Development Service
GLOW	Gay and Lesbian Organisation of Witwatersrand
GnRHa	Gonadotropin-releasing hormone agonist
HCCA	Health Care Consent Act
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HRC	Human Rights Council
HRT	Hormone Replacement Therapy
ICCPR	International Covenant on Civil and Political Rights
ICD	International Classification of Diseases
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual and others

MCA	Mental Capacity Act
MDM	Mass Democratic Movement
NCGLE	National Coalition for Gay and Lesbian Equality
NGO	Non-governmental organisation
NHA	National Health Act
NHI	National Health Insurance
NHS	National Health Service
PATHSA	Professional Association for Transgender Health Aotearoa
PATHSA	Professional Association for Transgender Health South Africa
PBs	Puberty blockers
PBT	Puberty-blocking treatment
POPIA	Protection of Personal Information Act
PrEP	Pre-Exposure Prophylaxis
PsySSA	Psychological Society of South Africa
QMMG	Quality Management Maturity Grid
RECs	Research ethics committees
SGD	Sexuality and Gender Division
SAGCP 2020	South African Good Clinical Practice
SAHCS	Southern African HIV Clinicians Society
SAHRC	South African Human Rights Commission
SALC	South African Law Commission
SALRC	South African Law Reform Commission
SOC	Standard of Care
SOCIESC	Sexual orientation, gender identity, gender expression and sex characteristics
UDHR	Universal Declaration of Human Rights
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations International Children's Emergency Fund
Yogyakarta Principles	Principles on the application of international human rights law in relation to sexual orientation and gender identity
WGSDSH	Working Group on the Classification of Sexual Disorders and Sexual Health
WHO	World Health Organization

WPATH	World Professional Association for Transgender Health

Table of contents

CHAPTER 1: INTRODUCTION

1.1 Introduction

> Children clearly have been disadvantaged by a rights theory premised upon capacity. The incapacities of children and their concomitant need to be protected from themselves and others permit the state to restrict the activities of children in ways that would be impermissible in the case of adults. Furthermore, these incompetencies suggest that the rights children do have are somehow different, less fundamental, and more easily overridden by paternalistic concerns for the safety and well-being of children. Consequently, the courts have authorized significant restrictions on the liberty interests of children as legitimate protective measures. Nevertheless, our laws may subject children to selective and discriminatory laws with concomitantly greater restrictions on their liberty than would be sanctioned in the case of adults.[1]

South Africa in ratifying the United Nations Convention on the Rights of the Child (UNCRC), 1989, assumed the obligation to:

> [t]ake all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.[2]

The ratification has brought about a significant change because the norms and principles in the UNCRC have to some extent found their way into the South African constitutional provisions, and the Children's Act 38 of 2005.[3] However, the application of legislation, policies and programmes addressing children's rights continue to be fragmented.

The Constitution of the Republic of South Africa, 1996,[4] is considered to be one of the most progressive legal documents because of its extensive Bill of Rights.[5] However, people who are experiencing gender dysphoria,[6] including, lesbian, gay, bisexual,

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[1] Katherine Hunt Federle, 'Rights flow downhill' (1994) 2 International Journal of Children's Rights 343-368 <https://doi.org/10.1163/157181894X00240> accessed on 23 November 2022.

[2] Article 2 of the UNCRC.

[3] Hereinafter referred to as the Children's Act.

[4] Hereinafter referred to as the Constitution.

[5] Chapter 2 of the Constitution.

[6] Gender dysphoria is a term that describes a psychological distress experienced by a person whose sex assigned at birth does not match their gender identity. People with gender dysphoria may experience severe emotional and psychological distress if they are not able to express their experienced gender and/or if they do not receive the support and acceptance they need. See Marta R Bizic, 'Gender Dysphoria: Bioethical Aspects of Medical Treatment' [2018] Biomed Research International 1 <https://doi.org/10.1155/2018/9652305> accessed on 23 November 2022.

transgendered and queer/questioning, intersex, asexual and other gender and sexual identities (LGBTQIA+), have remained largely marginalised and silenced by society. The marginalisation of the LGBTQIA+ community is mostly discriminatory, gender binary and prescriptive. The reality is that the application of the Bill of Rights as entrenched in the Constitution, and the Alteration of Sex Description and Sex Status Act 49 of 2003,[7] remains an ongoing struggle.

The introduction of child-focused human rights conventions and legislation has helped in transforming children's lives around the world, through the recognition of the importance of children's rights. According to both the national and international legal frameworks, all persons, including children[8] are afforded a right to gender identity, bodily autonomy, dignity and equality.[9] Unfortunately, due to homophobic attitudes, hate crimes, and other forms of abuses, the LGBTQIA+ community is prevented from fully exercising their human rights.[10]

Gender dysphoria manifests early in childhood. People often begin to identify themselves and their sexual orientation during their pre-adolescent or in their adolescent years.[11] Untreated gender dysphoria can result in poor quality of life because of stigmatisation and other abuses, beginning in childhood, and lasting throughout adolescent stage and even adulthood.[12] It is worth noting that gender dysphoria was previously treated as a psychological condition, therefore, the medicine utilised for gender diverse individuals was inherently pathologising. The focus was on psychological intervention purposed at aligning the mind with the body. In recent

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[7] Hereafter referred to as the Alteration Act.

[8] In terms of s 28(3) of the Constitution a child means a person under the age of 18 years.

[9] These rights are also entrenched in the Constitution.

[10] Victor Madrigal-Borloz, Human Rights Council. Report of the Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity (Geneva: UN General Assembly 2018) 19; Eric Mawira Gitari and Mark Walters, Hate Crimes against the LGBT Community in the Commonwealth: A Situational Analysis (Human Dignity Trust, 2020) 8.

[11] World Health Organization (2015). International statistical classification of diseases and related health problems, 10th revision, Fifth edition, 2016. World Health Organization. <https://apps.who.int/iris/handle/10665/246208> accessed on 13 August 2022; Johndré Barnes, 'A Right to Legal Gender Recognition for Transgender Children in South Africa' (LLM thesis, University of Stellenbosch 2020) 25.

[12] Jamie Smith, 'Gender as a Socially Constructed Phenomenon' [2016] <http://digitalcommons.winthrop.edu/sewsa/2016/fullschedule/123/> accessed on 13 August 2023.

years, the paradigm has shifted with the advent of medical treatments such as puberty suppression and cross-sex hormones[13] in gender dysphoric adolescents and children.

However, due to the global media environment and the coercive messages from family and community members, the LGBTQIA+ community is somehow pressured to resort to seeking reparative or conversion therapies[14] which do not alter their sexual orientation. Some elect to undergo medical treatments that change their bodies to make them more compatible with their gender identity. This treatment includes surgery where applicable.

Previously, the Child Care Act 74 of 1983[15] capacitated children above 14 years to independently consent to medical treatment, and children above 18 years could consent to an operation.[16] There was, however, a realisation of several shortcomings with the Act, as a result, it had to be repealed to give effect to the Children's Act that fully acknowledges children as rights-holders as envisaged in the Constitution. The Constitution also aligns with the African Charter on the Rights and Welfare of the Child (ACRWC)[17] and the UNCRC regarding elevating children as independent legal actors. These instruments provide for the right to the enjoyment of the highest attainable standard of physical and mental health. They also recognise that the best interest of the child should be a primary consideration; and that children must be allowed to express their views.

1.2 South African legal framework around child decision-making

The main reason for the Child Care Act to be repealed was amongst others, its perceived inherent weaknesses in giving effect to children's constitutional rights. It

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[13] This includes masculinising hormones (testosterone) for trans men and testosterone blockers and feminising hormones (estrogen and progesterone) for trans women. 'Trans' is often used as shorthand for transgender.

[14] Sean Young, 'Does "Reparative" Therapy Really Constitute Child Abuse?: A Closer Look' (2006) 6 Yale Journal of Health Policy, Law, and Ethics 170.

[15] The Child Care Act was wholly repealed by the Children's Act.

[16] Section 39(4) as repealed provided as follows: (a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and (b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child.

[17] South Africa has ratified the UNCRC, in 1996 and the African Charter on the Rights and Welfare of the Child (ACRWC), in 2000.

further prescribed cumbersome processes that failed to prioritise the interests of minors who needed access to medical treatment.[18]

The Children's Act has set the age of consent to medical and surgical treatment at 12 years. It provides as follows:

> A child may consent to his medical treatment if over the age of 12 years and the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.[19]

The provision suggests that should the proposed treatment involve a surgical procedure, a child of 12 years who is sufficiently mature may still consent on condition that he/she is duly assisted by his or her parent or guardian.[20] This is an aspect which remains controversial, especially because the Choice on Termination of Pregnancy Act[21] provides a minor girl (of any age) with a right to terminate her pregnancy without anyone else's consent, only the girl's consent is necessary.[22] As a result, it seems like a minor's reasoning, understanding and decision-making regarding abortion is a priority, but not for the times when a minor's medical treatment and surgical operations are invoked. It is therefore noted that although legislative frameworks exist, their discrepancies and ambiguity on the child's age of consent cannot be ignored.

It is worth noting that in most countries, children can begin hormonal treatment therapy[23] when they reach 16 or 18 years, whereas gender reassignment therapy is widely restricted to individuals of 18 years and above. It is, therefore, extremely difficult for minors to individually have access to transition related health care services relating to sex reassignment surgery, and hormonal replacement therapy before the age of 18.

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[18] Carina Van der Westhuizen, 'Medical Treatment v Surgery: Where does Medical Treatment end and Surgery begin in terms of section 129 of the Children's Act?' (2018) 39 Obiter 791.

[19] Section 129(2).

[20] Section 129(3).

[21] Choice on Termination of Pregnancy Act 92 of 1996.

[22] Section 5 Choice on Termination of Pregnancy Act. It provides as follows: "(1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman. (2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy. (3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them".

[23] Barnes, 'A Right to Legal Gender Recognition for Transgender Children in South Africa' 95.

This is even though the UNCRC guarantees children the right to autonomy and physical, mental, and emotional integrity.

The Health Professions Council of South Africa (HPCSA) guidelines suggest a similar approach. In terms of their provisions, the age is not the only determining factor, a competent child is the one who understands the treatment or surgery, the accompanying risks and the alternative options and related consequences.[24]

The issue of whose consideration bears much weight remains a grey area. The provision is that consideration must be given to the maturity of the child concerned, the wishes and opinions of the parent(s) or guardian, including the nature and implications of the proposed procedure. It is common knowledge that some of these considerations may clash, as there may be instances where a minor child's views and standpoints are inconsistent with those of the parent/guardian, insofar as medical treatment is concerned.

The Children's Act, however, provides that the overriding principle is the best interests of the child.[25] In determining the best interests of the child, the maturity, views, and preferences of the child should be considered.[26] Similarly, the objections, reasons,

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[24] HPCSA Guidelines for Good Practice in the Health Professions Booklet 9: Seeking patients' informed consent: the ethical considerations. Pretoria, 2009. It provides as follows:
"9.5.1 Health care practitioners must assess a child's capacity to decide whether to consent to or refuse a proposed investigation or treatment before they provide it.
9.5.2 In general, a competent child will be able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment.
9.5.3 A health care practitioner's assessment must take account of the following: 9.5.3.1 A minor with sufficient maturity over the age of 12 years can be treated as an adult and is legally competent to decide on all forms of treatment, and medical and surgical procedures.
9.5.5 Where a child is not legally competent to give or withhold informed consent, the parent or guardian may authorise investigations or treatment which are in the child's best interests. Such parent or guardian may also refuse any intervention, where they consider that refusal to be in the child's best interests, but health care practitioners are not bound by such a refusal and may seek a ruling from the court.
9.5.6 In an emergency where there is no time to contact the parent or guardian and the health care practitioners consider that it is in the child's best interests to proceed, they may treat the child, provided it is limited to treatment which is reasonably required in that emergency. In such circumstances in State Hospitals consent must be given by the clinical manager".

[25] Section 28 of the Constitution provides that "a child's best interests are of paramount importance in every matter concerning the child".

[26] Section 10 of the Constitution provides as follows: "Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration".

views, and opinions of the parent/guardian are considered as part of the decision-making process. If the disagreements cannot be resolved, it may be necessary to refer the matter to the legal department of the hospital wherein the relevant officer may approach the court for a ruling or apply to the Minister of Health for consent.[27]

In the landmark English case of *Gillick v. West Norfolk and Wisbech Area Health Authority*, Lord Fraser held that:

> [P]arental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child, and they are justified only in so far as they enable the parent to perform his duties towards the child, and towards other children in the family.[28]

It is accordingly submitted that the denial of a minor's access to sex transition related health care is an injustice and may be equivalent to inhuman or degrading treatment.[29] This is because minors will continue experiencing the dysphoria,[30] resulting in poor quality of life through puberty, until they reach the age of majority.[31] It is argued in this research that such a prevention is not in the best interests of those minors. The denial further, provides legal uncertainty regarding the principle of the best interests of the child and how it ought to be applied in gender reassignment issues.

Section 27 of the Constitution recognises that access to health care is a basic human right. It further imposes a duty on the state to take all reasonable measures within its available resources to achieve the progressive realisation of this right.[32]

One of the fourfold obligations as defined by the UN Committee on Social, Cultural and Economic Rights[33] in General Comment No 14, include the following: "The obligation to promote requires the State to disseminate appropriate information; foster

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[27] Section 129(7).

[28] *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 170.

[29] Article 37 of the UNCRC. It provides that: States Parties shall ensure that: "(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment".

[30] Distress caused by a mismatch between the felt and perceived gender identity.

[31] During puberty, the body begins to change and develop inconsistently with the minor's gender identity. Such a change can be very distressing in some instances.

[32] Section 27(1) and (2).

[33] South Africa ratified the Covenant on 12 January 2015.

research and support people to make informed choices".[34] This may mean that a child who desires puberty blocking treatment or surgery is entitled to such a comprehensive primary care. Harris and others argue that:

> [P]uberty blocking treatment (PBT) is a critical component of the medical management of the transgender youth; it allows gender consistency for an already socially transitioned child, can circumvent the need for future gender-affirming medical treatments, and provides time for youth to continue gender exploration while supressing distressing secondary sex characteristics.[35]

As a result, while the Children's Act can be commended for its identification of having specified the age of consent regarding medical treatment, it seems that the interpretation of the legislation is daunted with questions. It is also clear that a dangerous precedent has been set by most countries who have set the age of individual consent to surgical operations strictly at 18 years.[36]

The principle of the best interests of the child has in the past been criticised as not having a clear description or limits, providing little guidance to those given the task of applying it to matters concerning children.[37] The decision makers also have a considerable discretion in giving weight to competing arguments and considerations when making decisions based on the best interests of the child.

In *S v M*, the Constitutional Court of South Africa held that the "expansiveness of the paramountcy principle creates the risk of appearing to promise everything in general while actually delivering little in particular".[38] The court argued that as much as the

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[34] General Comment No.14, The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant of Economic, Social and Cultural Rights). UN Committee on Economic, Social and Cultural Rights, 2000 paras 34-37.

[35] Rebecca M Harris and others, 'Decision Making and the Long-Term Effects of Puberty Blockade in Transgender Children' (2019) 19 The American Journal of Bioethics 67 <https://www.tandfonline.com/doi/full/10.1080/15265161.2018.1557284> accessed on 14 August 2022.

[36] Bulgaria, Cyprus, Greece, France, Hungary, Romania and Slovakia recognise 18 years as the minimum age for autonomous consent to medical treatments. Australia has also set the age of autonomous consent at 18 years. However, there are circumstances in which patients under the age of 18 can consent to their own medical treatment. European Union Agency for Fundamental Rights, 'Mapping minimum age requirements concerning the rights of the child in the EU <https://fra.europa.eu/en/publication/2017/mapping-minimum-age-requirements-concerning-rights-child-eu/consenting-medical-treatment-without-parental-consent> accessed on 08 September 2022.

[37] Trynie Boezaart, 'General Principles' in Davel CJ and Skelton AM (eds) *Commentary on the Children's Act* (Juta Cape Town loose-leaf updates) ch 2 paras 2-6; S v M (Centre for Child Law as Amicus Curiae) 2007 2 SACR 539 (CC) para 23.

[38] *S v M* (Centre for Child Law as *Amicus Curiae*) 2008 (3) SA 232 CC [23].

best interests of the child may be paramount in all matters concerning the child, the principle is not decisive as there are other factors that should be taken into consideration.[39]

The inability of the legislator to expressly establish whether the principle of the best interests of the child should be applied as a substantive right in gender reassignment matters, raises concerns. The argument is that although the best interests of the child principle can be used as a constitutional right, it can still be limited in terms of section 36 of the Constitution, as it is not an absolute right.[40]

The UNCRC provides that children's participation in decision making processes is required in matters pertaining to them.[41] The Convention, however, does not stipulate the age for the child's participation. It rather, extend the right to participate to any child who has a view on a matter of concern to them, and further that their views must be given due weight, having regard to their age and maturity. In health care, the right of children to participate has become an established principle.

1.3 The objectives of the research

This study explores the issue of adolescents and children with gender dysphoria, the often-marginalised group that faces stigmatisation, discrimination, and violence

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[39] *S v M* at para 112 Madala J held as follows: "[r]endering the child's best interests paramount does not necessitate that other competing constitutional rights may be simply ignored or that a limitation of the child's best interest is impermissible". Anne S Louw *Ex Parte MS* 2014 JDR 0102 Case No 48856/2010 (GNP): Surrogate Motherhood Agreements, Condonation of Non-compliance with Confirmation Requirements and the Best Interest of the Child (2014) 47 De Jure 118.

[40] Ann Skelton, 'Constitutional Protection of Children's Rights' in T Boezaart (ed) *Child Law in South Africa* (Juta Cape Town 2009) 280. S 36 of the Constitution provides as follows: "(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-(a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relation between the limitation and its purpose; and (e) less restrictive means to achieve the purpose. (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights".

[41] Art 12 provides as follows: "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.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law".

around the world. The study focuses on the child's right, with specific focus on the medical and gender reassignment decision making. It purposes to offer a new understanding on aspects of medical care that may obstruct the principle of the best interests of the child. It contributes towards the realisation that section 129 of the Children's Act in its current form, does not sufficiently realise the child's right to consent to medical treatment, and it is not entirely in accordance with the best interests of the child. It explores the best interests of the child from the perspective of the affected children, their parents, and the clinical aspects involved. The study is premised from the perspective that any effort that prevents minors with dysphoria from receiving gender transition care, including puberty blockers, hormonal therapy, and surgical intervention, violates the child's rights.[42]

It is, however, clear that the ability afforded to children in consenting to medical care and surgery is still largely dependent on the actions of parents and health care professionals. In terms of the provisions of the Act, the notion that minors lack cognitive capacity and maturity to independently consent to surgical procedures, continue to thrive. Further, it is presumed that the natural bond of affection between parents and children will cause parents to take the correct treatment decision that is in the best interests of their children.[43] However, this is not always the case, parents can make decisions that have far-reaching consequences, and contrary to the child's best interests.[44] Van Bueren[45] argues that:

> [a] lack of certainty or indeterminacy is inherent in the best interests principle. Indeed, such a lack of certainty, which some may regard as flexibility and as a virtue, is essential in the case-by-case approach, which the best interest standard requires.[46]

It is therefore, submitted that the application of the best interests principle must demonstrate a commitment towards a child-centred and child-sensitive dispensation when dealing with child gender reassignment matters.

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[42] Amongst others the right to dignity, equality and access to healthcare services.

[43] Michael Freeman, 'The Value and Values of Children's Rights' in: A. Invernizzi & J. Williams (eds), *The Human Rights of Children: From Visions to Implementation* (Surrey: Ashgate 2011) 23.

[44] Freeman, The Value and Values of Children's Rights 23.

[45] Geraldine Van Bueren, Pushing and Pulling in Different Directions – The Best Interests of the Child and the Margin of Appreciation of States, in Child Rights in Europe (Council of Europe 2007).

[46] Bueren, Pushing and Pulling in Different Directions 32.

The provision dealing with child participation, section 10 of the Children's Act, provides that:

> [e]very child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.[47]

However, the Children's Act does not provide specific guidelines to measure the maturity and stage of development of the child and this may cause discrepancies.

Children's capacity to consent seems to be restricted to specific decisions. While the legal instruments accord children some competency to make some medical decisions, it appears like they do not have the capacity to make all medical decisions independently. This is because minors by law are presumed to be incapable of making decisions about their own health.[48]

Another aspect is that a decision whether a child has the capacity to consent can be difficult as it does not only consider intellectual maturity. The decision makers must, in addition, exercise careful professional judgement in determining whether the child's mental state interferes with their capacity to consent to assessment or treatment. This research explores and proposes the most appropriate ways and available best practices to ensure the effective implementation of the legal instruments, including health care aspects.

In summary, the objectives of this research are as follows:

(a) To determine if the South African child focused legal framework meets the increased and immediate need to ensure child participation in medical and gender reassignment issues;

(b) to examine the extent to which the parental responsibility and the state intervention interferes with child participation in medical and gender reassignment decision making;

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[47] Section 10.

[48] Hannaretha Kruger, 'The Protection of Children's Right to Self-Determination in South African Law with Specific Reference to Medical Treatment and Operations' (2018) 21 PER 2. See also PQR Boberg, *The Law of Persons and the Family* (Juta 1977) 643.

(c) to compare, where applicable, our legal framework with other international jurisdictions, identify inconsistencies, and make recommendations for possible legislative reform; and

(d) to examine and where possible propose the available alternatives where gender reassignment surgery is not possible.

1.4 Research questions

Recognition of the child's right to be heard could be interpreted as acting in the child's best interests. However, whether children should be considered ethically and legally able to make their own decisions, is a highly contested issue.

The questions this study intends to answer are the following:

(a) When would it *not* be in the best interest of the child to consent to his or her hormonal treatment and gender reassignment therapy?

(b) What constitutes 'sufficient maturity'?

(c) What are the challenges experienced by decision makers in determining the best interests of the child?

(d) What impact do the implementation of clinical gender reassignment processes have on children? What are the risks and benefits?

The last research question will explore the medical uncertainties or potential risks associated with the transition processes and procedure. This also links with the last point of the objectives of this research.

1.5 Literature review

This study is underpinned by section 28(2) of the Constitution, section 129 of the Children's Act, article 3(1) of the UNCRC and article 4 of the ACRWC. These legal frameworks enshrine the 'best interests of the child' as a fundamental legal principle of interpretation advanced to limit the extent of adult authority over children in all matters affecting them. A deeper study suggests that the underlying and sometimes profound discord revolves around what is implied by the term 'best interests of the child', and therefore under what conditions best interests point to individualistic child consent as a positive solution. This is relevant not only to decisions about individual children, but also to the restrictions placed on children in a country's overall child protection policy, and the appropriateness of the way in which issues of medical treatment and surgical operations are carried out.

Article 12 of the UNCRC obliges the state to assure that the child who can form his/ her own views has the right to express those views freely in all matters affecting him/ her. But a child's participation remains a contentious area. Researchers are entangled in the struggle of finding a comprehensive way of interpreting 'child participation' especially where the best interests of the child are involved. Burns and Grove[49] on the one hand argue that participation has to do with "the right to self-determination" which is based on the ethical principle of respect for a person. The fact, however, remains that although self-determination is a fundamental international right, its practice remains sensitive, it embodies major conflict of values and interests, as a result, it is difficult to implement and fulfil. Kruger on the other hand, defines the term to mean "the right to make medical decisions independently, without the assistance of the parents or guardians or other substitute decision-makers".[50]

Despite the rhetoric and the concerns that have been expressed about the children's lack of capacity to consent, Redding argues "that children often are capable of making important life decisions in a rational matter, including decisions about medical and psychological treatment".[51] Piaget argues that the child's ability to reason abstractly and to predict future consequences of an action, occurs when a child reaches the ages of 11-14 years.[52]

There are also some criticisms levelled against child participation. Hafen and Hafen argue that participation and a child's rights are equivalent to "irresponsible

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[49] Jennifer R Grey and Susan K Grove, *Burns and Grove's The Practice of Nursing Research: Appraisal, Synthesis and Generation of Evidence* 9th edn, (Elsevier St. Louis Missouri 2020) 195.

[50] Kruger, 'The Protection of Children's Right to Self-determination in South African Law with Specific reference to Medical Treatment and Operations' 1.

[51] Richard Redding, 'Children's Competence to Provide Informed Consent for Mental Health Treatment' (1993) 50 Wash Lee Law Review 708.

[52] Jean Piaget, 'Intellectual Evolution from Adolescence to Adulthood' (1972) 15 Human Development 1-2.

autonomy".[53] Collins seems to concur, as he holds that participation is multifaceted, as it "does not require children to have more influence or authority but requires consideration of their views along with others".[54] As Freeman cautions the UNCRC is not to be depicted as "the final victory for children".[55] This is because, as much as the UNCRC obliges state parties to "assure to the child who is capable of forming his/her own views the right to express those views freely in all matters affecting the child", it also provides that such views of the child must be "given due weight in accordance with the age and maturity of the child".[56] This poses a challenge, as the provision seem to be in discord with itself. The question of age as the determining factor may overshadow the nature of the child's participation, further, it may result in a dichotomous approach to maturity. Decision makers may disregard the cognitive development of an adolescent child when weight is given in accordance with the child's age, even though younger children can also articulate clear preferences. This may be because a similar process of participation may be offered to children above the age of 18, whilst neglecting to develop a different approach or a range of processes that matches children of different ages who may have different preferences.[57] Fundamentally, a child's meaningful and genuine participation requires an attitude that does not underestimate the age of the specific child and his/her views. Therefore, the notion that a child's age can determine the scope of the right of a child to consent or be heard is troublesome. The right for children to participate must be encouraged at any age, especially in matters affecting them. The question yet to be answered is whether there is a need to establish legal norms that address the legal capacity of children in important decisions that confront them.

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[53] Bruce Hafen and Jonathan Hafen, 'Abandoning Children to Their Autonomy: The United Nations Convention on the Rights of the Child' (1996) 37 Harvard International Law Journal 449-91.

[54] Tara M Collins, 'Child Participation in Monitoring the Convention on the Rights of the Child' in Tali Gal and others (eds), *International Perspectives and Empirical Findings on Child Participation: From Social Inclusion to Child-Inclusive Policies* (Oxford University Press 2015) 409.

[55] Michael Freeman, 'Hamlyn Lecture 2015: A Magna Carta for Children?' YouTube posted December 2015 <https://www.youtube.com/watch?v=RZXpm7n7kFI> accessed on 29 August 2022.

[56] Article 12 of the CRC.

[57] Aoife Daly, *Children, Autonomy and the Courts: Beyond the Right to be Heard* (Brill Nijhoff Leiden Boston 2018) 93.

The literature also tends to make assumptions that generalise children as if they are a homogenous group of people, identical across time and space.[58] Jurisprudence will as a result, through case studies, lead to the development of solutions for individual situations or an entire group of children.

Although the focus is not on the definition of the term "medical treatment" as provided in the Children's Act, differences in the understanding of the term may prevent uniform standards of practice as far as treatment is concerned. Strode argues that the Children's Act fall short of the definition of "medical treatment" as a right and that it does not even specify which therapies falls under that umbrella.[59] The Southern African HIV Clinicians Society (SAHCS) guidelines argue that the term is understood to include "access to psychosocial and mental health".[60] Van der Westhuizen argues that a deduction from the dictionary meaning seem "to include both medical and dental treatment, as well as surgery"[61] Therefore, the study will seek to suggest the use of an inclusive, but non-exhaustive, list that will set out clearly what is included in the broad definition of "medical treatment". Such guidelines will serve as a tool for making treatments more consistent and efficient.

Another aspect worth noting is that there is no consensus amongst the academic writers regarding the quality of life for individuals post gender reassignment surgery. Davey and others[62] indicate that the quality of life deteriorates post the reassignment surgery. Castellano and others[63] differ and argues that there is no difference in the quality of life or psychological functioning of individuals post the surgery. An

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[58] Graham Mekada, 'Changing Paradigms and Conditions of Childhood: Implications for the Social Professions and Social Work' (2011) 41 British Journal of Social Work 1-16.

[59] Ann Strode, 'Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)?' (2020) 21 Southern African Journal of HIV Medicine; Lawrence Ivan Schäfer *Child Law in South Africa: Domestic and International Perspectives* (LexisNexis 2011) 3.

[60] Anastacia Tomson and others, 'Southern African HIV Clinicians Society gender-affirming healthcare guideline for South Africa' (2021) 22 Southern African Journal HIV Medicine 21, <https://doi.org/10.4102/sajhivmed.v22i1.1299> accessed on 30 July 2022.

[61] Carina Van der Westhuizen, 'Medical Treatment v Surgery: Where does Medical Treatment end and Surgery begin in terms of section 129 of the children's act?' (2018) 39 Obiter 791.

[62] Amanda Davey and others, 'Social Support and Psychological well-being in Gender Dysphoria: A Comparison of Patients with Matched Controls' (2014) 11 Journal of Sex and Medicine 2976-2985 <http://dx.doi.org/10.1111/jsm.12681> accessed on 31 July 2022.

[63] Elena Castellano and others, 'Quality of Life and Hormones after Sex Reassignment Surgery' (2015) 38 Journal of Endocrinological Investigation 1373-1381 <https://doi.org/10.1007/s40618-015-0398-0> accessed on 31 July 2022.

exploration of how the quality of life is affected by reassignment procedures will help in proposing available alternatives, where applicable.

1.6. Justification of the study

The phenomenon of gender reassignment procedures being performed on individuals is not new practice in South Africa. Gender reassignment surgeries have received widespread international attention in the 1950s.[64] However, surgeries in response to children with a gender that is not typically associated with their biological sex identified at birth, have been performed since the mid-nineteenth century.[65] There has been a global rise in the number of teenagers seeking to go through gender reassignment procedures, which led to a series of court cases around the world, some of which will be discussed in this thesis. Many of these cases dealt with questions regarding the age at which young persons should be allowed to individually consent to a gender transition, and who should have the final word.

It should be noted that gender reassignment issues are too broad to rely on legal frameworks alone, consequently, engaging with this subject would require a multidisciplinary approach. The incorporation of other disciplines, such as psychology and sociology (non-surgical fields), where applicable, may offer new perspectives and unravel some alternatives, especially where surgery is not possible.

1.7 Scope and limitations of the study

While this thesis makes several significant contributions to existing knowledge through addressing the research questions, its scope and limitations are worth noting. This thesis focuses on the best interests of the child and adolescent in accessing gender affirming health care, including issues of informed consent and the decision-making processes. Although the study refers to the LGBTQIA+ individuals in some instances, it must be noted that the focus is limited to children and adolescents with gender dysphoria. A limitation of this thesis is that it does not comprehensively examine all

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[64] Ettner Monstrye and Eyler (eds), *Principles of Transgender Medicine and Surgery* (The Haworth Press 2016) 107; Zilavy Santucci and Gallegos, 'The History of Gender-Affirming Vaginoplasty Technique' (2022) 165 International Journal of Urology 366.

[65] Samuel Reis-Denis and Elizabeth Reis, 'Are Physicians Blameworthy for Iatrogenic Harm Resulting from Unnecessary Genital Surgeries?' (2017) 19 AMA Journal of Ethics 826.

barriers preventing children and adolescents in accessing gender-affirming health care. However, as the number of children and adolescents with gender dysphoria is growing, future research that takes into consideration the specific obstacles for this group of persons is necessary. While this research points to the need for law reform regarding the capacity of adolescents to provide consent, an exploration of how this could be achieved falls outside the scope of this research.

1.8 Methodology and theoretical framework

The research methodology is qualitative in nature. It employs a desk top based research, which involves a critical analysis of both primary and secondary sources (both nationally and internationally), including relevant legal instruments, case law, books, scientific journals, and articles. The approach adopted further includes a comparative analysis on pertinent medico-legal issues and the best interest of the child principle in gender reassignment decisions. It is worth noting that South Africa lacks a comprehensive and comparative study exploring how its national legal framework effectively compares with the law in other jurisdictions, particularly, regarding consent to access gender affirming care for transgendered minors with gender dysphoria. The aim of the research is thus to identify gaps and find answers to the research questions noted above, particularly, consent to hormonal and surgical treatment of children and adolescents with gender dysphoria.

1.9 Chapter framework

The research questions are dealt with as follows in the different chapters of the thesis:

Chapter 1

Chapter 1 introduces the research, articulating the problem statement, research questions, and a literature review relating to the research questions. The aim is not only to show why this research is timeous and relevant, but also to critically reflect on certain assumptions underlying conventional approaches to the research topic.

Chapter 2

Chapter 2 provides a historical background to the evolution of LGBTQIA+ rights and children's rights. It also elaborates on the principle relating to the best interests of the child in South Africa. This chapter analyses to what extent the rights of children have to date been overlooked. This is followed by a discussion on child participation in matters affecting them, specifically, issues of consent to medical treatment and surgery. The best interests of the child *vis-à-vis* parental responsibilities and rights are also discussed.

Chapter 3

This chapter surveys the clinical aspects of gender reassignment procedures. It highlights the disadvantages experienced by children below the age of 18, who are denied transition related therapy because of legislation requiring parental assent or consent. The effect of hormonal therapy *vis-à-vis* surgery are analysed, considering the current state and the gender affirming health care (standard of care) guidelines associated with these procedures. These guidelines, particularly the World Professional Association for Transgender Health (WPATH), is reviewed in relation to children's rights and participation within the context of gender affirming health care.

Chapter 4

Chapter 4 explores the international regulatory framework governing children's consent to medical procedures, followed by a comparative analysis of the legal position regarding children's consent in English law as influenced by the landmark case of *Gillick v. West Norfolk and Wisbech Area Health Authority*[66], including the jurisdictions of Australia, New Zealand, Canada, and Denmark with reference to their relevant landmark decisions on children's consent. Both Australia and Canada are, like South Africa, jurisdictions influenced by a common law tradition. Australia has a National Children's Commissioner and has ratified the UNCRC in December 1990. Canada despite ratifying the UNCRC in 1991, also following the best interest of the child standard and having a Charter on Rights and Freedoms, it came under criticism recently for not having a central independent mechanism for monitoring children's

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[66] [1986] AC 112.

rights.[67] Denmark has taken a progressive approach towards gender recognition reform. These jurisdictions' experiences are compared with that of South Africa, specifically regarding their understanding of children's consent in the context of medical decision-making, with emphasis on gender reassignment procedures.

Furthermore, since the age of individual consent in medical procedures is restricted to 18 years in most jurisdictions, it is argued in this chapter that the construction of childhood has changed overtime, and unnecessary paternalistic interventions in the lives of children must change. The critical analysis provides a good basis for understanding the 'loopholes,' vagueness and inconsistencies in the legal instruments and the strengths and weaknesses of the enforcement, including monitoring mechanisms as contributory factors to the injustices of the child.

Chapter 5

Chapter 5 is the last chapter and comprises the conclusion of this thesis. It provides an overview of the research and attempts to fill in the gaps in the research literature and our legal system. This chapter also puts forward suggestions for the reform of the South African law and/or guidelines regarding adolescents' gender reassignment cases with reference to other legal systems, including gender affirming health care guidelines as currently applicable.

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[67] Anne Levesque and Malorie Kanaan, 'Are the kids alright? Why Canada must urgently step up to ensure children's rights. The Conversation (June 27, 2022)' <https://theconversation.com/are-the-kids-alright-why-canada-must-urgently-step-up-to-ensure-childrens-rights-185565> accessed on 05 September 2022.

CHAPTER 2: THE HISTORICAL EVOLUTION OF LGBTQIA+ RIGHTS AND CHILDREN'S RIGHTS

2.1 Introduction

Chapter 1 has laid a foundation where the problem statement; aims of the study; and research methodology were explained. The aim of this chapter is to provide a background on the evolution of the South African LGBTQIA+ and children's rights. This is done by way of tracing the development of these rights over time. The history of LGBTQIA+ will focus on some of the major events in South Africa from 1957.

The history on children's rights will focus on three historical periods: The Roman era, the apartheid era of segregation, and the constitutional era. Briefly canvassing the evolution of children's rights over time will assist with an informed comprehension of the current position regarding children's right to health care services and gender reassignment issues in South Africa. As Kipnis[68] writes, childhood is arguably the most vulnerable period of human life. Children's vulnerabilities are based on several factors including but not limited to the following:

> they commonly lack the capacity to make mature decisions; (ii) they are subject to the authority of others; (iii) they (and their parents) may be deferential in ways that can mask underlying dissent; (iv) their rights and interests may be socially undervalued; (v) they may have acute medical conditions requiring immediate decisions not consistent with informed consent; (vi) they may have serious medical conditions that cannot be effectively treated; and (vii) they (and their parents) may lack important socially distributed goods.[69]

Therefore, the impetus of this chapter is to define, outline and interpret the LGBTQIA+ and children's right to health care services and gender reassignment through the lens of the national legal framework.

The Constitutional protection afforded to the rights of LGBTQIA+ persons and those of children has led to a profound transformation in the South African legal context. As

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[68] Kenneth Kipnis, 'Seven Vulnerabilities in the Pediatric Research Subject' (2003) 24 Theoretical Medicine and Bioethics 107-120.

[69] Kipnis, 'Seven Vulnerabilities' 107.

far as children are concerned, the Children's Act was a watershed moment in legislation to help protect children and ensure that their rights are respected. The aim of the Children's Act is to serve various purposes, which are to:

a) [P]rotect children and promote their rights;
b) put the best interests of children first;
c) allow children to take part in decisions which affect them;
d) preserve and strengthen families; and
e) recognise the role of the community in the lives of children.[70]

The realisation of rights for LGBTQIA+ persons has followed a different trajectory, discussed next.

2.2 The evolution of LGBTQIA+ rights in South Africa

Research reveals that the African continent predominantly holds negative attitudes toward LGBTQIA+ people.[71] This is further compounded by the continent's general lack of understanding and recognition of gender and sexual diversity.[72] South Africa has its own LGBTQIA+ rights jurisprudence. During the apartheid period from 1960s to 1980s, General Viljoen, the then Head of the South African National Defence Force, ordered that steps should be taken to combat homosexuality in the military. As such, gay and lesbian soldiers were forced to undergo medical cues purposed at curing their sexuality.[73] They were subjected to brutal forms of treatment, which included a type of medical torture as part of the "Aversion Project", which applied electroshock therapy, chemical castration, and also included gender reassignment surgery carried out at the Military Hospital in Pretoria.[74] It should be noted that South Africa had enacted legislation against homosexuality during the apartheid era, through the Immorality Act

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[70] Children's Rights (internet) <https://www.etu.org.za/toolbox/docs/government/children.html> accessed 14 on October 2022.

[71] Patrick Awondo, Peter Geschiere, and Graeme Reid, 'Homophobic Africa: Towards a More Nuanced View' (2012) 55 (3) African Studies Review 145.

[72] Awondo, 'Homophobic Africa: Towards a More Nuanced View' 145.

[73] Aaron Belkin and Margot Canaday, 'Assessing the integration of gays and lesbians into the South African National Defence Force' (2010) 38 Scientia Militaria South African Journal of Military Studies 3 <https://doi.org/10.5787/38-2-87> accessed on 10 October 2022.

[74] Mikki Van Zyl and others, Human rights abuses of gays and lesbians in the South African Defence Force by health workers during the apartheid era 1999 <http://196.21.144.194/healthsystems/aversion.pdf> accessed on 10 October 2022.

(later referred to as the Sexual Offences Act).[75] Any form of non-heterosexuality was regarded as a criminal offence in the country.[76]

The years between 1980 and 1992 witnessed the formation of two major gay rights groups. The Gay Association of South Africa (GASA) was founded in 1982, and the Gay and Lesbian Organisation of Witwatersrand (GLOW) in 1988.[77] Towards the end of 1994, the National Coalition for Gay and Lesbian Equality (NCGLE), which was later known as the Lesbian and Gay Equality Project (LGEP) was formed.[78] These organisations aimed to ensure that gay people were afforded effective access to and enjoyment of existing rights. As such, efforts by these organisations led to significant advancements towards transformation within the gay rights movements, culminating ultimately into South Africa setting an example with its progressive move on LGBTQIA+ legal issues. This was evident when South Africa became the first country to constitutionally outlaw discrimination based on sexual orientation in May 1996.[79] The term "sexual orientation" was formulated by Justice Ackerman as follows:

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[75] Sexual offences Act 24 of 1957. Section 20A as repealed provided as follows:
"(1) a male person who commits with another male person at a party any act which is calculated to stimulate sexual passion or to give sexual gratification, shall be guilty of an offence.
(2) For the purposes of subsection (1) a party' means any occasion where more than two persons are present.
(3) The provisions of subsection (1) do not derogate from the common law, any other provision of this Act or a provision of any of this Act or a provision of any other law".

[76] Section 20A of the Act made provision for "unnatural sexual offence" of sodomy to be punishable with a penalty of up to two years of imprisonment or a fine of up to R400, or both.

[77] Kobus du Pisani, 'Shifting sexual morality? Changing views on homosexuality in Afrikaner society during the 1960s' (2012) 57 Historia 194. He writes that "the draft legislation was initiated in the form of an Immorality Amendment Bill…fortunately the Department of Justice did not regard the bill as a final product and did not plan to rush it through parliament". See also Neville Wallace Hoad, Karen Martin and Graeme Reid, *Sex and Politics in South Africa* (eds) (Juta 2005) 18.

[78] This organisation's initial purpose was to launch a fight for the retention of the sexual orientation as one of the rights in the equality clause of South Africa's final Constitution. However, in 1995 national conference defined the 4 major aims of the organisation as follows: "to retain the equality clause in the final constitution; to scarp unjust laws; to challenge discrimination through constitutional litigation; and to train representative and effective lesbian and gay leadership.' See Wallace and others, '*Sex and Politics in South Africa"* 11.

[79] *National Coalition for Gay and Lesbian Equality and Others v Minister of Home Affairs and Others* (1999) ZACC 17; 2000 (2) SA 1 (CC); 2000 (1) BCLR (39) (CC) para 53. The Constitutional Court in this case highlighted the importance of the concepts of human dignity, equality and freedom for our equality jurisprudence on same-sex relationships. The courts summarised as follows: "(i) Gays and lesbians have a constitutionally entrenched right to dignity and equality;
(ii) sexual orientation is a ground expressly listed in s 9(3) of the Constitution and under s 9(5) discrimination on it is unfair unless the contrary is established;
(iii) prior criminal proscription of private and consensual sexual expression between gays, arising from their sexual orientation and which had been directed at gay men, has been struck down as unconstitutional;

> Sexual orientation is defined by reference to erotic attraction: in the case of heterosexuals, to members of the opposite sex; in the case of gays and lesbians, to members of the same sex. Potentially a homosexual or gay or lesbian person can therefore be anyone who is erotically attracted to members of his or her own sex ... It applies equally to the orientation of persons who are bi-sexual, or transsexual and it also applies to the orientation of persons who might on a single occasion only be erotically attracted to a member of their own sex.[80]

This was soon followed by the 1998 Constitutional Court judgment that declared section 20A of the Immorality Amendment Act inconsistent and in violation of the equality clause (section 9) of the Constitution. The same decision also ruled the criminalisation of sodomy, and 'unnatural acts' as unconstitutional. In a further landmark judgment in 2002, in the case of *Du Toit and Another v Minister of Welfare and Population Development and Others*,[81] the joint adoption of children by same-sex parents was introduced.[82] This case involved a lesbian couple in a long-term partnership. This couple brought an application to jointly adopt two children, a brother and a sister. The provisions of the Child Care Act (now repealed) prohibited them from doing so, the reason being that only married couples were allowed joint guardianship. The applicants argued that the provisions of the Child Care Act discriminated against them based on their sexual orientation and marital status. The prohibition of joint guardianship also violated section 28(2) of the Constitution which provides that "a child's best interests are of paramount importance in every matter concerning the

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(iv) gays and lesbians in same-sex life partnerships are as capable as heterosexual spouses of expressing and sharing love in its manifold forms, including affection, friendship, eros and charity;
(v) they are likewise as capable of forming intimate, permanent, committed, monogamous, loyal and enduring relationships; of furnishing emotional and spiritual support; and of providing physical care, financial support and assistance in running the common household;
(vi) they are individually able to adopt children and in the case of lesbians to bear them;
(vii) in short, they have the same ability to establish a consortium omnis vitae;
(viii) finally, . . . they are capable of constituting a family, whether nuclear or extended, and of establishing, enjoying and benefiting from family life which is not distinguishable in any significant respect from that of heterosexual spouses".

[80] It is clear from the definition that 'sexual orientation' exists in a number of different forms of and emotional relationships. This is because it is not limited to people who suffer discrimination because of their emotional and erotic attraction to people of the same sex. It alludes to aspects of attraction in sexually diverse individuals.

[81] *Du Toit and Another v Minister of Welfare and Population Development and Others* 2002 ZACC 20; 2002 (10) BCLR 1006; 2003 (2) SA 198 (CC).

[82] Para 30. The court stated as follows: "As the applicants have succeeded in establishing that the provisions of the Child Care Act constitute an infringement of the rights protected by ss 28(2), 9(3) and 10 of the Constitution, so for the same reasons have they established that section 1(2) of the Guardianship Act constitutes an infringement of the Constitution. The provisions of the Guardianship Act are premised on the assumption that same-sex life partners cannot be joint guardians of children. That assumption arises, in particular, from the provisions of section 17 of the provisions of section 17 of the Child Care Act [which lists the categories of persons entitled to adopt children, excluding same-sex couples]. For the same reasons that s 17 is in conflict with the Constitution, then, s 1(2) of the Guardianship Act is".

child". By denying the applicants joint guardianship, section 17 of the Child Care Act was found to have violated the best interest principle, as well as defeating the purpose of adoption, which is to provide "stability, commitment, affection and support important to a child's development".

In 2005, in the case of the *Minister of Home Affairs v Fourie*, the South African Marriage Act was declared unconstitutional for failing to include same sex partnerships in its common law definition of marriage. Justice Sachs explains the court's thinking in this matter as follows:

> The exclusion of same-sex couples from the benefits and responsibilities of marriage, accordingly, is not a small and tangential inconvenience resulting from a few surviving relics of societal prejudice destined to evaporate like the morning dew. It represents a harsh if oblique statement by the law that same-sex couples are outsiders, and that their need for affirmation and protection of their intimate relations as human beings is somehow less than that of heterosexual couples. It reinforces the wounding notion that they are to be treated as biological oddities, as failed or lapsed human beings who do not fit into normal society, and, as such, do not qualify for the full moral concern and respect that our Constitution seeks to secure for everyone. It signifies that their capacity for love, commitment and accepting responsibility is by definition less worthy of regard than that of heterosexual couples.[83]

Failing to acknowledge same sex couples in the definition of marriage may be equated to the denial of same-sex couples to enjoy the status and the benefits coupled with responsibilities it accords to heterosexual couples. Further, the fact that s 30(1)[84] of the Marriage Act[85] omits to include the words *or spouse* after the words *or husband*, was found to be inconsistent with the Constitution. This resulted in the Marriage Act being declared invalid to the extent of this inconsistency.[86] Consequently, the Court gave Parliament 12 months to cure the defect.[87]

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[83] *Minister of Home Affairs and Others v Fourie and Others* 2006 (1) SA 524 (CC) Para 553C-D.

[84] Section 30(1) provided as follows: "In solemnizing any marriage the marriage officer, if he is a minister of religion or a person holding a responsible position in a religious denomination or organization, may follow the rites usually observed by his religious denomination or organization, but if he is any other marriage officer he shall put the following questions to each of the parties separately, each of whom shall reply thereto in the affirmative: 'Do you, A.B., declare that as far as you know there is no lawful impediment to your proposed marriage with C.D. here present, and that you call all here present to witness that you take C.D. as your lawful wife (or husband)?', and thereupon the parties shall give each other the right hand and the said marriage officer shall declare the marriage solemnized in the following words: 'I declare that A.B. and C.D. here present have been lawfully married'".

[85] 25 of 1961.

[86] *Fourie* para 586E-G.

[87] Para 584A.

In 2006, following the judgment in *Minister of Home Affairs v Fourie*, the legislature passed the Civil Union Act,[88] a law that, among others, legalised same sex marriages. The Civil Union Act was signed into law in November 2006.[89]

It should be borne in mind that in the 1976 case of *W v W*,[90] the Court refused to accept the description on the persons' altered birth certificate as their 'true sex'. The judge concluded that the biological sex which was fixed at birth cannot be changed either by the use of hormones to develop the features of the desired sex or by medical/surgical means. The court employed the so-called "Ormrod Test" (strict biological criteria), from the English Case of *Corbett v Corbett.*[91] The court's conclusion was that sexual realignment surgery did not result in change in sex. As a result, s7B of the Birth, Marriage and Deaths Registration Act[92] was repealed, making it impossible for a person who had a sex realignment operation to apply for an amended birth certificate.

The Alteration of Sex Description and Sex Status Act[93] which was enacted in 2003 is a fundamental piece of legislation in South Africa that allows gender reassignment, particularly for transgender (hereafter "trans person") and intersex persons. The Act describes gender reassignment to include any process undertaken for the specific purpose of reassigning a person's sex by changing physiological or other sexual characteristics. The Act further stipulates that persons who had medical treatment to alter their hormonal patterns for the purpose of gender reassignment can apply for documents that matches their new gender. Section 2(1) states:

> Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General

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[88] Act 17 of 2006.

[89] Pierre De Vos and Jaco Barnard, 'Same Sex Marriage, Civil Unions and Domestic Partnerships in South Africa: Critical reflections on an ongoing saga' (2007) 124 South African Law Journal 798.

[90] *W v W* 1976 (2) SA 308 (WLD).

[91] *Corbett v Corbett* [1970] 2 All ER 33.

[92] Births, Marriages and Deaths Registration Act 81 of 1963. This section provided that "The Secretary for the Interior may, on the recommendation of the Secretary for Health alter, in the birth register of any person who has undergone a change of sex, the description of the sex of such person, and may for the purpose call for such medical reports and institute such investigation as he may deem necessary".

[93] 49 of 2003.

> of the National Department of Home Affairs for the alteration of the sex description on his or her birth register.[94]

This provision makes it possible for trans persons to attain legal recognition of their altered gender. Because the wording of the Act suggests that hormonal treatment is enough, children need not undergo gender reassignment surgery first before their altered gender will be recognised by law. However, the challenge is that individuals can only commence hormonal treatment (cross sex hormones) and surgical procedures when they possess the capacity to make a fully informed decision and consent to treatment, which is when they turn 18 in most instances.[95]

The sad reality in South Africa is that despite huge progress towards recognising the rights of the LGBTQIA+ community in legislation and beyond, the LGBTQIA+ community is still suffering endless stigmatisation. Nienaber opines that “stigmatisation leads to discrimination and a violation of equality”,[96] efforts are however, made to address widespread anti-LGBTQIA+ discrimination and violence. Another challenge experienced by the LGBTQIA+, especially trans persons, is that South African law does not recognise a third gender classification.[97] This third gender classification would allow trans persons who identify as neither female or male (non-binary) to register a third option in accordance with their non-binary gender identity.[98] Section 2 of the Alteration of Sex Description and Sex Status Act[99] suggests that although the 1996 Constitution is heralded as one of the most progressive constitutions in the world, it still remains unthinkable that the South African legislature does not recognise any person who identifies himself or herself as anything other than a male and female.[100] Although gender identity is not one of the listed grounds in section 9(3) of the Constitution, the judgment in *Harksen v Lane NO and Others*[101] recognises that the reference to “unspecified” grounds in section 9(3) opens the

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[94] Alteration of Sex Description and Sex Status Act.

[95] Cécile A Unger, ‘Hormone therapy for transgender patients’ (2016) 5 Translational Andrology and Urology 877-884 <https://doi.org/10.21037/tau.2016.09.04> accessed on 27 February 2023.

[96] Annelize G Nienaber, ‘Informed consent to participation in preventive HIV vaccine efficacy trials in the light of section 12(2)(c) of the South African Constitution’ (2008) 33 Journal for Juridical Science 88.

[97] Rachel Sloth-Nielsen, ‘Failure to recognise a third gender option: Unfair discrimination or justified limitation?’ (2021) 25 Law Democracy and Development <http://dx.doi.org/10.17159/2077-4907/2021/ldd.v25.4> accessed on 12 November 2022.

[98] Sloth-Nielsen, ‘Failure to Recognise a third gender option.’

[99] 49 of 2003.

[100] Sloth-Nielsen, ‘Failure to Recognise a third gender option.’

[101] 1998 (1) SA 300 (CC).

possibility of the recognition of other non-listed grounds. To succeed, a trans person must prove that there is a different or discriminatory treatment. Further, that the reason for the differentiation is based on attributes or characteristics which have the potential to impair the fundamental dignity of trans persons as human beings, or that such treatment affects them adversely in a comparably serious manner.[102] The Constitutional Court describes these attributes or characteristics in the following terms:

> What the specified grounds have in common is that they have been used (or misused) in the past (both in South Africa and elsewhere) to categorise, marginalise and often oppress persons who have had, or who have been associated with, these attributes or characteristics. These grounds have the potential, when manipulated, to demean persons in their inherent humanity and dignity. There is often a complex relationship between these grounds. In some cases they relate to immutable biological attributes or characteristics, in some to the associational life of humans, in some to the intellectual, expressive and religious dimensions of humanity and in some cases to a combination of one or more of these features.[103]

What becomes clear from the judgement is that discrimination is constituted when the reason underlying the different treatment impairs the fundamental human dignity of the person who complains that he/she has been discriminated against. It is therefore, argued that the non-recognition of the third gender classification infringes on trans persons' rights to equality and dignity as enshrined in the Constitution. The values of equality and dignity are affirmed by the Bill of Rights, as such, all persons, including trans persons, deserve to be treated with dignity, appropriately as equally worthy of respect.[104] In the case of *September v Subramoney NO and Others*,[105] a trans person who was serving a prison sentence inside a male correctional facility sought relief for the violation of her fundamental rights to equality and human dignity. She further petitioned for the right to express her gender whilst incarcerated. This entailed amongst others, keeping her hair long, to wear make-up, including to wear female underwear. The Court ruled largely in favour of the applicant and acknowledged competing constitutional rights in its judgement. On balancing the competing rights, the court stated as follows:

> These steps should balance the competing interests raised by this dispute. They should allow for gender expression, but also not undermine the safety of the

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[102] Para 47.

[103] Para 50.

[104] Iain Currie, Johan De Waal and Gerhard Erasmus, *The Bill of Rights Handbook* 4th edn (Lansdowne: Juta 2001) 273.

[105] (EC10/2016) [2019] ZAEQC 4; [2019] 4 All SA 927 (WCC).

> applicant or detention facilities… the relief granted in *casu* should be nuanced and make provision for a balanced enforcement of the constitutional rights of the applicant and the constitutional obligations of the respondents.[106]

The court reiterated the state's obligation to respect, protect, promote and fulfil the rights entrenched in the Constitution. As a result, it paved a way for the government to take reasonable steps to accommodate the applicant. This is because the Constitution has included in section 9 a justiciable right that provides for non-discrimination against any person on any ground, including sex, gender and sexual orientation. This constitutional right, however, seem not to have been fully realised in South Africa due to lack of recognition for the third gender classification.[107]

2.3 A brief history of children's rights

2.3.1 The Roman Law era

From a legal-historical perspective, parental rights over children can be traced to ancient Roman law under which children were viewed in terms of inferiority, dependency and powerlessness.[108] Children were categorised in Roman law as legally incompetent, consequently, not entitled to exercise a wide range of rights on their own. The Roman law concept of *pater familias* related to a position of power and authority over a family, and it was occupied by the male head of a family.[109] This position provided the male head of a family with often limitless authority known as *patria potestas*.[110] *Patria potestas* gave the father immense power over his offspring and this power was absolute even after the children had reached adulthood. Those subject to *patria potestas* could not own property or wealth of their own, no matter how old they were.[111] This is because if they remained in the power of the *pater familias*, he would legally own all the possessions of his family members. During Roman times

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[106] Para 128.

[107] Sloth-Nielsen, 'Failure to Recognise a third gender option'.

[108] Antti Arjava, 'Paternal Power in Late Antiquity' (1998) 88 The Journal of Roman Studies 147.

[109] Theoretically, the power of the *pater-familias* was general and absolute. He had power not only on the slaves and the estate, but his power extended also on the wife and the children which had not by marriage or emancipation passed into the power of another *pater-familias*. See Arjava, 'Paternal power in Late Antiquity' 147.

[110] *Patria potestas* included amongst others, the power of life and death the father had on his descendants, the power to sell them, the power to give children in marriage and divorce them at his will, and the right to give them in adoption and emancipate them at his will. See Arjava, 'Paternal power in Late Antiquity' 147.

[111] Arjava, 'Paternal power in Late Antiquity' 147.

a child would be dependent upon the father until the child's death. Only the father's death would legally free the child, unless the father would have voluntarily freed the child by emancipation. *Patria potestas* therefore, consisted of the set of legally recognised rights that parents had over their unemancipated children.[112] These rights were designed to ensure that children would fulfil the obligations imposed upon them by their parents. Gradually, the development of the law by the classical jurists led to the institution of the *peculium castrense*,[113] which referred to property acquired by a minor son who was in military service. The recognition of *peculium castrense* led to the decline of *patria potestas* until it eventually "lost its social function, and thus, its definition as a legal concept". This took place after the fall of the Western Roman Empire in AD 476.[114]

2.3.2 The child under potestas

The development of Roman law as recorded by Justinian and Gaius brought a shift in the attitude towards children and their ages of accountability. Generally, children from birth until the age of 7 were referred to as *infantes* until puberty[115] (as *impuberes*), and those between puberty and the age of 25 were generally referred to as *minores*.[116] Under classical Roman law, children could be released from their father's *potestas* through *emancipatio.* The result of the process of *emancipatio* was that the released children would immediately be regarded as legally independent (*sui iuris)*.[117] These children could then own and manage property independently if they were of age. The late classical and post-classical periods were marked by certain characteristics relating to the application of some rules pertaining to children. For example, children

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[112] Arjava, 'Paternal Power in Late Antiquity' 147.

[113] The introduction of the concept led to the abandonment of the rule that sons in power could not own property. See Arjava, 'Paternal power in Late Antiquity' 149.

[114] Manuel Via-Dumas, 'Parents, Children and the Law: *Patria Potestas* and Emancipation in the Christian Mediterranean during Late Antiquity and the Early Middle Ages' (2014) 39 Journal of Family History 307-329 <https://doi.org/10.1177/0363199014554862> accessed on 14 October 2022.

[115] Justinian in his legislation fixed the full age for boys at 14 and for girls at 12. Therefore, puberty commenced at ages 12 and 14 respectively. See W Buckland, *A Text-book of Roman Law from Augustus to Justinian* (3 edn, 1963) 142-173.

[116] See Ville Vuolanto, 'Children in Roman Law' <https://doi.org/10.1093/acrefore/9780199381135.013.8200> accessed on 05 November 2022.

[117] Arjava, 'Paternal Power in Late Antiquity'148.

who were *alieni iuris* (those under *potestas*[118] or under the power or authority of another) could also be given the *peculium* and as a result, some of the rules applicable to children *sui iuris* (who were under *tutela* or *cura*)[119] were also applied to the *alieni iuris*. Children under the age of 7 (*infantes*) were not able to administer their own affairs under any circumstances. These children were considered to lack understanding of their actions and as a result, they were not liable even if they had committed delictual acts. A tutor oversaw the activities of children in *pupillari aetate* (those who had not yet reached puberty),[120] conversely, a *curator* was responsible for the children in *minore aetate*,[121] which he represented until the age of 25.

Children under *tutela* or *impuberes* who were *sui iuris*, could administer their affairs with specific consent from tutors. They had the capacity to conclude unilateral contracts without their guardian's consent, although such consent was necessary for multilateral contracts.[122] At reaching puberty or *minores,*[123] children who were *sui iuris* attained full capacity to act. The *curator* was responsible for assisting the minor in concluding juristic acts. However, lack of consent from the *curator* did not invalidate the minor's contract. In the post-classical period, a minor required the consent of the *curator* when concluding a contract.[124] A contract concluded without the assistance of the minor's *curator* was sometimes regarded as void.[125] Children who passed the limits of *infantes* but had not yet reached the age of puberty, had limited capacity to act.[126]

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[118] The word *potestas* has different meanings: "in the person of a magistrate, it means supreme political power (*imperium*); in the person of a child, it means paternal power; in the person of a slave, ownership". See Rafael Domingo, 'Roman Law: Basic Concepts and Values' 2017 <http://dx.doi.org/10.2139/ssrn.2989010> accessed on 05 November 2022.

[119] As understood in the Middle Ages, a curator was appointed solely to protect the minor's property or to assist him in litigation. A tutor on the other hand, was appointed in part to care for the child's person, although he would have *administratio* of the child's goods. As such there was no clear distinction between a tutor and a curator in the classical nor medieval Roman Law era. See Arjava, 'Paternal power in Late Antiquity' 149.

[120] Puberty was normally set at age 14 for boys and 12 for girls. See Buckland, *A Text-book of Roman Law* 145.

[121] These are children who had passed the stage of puberty but had not yet reached the age of majority. See Richard H Helmholz, 'Roman Law of Guardianship in England, 1300-1600' [1978] University of Chicago Law School Journal 231.

[122] Joseph A C Thomas, *The Institutes of Justinian: Text, Translation and Commentary* (Juta 1975) 54.

[123] These children were above the age of puberty, but below the age of 25. See Helmholz, 'Roman Law of Guardianship' 232.

[124] Hannaretha Kruger, 'The Legal Nature and Development of Parental Authority in Roman, Germanic and Roman-Dutch Law - A Historical Overview' [2004] Fundamina: A Journal of Legal History 95.

[125] Kruger, 'The Legal Nature and Development of Parental Authority' 95.

[126] Kruger, 'The Legal Nature and Development of Parental Authority' 95.

These children were deemed capable of understanding what they were doing and could be held legally liable for their actions. They could as a result, conclude valid juristic acts with the assistance of their tutors. Initially, full capacity to act was afforded to children who were above the age of puberty, but below the age of majority. However, it would seem that during the post classical period, they were afforded limited capacity to act.[127]

Following the above prefatory outline on Roman law, next considered is the position of a child under the common law.[128]

2.3.3 Common law

From a legal-historical perspective, the common law mainly regarded parents as having parental authority or power over their children until they attained majority status.[129] This authority bestowed parents with rights, powers, duties and responsibilities in respect of the child and the child's property.[130] Children were regarded as legal subjects lacking legal accountability and generally incapable of providing informed consent, for example, to the carrying out of medical treatment. Concepts of parental autonomy and family privacy were included under common law rules of parental consent. Common law also considered the importance of familial bonds, including a narrower construction of the notion that parents are legally responsible for the care and support of their children.[131] Parental consent implied that family privacy was paramount and that parents would consistently act in the best interests of their children.[132] The notion of parental consent was absorbed into the common law as we know it today, which requires parental consent or consent from a

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[127] Kruger, 'The Legal Nature and Development of Parental Authority' 95.

[128] Roman-Dutch law remains the basis of South Africa's common law to this day. It is however, consistently not in its original form due to legislative and judicial adaptations. See Jeremy Sarkin, 'The Common law in South Africa: Pro-Apartheid or Pro-Democracy' (1999-2000) 23 Hastings International and Comparative Law Review 1. See also Francois Du Toit, 'Roman-Dutch law in modern South African succession law' <http://hdl.handle.net/10566/1316> accessed on 05 November 2022.

[129] C Ngwena, 'Health care decision-making and the competent minor: the limits of self-determination' (1996) 132 Acta Juridica 139-143.

[130] Jacqueline Heaton and Hannaretha Kruger, *South African Family Law* (4th edn LexisNexis 2015) 283.

[131] Judith McMullen, 'Privacy, Family Autonomy, and the Maltreated Child' (1992) 75 Marquette Law Journal 569.

[132] McMullen, 'Privacy, Family Autonomy and Maltreatment' 569.

legally appointed guardian before medical treatment may be administered to a child below the age of 12 years.[133] The High Court as the upper guardian of all minor children could be approached in situations where the required consent could not be obtained.[134] The application of this common law position led to conflicting interpretations among academic writers. Whilst Boberg argued that minors were deemed to have insufficient capacity to give consent for their own medical treatment,[135] Strauss maintained that minors were able to make health care decisions in certain circumstances, and such capacity could be exercised without parental consent.[136]

2.4 The evolution of children's rights in South Africa

South African children suffered some of the most severe violations of human rights under apartheid, with some being "detained without trial, tortured and assaulted".[137] There was no strategy in place to ensure that children were treated humanely and with adherence to just principles. Many of these children were deprived of access to adequate housing, health care and education.[138] These gross violations resulted in massive children's rights campaigns. These campaigns were launched by non-governmental organisations (NGO's) and community-based organisations (CBO's) from the mid 1970's to the early 1990's.[139] The aim of these organisations was to emphasise the difficult conditions children were facing, as well as to protect the interests of defenceless children who were victims of discriminatory practices in the apartheid South Africa.[140] In addition, several conferences focusing on the impact of apartheid on the most vulnerable members of the society (women and children), were

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[133] Ngwena, 'Health care decision-making' 140.

[134] Section 45(4) of the Children's Act. It provides as follows: "Nothing in this Act shall be construed as limiting the inherent jurisdiction of the High Court as upper guardian of all children". See also Ngwena, 'Health care decision-making' 140.

[135] PQR Boberg, *Law of persons* (1 edn Juta 1977) 643.

[136] SA Strauss, *Doctor, Patient and the Law* (3 edn 1991) 171-74.

[137] Kashifa Abrahams and Tasneem Matthews, *Promoting children's rights in South Africa: a handbook for Members of Parliament* [Cape Town]: (Parliament of the Republic of South Africa 2011) 10 <http://www.parliament.gov.za> accessed on 09 October 2022.

[138] Tshepo L Mosikatsana, 'Children's Rights and Family Autonomy in the South African Context: A Comment on Children's Rights Under the Final Constitution' (1998) 3 Michigan Journal of Race and Law 343.

[139] Abrahams and Matthews, *Promoting Children's Rights in South Africa.* See also A Skelton 'Juvenile Justice Reform: Children's Rights and Responsibilities versus Crime Control' in Davel, C. J. (eds) *Children's Rights in a Transitional Society* (1999).

[140] Abrahams and Matthews, *Promoting Children's Rights in South Africa*.

held during the 1980's.[141] In 1987, a conference with a specific focus on women and children was held in Harare, Zimbabwe, where legitimate concerns regarding the plight of children were raised.[142] This conference provided a platform to those directly affected to voice the truth about the violent repression inflicted by apartheid, which included the beating, shooting, torture, detention and imprisonment of children. The conference further created a platform for all those whose work involved special responsibilities for children to firmly advocate for the protection of the children of South Africa and to help free them from the clutches of apartheid. One of the declarations the conference proclaimed at is as follows:

> We recognize that the children of South Africa cannot lead a normal life as long as the apartheid system remains. The children themselves, having recognized this fact, have displayed heroic courage in their readiness to engage their ruthless oppressors in daily struggle. Their commitment and determination is an inspiration to us all. We pledge ourselves, collectively and as individuals, to use all our resources to work towards the realization of a united non-racial and democratic South Africa and thereby ensure a speedy end of the racial tyranny whose violence spares neither old nor young-in South Africa, Namibia and throughout Southern Africa.[143]

Consequently, the conference made it possible for the African National Congress (ANC) in exile and the Mass Democratic Movement (MDM)[144] to be granted an opportunity to protect and to develop children's rights in South Africa.[145] During the period between 1987 and 1989, the United Nations International Children's Emergency Fund (UNICEF) issued a publication which led to an extensive mobilisation on the rights of children in South Africa.[146]

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[141] Sharmla Rama and Sulaiman Bah, 'Monitoring Child Rights in a Society in Transition: The Opportunities Afforded by a Transformed Statistical Agency and the Culture of Child Rights Activism' (2000, Discussion document) <http://www.statssa.gov.za> accessed on 09 October 2022.

[142] The International Conference on "Children Repression and the Law in Apartheid South Africa" took place from the 24-27 September 1987. See Rama and Bah 'Monitoring Child Rights in a Society in Transition'.

[143] United Nations, 'United Nations Centre against Apartheid "Declaration of The International Conference on Children, Repression and the Law in Apartheid South Africa, held in Harare, Zimbabwe, 24-27 September 1987"' (1988) 13 Alternatives Global Local Politics 411-412. <https://doi.org/10.1177/030437548801300307> accessed on the 10 October 2022.

[144] This is the name granted to the anti-apartheid movement in South Africa. See Rama and Bah, 'Monitoring Child Rights in a Society in Transition.'

[145] Rama and Bah 'Monitoring Child Rights in a Society in Transition.'

[146] The publication was entitled "Children on the Frontline: The Impact of Apartheid, Destabilisation and Warfare on Children in Southern and South Africa". See Rama and Bah 'Monitoring Child Rights in a Society in Transition.'

Several meetings conducted between MDM members, NGO's and UNICEF led to the formation of the National Committee on the Rights of the Child.[147] Although South Africa had a history of children's rights movements in both the national and international spheres, many laws that aggravated the ill-treatment of children continued to be rooted in the apartheid legal system. Because of its gross human rights violations, South Africa as a nation became side-lined from the international stage.[148]

The UNCRC, in collaboration with UNICEF, however supported South Africa's post-apartheid government to institutionalise children's rights as a fundamental pillar of the country's new democracy. From the period 1990 to 1992, the negotiations, known as the Convention for a Democratic South Africa (CODESA), convened to negotiate a way out of apartheid and to forge a smooth transitional process towards democracy. The UNCRC addressed the major political parties present on the need for the Government of National Unity which should prioritise the rights of children.[149] In 1992, over 200 South African children[150] gathered at the International Summit on the Rights of Children facilitated by the NGO forum. The purpose of the summit was to address the gross violations of children's rights and the challenges they continued to face following apartheid.[151] The drafting of the South African Children's Charter was influenced by the International Summit's intense debates and consultations.[152] The

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[147] NCRC became the first national organisation that was promoting the rights of children in South Africa. See Rama and Bah, 'Monitoring Child Rights in a Society in Transition.'

[148] Warrend Binford, 'The Constitutionalization of the Children's Rights in South Africa' (2016) 60 NYLS Law Review 342.

[149] Rama and Bah, 'Monitoring Child Rights in a Society in Transition.'

[150] These children were aged between 12 and 16 from 20 different regions in South Africa. They came from different backgrounds and their representation was in terms of race, class, gender and disability. Workshops in preparation of the Summit were held moths before, the aim being to identify needs and goals for the Summit. Children were then elected or nominated by other children to attend and represent their regions at the Summit. See 'South African Children speak out' (1993) 1 International Journal of Children's Rights 71.

[151] The International Summit on the Rights of Children in South Africa was held from May 27 through June 1, 1992, in the Western Cape, Cape Town, South Africa. See Barbara Bennett Woodhouse, 'Recognizing Children's Rights: Lessons from South Africa' (1999) 26 Human Rights 15.

[152] The Children's Charter of South Africa. The preamble of the Charter asserts as follows: "Realizing that, all children are created equal and are entitled to basic human rights and freedoms and that all children deserve respect and special care and protection as they develop and grow and Recognizing that, within South Africa, children have not been treated with respect and dignity, but as a direct result of Apartheid have been subjected to discrimination, violence and racism that has destroyed families and communities and has disrupted education and social relationships and

Children's Charter of South Africa became a historical turning point in realising a culture for children's participation in the advocacy of their rights in South Africa.[153] The Children's Charter further reflected the voices of South African children, including their despairing appeal to be respected and consulted on issues affecting them and their future.[154] As part of the summit resolutions, the plight of children as recognised in the Children's Charter was to be given a significant value by those engaged in the drafting of the final Constitution.[155] In the same year, 1992, the UNCRC continued advocating for the rights of children during CODESA negotiations, calling upon political parties to prioritise the rights of the child. The South African Children's Charter was also submitted to the CODESA participants.[156] The submissions that were made found their way into the introduction of the Constitution and the Bill of Rights.[157]

The basic idea was that children's rights should be designed to capture the value of children as developing citizens. Further, to safeguard their rights and afford them an opportunity to develop an understanding of their rights and gain proficiency in exercising those rights. Consequently, the UNCRC ensured that the rights of the child became entrenched in the Constitution of South Africa.[158]

Acknowledging that, at the present time, children have not been placed on the agenda of any political party, or the existing government or within the CODESA negotiations and are not given the attention that they deserve.
Taking into consideration the cultural values, languages, and traditions of all the children and,
Recognizing the urgent need for attention to improving the life of children and protecting their rights in every region, in particular those regions which have been especially subjected to violence, political unrest and poverty…" <https://www.naturalchild.org/articles/advocacy/childrens_charter.html> accessed on 10 October 2022.

[153] The Children's Charter of South Africa recognised many of the children's rights. These rights were previously recognised by the Union of South Africa, Nelson Mandela, and the African National Congress (ANC), and that were demanded by the children of South Africa, including rights to name and nationality; freedom from discrimination; freedom of expression; free legal representation; freedom of religion; cultural integrity; freedom from violence; freedom from wrongful detention; a healthy and loving family life; clean water, food security, and economic well-being; free and universal compulsory education; freedom from slavery and exploitative child labour; and housing. See the Children's Charter of South Africa. See also Binford, 'The Constitutionalization of the Children's Rights' 343.

[154] "South African Children speak out" 71.

[155] "South African Children speak out" 71.

[156] This submission was made by children who were given an opportunity to participate. See Rama and Bah, 'Monitoring Child Rights in a Society in Transition.'

[157] Ann Skelton, 'Children's Rights' in Jason Brickhill (ed), *Public Interest Litigation in South Africa* (Juta, 2018) 259.

[158] Rama and Bah, 'Monitoring Child Rights in a Society in Transition.'

2.4.1 Health care services during apartheid

Health care services in South Africa under apartheid were "fragmented, inadequate, ineffective, poorly distributed and inefficiently distributed" and children continued to be afflicted by the consequences of the apartheid system.[159] Apartheid thrived from the 1940's till the early 1990's in South Africa. It was a repressive system created by the then government of South Africa. This system consisted of an institutionalised segregation which classified people into racial groups, such as whites, Indians, coloureds and blacks.[160] The system gave preference to a small minority of white South Africans and created class divisions which forced people to migrate to *homelands* which were divided along ethnic grounds.[161] Resultantly, health care services for whites were better than those of the other class divisions, with services provided to blacks being the worst. Access to health care services was also significantly worse for blacks in rural areas in comparison to their urban counterparts. Consequently, basic health care remained out of reach for most of the black population for a prolonged period of time.[162]

2.4.2 The child defined

Etymology reflects that the concept *child* is derived from the Latin *infans* meaning "the one who does not speak".[163] Broadly speaking, a child refers to a human being from birth until adulthood.[164] The 'child' in the South African Constitution refers to "a person under the age of 18 years."[165] Similarly, the Children's Act describes a child as a person under the age of 18.[166] It also states that a child, male and female equally, will

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[159] Yogan G Pillay and Patrick Bond, 'Health and social policies in the New South Africa' (1995) 25 International Journal of Health Services 727-743 <http://dx.doi.org/10.2190/yju7-0hdm-7tyw-xlmf> accessed on 08 October 2022.

[160] Hoosen Coovadia and others, 'The health and health system of South Africa: historical roots of current public health challenges' (2009) 374 Lancet 817-834 <https://doi.org/10.1016/S0140-6736(09)60951-X> accessed on 10 October 2022.

[161] This was made possible through the Group Areas Act of 1950. In terms of the Act non-white people were not allowed to live in developed areas of the cities which were made exclusively for white people. See also Coovadia and others, 'The health and health system of South Africa.'

[162] Coovadia and others, 'The health and health system of South Africa.'

[163] Devnarayan Meena, 'Legal rights of Orphan Children in India– An attempt to study the role of society' [2020] Chhattisgarh Law Journal 147-155. See also Children's Right Education 'What are Children's Rights' <http://childrensrightseducation.com/childrens-rights.html> accessed on 15 October 2022.

[164] Meena, 'The Legal Rights' 2.

[165] Section 28(3) of the Constitution.

[166] Section 17 of Act 38 of 2005.

be regarded as major upon reaching the age of 18 years.[167] In this instance, age is the sole determining factor, unrelated to the psychological or physical development of a particular child.[168]

2.4.3 The Child Care Act 74 of 1983

The Child Care Act, repealed in 2006, afforded only children above the age of 14 the right to consent to medical treatment and non-surgical procedures.[169] Section 39(4)(b) provided that children over the age of 14 years could consent to medical treatment, whilst children above the age of 18[170] years were competent to consent to surgical procedures without parental consent.[171] In circumstances where consent could not be obtained from parents or legal guardians, a social worker had to send a report to the provincial Department of Social Development for authorisation, alternatively, the court had to be approached.[172] The medical superintendent could only give consent where it was not possible for the parents or guardians to do so.[173] This could only be conducted in emergency situations where treatment or surgery would preserve life or even avoid permanent disability.

Section 39(4) of the Child Care Act clearly did not exclude parental rights. This section's parent centredness was inconsistent with the provisions of section 5 of the Choice on Termination of Pregnancy Act 92 of 1996[174] (CTPA) which permits minors, regardless of age, to consent to an abortion during the first 12 weeks of the gestation period of her pregnancy. In terms of this section, a minor is able to obtain an abortion without parental consent. The minor's abortion can be performed even against the wishes of her parents or guardians.[175] The Act also suggests that the minor concerned

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[167] Section 17.

[168] Section 1(g).

[169] Child Care Act, 1983. Section 39(4)(b) provides as follows: "any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child".

[170] The age of majority was 21 years at the time. Age of Majority Act 57 of 1992, s 1.

[171] Section 39(4)(b) of the Child Care Act.

[172] Section 39(1).

[173] Section 39(2).

[174] It replaced the old law of Abortion and Sterilisation Act of 1975.

[175] Section 5 (1-3) of the act provides as follows: "(l) Subject to the provisions of subsections (4) and (5), the termination of a 45 pregnancy may only take place with the informed consent of the pregnant woman.

is in the best position to make that decision, and health care professionals cannot infringe upon her rights.[176] This is in support of the Act's purpose, which amongst others, "extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs".[177]

In 1995 the government established that the Child Care Act was no longer relevant to South Africa and had to undergo a review process.[178] The process began when the Minister of Justice made a proposal to the South African Law Commission[179] to include an investigation into issues relating to juvenile justice in its programmes.[180] The law reform was necessitated by the realisation that there were a number of shortcomings found with the Act, one of which pertained to the Act's failure to fully acknowledge children as rights-holders.[181] The project Committee established by the South African Law Commission declared the Act as "an apartheid statute" and as a result outdated.[182] The review process began in 1997, with the aim to develop recommendations for "new, appropriate and far-reaching child legislation" which would give life to the UNCRC.[183] It should be considered that the Child Care Act was drafted

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(2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.

(3) In the case of a pregnant minor, a medical practitioner, or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them".

[176] Section 5 of Choice on Termination of Pregnancy Act 92 of 1996.

[177] Preamble of Choice on Termination of Pregnancy Act.

[178] Roseline September, 'A New Children's Act for South Africa: Making it work For Children and Families' **(**2008) 44 Social Work 143 <http://dx.doi.org/10.15270/44-2-247> accessed on 16 October 2022. See also UNICEF Innocenti Publications, 'Reforming Child Law In South Africa: Budgeting and Implementation Planning' [2007] 19 <https://www.unicef-irc.org/publications/pdf/reformingchildlaw_reprint.pdf> accessed on 16 October 2022.

[179] The South African Law Commission Act, 1973 (Act 19 of 1973) provides for the establishment of a South African Law Commission. In terms of Section 4 of the Act, the SALC's function is to, *inter alia, "* do research with reference to all branches of the law of the Republic and to study and to investigate all such branches of the law in order to make recommendations for the development, improvement, modernization or reform thereof, including - (a) the repeal of obsolete or unnecessary provisions; (b) the removal of anomalies; (c) the bringing about of uniformity in the law in force in the various parts of the Republic; (d) the consolidation or codification of any branch of the law; and (e) steps aimed at making the common law more readily available".

[180] UNICEF 'Reforming Child Law' 19.

[181] UNICEF 'Reforming Child law' 19.

[182] Carmel R Matthias and Frederick N Zaal, 'Supporting Familial and Community Care for Children: Legislative Reform and Implementation Challenges in South Africa' (2008) (18) International Journal of Social Welfare 292. See also September, 'A New Children's Act for South Arica' 143.

[183] South African Law Commission, 'The Review of the Child Care Act' (Issue Paper 13: 1998) 27.

and promulgated during apartheid era, before the negotiation and adoption of the Constitution. The Act was clearly misaligned with a child's constitutional rights as entrenched in section 28[184] of the Constitution, as well as similar provisions contained in international law. There was an urgent need for a new law which would fully recognise and afford participation rights to children in matters that affect them.[185]

2.5 Children's rights in the constitutional era

A fundamental change concerning children's rights happened in 1994 with the dawning of the Constitution. This period ushered in the recognition of inalienable rights, including the right of access to health care services for all South Africans, regardless of race. Attention was also paid to the recognition of and respect for a particularly vulnerable, often ignored group in society, namely children.[186]

The Constitution provides in section 12(2)(a) that "everyone has the right to bodily and psychological integrity, which includes the right … to make decisions concerning reproduction."[187] The Constitution additionally recognises everyone's the right of access to health care services, which includes reproductive health care services.[188] The CTPA may be seen as reflecting a recognition of reproductive choices as an essential component in the achievement of women's equality, security, and human

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[184] The section provides an important benchmark in the rights of children. It states as follows: "(1) Every child has the right— (a) to a name and a nationality from birth; (b) to family care or parental care, or to appropriate alternative care when removed from the family environment; (c) to basic nutrition, shelter, basic health care services and social services; (d) to be protected from maltreatment, neglect, abuse or degradation; (e) to be protected from exploitative labour practices; (f) not to be required or permitted to perform work or provide services that— (i) are inappropriate for a person of that child's age; or (ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development; Chapter 2: Bill of Rights 12 (g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be— (i) kept separately from detained persons over the age of 18 years; and (ii) treated in a manner, and kept in conditions, that take account of the child's age; (h) to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and (i) not to be used directly in armed conflict, and to be protected in times of armed conflict. (2) A child's best interests are of paramount importance in every matter concerning the child. (3) In this section "child" means a person under the age of 18 years".

[185] September, 'A New Children's Act' 143.

[186] *Mpofu v Minister for Justice and Constitutional Development and Others* 2013 ZACC (15); 2013 (9) BCLR 1072 (CC); 2013 (2) SACR 407 (CC) para 1 Van der Westhuizen J provides that "Children are a particularly vulnerable group in our society, deserving of protection".

[187] Section 12(2)(a).

[188] Section 27(1)(a).

dignity. Section 130(1) of the Children's Act provides for consent by children (12 years and older) to HIV testing as a special provision on condition that such a test is in the best interest of the child.[189] In terms of section 130(2), consent for an HIV test may be obtained from, among others:

> (a) The child, if the child is-
>
> (i) 12 years of age or older; or
>
> (ii) If the child is 12 years of age or older, or the child is under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test.[190]

In terms of the above provisions, a girl of any age may consent to an abortion, additionally, consent for an HIV test may be given by a child of 12 years or older without parental consent. This child may individually consent to an HIV test on condition that he or she is mature enough to understand its benefits, risks and social implications that may accompany an HIV test.

Section 134 highlights another varying demonstrative burden on children and health care professionals relating to different health procedures and interventions. This section uses the benchmark of 12 as an age that entitles a child to have access to condoms and other contraceptives without the consent of a parent or guardian. It seems to suggest that attaining the age of 12 or older makes a child capable of making autonomous decisions, at least in the context of his or her reproductive health.[191] It provides that:

> (1) No person may refuse to –
>
> (a) to sell condoms to a child over the age of 12 years; or
>
> (b) to provide a child over the age of 12 years with condoms on request where condoms are provided or distributed free of charge.
>
> (2) Contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or care-giver of the child if-

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[189] Children's Act.

[190] Children's Act.

[191] Wandile Ganya, Sharon Kling and Keymanthri Moodley, 'Autonomy of the child in the South African context: is a 12-year-old of sufficient maturity to consent to medical treatment?' (2016) 17 BMC Medical Ethics <https://doi.org/10.1186/s12910-016-0150-0> accessed on 20 October 2022.

> (a) the child is at least 12 years of age;
>
> (b) proper medical advice is given to the child; and
>
> (c) a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child. [192]

In consideration, both sections 12(2)(a) and 27(1)(a) of the Constitution read with section 5 of the CTPA and sections 130 and 134 of the Children's Act, strengthens and promotes autonomous decision-making for children in matters affecting their health or life circumstances.[193]

This thesis argues in further chapters that this significant step in respecting the rights of a child to choose to end or continue with a pregnancy in the early stages, as well as the child's right to bodily integrity and reproductive autonomy, should also apply to children who wish to have gender reassignment procedures.

Shortly after the enactment of the final Constitution, the National Health Act 61 (NHA) was promulgated in 2003. The NHA aims to facilitate children's rights in a health care context and elaborates on accessing constitutional rights. It provides "a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services".[194] The triad of the Constitution, the NHA and the Children's Act may be credited with giving effect to children's rights in the health context, which is the backdrop for this thesis.

The following discussion will turn to legislative changes relating to children's consent to medical treatment following the promulgation of the Children's Act. Consideration will also be given to the rights to equality, dignity and privacy, as they are core to prohibiting unfair discrimination based on gender identity and for providing a safe, welcoming environment for transgender and gender diverse individuals.

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[192] Children's Act.

[193] Section 2 of Choice on Termination of Pregnancy Act 92 of 1996.

[194] The preamble to the Act.

2.5.1 Children's age of consent to medical treatment

The Children's Act provides that a child is a person under the age of 18 years. Furthermore, the Children's Act, considers a child as having absolute individuality, a right-holder who is not merely an extension of his/her parents or an object of adult concern.[195] Sachs J's observation is as follows:

> Every child has his or her own dignity. If a child is to be constitutionally imagined as an individual with a distinctive personality, and not merely as a miniature adult waiting to reach full size, he or she cannot be treated as a mere extension of his or her parents umbilically destined to sink or swim with them.[196]

Children are considered sufficiently developed, with a sense of responsibility to participate in socio-economic issues on equal terms with adults. The Act recognises the importance of considering the child's evolving capacities,[197] which includes the right to express their views freely in matters affecting them. Section 129 of the Children's Act is of particular interest as it pertains to the consent of children to medical treatment and surgical procedures specifically.

Section 129 expressly dictates the prerequisites for children consenting to their own medical treatment. It stipulates as follows:

> A child may consent to his or her own medical treatment or to the medical treatment of his or her child if-
>
> (a) the child is over the age of 12 years; and
>
> (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.[198]

Section 129 of the Children's Act has thus introduced a lower threshold for age of consent as a means to promote access to health services and to promote participation

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[195] Medical Protection Society, 'Consent: Children and young people' 2014 <http://www.medicalprotection.org/docs/default-source/pdfs/sa-junior-doctor-pdfs/may-2014.pdf?sfvrsn=2> accessed on 13 October 2022.

[196] *S v M* para 18.

[197] Ann Strode, Catherine Slack and Zaynab Essack, 'Child consent in South African Law: Implications for researchers, service providers and policy-makers' (2010) 100 South African Medical Journal 247-249.

[198] Children's Act.

of children in health decisions affecting them in accordance with domestic and international trends.[199]

The age at which a child can individually consent to medical treatment (12 years) is not the only key issue. In terms of sections 129(2)(a) and 129(2)(b) of the Children's Act, there are two requirements to be met before a child can access medical treatment on his/her own accord without any consent from a parent, guardian, or caregiver. The child must have "sufficient maturity" and decisional capacity to understand the "benefits, risks, social and other implications of the treatment".[200]

2.5.2 *Children's consent to surgery*

With regards to surgery, section 129(3) reads as follows:

> A child may consent to the performance of a surgical operation on him or her or his or her child if-
>
> (a) the child is over the age of 12 years; and
>
> (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
>
> (c) the child is duly assisted by his or her parent or guardian.

It is submitted that a little reflection will indicate that some difficulties are likely to arise in the construction and application of section 129(3). This is because it has an [unnecessary] additional safeguard regarding a child's consent to surgical procedures. The child cannot individually decide according to his/her wishes or choice, because "assistance" from a parent or guardian is a requirement. By implication, the health care provider will not be able to perform a gender reassignment procedure on a minor without the consent of the parent or guardian. In the context of gender reassignment surgery, the minor's wishes may potentially be overridden if the parents or guardians do not provide the required "assistance". This means that in such a case, only the instructions of the parent or the minister or the court ordered consent will be followed.

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[199] WR Du Preez, 'The Medical Treatment of Children and the Children's Act 38 of 2005' [2012] <http://hdl.handle.net/2263/27868> accessed on 13 October 2022.

[200] Thoko Kaime, 'The African Children's Charter: Does it represent a relevant vision of childhood and children's rights?' (2009) 29 Children's Legal Rights Journal 11-29.

The fact that a minor's capacity to consent to surgery according to the Children's Act depends not only on his/her maturity but mainly on the child's age, complicates matters for children who are mature enough to consent to treatment but have not yet reached the age of autonomous consent.

It may be argued that the explicit requirement that the child must be mature enough to understand the consequences and the risk of the surgical procedure strengthens the protection of children lacking the developmental maturity. However, as outlined, it is evident from the provisions of section 129(3) that maturity is not the only key requirement. The child's age could prevent him/her from having surgery performed on him/her without parental assistance despite the child having passed the maturity test. Determining maturity is a complex matter. Who bears the responsibility of making this determination—the parents or guardian of a child, or the health care practitioner involved? Ross rightly raises a concern that even practitioners who may be trusted with the responsibility of assessing are not trained to assess the decision-making abilities of children. He further states that one other problem is that there is no existing (or formally acknowledged or prescribed) test to evaluate maturity.[201] It is therefore, submitted that section 129(3) fails to recognise the maturity of a minor who has reached a level of understanding similar to that of an adult, especially considering the constitutional recognition of the right to physical and psychological integrity, including autonomy. The anomaly with the provisions of the CTPA is again relevant here. An adolescent girl of 12 years may be able to fall pregnant and decide on the termination of her pregnancy without her parents' or guardian's consent or knowledge. The Act furthermore stipulates that a medical practitioner or a registered midwife must advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated.'[202] In general, a minor retains a discretion to act in accordance with the advice, failure to inform or consult does not affect her right to terminate. It is submitted that terminating a pregnancy is a type of intervention that is associated with serious emotional and physical consequences that cannot be compared to ordinary surgery. In the latter instance, age is not a factor for the

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[201] Lainie Ross, 'Health care decision-making by children: Is it in their best interest?' In M Freeman (ed) *Children, medicine and the law* (2006) 490.

[202] Section 5(3) of the CTPA.

legislator, but bizarrely enough, it is relevant for the purposes of section 129 of the Children's Act.

Although the Children's Act does not define the concept of "sufficient maturity", Ganya argues that it can be inferred that a degree of cognitive development affords a child the kind of engagement necessary in decision-making.[203] Such an engagement is comparable to that of fully developed persons, namely, adults.[204] In addition, the guidelines for South Africa's National Department of Health's HIV Counselling and Testing Policy provide that children who are considered to be sufficiently matured can "demonstrate that they understand information on HIV testing and can act in accordance with that appreciation".[205]

Havenga and Temane notes that as much as the National Department of Health's Policy seems to suggest that maturity is determined by cognitive ability, it should be considered that maturity also "includes levels of physical, emotional, and moral development".[206] They further argue that children who had exposure to surgery, illness, hospitalisation and health care are likely to have a mental ability to understand health care related matters.[207] From what has been analysed above, a child concerned needs to have the mental capacity to make reasoned treatment decisions and be accountable for the decision in the specific situation.

Therefore, the child who is above the statutory age of consent, and is of sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of a surgical operation must be allowed to consent to the performance of a surgical operation on him/her.[208] Additionally, the parent or guardian of the child must "duly assist" the child with his/her consent regarding the performance of a surgical

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[203] Ganya and others, 'Autonomy of the child in the South African context.'

[204] Du Preez, 'The Medical Treatment of Children and the Children's Act 38 of 2005.'

[205] Department of Health, South Africa, *National HIV counselling and testing (HCT) policy guidelines*. Pretoria, South Africa (2010): National Department of Health.

[206] Y Havenga and M Temane, 'Consent by children: Considerations when assessing maturity and mental capacity' (2016) 58 South African Family Practice 43-46. <https://doi.org/10.1080/20786190.2014.977058> accessed on 16 November 2022.

[207] Havenga and Temane, 'Consent by children.'

[208] Section (3)(a) and (b).

procedure.[209] The notion of assistance in terms of section 129(3)(c) of the Act ought to be interpreted differently from the assistance in terms of section 14.[210] Children who lacks sufficient maturity and mental capacity to comprehend the benefits, risks and social implications of a surgical procedure should receive consent from the parent or guardian.[211] In circumstances where the minor has no parent or guardian, the *curator ad litem* must consent. Section 129(9) also, makes provision for the High Court or Children's Court to make an order of consent where the court has found that a person who may legally consent on behalf of a child, refuses or is unable to consent to a surgical procedure to be done on a child. [212]

Section 129(3) of the Act is not subject to section 31 of the Act. It in fact, provides an opportunity to realise section 31 as it links the child's right to participation with the consideration that should be afforded to children's views and wishes by persons with parental responsibilities and rights.[213] Section 31 deals with major decisions involving the child. It provides that views of the child must be considered in all matters where the child would be affected in a significant or an adverse way. Subsection 1(a)

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[209] MN Slabbert, 'Parental Access to Minors' Health Records in the South African Health Care Context: Concerns and Recommendations' (2004) 2 Potchefstroom Electronic Law Journal 171. She mentions that the requirement for assistance of a child twelve years and older with sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of the surgical operation, is difficult to understand. She poses the questions what would be the implication if the parent does not assist the child or refuses to assist the child? The answer to these questions appears to be in ss 129(7)(a) to (d) and 129(9) of the Act.

[210] Section 14 provides as follows: "[e]very child has the right to bring, and to be assisted in bringing a matter to a court, provided that matter falls within the jurisdiction of that court". The word 'assist' in s 14 of the Act deals with the child's right when instituting proceedings at court, and in this instance, the principle remains the same. In terms of common law, minors had no *persona standi in iudicio* and could not institute court proceedings or defend legal proceedings without the assistance of their parents or guardians. Therefore, a parent, guardian or person with parental responsibilities and rights must assist minors in their representative capacity. The same principle could apply in the agreement for surgical intervention. Davel and Skelton in Commentary on the Children's Act 2-23 writes that s 14 of the Children's Act has a general application and is thus not confined to matters relating to the Children's Act. Its application is wider than representation in s 28(1)(h) of the Constitution and should there be the choice to approach the court to nullify the parent's refusal to assist in terms of s 129(3)(c), the child may be assisted by curator ad litem or a legal representative in terms of s 28(1)(h) of the Constitution.

[211] As is provided for in s 129(4)(b) of the Act, but subject to s 31 of the Act.

[212] Children's Act.

[213] This section deals with a child below the age of 12 and it provides a s follows: "The parent, guardian or care-giver of a child may, subject to section 31, consent to the medical treatment of the child if the child is- (a) under the age of 12 years; or (b) over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment". It is therefore, clear the provision of the section that the parent, guardian or person with parental responsibilities and rights is not required to "give due consideration to any views and wishes expressed by the child, bearing in mind the child's age, maturity and stage of development".

specifically provides that the child's age, maturity and stage of development and the view of the child must be considered when a major decision is taken regarding the child. This subsection recognises that a child's development is not a static condition.[214] Further that as children grow older, they naturally become more matured. It is also a fact that some children may be capacitated to take serious health care decisions at an earlier age than their counterparts.[215] Parents should, therefore, facilitate child participation in all disputes concerning the child in accordance with the provisions of section 31(1)(a) of the Act. Parents should, ensure that children are informed of any action or decision taken concerning them, especially in matters which significantly affects the concerned children. As Yasenik and other provides:

> [g]aining a sense of the child through meeting the child is the only way to know who the child is and how the child is managing and coping, without relying on others' perceptions.[216]

As outlined above, the inherent problem with the Children's Act is that it does not provide guidelines on how the health care practitioner ought to assess a child's decisional capacity. This is exacerbated by the fact that there currently is no standard objective tool for assessing the decisional capacity of children.[217] As a result, decision makers use their wide discretionary powers when assessing the child's decisional capacity, and those decisions could be made according to their own principles and standards. However, the Act has introduced a child-centric approach entrenched in the fundamental understanding of every child as a unique individual with preferences and interests.[218] This approach has a bearing on the determination of the individual child's best interests as they are inextricably connected to the specifics of their situation.

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[214] Carina Van der Westhuizen, 'Medical treatment v surgery: where does medical treatment end and surgery begin in terms of section 129 of the Children's Act?' 2018 (39) Obiter 793.

[215] Van der Westhuizen, 'Medical treatment v surgery' 793.

[216] Lorri Yasenik, Jonathan Graham and Linda Fieldstone, 'Child Voice in Parenting Coordination: Toward a Model of Inclusion' 2020 Family Court Review 763 <https://doi.org/10.1111/fcre.12511> accessed on 19 October 2022.

[217] Irma Hein and others, 'Assessing children's competence to consent in research by a standardized tool: a validity study' (2012) 12 BMC Pediatrics <https://bmcpediatr.biomedcentral.com/articles/10.1186/1471-2431-12-156> accessed on 19 October 2022.

[218] Section 28(2).

2.5.3 Children's consent to research

Loveday and others[219] argue that the South African legal frameworks have conflicting positions on who should provide informed consent for adolescents, especially in health-related research matters. This lack of clear legal guidelines demarcating the circumstances under which adolescents can provide independent consent pose major challenges and continuing confusion.[220] They perpetuate a debate about the proper interpretation of legal principles and research ethics guidelines about who may provide consent. They further impede on the adolescents' capacity to provide their own consent to participate in health-related research. Section 71 of the NHA requires mandatory active written consent from a parent or legal guardian for all research conducted with minors. The section provides as follows:

> (1) Notwithstanding anything to the contrary in any other law, research or experimentation on a living person may only be conducted-
>
> (a) in the prescribed manner; and
>
> (b) with the written consent of the person after he or she has been informed of the objects of the research or experimentation and any possible positive or negative consequences on his or her health.
>
> (2) Where research or experimentation is to be conducted on a minor for a therapeutic purpose, the research or experimentation may only be conducted-
>
> (a) if it is in the best interests of the minor;
>
> (b) in such manner and on such conditions as may be prescribed;
>
> (c) with the consent of the parent or guardian of the child; and
>
> (d) if the minor is capable of understanding, with the consent of the minor.
>
> (3) (a) Where research or experimentation is to be conducted on a minor for a non-therapeutic purpose, the research or experimentation may only be conducted-
>
> (i) in such manner and on such conditions as may be prescribed; (ii) with the consent of the Minister;
>
> (iii) with the consent of the parent or guardian of the minor; and
>
> (iv) if the minor is capable of understanding, the consent of the minor.

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[219] M Loveday and others, 'Ethically Acceptable Consent Approaches to Adolescent Research in South Africa' 2022 (23) Southern African Journal of HIV Medicine <https://doi.org/10.4102/sajhivmed.v23i1.1385> accessed on 20 October 2022.

[220] Loveday and others, 'Ethically Acceptable Consent Approaches.'

> (b) The Minister may not give consent in circumstances where-
>
> (i) the objects of the research or experimentation can also be achieved if it is conducted on an adult;
>
> (ii) the research or experimentation is not likely to significantly improve scientific understanding of the minor's condition, disease or disorder to such an extent that it will result in significant benefit to the minor or other minors;
>
> (iii) the reasons for the consent to the research or experimentation by the parent or guardian and, if applicable, the minor are contrary to public policy;
>
> (iv) the research or experimentation poses a significant risk to the health of the minor; or (v) there is some risk to the health or wellbeing of the minor and the potential benefit of the research or experimentation does not significantly outweigh that risk.

With reference to research (both therapeutic and non-therapeutic)[221] conducted with children, subsection (2) and (3) require written consent from a parent or a legal guardian, irrespective of a particular child's age. These provisions place the parent or legal guardian's provision of informed consent which is a requirement for their child's involvement in research as a model in contrast with the children's autonomy as provided in sections 129(2)(a) and 129(2)(b) of the Children's Act.[222]

In addition, minors can jointly consent with their parents or legal guardians on condition that they have sufficient understanding. The section, however, seem to leave no room for independent adolescent consent, especially relating to studies exploring their sexual and reproductive health. The criticisms against these provisions are that they fail to sufficiently take into account the emerging autonomy of the adolescent.[223] Section 71 of the NHA also seems to be counter-productive in that it allows children to independently access services that impact their sexual, general, and mental health, but prevents them from accessing research that could be of great benefit to them without legal guardians on grounds of "diminished capacity and autonomy".[224] The over-emphasis of consent from parents or guardians further excludes other caregivers in giving consent for a child's participation in research, especially taking into account

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[221] The Regulations defines therapeutic research as being research "that holds out the prospect of direct benefit" to the child participant, whist non-therapeutic research is defined as "research that does not hold out the prospect of direct benefit to the participant but holds out the prospect of generalizable knowledge". See South African Government. Regulations Relating to Research with Human Participants. Government Gazette No. R 719 of 19 September 2014.

[222] Children's Act.

[223] Loveday and others, 'Ethically Acceptable Consent Approaches.'

[224] Loveday and others, 'Ethically Acceptable Consent Approaches.'

situations where children do not reside with either a parent or a guardian.[225] I am of the view that the stricter control placed on children regarding research does not only disregard the emerging autonomy of the child, but it is also in contravention of sections 129(2)(a) and 129(2)(b) of the Children's Act. Consequently, it is not in the best interests of children and may also be undermining their constitutional rights.

In 2020, the 3rd edition of the South African ethical guidelines referred to as South African Good Clinical Practice: Clinical Trial Guidelines (SA GCP 2020) was released.[226] This guideline supersedes the guidelines that were originally published in 2006 that took a different approach to child research. These guidelines provide that research with children is acceptable for studies with no direct benefit to participants on condition that they present no greater than minimal risk. In terms of this guidelines, a study which presents more than minimal risk, but has the prospect of direct benefit for participants, may result in the risks being justified by the anticipated benefit. Regarding informed consent for other forms of health research, the consent of the parent is required, however, the minor's independent consent is sufficient for older adolescents in low-risk research. The guidelines also make provision for consent by custodians of children in some circumstances.

The 2015 Department of Health Guidelines on Ethics in Health Research[227] states that in some situations children and especially older adolescents may consent independently to research as long as: (i) the research poses no more than minimal risk to them; (ii) there is an ethical justification through engagement with communities and other involved parties for which children should independently consent; (iii) the Research Ethics Committee (REC) has approved that parental consent should be waived.

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[225] Ann Elaine Strode and Catherine May Slack, 'Using the concept of "parental responsibilities and rights" to identify adults able to provide proxy consent to child research in South Africa' (2011) 4 South African Journal of Bio-ethics and Law 71.

[226] The document was released by the South African Health Products Regulatory Authority on the 21 July 2021.

[227] South African National Department of Health, Ethics in Health Research: principles, processes and structures 2015 Pretoria: National Department of Health <https://www.health.gov.za/nhrec-home/> accessed on 11 February 2023.

It is clear that there is an inconsistency between the NHA and the guidelines.[228] The NHA requires mandatory parental/legal guardian consent for health research involving children, on the other hand, the ethical guidelines offer a flexible approach to consensual issues. This flexibility includes granting authority to the Research ethics committees (RECs) to grant waivers of parental or guardianship consent under some circumstances.[229] Therefore, as Loveday and others argue, this disjuncture between the law and ethics on child consent needs to be addressed.[230]

2.5.4 Parents' refusal to consent

Children as right holders are entitled to obtain, as well as to refuse, health care services. The refusal of a parent to consent to a child's surgical procedure can affect the child's ability to obtain health care services. The Children's Act has specific provisions that serve as guidelines in cases where a parent refuses to consent to medical treatment and surgical operations of a child. These provisions are set out in section 129(7), and they read as follows:

> (7) The Minister may consent to the medical treatment of or surgical operation on a child if the parent or guardian of the child—
>
> (a) Unreasonably refuses to give consent or to assist the child in giving consent;
>
> (b) is incapable of giving consent or of assisting the child in giving consent;
>
> (c) cannot readily be traced; or
>
> (d) is deceased.
>
> (8) The Minister may consent to the medical treatment of or surgical operation on a child if the child unreasonably refuses to give consent.
>
> (9) A High Court or children's court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent
>
> (10) No parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsections (4) and (5) by reason only of religious or other beliefs, unless that parent or guardian can show

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[228] Loveday and others, 'Ethically Acceptable Consent Approaches.'

[229] South African National Department of Health, Ethics in Health Research. See also Ann Strode and Zaynab Essack, 'Parental waivers to enable adolescent participation in certain forms of health research: lessons from a South African case study' (2022) 23 BMC Medical <https://doi.org/10.1186/s12910-022-00833-5> accessed on 11 February 2023.

[230] Loveday and others, 'Ethically Acceptable Consent Approaches.'

> that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

It has been submitted that parents have different reasons for refusing to consent to their children's surgical operations. Such reasons may "pertain more to their rights as parents rather than the rights and interests of the child".[231] For example, most cases relate to parents refusing to give the required consent solely for religious reasons. The case of *Christian Education South Africa v Minister of Education*, bears reference. In this case it was held by the Constitutional Court that:

> Courts throughout the world have shown special solitude for protecting children from what they have regarded as the potentially injurious consequences of their parents' religious practices. It is now widely accepted that in every matter concerning the child, the child's best interest must be of paramount importance.[232]

Another case dealing with refusal based on religion is *Hay v B.*[233] In this case the court declared that the parent's refusal to consent to the blood transfusion of the child is unconstitutional and unlawful. Jajbhay J held that the best interests of the child dictates that his right to life must be protected, and that the religious beliefs of his parents could not override this right and other constitutional rights.[234]

From the above legislative provisions and judicial authority, it is clear that the High Court, as upper guardian of all children, will protect the rights of children in certain instances. The courts must ensure that no limitation is enforced against a child unless that limitation is in the best interests of a child.

2.5.5 Children's' participation

The Constitution and the Children's Act make provision for a child's right to participate and to have a voice in all matters affecting their future. Section 10 of the Children's Act provides as follows:

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[231] Caire Breen*, Age Discrimination and Children's Rights: Ensuring Equality and Acknowledging Difference* (Martinus Nijhoff 2006) 55.

[232] *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) Para 41.

[233] *Hay v B and Others* 2003 (3) SA 492 (W).

[234] Para 494-495. The court held as follows: "In my view, the limitation imposed by section 129 (10) on the parent's right to object to the medical treatment of a child for religious reasons reflects a balancing of the child's right to life and to have his best interests inform all decisions concerning the child against the parents' right to religion".

> Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.

Child participation underpins the democratic values such as equality, freedom of expression;[235] freedom of opinion[236] and the best interest of the child.[237] De Waal and others argue that children's right to self-determination [participation] is difficult and complex to resolve and requires "a balance to be struck between the interests of children, parents and the state".[238] Boniface submits that 'participation" is not only limited to taking part in an activity, but it also refers specifically to taking part in decision-making.[239] She further alludes that the "participation principle" creates a space for a child to think and act independently. The principle expects adults to place more value on the child's inputs.[240] Decision makers are therefore obliged to respect, protect, and promote the child's participation rights in matters affecting them. Kenny explains how this may play out in the health care context:

> The child's interests must always be the basis for a decision to be followed by the healthcare team. This approach does not discount the parents' concerns and authority, but it does recognise the child (albeit as a member of a family) as the particular patient to whom the healthcare team has a primary duty of care.[241]

Eekelaar is of the view that children should be seen as future adults,[242] but that such an exercise may be complicated by the conflicting interests between the children and their parents. Consequently, children's interests should be conceived only in terms of "those benefits which the subject himself or herself might plausibly claim in themselves".[243] He further proposes that in order to determine whether children have the ability to appreciate what will serve them best, adults should "make some kind of

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[235] Section 16(1)(b) which provided for the "freedom to receive or impart information or ideas".

[236] Section 15(1) provides that "Everyone has the right to freedom of conscience, religion, thought, belief and opinion".

[237] Section 7(1) of the Constitution provides as follows: "This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom".

[238] Currie and De Waal, T*he Bill of Rights Handbook* 457.

[239] Amanda E Boniface, 'Resolving Disputes with Regards to Child Participation in Divorce Mediation' (2013) 1 Speculum Juris 13-147.

[240] Boniface, 'Resolving Disputes' 1.

[241] Nuala Kenny, Jocelyn Downie and Christine Harrison, Respectful involvement of children in medical decision making. In: Singer PA, Viens AM (Eds) *The Cambridge Textbook of Bioethics* (Cambridge: Cambridge University Press 2008).

[242] J Eekelaar, 'The Emergence of Children's Rights (1986) 2 Oxford Journal of Legal Studies 166.

[243] Eekelaar 'The Emergence of children's Rights' 169.

an imaginative leap and guess what a child might retrospectively have wanted once it reaches a position of maturity”.[244] In this instance, an assumption on what is best for a specific child will be made. Freeman, on the other hand, argues that children should be understood as “potentially rational” and *that* should be the basis of attributing their rights.[245] Campbell, however, takes a different position and challenges the view of putting focus on rationality (or potential rationality).[246] He submits that the concept of “potential rationality” can impede on the notions of children’s rights and may be used to exclude children (and others) as lacking rationality from possessing rights. He argues that children’s interests, particularly their current interests in being a child, are of particular importance and should be the focal point.[247] This view suggest that children’s rights should be evaluated logically according to how well they serve their purpose, and that it should always be the child’s views that are sought.

The status of children as independent decision-makers is not accepted by some scholars, who maintain that children have limited capacity to know what is best for them. As a result, it is not always considered desirable to attribute autonomous rights to children. MacCormick writes:

> The presumption that people are the best judges of what is good for them and of whether to have it or not is not and should not be extended to children, certainly not young children… Children are not always or even usually the best judges of what is good for them, so much so that even the rights which are the most important to their long-term well-being, such as the right to discipline or to a safe environment, they regularly perceive as being the reverse of rights or advantages.[248]

Progressive views acknowledge that children depend on adults for nurture and guidance, however, there is a need that they should grow towards independence. Their participation, therefore, requires a parent-child relationship which will guarantee that their views are heard and valued in decisions that affect them. As Jewel writes:

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[244] Eekelaar, ‘The Emergence of Children’s Rights’ 170.

[245] M D A Freeman, The Limits of Children's Rights in Freeman, M D A and Veerman, P eds) *The Ideologies of Children's Rights* (Netherlands: Kluwer Academic Publishers 1992).

[246] Tom Campbell, ‘Really Equal Rights? Some Philosophical Comments on 'Why children shouldn't have equal rights' by Laura M. Purdy' (1994) 2 The International Journal of Children's Rights 259-263.

[247] Campbell, ‘Really Equal Rights?’

[248] Neil MacCormick, ‘Children's Rights: A Test-Case for Theories of Right’ (1976) 63 Archives for Philosophy of Law and Social Philosophy 305-317.

> Children should be educated to be ideal citizens, capable of making rational and informed decisions… [and]… societies that favour liberalism preach the primacy of the individual autonomous citizen and a concomitant tolerance for others.[249] (Own insertion)

For Campbell, the idea of viewing children as future adults is misguided, as this view is “very adult centred”. He proposes that the focus should rather be on children’s current concerns, including their situations and happiness.[250] Alderson and Goodwill argue that “…if children are defined by their incompetence, ignorance and folly, then *children’s rights* is essentially a contradictory term.”[251] Freeman warns that if a young child is denied the protection of nurturance rights, the likelihood is that he/she may never reach the stage of being in a position to assert or exercise the sort of autonomy envisaged by the liberationists.[252] It is submitted that parents cannot and should not monopolise wisdom, further, it should not be presumed that they know better. Under the Constitution, everyone has the right to freedom of conscience, religion, thought, belief and opinion.[253] Therefore, the fact that children do not have the capacity to be articulate or reason logically as adults, should not mean that their choices are irrational and do not deserve to be given due weight. This ideal is based on democratic principles, where an interest in equality, participation, and inclusion of a child’s wishes is paramount.

2.5.6 The best interests of the child

According to Skelton, the concept of the best interest principle was coined in the early 1900’s, and it was entrenched in our South African legal system through case law.[254] She further highlights that it was then an essential legal principle and not a right.[255]

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[249] Paul Jewel, ‘Autonomy and liberalism in a multicultural society’ (2005) 6 International Education Journal 494.

[250] Tom D Campbell, ‘The Rights of the Minor: as Person, as Child, as Juvenile, as Future Adult’ (1992) 6 International Journal of Law and Family 20-21.

[251] P Alderson and M Goodwin, ‘Contradictions in concepts of children's rights’ (1993) The International Journal of Children’s Rights 308.

[252] Freeman, `The limits of children's rights' 17.

[253] Section 15(1) of the Constitution.

[254] Ann Skelton, ‘Too much of a good thing? Best interests of the child in South African jurisprudence’ (2019) 52 De Jure Law Journal <http://dx.doi.org/10.17159/2225-7160/2019/v52a32> accessed on the 10 November 2022.

[255] It only became a right through its inclusion in an Interim Constitution which contained the Bill of Rights. Currie and De Waal attests that the inclusion of the best interests concept into the Constitution “elevates it from a mere guiding principle to a self-standing right that also strengthens other rights”. See Skelton “Too much of a good thing”; Currie and De Waal Bill of Rights Handbook 619.

The 1948 case of *Fletcher v Fletcher*[256] provided that the courts should consider the best interests of the child as the most important factor when decisions regarding a child are made. The court however, admitted that the *best interests* standard has always fallen short of being appropriately defined or given exhaustive content in both the national and international laws. The court further confirmed that it is not the rights of parents that should serve as a guiding factor, but the best interests standard, especially in matters concerning the child.[257] The applicable standard of the child's best interests was labelled by the courts as "a golden thread which runs throughout the whole fabric of our law relating to children".[258]

The initial best interests principle was later entrenched in the Constitution. The protection offered by the best interests principle had initially been applied in matters regarding child custody, the relationship between children and their parents, adoptions, and child protection.[259] Codifying section 28 into the Constitution now provides a benchmark in making children's rights a priority, including protection of children. Section 28(2) provides that "a child's best interests are of paramount importance in every matter concerning the child". A simple reading of the word "every matter", suggests that its scope is wide, and includes all legal matters concerning children.[260] The constitutional endorsement of the best interests principle extends the reach of its protection beyond the ambit of its previous application in the common law. In this regard, the explanation in the judgment of *Minister of Welfare and Population Development v Fitzpatrick and Others*[261] is significant:

> Section 28(2) requires that a child's best interests have paramount importance in every matter concerning the child. The plain meaning of the words clearly indicates that the reach of s 28(2) cannot be limited to the rights enumerated in s 28(1) and 28(2) must be interpreted to extend beyond those provisions. It creates a right that is independent of those specified in s 28(1).[262]

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[256] 1948 (1) SA 130 (A) 143.

[257] Bernard Bekink and Mildred Bekink, 'Defining the standard of the best interests of the child: Modern South African perspectives' (2004) 37 De Jure 22-23.

[258] *Kaiser v Chambers* 1969 4 SA 224 (C) 228F.

[259] Lize Mills, 'Failing Children: The Courts' Disregard of the Best Interests of the Child in Le Roux v Dey' (2014) 131 South African Law Journal 847-848.

[260] K Muller and M Tait, 'The best interest of children: a criminal law concept' (1999) 32 De Jure 323.

[261] *Minister of Welfare and Population Development v Fitzpatrick and Others* 2000 (3) SA 422 (CC).

[262] Para 17.

The best interests clause enshrined in section 28(2) has an unlimited scope that extends beyond the rights enumerated in section 28(1). This section represented a radical reform of the South African children's rights, particularly because the best interest principle has acquired the force of a right which promotes and protect the interests of children in all matters affecting them. This right, however, is not absolute and can be restricted in terms of the limitation clause, like any other right, in the Bill of Rights as discussed below.[263]

What is considered the best interests of the child is obviously a factual question that has to be adaptable to the situation of each child and determined according to the circumstances of each case.[264] Over time, courts facing this determination had determined guidelines to assist with determining the best interests of the child. In *Van Deijl v Van Deijl*,[265] the court observed that the determination of what is in the best interests of the child must consider that the interests of the minor mean the welfare of the minor. Further, it was emphasised that the word welfare is a comprehensive one and must be used in its broadest sense to include economic, social, moral and religious considerations. The emotional needs and ties of affection must also be considered, especially where children are older, meaning that their wishes in the matter cannot simply be ignored.[266] It is also submitted that the best interests of the child means taking the child's wishes into consideration before making a decision that affects his/her sexual life.

As alluded to above, determining the best interests of a child has prompted the judiciary to set out a list of factors which serves as a guide to determine the best interests of the child in custody cases. Subsequently, valuable guidelines were added, determining that a feeling of safety, stability and security are important factors to be considered during the determination of the child's best interests.[267]

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[263] Ann Skelton, 'Children' in Currie I & de Waal J *The Bill of Rights Handbook* 6 edn (Cape Town: Juta & Co. 2013) 619-620.

[264] *Van Oudenhove v Gruber* 1981 4 SA 857 (A) 868C; *Godbeer v Godbeer* 2000 3 SA 976 (WLD) 981I.

[265] 1966 4 SA 260 (R). The case dealt with custody and guardianship issues.

[266] Para 261H.

[267] *French v French* 1971 4 SA 298 (W) 298H.

In 1994, for the first time in South African legal history, the most comprehensive list of factors was proposed in the judgment of the case of *McCall v McCall*,[268] designed, however, specifically for resolving custody disputes. Not long after this judgment, a statutory list of factors to determine the best interests of a child[269] was provided in the Natural Fathers of Children Born out of Wedlock Act.[270] Section 7 of the Children's Act, promulgated a few years later, now sets out factors that must be considered when determining what is in the child's best interest, some of which include those mentioned in earlier judgments and in the Natural Fathers of Children Born out of Wedlock Act.[271]

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[268] 1994 3 SA 201 (C) 205B-G. The following criteria was provided: "(a) the love, affection and other emotional ties which exist between parent and child and the parent's compatibility with the child; (b) the capabilities, character and temperament of the parent and the impact thereof on the child's needs and desires;
(c) the ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings;
(d) the capacity and disposition of the parent to give the child the guidance which he requires; (e) the ability of the parent to provide for the basic physical needs of the child, the so-called `creature comforts', such as food, clothing, housing and the other material needs generally speaking, the provision of economic security;
(f) the ability of the parent to provide for the educational wellbeing and security of the child, both religious and secular;
(g) the ability of the parent to provide for the child's emotional, psychological, cultural and environmental development;
(h) the mental and physical health and moral fitness of the parent; (i) the stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo;"

[269] Those factors were however, designed to establish the best interests of the child when a court considers the father's application for access, custody or guardianship of his extra marital child. Therefore, those factors have little or no bearing on the medical and health services context.

[270] 86 of 1997.

[271] Those factors are: "(a) the nature of the personal relationship between- (i) the child and the parents, or any specific parent; and (ii) the child and any other care-giver or person relevant in those circumstances;
(b) the attitude of the parents, or any specific parents, towards- (i) the child; and (ii) the exercise of parental responsibilities and rights in respect of the child
(c) the capacity of the parents, or any specific parent, or of any other care-giver or person, to provide for the needs of the child, including emotional and intellectual needs;
(d) the likely effect on the child of any change in the child's circumstances, including the likely effect on the child or any separation from- (i) both or either of the parents; or (ii) any brother or sister or other child, or any other care-giver or person, with whom the child has been living;
(e) the practical difficulties and expense of a child having contact with the parents, or any specific parent, and whether that difficulty or expense will substantially affect the child's right to maintain personal relations and direct contact with the parents, or any specific parent, on a regular basis;
(f) the need of the child- (i) to remain in the care of his or her parent, family and extended family; and (ii) to maintain a connection with his or her family, extended family, culture or tradition;
(g) the child's- (i) age, maturity and stage of development; (ii) gender (iii) background; and (iv) any other relevant characteristics of the child;
(h) the child's physical and emotional security and his or her intellectual, emotional, social and cultural development;
(i) any disability that a child may have;
(j) any chronic illness from which a child may suffer;

These factors are universal, but their application and interpretation may alter in subtle ways, depending on the facts of each case. Reyneke describes these factors as "a national standard relating to the best interests of the child".[272] She acknowledges, however, that the list of factors may not be suitable for some contexts, for example the health care context, although they may be adapted for application in such situations. Whilst Reyneke's observation on the application of the identified factors may be true, the application of these factors in certain contexts is more complex and nuanced.

The paramountcy of the best interests of the child has received many criticisms from both local and international scholars. The criticism is extended to the entire concept of the best interests of the child principle in its entirety for its wide reach.[273] Satchwell J remarks that:

> "Best interests" standards are regarded as indeterminate because the phrase is, as indicated above, inherently subjective. Interpretation of the principle must inevitably be left to the judgment of the person, institution or organisation applying it. In so doing, interpretation as to what is "best" amongst a selection of "interests" creates a discretion in the power who or which makes that selection.[274]

Sachs J also refers in *S v M* to the principle as being too vague and consequently failing to provide a clear definition of what the best interests of the child entail.[275]

Historically, children have been perceived as too immature to decide what is best for themselves. They were therefore denied the right to make decisions about matters

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(k) the need for a child to be brought up within a stable family environment and, where this is not possible, in an environment resembling as closely as possible a caring family environment;
(l) the need to protect the child from any physical or psychological harm that may be caused by- (i) subjecting the child to maltreatment, abuse, neglect, exploitation or degradation or exposing the child to violence or exploitation or other harmful behavior; or (ii) exposing the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behavior towards another person;
(m) any family violence involving the child or a family member of the child; and
(n) which action or decision would avoid or minimize further legal or administrative proceedings in relation to the child".

[272] Jacomina Reyneke, 'The best interests of the child in school discipline in South Africa' (LLD thesis Tilburg University 2013) 203.

[273] Elsje Bonthuys, 'The Best Interest of Children in the South African Constitution' (2006) 20 International Journal of Law Policy and the Family 23.

[274] *LW v DB* 2020 (1) SA 169 (GJ) 66.

[275] 2007 ZACC (18), 2008 (3) SA 232 (CC), 2007 (12) BCLR 1312 (CC) para 23; Skelton, 'Children's Rights' in Jason Brickhill 266. See also Benyam Dawit Mezmur, '"Don't Try this at Home?": Reasonable or Moderate Chastisement, and the Rights of the Child in South Africa with YG v S in Perspective' (2018) 32 Speculum Juris 85-86.

that affect them.[276] This was further perpetuated by the view that they are morally incompetent, inexperienced, and incapable of making rational decisions.

There is no doubt that most parents have their children's best interests at heart, especially because they already care for them. However, Freeman argues persuasively that this view idealises the parent-child relations, in that parents can abuse the power that they have over their children.[277] He argues that parents also have their own interests in mind and may have intentions that are not aligned with the best interests of their children. As a result, there is a tendency to protect their rights over those of their children. Parents may interpret their children's interests in a manner consistent with their own wishes. Alderson and Goodey rightly conclude as follows:

> Children are marginalised in adult-centred society. They experience unequal power relations with adults and much of their lives is controlled and limited by adults. The main complications do not arise from children's inabilities or misperceptions, but from the positions ascribed to children.[278]

The courts have historically seemed to be acting in accordance with the principle of respecting the opinion of parents. This happens when courts ostensibly decide according to the best interests of the child but then defer such a determination to parents as decision makers. It is submitted that deferring to parents imply that courts are respecting the opinion of parents about which course of action is in the best interest of their child, even when their decisions may collide with a child's best interests. Although the legal authority given to parents is based to some extent on an assumption that they will generally make the decisions in the best interests of their child, the opposite may be true.

An assumption exists that minor patients lack capacity to decide, solely because of their age, emotional maturity, disability, or because health practitioners generally believe that minors' decisions are superficial. Health care practitioners operate to some extent on paternalistic presumptions that every *adult* patient has the capacity to decide whether to agree to or decline health care services, except when the clinical

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[276] Ngwena, 'Health care decision-making' 140.

[277] Freeman, `The limits of children's rights' 18.

[278] Priscilla Alderson and Christopher Goodey, 'Research with disabled children: How useful is child centered ethics?' (1996) 10 Children and Society 106-116 <https://doi.org/10.1111/chso.1996.10.2.106> accessed on 12 November 2022.

assessment of the patient exposes unfitness. The same paternalistic tradition reinforces its opinion regarding children's general immaturity and ignorance. As this thesis explores, significant changes over the past few decades have undoubtedly influenced children's intellectual and emotional abilities, shaping their developmental progress in ways never seen before.

Returning to the prevalence of paternalism lingering in the health care context, it is instructive to refer to Booklet 4 of the HPCSA Guidelines, that provide as follows:

> It is for the patient, not the health care practitioner, to determine what is in the patient's own best interests. Nonetheless, practitioners may wish to recommend a treatment or a course of action to patients, but they must not put pressure on patients to accept their advice.[279]

Slabbert and Labuschaigne fully concur, suggesting that patients are "now the ultimate decision-makers with regard to their own bodies and health."[280] The HPCSA guidelines suggest that a child who needs a gender reassignment surgery must be heard and advised accordingly, provided that the child has the ability to understand the benefits, risks and consequences relating to the procedure. The advice should include other treatments, for example, the PBTs where applicable.

2.5.7 The child's right to equal protection under the law

This chapter has alluded to South Africa's long history of racial discrimination. For decades, the apartheid system severely disadvantaged most of the South African population.[281] In light of this heavy historical burden, the court in *Brink v Kitshoff*[282] concluded that the theory of equality requires equal application of the law to all groups. The Court explained the primary purpose of section 8 of the then interim Constitution as follows:

> In drafting section 8, the drafters recognised [sic] that systematic patterns of discrimination on grounds other than race have caused, and may continue to cause, considerable harm .... Section 8 was adopted then in the recognition that discrimination against people who are members of disfavoured [sic] groups can

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[279] HPCSA Booklet 4, 8.

[280] Slabbert and Labuschaigne, 'Legal reflections on the doctor-patient relationship' 32.

[281] Coovadia and others, 'The health and health system of South Africa.'

[282] *Brink v Kitshoff* 1996 (4) SA 197 (CC).

> lead to patterns of group disadvantage and harm. Such discrimination is unfair: it builds and entrenches inequality amongst different groups in our society.[283]

In *Minister of Finance v Van Heerden,* [284] the Constitutional Court held as follows:

> The achievement of equality goes to the bedrock of our constitutional architecture. The Constitution commands us to strive for a society built on the democratic values of human dignity, the achievement of equality, the advancement of human rights and freedom. Thus, the achievement of equality is not only a guaranteed and justiciable right in our Bill of Rights but also a core and foundational value; a standard which must inform all law and against which all must be tested for constitutional consonance.[285]

The scope of section 27[286] complements the equality clause of the Constitution. It is well-accepted in the South African constitutional jurisprudence that section 27 guarantees everyone formal and substantive equality when accessing health care services in South Africa. Formal equality encompasses the notion that all persons who are in the same situation must be accorded the same treatment.[287] Basically, everyone should be treated equally. This formal notion of equality holds the value that inequality is irrational and arbitrary. It views any action that explicitly uses prohibited grounds such as age and sexual orientation as criteria for decision-making, as irrational and constitutionally suspect.[288] Thus, formal equality places individuals on an equal footing in order to compete fairly. Substantive equality on the other hand, tries to compensate or eradicate the social standard that hinders equality. This notion endorses and justifies differential treatment between groups when such treatment is undertaken to protect or advance the rights of vulnerable people or to redress historical injustices. In

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[283] Para 42; *National Coalition for Gay and Lesbian* case paras 41-42. See also *President of the Republic of South Africa and Another v Hugo* 1997 (6) BCLR 708) para 41. This case contextualised the philosophical nature of Section 8 of the interim constitution. It provided as follows: “The prohibition on unfair discrimination in the interim Constitution seeks not only to avoid discrimination against people who are members of disadvantaged groups. It seeks more than that. At the heart of the prohibition of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups. The achievement of such a society in the context of our deeply inegalitarian past will not be easy, but that that is the goal of the Constitution should not be forgotten or overlooked”.

[284] *Minister of Finance v Van Heerden* 2004 (6) SA 121 (CC).

[285] *Van Heerden* case para 22.

[286] The Constitution. See also C Ngwena, ‘The recognition of Access to Healthcare in South Africa: is it enough? (2005) 5 Health and Human Rights 26-44.

[287] A Smith, ‘Equality Constitutional Adjudication in South Africa’ 2014 African Human Rights Law 609-632.

[288] Catherine Albertyn, ‘(In)equality and the South African Constitution’ (2019) 36 Development South Africa 756 <https://doi.org/10.1080/0376835X.2019.1660860> accessed on 14 November 2022.

terms of the formal notion, age and sexual orientation of a person should not be a hindrance to access medical services in South Africa.[289]

The provisions of section 27 clearly try to level the playing field when it comes to substantive equality. The income of a person or his or her area of residence should not serve as an impediment to access health care services.[290] The substantive notion recognises that the state does not only have a negative duty not to interfere with another person's right to have access to health care services. The state instead, must protect or advance vulnerable groups to rectify ongoing patterns of historical socio-economic injustice. The state, therefore, has the responsibility of providing such health care services to everyone living in South Africa.

It has been outlined above that South Africa had disparities in the distribution and delivery of health services. The NHA was promulgated to address such inequalities in access to health services. The purpose of the Act amongst others is to assist in establishing a uniform health system. The vision of the Constitution of South Africa includes, among others, to "improve the quality of life of all citizens and to free the potential of each person".[291] Consequently, the NHA endorses the Bill of Rights and gives recognition to section 27 of the Constitution. The goal is to achieve a structured and a better health system in South Africa in accordance with the constitutionally imposed obligations and other relevant laws regarding health services within the Republic.[292] The focus of the NHA is the following:

> The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by a) establishing a national health system which i) encompasses public and private providers of health services; ii)

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[289] Albertyn, '(In)equality and the South African Constitution' 757.

[290] Notice 657 of 1994, 1 July 1994. It provides that the state will ensure that pregnant women and children under the age of 6 years are exempted from paying for health services. This is the government's way of providing them with free health services. Van Rensburg writes that access to free health care has also been broadened to include primary health care (PHC) services. This resonates with the egalitarian values that underlie the concept of PHC. Free services have also been introduced for children up to 12 years at public clinics. In addition, several pieces of legislation that impact on free health care policies have been passed to ensure compliance in delivering quality care. See HCJ Van Rensburg, 'Health and health care in South Africa in transition: A macro perspective' (1999) 31 Acta Academica, 1-26.

[291] Preamble of the Constitution.

[292] Government Communication and Information System – Health, 2016/17 South Africa Yearbook 2017 <https://www.gcis.gov.za/sites/default/files/docs/resourcecentre/yearbook/Health2017.pdf> accessed on 06 December 2022.

> and provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford.[293]

This goal was earlier expressed in the 1997 White Paper for the Transformation of the Health System in South Africa.[294] This paper sought to give content to the right of access to health care services. In order to accomplish this goal of ensuring access to health care services by all, the White paper explained that the health policy aims to:

> [I]ntegrate the activities of the public and private health sectors, including NGOs and traditional healers, in a way which maximises the effectiveness and efficiency of all available health care resources; and to establish health care financing policies to promote greater equity[295] between people living in rural and urban areas, and between people served by the public and private health sectors.[296]

The purpose was not only to unite the public and private health care activities, but also to deliver the best possible service to the public in terms of the available health care resources. The unequal distribution of health care professionals between the private and the public sectors has been problematical for several years. A further aim of the policy was to ensure that there is a fair distribution of health care professionals and services in the private and public care, urban and rural care and hospital and community care.

The Medical Schemes Act[297] which came into effect on 1 January 2000, illustrated a strong transformative purpose and sought to ensure that access to and coverage offered by a medical scheme were non-discriminatory. In promoting equitable access to health care resources, financial barriers experienced by persons trying to access health services were flagged for attention.

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[293] NHA, Chapter 1.

[294] Adila Hassim, Mark Heywood and Jonathan Berger, 'Health and Democracy – A Guide to human rights, health law and policy in post-apartheid South Africa: The private health care sector. Introduction to Health Law' (Siber Ink, Cape Town, 2007) 285.

[295] Equity in health has been defined as the absence of systematic inequality in attaining the good-quality healthcare services. The concept implies the absence of obvious disparities in health or its social determinants across population groups due to their social, economic, demographic and geographic categorisation. See N Abu Al-Saad, C Skedgel and J Nortje, 'Principles of resource allocation in critical care' (2017) 17 BJA Education 390-395 <https://doi.org/10.1093/bjaed/mkx029> accessed 17 November 2022.

[296] Department of Health, White paper for the transformation of the health system in South Africa: towards a National Health System (Pretoria Notice 667 of 1997) Chapter 1.

[297] Medical Schemes Act (MSA) 131 of 1998.

Section 9(1) of the South African Constitution[298] determines that "[e]veryone is equal before the law and has the right to equal protection and benefit of the law". Subsection 2 further provides that "[e]quality includes the full and equal enjoyment of all rights and freedoms". In terms of section 9(2), 'age' is one of the listed grounds on which unfair discrimination is prohibited, as a result, this distinction between children based on their age will be scrutinised to determine whether the distinction in question amounts to discrimination in the substantive sense.[299]

I submit that a minor's right of access to health services protected in sections 28(1)(c) and section 27(1)(a) of the Constitution are violated by the applicable age limitation. Sections 129(2) and 129(3) of the Children's Act empower minors 12 years old and older, who are sufficiently mature, to consent to medical treatment without parental assistance. On the other hand, there is a restriction placed on the minors who are 12 years and older, and in need of surgical procedure. As already outlined, the provision is that these minors may consent to such surgery, provided that they are "duly assisted" by their guardians or parents.[300] I submit that these sections may be constitutionally challenged on the ground that they infringe upon the best interests of the child to exercise the right of access to health care services, which include surgical operations. The age restriction is in general unconstitutional, especially when used in legislation aimed at giving effect to the right to access health care services and children's right to basic health care services. In this instance, I contend that access to essential surgical services must be included as part of the right of access to health care services.

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[298] Constitution of the Republic of South Africa, 1996. Section 9 provides that "1. Everyone is equal before the law and has the right to equal protection and benefit of the law. 2. Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken. 3. The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth".

[299] The provisions of section 5 of the Choice on Termination of Pregnancy Act 92 of 1996 which permits minors, regardless of age, to consent to abortion. The definition of discrimination is "treating persons differently in a way which impairs their fundamental dignity as human beings, who are inherently equal in dignity". See *National Coalition* case para 47.

[300] Section 129(3) of the Constitution.

I have already referred to the anomaly in the CTPA,[301] which allows girls of any age to consent to a termination of pregnancy without involving their parents or guardians, including doing so without the knowledge of her parents or guardian (section 5(3) of the Act). Consequently, I argue that the age limitation contained in section 129 of the Children's Act is unconstitutional, as it is furthermore, arbitrary and not based on rational, reasonable and fair considerations.

2.5.8 Autonomy and self-determination in the context of South Africa

The debate over the nature and value of children's rights underpins debates around the autonomy of children. Considerations regarding the autonomy of children became a discussion point with the promulgation of the Children's Act. This is because initially children were not considered to be autonomous rights holders. Section 12 of the Constitution enshrines the right to psychological and bodily integrity and entrenching rights in the Constitution mandates change. Health care practitioners have a positive duty to respect the rights of patients to self-determination or to make their own informed choices. Medical treatment and surgical interventions must be conducted in such a manner that patient's self-worth is not violated. Section 12(2)[302] puts more emphasis on the importance of personal autonomy and the self-determination in relation to bodily integrity.

The reference in section 12 to "everyone" includes children. Children have an autonomous right to bodily and psychological integrity, which may be limited in terms of section 36 of the Constitution. The constitutional duty is placed upon the state to protect the right to psychological and bodily integrity. The concept of autonomy has however, become embroiled in controversy and ideological conflict. This is because autonomy and informed consent have a close relationship with each other, as a result, they cannot be divorced.[303] It is trite that the principle of autonomy empowers the patients to be the ultimate decision-makers in matters pertaining to their health and

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[301] Section 5 CTPA.

[302] Section 12(2) states as follows: "Everyone has the right to bodily and psychological integrity, which includes the right:
a. to make decisions concerning reproduction;
b. to security in and control over their body; and
c. not to be subjected to medical or scientific experiments without their informed consent".

[303] Engelbrecht, 'Can Autonomy be limited-An Ethical and Legal Perspective in a South African Context' 35.

wellbeing. For a patient to be able to make an informed decision, the health care practitioner must ensure that the patient does not only understand information offered on the proposed health intervention, but also appreciate the risks and benefits of treatments, and offer reasons for their decisions.

'Autonomy' in the context of self-determination derives from Greek and means to 'own' (auto) and 'judicial' (nomos).[304] With respect to children, it would therefore signify the legal capacity of a child to act on its own discretion. Loosely translated, this is a right that entitles a person to decide what they want to be done with their bodies without anyone imposing a conflicting decision.

Autonomy and self-determination are interrelated and refer in respect of children to:

> Those potential rights which allow children to exercise control over their environments, to make decisions about what they want, to have autonomous control over various facet of their lives.[305]

Archard, however, points out that

> [i]t is simply inconsistent to see self-determination as the fundamental right of all children and yet in the case of very young, to speak of rights which are possessed but not exercised by their holders and which must thus be upheld by adult protectors. Obviously very young children are less equal than others in their right to self-determination.[306]

According to Archard, young children are incapable of exercising their right to self-determination. He also seems to suggest that a hierarchy of rights to self-determination exists, with very young children possessing a lesser claim to the right. This explanation cannot be accepted, as all rights holders should possess rights in the same degree (fully). The limitations clause is the only constitutional limitation that may curtail a right. The correct position would be that very young children, although entitled to the right to self-determination, are limited in exercising this right due to compelling

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[304] Annelize Nienaber and Kirsten N Bailey, 'The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?' (2016) 9 South African Journal of Bioethics and Law 73. See also A Eide, 'Cultural Autonomy: Concept, Content, History and Rile in the World Order' in M Suski (edn) *Autonomy Applications and Implications* (Kluwer Law International 1998) 252.

[305] Carl M Rogers and Lawrence S Wrigtsman, 'Attitudes towards children's rights: Nurturance or self-determination?' (1978) 59 Journal of Social Issue <https://doi.org/10.1111/j.1540-4560.1978.tb01029.x> accessed on 18 November 2022.

[306] D Archard, *Children: Rights and Childhood* (London, Routledge, 1993) 50.

limitations that meet the requirements in section 36 of the Constitution. Beauchamp and Childress maintain that autonomy encompasses an acknowledgement of the patient's "rights to hold views, to make choices, and to take actions based on values and beliefs".[307] Consequently, acceptance and recognition of patients' autonomy is an acceptance of their basic right of decision-making. Such decisions are premised on the patients' own values and principles regarding the treatment they wish to accept.[308] For Beauchamp and Childress, autonomy is not limited to "not interfering with the patient's decisions and autonomous actions", but it also means providing support to the patient's actions when they have the intention but lacks in ability.[309] Julia Sloth-Nielsen and Helen Kruuse rightly emphasise that constitutional protection signifies that children's rights "cannot be overlooked, rendered perfunctory or written out of the script".[310]

In support of the child's right to autonomy, Freeman proposes four categories of rights that children are entitled to. These rights are rights to welfare, rights to protection, rights to be treated as adults and rights against parents.[311] The third and fourth categories respectively are of utmost importance to this study since they seem to validate the child's autonomous rights. In his third category (rights to be treated as adults), Freeman proposes that the rights and liberties afforded to adults should also be extended to children. Freeman argues that there should be a constant review of the legal age-related restrictions placed on children. He further proposes that the legal capacity of children to make decisions should be determined in accordance with the facts of each case. In support, Eekelaar's view is that there should be no distinction between children and adults. He argues that they are equally worthy of respect. He writes that children's rights "should be respected just as adults rights should be; certainly no less, but also no more".[312] Therefore, the determination of the child's

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[307] Beauchamp and Childress, *Principles of Biomedical Ethics.*

[308] Beauchamp and Childress, *Principles of Biomedical Ethics.*

[309] Liwei Zhu and others, 'Respect for Autonomy: Seeking the Roles of Healthcare Design From the Principle of Biomedical Ethics' (2020) 3 Health Environments Research & Design Journal 230-244 <https://doi.org/10.1177/1937586720908508> accessed on 12 October 2022.

[310] Julia Sloth-Nielsen and Helen Kruuse, 'A Maturing Manifesto: The Constitutionalisation of Children's Rights in South African Jurisprudence 2007–2012' (2013) 21 Int'l J of Children's Rights 677.

[311] M Freeman, 'The Rights of Children in the International Year of the Child' (1980) 33 Current Legal Problems 17. See also Hannaretha Kruger, 'The realization of children's rights to participate in selected medical decisions in South Africa' 2018 (1) South African Law Journal 94.

[312] John Eekelaar, 'Beyond the welfare principle' (2002) 14 Child and Family law Quarterly 249.

wishes must consider the fact that children have different levels of maturity, and those maturity levels are not related to their age.[313] In support, Heaton emphasises the importance of an individualised and contextualised assessment of the position of each child when applying the best interests of the child criterion. In this assessment, the impact of each relevant factor on the child should be explored and taken into consideration.[314]

Traditionally, a distinction between two approaches to the protection of children's rights is drawn. The two approaches refer to the so-called "self-determination/autonomy approach" and the "nurturance approach".[315] The nurturance approach asserts "giving children what's good for them", whereas the self-determination approach emphasises "giving children the right to decide what's good for themselves".[316] According to Freeman, the rights to welfare and protection can be classified under the "nurturance approach", whereas the right to be treated as an adult and rights against parents can be classified under the "self-determination approach".[317]

2.5.9 Informed consent in medical practice

In medical practice, the notion of informed consent is both a legal and an ethical issue relating to autonomy.[318] The core value of informed consent is respecting a person's autonomy to make personal choices. Historically, decision making in health care services, including medical treatment and surgical procedures were governed by paternalistic thinking.[319] The great philosopher and father of medicine, Hippocrates,

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[313] Freeman, The Rights of Children in the International Year' 17.

[314] J Heaton, 'An Individualised, Contextualised and Child-centred Determination of the Child's Best Interests, and the Implications of such an Approach in the South African Context' 2009 Journal of Juridical Science 1-18.

[315] Freeman, 'The Rights of Children in the International Year' 17. See also Kruger, 'The realization of children's rights' 94.

[316] Freeman, 'The Rights of Children in the International Year' 17. See also Kruger, 'The realization of children's rights' 94.

[317] Freeman, 'The Rights of Children in the International Year' 17. See also Kruger, 'The realization of children's rights' 94.

[318] Sylvester Chima, 'Respect for autonomy as prima facie right: Overriding patient autonomy in medical practice' (2009) 53 Journal of the Colleges of Medicine of South Africa (CMSA) 38-42 <https://doi.org/10.1186/1472-6939-14-S1-S3> accessed on 13 October 2022.

[319] A Dhai, 'Informed consent' (2008) 1 South African Journal of bioethics and Law 27. See also Sheldon F Kurtz, 'The Law of Informed Consent From "Doctor is right" to "Patient has rights"' (2000) 50 Syracuse Law Review 1243.

believed that health care providers should “conceal most things from the patient while [they are] attending to him… revealing nothing of the patient’s future or present condition.”[320] It was assumed that withholding information from the patient would prevent despair to patients. The withholding of information was not regarded as negating the ethos of the medical profession. This is because the Hippocratic oath dictated that health care providers will “prescribe regimens for the good of [his] patients according to [his] ability and [his] judgment and never do harm to anyone…”[321]

Medical paternalism dominated the ethos of medical profession until the 19th century.[322] During this era, patients were not informed about their conditions, neither was consent sought from them for treatment or procedures. The 1847 American Medical Association Code of Medical Ethics, for example, was silent on the rights of patients and stated as follows:

> The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them.[323]

It was only until much later that consent was sought from patients.[324] The United States of America is considered to be the country of origin regarding establishing informed consent as a requirement for health decisions. The concept of informed consent was recognised in 1957 and introduced into clinical practice following the case of *Salgo v. Leland Stanford Jr. University Board of Trustees*.[325] In his ruling Justice Bray indicated that:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise, the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent… The instruction given should be modified to inform the jury that the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent.[326]

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[320] Kurtz, ‘The Law of Informed Consent’ 1243.

[321] Kurtz, ‘The Law of Informed Consent’ 1243.

[322] Slabbert and Labuschaigne, ‘Legal reflections on the doctor-patient relationship’ 32.

[323] V Mallardi, ‘The Origin of informed Consent’ (2005) 25 Acta Otorhinolaryngologica Italica <https://pubmed.ncbi.nlm.nih.gov/16602332/> accessed on 13 November 2022.

[324] Kurtz, ‘The Law of Informed Consent’ 1244.

[325] *Salgo v Leland Stanford Etc. Board of Trustees* (1957) 154 Cal. App. 2d 560; 317 P.2d 170.

[326] *Salgo v Leland Stanford Etc. Board of Trustees* (1957) 154 Cal.App.2d 560 317 P 2d 170 [578].

This paved a way for the patients' right to participate in decisions affecting their health. These rights and provisions are entrenched in different national and foreign legal frameworks, including South Africa.

Informed consent in medical law is aligned to the ethical principle of respect for autonomy or freedom of choice.[327] Van Oosten submits that informed consent is a constitutionally protected right that requires a medical practitioner to seek a patient's informed consent before providing medical treatment.[328] The principle of informed consent in South Africa protects the patient's rights. This principle requires medical practitioners to properly inform their patients of associated risks and consequences of the treatment or procedure. Failure to inform the patient of the risks and consequences can constitute medical malpractice. In terms of the NHA:[329]

> 7. (1) Subject to section 8, a health service may not be provided to a user without the user's informed consent. unless-
>
> *(a)* the user is unable to give informed consent and such consent is given by a person-
>
> (i) mandated by the user in writing to grant consent on his or her behalf; or
>
> (ii) authorised to give such consent in terms of any law or court order;
>
> *(b)* the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;
>
> (c) the provision of a health service without informed consent is authorised in terms of any law or a court order;
>
> *(d)* failure to treat the user, or group of people which includes the user will result in a serious risk to public health; or
>
> *(e)* any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.
>
> (2) A health care provider must take all reasonable steps to obtain the user's informed consent.[330]

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[327] Chima, 'Respect for autonomy as prima facie right' 38-42.

[328] Ferdinand Van Oosten, 'Informed consent: patient rights and the doctor's duty of disclosure in South Africa' (1988-1989) 7 Medicine and Law 444.

[329] 61 of 2003.

[330] Section 7 NHA.

The wording of the Act also reflects that a valid consent can be obtained only from a patient who is well informed. The NHA stipulates what information should be provided to a patient to satisfy the "informed" part of informed consent:

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

The health care provider as an expert of his or her field, must provide his patient with all the necessary information required to make a well-informed decision.

The HPCSA has also set guidelines on patients and informed consent that practitioners must meet. The guidelines relate to the standards of competence, care and conduct of the practitioner in relation to the individual needs of patients.[331] These guidelines resonate with the Constitution and the NHA. They elaborate on the concerns dealt with in the NHA and the Patient's Charter.[332] The guidelines stipulate that a comprehensive informed consent process must take place, and that in certain cases, a written record of the patient's consent must be taken in relation to the proposed treatment. This applies especially where the nature of the risks to which the patient might be exposed are such that it may warrant it.[333] The written consent will serve as proof should a need arise where such proof of understanding between health

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[331] HPCSA, Booklet 4, 3.

[332] The Patients' Rights Charter [Internet] [updated 2007 November 14] <http://www.justice.gov.za/vc/docs/policy/Patient%20Rights%20Charter.pdf.> accessed on 10 January 2023. This guiding document does not only list patients' rights, but it educates people regarding their health care related rights. It is a legislative document used in national health-care institutions to ensure patients' safety. It affords every citizen the right to participate in the decision making on matters impacting on their health. It further, makes provision for disclosure of personal information.

[333] HPCSA Booklet 4 para 12.2. See also Dhai, 'Informed Consent' 27.

care practitioner, the patient and anyone else involved in carrying out the procedure or providing care is required. The guidelines provide further that "[h]ealthcare practitioners should obtain written consent... [where] ...the treatment or procedure is complex or involves significant risks and/or side effects".[334] Although the NHA does not specifically require that informed consent be provided in writing, the guidance in the HPCSA guidelines recommending consent to be in a written form in certain instances, are legally sound and they also provide a record of the consent.

In the case of *Christian Lawyers Association v Minister of Health*,[335] the court stated as follows:

> The concept of [informed consent] is not alien to our common law, it forms the basis of the doctrine of *volenti non fit injuria* conduct that would otherwise have constituted a delict or crime if it took place without the victim's informed consent. More particularly, day to day invasive medical treatment, which would otherwise have constituted an invasion of a patient's privacy and personal integrity, is justified and is lawful only because, as a requirement of the law, it is performed with the patient's informed consent.[336]

It should, therefore, be emphasised that the quality of informed consent depends largely on the disclosure of information. Failure to obtain the required consent from the patient may constitute malpractice. The late Professor Van Oosten,[337] the first legal scholar in South Africa to write his doctoral dissertation on informed consent in a medical law context, concurs with the *Christian Lawyers Association* judgment in that consent in South Africa "forms the basis of the doctrine of *volenti non fit injuria."*[338] He further argues that informed consent should meet the following requirements in order to be used as a legal defence:

> a. What is consented to must be recognized by law, i.e. it must not be *contra bono mores;*
>
> b. it must be given by a person capable in law of consenting i.e. by someone who is capable of forming and intention or of understanding what he consents to;

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[334] HPCSA Booklet 4 para 12.3.1. See also Dhai, 'Informed Consent' 27.

[335] *Christian Lawyers Association v Minister of Health (Reproductive health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T) para 515.

[336] *Christian Lawyers Association* case para 515.

[337] FFW Van Oosten, The Doctrine of Informed Consent in Medical Law (Unpublished LLD Thesis, UNISA 1989) 448-449.

[338] Para 515. The concept *volenti non fit iniuria* is loosely translated as 'to him who consents, no harm can be done". See Slabbert and Labuschaigne, 'Legal reflections.' 32.

> c. it must be free or voluntary i.e. not induced by fear or force or fraud;
>
> d. the consenting party must have had knowledge and been aware of the nature and extent of the harm or the risk;
>
> e. the consenting party must have appreciated and understood the nature of the harm or risk;
>
> f. the consenting party must have consented to the harm or assumed the risk
>
> g. it must be comprehensive i.e. extend to the entire transaction inclusive of its consequences;
>
> h. it must be clear and unequivocal;
>
> i. it must precede the conduct in question;
>
> j. it must be manifested externally to qualify as a legal act;
>
> k. it must as a rule be granted by the plaintiff or claimant himself;
>
> l. the conduct in question must fall within the limits of the consent given i.e. it must not exceed the bounds of the consent given.[339]

In the 1923 case of *Stoffberg v Elliot*, one of the leading cases on the legal doctrine of informed consent in South Africa, a patient sued his doctors for the wrongful amputation of his penis. The penis was amputated due to penile cancer without his consent, and consequently, the doctors were sued for damages for assault. While instructing the then jury (the jury system was abolished in 1969 in South Africa), Watermeyer J explained as follows:

> In the eyes of the law, every person has certain absolute rights, which the law protects. They are not dependent upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person….Any bodily interference with or restraint of a man's person which is not justified in law or excused by law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.[340]

The 1994 case of *Castell v De Greef* remains the leading authority in advocating for the standard of disclosure required for informed consent to medical or surgical treatments. This case established a patient-centred approach in determining a doctor's

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[339] A Barit, 'The doctrine of informed consent in South African medical law' (LLM dissertation University of Pretoria 2016) 8.

[340] *Stoffberg v Elliot* 1923 CPD 148.

duty to disclose to the patient any material risk relating to the proposed surgery. The court defined "material risk" as follows:

> A risk is material if, in the circumstances of a particular case:
>
> (1) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or
>
> (2) the doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[341]

In *Castell a* patient sued her plastic surgeon for medical negligence. The surgeon had advised the patient to consider having a mastectomy to reduce the risk of cancer as a precautionary measure. The patient was however, not advised of the risks involved with the mastectomy. Further, the complications of such procedures or an alternative surgical procedure were not disclosed to the patient. The patient successfully sued for damages due to failed surgery. The court had to determine, amongst others, whether the patient would have undergone surgery had she known about the inherent risks of an operation. The court had to balance a patient's autonomy or right to reach his or her own decision concerning surgery*,* against a duty upon a medical practitioner regarding the circumstances that required such a disclosure. The court endorsed the approach of Scott J in the court *a quo* and stated that:

> A medical practitioner undoubtedly has a duty in certain circumstances to warn his patient of the risks involved in surgery . . . but that '[t]he difficulty is to determine when that duty arises and what the nature and extent of the warning must be.[342]

This decision embraced a complex of ethical, legal, and medical issues. It has been generally determined that the doctor has a duty to disclose certain dangers attached to the surgery. Further, that failure to disclose may lead to the doctor being sued for medical negligence. The difficulty arises where the risks have been disclosed and the patient refuses to consent to the operation even though it may be in his or her best interests to undergo such proposed surgery. In *Richter and Another v Estate Hamman*[343] Watermeyer J formulated what has become known as the 'reasonable doctor' test in so far as it relates to the standard of disclosure:

> It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be

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[341] *Castell* case 426.

[342] Scott J quoted in Castell 416.

[343] *Richter and another v Estate Hamman* 1976 (3) SA 226 (C).

> tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.[344]

After *Castell,* the emphasis shifted to accommodate the patient's right to participation in medical decision-making. South Africa codified the legal requirement for obtaining consent in the NHA. Section 8 of the National Health Act 2003 (NHA) provides as follows:

> 8. (1) A user has the right to participate in any decision affecting his or her personal health and treatment.
>
> (2) (a) If the informed consent required by section 7 is given by a person other than the user: such person must, if possible, consult the user before giving the required consent.
>
> (b) A user who is capable of understanding must be informed as contemplated in section 6 even if he or she lacks the legal capacity to give their informed consent required by section 7.
>
> (3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.

Section 8 acknowledges the right of a patient to participate in decision-making regarding his or her health or medical treatment. This is despite the fact that the health care provider may have obtained consent from another person who is authorised to give consent. The right to participate in decision-making extends to a situation where a patient was unable to give consent when health care services were administered on him or her. In such circumstances, a health care provider must inform the patient of his/her health status and the nature of the treatment administered on him or her whilst he/she was unable to provide consent, unless that disclosure would be contrary to his/her best interests. This provision includes minors who at the time of the treatment or procedure lacked the "legal capacity to give the informed consent."[345] Section 8 recognises patient autonomy through all the steps of medical decisions concerning that patient. Therefore, in cases of gender reassignment, health care providers must explain to the patient "the probabilities of success, or the risk of failure of, or harm

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[344] Para 232H.

[345] Section 8(b).

associated with options for treatment, using accurate data”,[346] including the costs generally associated with each option.[347] Slabbert and Labuschaigne[348] maintain that although self-determination and autonomy are currently a cardinal principle, there are other factors that should be considered before treatment is offered to a patient. They point out that although the patient may be fully informed about the proposed treatment and alternatives of such a procedure or intervention, payment for the procedure may significantly affect the patient’s decision, especially when the patient is not in a position to cover or contribute to the costs of the procedure, both in the private or the public health care context.[349] This imply that doctors may refuse to provide a procedure or intervention before the payment is made, which diminishes patient autonomy in favour of economic considerations. Consequently, prior to the procedure, there must be “clarity on who will be footing the bill”.[350] In the private health care sector, only medical aid settlements or payments directly from the patient will be accepted before the procedure or intervention is undertaken. Services in the public sector will, however, depend on whether the relevant health department has available resources.

2.5.10 The right to privacy

It is common knowledge that transgender people and gender diverse individuals continue to experience routine discrimination, stigmatisation, harassment and violence based on their different gender identity or gender expression. Article 12 of the Universal Declaration of Human Rights[351] does not only promote the right to privacy, but it also provides a framework for examining this right from a gender perspective. The UN Human Rights Council[352] and the General Assembly[353] called on States “to further develop or maintain, in this regard, preventive measures and remedies for violations and abuses regarding the right to privacy” affecting all individuals.

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[346] HPCSA Booklet 4, 7

[347] HPCSA Booklet 4, 8.

[348] Slabbert and Labuschaigne, ‘Legal reflections on the doctor-patient relationship.’ 32.

[349] Slabbert and Labuschaigne, ‘Legal reflections on the doctor-patient relationship.’ 32.

[350] Slabbert and Labuschaigne, ‘Legal reflections on the doctor-patient relationship.’ 32.

[351] United Nations. Universal Declaration of Human Rights. 1948. Article 12 provides as follows: “No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks”.

[352] HRC resolution 34/7.

[353] United Nations General Assembly (2014), "The right to privacy in the digital age”, A/RES/71/199. United Nations, last modified January 21, 2014, <https://undocs.org/A/RES/68/167> accessed on 17 September 2023.

Knijnenburg and others reflects on privacy as follows:

> There is a wide range of privacy theories and frameworks that approach the topic in different ways. Some classify information types by sensitivity, others focus on privacy as awareness and control of information, and still others approach it from a state-based perspective where there are different privacy states that affect how we engage with others (e.g., anonymity, intimacy).[354]

Section 14 of the Constitution protects a person's (in this case, a patient's) right to privacy and confidentiality of his or her personal medical information. To further protect transgender individuals' rights, the Protection of Personal Information Act (POPIA)[355] has been enacted with the purpose of giving effect to the constitutional right to privacy by providing the legal framework for the protection of personal information. POPIA provides guiding principles that are intended to safeguard the privacy and the confidentiality of individuals. Therefore, these guidelines are to be applied to the processing of personal information in a context-sensitive manner. In terms of POPIA, a patient must consent to the disclosure and further sharing of medical records to third parties (such as other health care providers), as this fall within the ambit of the privacy clause. Its preamble provides that the right to privacy includes, "a right to protection against the unlawful collection, retention, dissemination and use of personal information".[356] POPIA utilises mandatory procedures and mechanisms for the handling and processing[357] of personal information.[358] POPIA defines personal information as:

> [In]formation relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to:
>
> a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health,

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[354] Bart P Knijnenburg and others, *Modern Socio-Technical Perspectives on Privacy* (eds) (Springer Nature Switzerland AG 2022) 3 <https://doi.org/10.1007/978-3-030-82786-1> accessed on 12 February 2023.

[355] POPIA 4 of 2013. This Act was signed into law in 2013 with the purpose of protecting people from harm through the protection of their personal information.

[356] POPIA Preamble.

[357] In terms of s 1 of POPIA 'processing' is defined as "any operation or activity or any set of operations, whether or not by automatic means, concerning personal information, including (a) the collection, receipt, recording, organisation, collation, storage, updating or modification, retrieval, alteration, consultation or use; (b) dissemination by means of transmission, distribution or making available in any other form; or (c) merging, linking, as well as restriction, degradation, erasure or destruction of information".

[358] Preamble to POPIA.

> well-being, disability, religion, conscience, belief, culture, language and birth of the person;
>
> b) information relating to the education or the medical, financial, criminal or employment history of the person;
>
> c) any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person
>
> d) the biometric information of the person;
>
> e) the personal opinions, views or preferences of the person;
>
> f) correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;
>
> g) the views or opinions of another individual about the person; and
>
> h) the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person.[359]

Consent is defined as "any voluntary, specific and informed expression of will in terms of which permission is given for the processing of personal information".[360]

Evidently, there are three conditions that need to be met for a person or an establishment to rely on consent as a legal ground for processing personal information: It must be voluntary,[361] specific[362] and informed.[363] Consent does not

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[359] Section 1.

[360] Section 1.

[361] Collins English Dictionary provides that ''voluntary actions or activities' are done because someone chooses to do them and not because they have been forced to do them.' <https://www.collinsdictionary.com/dictionary/english/voluntary> accessed on 14 February 2023.

[362] Section 13(1) of the POPIA provides that: "Personal information must be collected for a specific, explicitly defined and lawful purpose related to a function or activity of the responsible party". The word 'specific' in terms of Collins English Dictionary is used to refer to a particular fixed area, problem, or subject. <https://www.collinsdictionary.com/dictionary/english/specific#:~:text=(sp%C9%AAs%C9%AAf%C9%AAk%20),area%2C%20problem%2C%20or%20subject.> accessed on 14 February 2023.

[363] Colins English Dictionary provides the following about 'informed consent': "Consent, usually written, given as by a patient to surgery, experimental treatment, etc. after having been informed of the potential medical risks' <https://www.collinsdictionary.com/dictionary/english/informed-consent.> accessed on 14 February 2023. The South African Medical Association [2012] provides that 'informed consent' is where '…sufficient information is provided to the patient to make an informed decision and that the patient actually understands the information and the implications of acting on that information". <https://www.samedical.org/images/attachments/guideline-on-informed-consent-jul012.pdf.> accessed on 14 February 2023.

qualify as voluntary, informed and specific if the person had no choice as it becomes non-violent coercion.[364]

The POPIA also states eight conditions for lawful data-processing.[365] These conditions are:

1. Accountability: All conditions for the lawful processing of personal information must be complied with. The processing must be done in a reasonable manner that does not infringe the privacy of the data subject.[366]
2. Process limitation: The party responsible for processing must ensure that the processing is used for explicitly defined purposes.[367]
3. Purpose specification: Personal information should be used or processed only after data subject has given his or her informed consent.[368]
4. Further processing limitation: Any additional processing of personal information should still be in accordance with the original purpose to which the informant consented.[369]
5. Information quality: The holder of the information should ensure that the information is accurate, up to date, complete and not misleading.[370]
6. Openness: All processes and operations involved in handling personal information should be transparent.[371]
7. Security safeguards: Personal information should always be protected and treated as confidential to maintain confidentiality and integrity, and to prevent data breaches.[372]
8. Data subject participation: The data subjects must be informed of their right to access, correct and delete their own personal information, and of the manner in which to do so.[373]

Section 14[374] of the NHA provides that all information concerning a user is confidential. This includes information relating to his or her health status, treatment or stay in a health establishment. The health care provider must, therefore, preserve absolute

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[364] Section 1 of the Act. Also see s 11 which sets out circumstances where consent is necessary.

[365] IT Governance Network, The Eight Conditions of Lawful Processing of Personal Information 2020 <https://itgovernance.co.za/popi/PPI%20and%20the%20Conditions%20for%20Processing%20Information.pdf> accessed on 13 February 2023.

[366] Section 8.

[367] Section 9-13.

[368] Sections 13-14.

[369] Sections 15.

[370] Section 16.

[371] Sections 17-18.

[372] Sections 19-22.

[373] Sections 23-25.

[374] NHA.

confidentiality in all aspects relating to a patient. In the case of *NM and Others v Smith and Others,*[375] the court concluded that the publication of the affected women's HIV status constituted a wrongful publication of a private fact and consequently a breach of the women's right to privacy. This case concerned a biography, titled 'Patricia de Lille,' in which the names of three HIV positive women were disclosed without their consent. As a result, the affected women filed a lawsuit and successfully argued that their rights to privacy, dignity and psychological integrity had been violated. The court had to determine whether the information that was published, related to private facts. Upon assessing this issue, it described private facts as matters whose disclosure: "will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private".[376]

Turning to the concept of privacy, Ackerman J observes as follows:

> Privacy recognises that we all have a right to a sphere of private intimacy and autonomy which allows us to establish and nurture human relationships without interference from the outside community. The way in which we give expression to our sexuality is at the core of this area of private intimacy. If, in expressing our sexuality, we act consensually and without harming one another, invasion of that precinct will be a breach of our privacy.[377]

It must, however, be noted that certain situations require the health care provider to disclose certain information even if it may be contrary to the patient's instructions. The Act provides that no person may disclose any information unless:

a) the user consents to that disclosure in writing;
b) a court order or any law requires that disclosure; or
c) non-disclosure of the information represents a serious threat to public health.[378]

It is very clear that privacy is recognised as a fundamental right in both the national and international legal frameworks. POPIA also remains consistent in its commitment

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[375] 2007 (5) SA 250 (CC).

[376] *NM and Others v Smith and Others* 2007 ZACC 6; 2007 (5) SA 250 (CC); 2007 (7) BCLR 751 (CC) para 34.

[377] Para 32 *National Coalition* case.

[378] The provisions of Section 14 of the NHA on confidentiality are the same as those of the POPIA. Section 11 of the POPIA provides as follows: "Personal information can only be processed: with the consent of the 'data subject'; or if it is necessary for the conclusion or performance of a contract to which the 'data subject' is a party; or it is required by law; or it protects a legitimate interest of the 'data subject'; or it is necessary to pursue your legitimate interests or the interest of a third party to whom the information is supplied".

to ensure that confidential information should be of the utmost importance and handled with utmost care. One of the reasons for this is to restrict unauthorised people from being privy to this information. Further, the sharing of such an information must strictly be aligned with the goal of helping the patient, [379] e.g., when a laboratory technician require access to the patient's information. Failure to ensure that data is properly protected and in terms of the Constitution and POPIA, may lead to privacy breaches which may become the focus of litigation.

2.5.11 The right to human dignity

Potential violations of transgender people's dignity are quite common. These attacks may exacerbate stigmatisation which can have negative health consequences for transgender individuals and produce obstacles in accessing health care.[380] The right to human dignity is highly relevant within the health care context, particularly among transgender and gender diverse people who are at the risk of different types of vulnerabilities. The right to human dignity ensures that everyone's equal worth and dignity is upheld and fully respected, without discrimination.[381]

The term dignity is derived from the Latin *dignitas*, which is associated with worth, honour and self-respect.[382] Dignity is a human right for every person, and an important concept in health care practice. The Constitution guarantees the child's right to basic health care.[383] The realisation of this right is indispensable for the enjoyment of other human rights as they are interrelated.[384] Consequently, a life of dignity entails that

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[379] The HPCSA Booklet 4. It provides as follows: "Sharing of information with members of a health care team providing a health service to a patient would be permissible to the extent that it is necessary to enhance the quality of care to be provided to that patient and the patient has given consent to treatment and disclosure of such information to another healthcare practitioner. This would include members beyond the HPCSA" 15. See also Amaboo Dhai and Jason Payne-James, 'Problems of capacity, consent and confidentiality' (2013) 27 Best Practice and Research Clinical Obstetrics and Gynaecology 67.

[380] Sam R Friedman, Diana Rossi and Gonzalo Ralón, 'Dignity denial and social conflicts' (2015) 27 Rethinking Marxism: A Journal of Economics, Culture and Society 65-84 <http://dx.doi.org/10.1080/08935696.2014.980675> accessed on 16 September 2023.

[381] Friedman and others, 'Dignity denial and social conflicts.'

[382] AC Steinmann, 'The core of human dignity' (2016) 19 Potchefstroom Electronic Law Journal 4.

[383] Section 28 (1) (c) and Section 27 of the Constitution.

[384] General Comment 14 (Committee on Economic, Social and Cultural Rights, The Right to the highest attainable standard of health (Twenty-second session 2000), U.N. Doc. E/C.12/2000/4 2000. This comment was reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies U.N. Doc. HRI/gen/1/Rev 6 (2003) 85.

every human being is entitled to the enjoyment of the highest standard of health. Human dignity is therefore, considered as the ability to maintain standards and principles.[385] Every person accessing health care services has the right to have their human dignity recognised and promoted. This right, enshrined in section 10 of the Constitution, stipulates that, “everyone has an inherent dignity and the right to have their dignity respected and protected”.[386] In the case of the *Teddy Bear Clinic for Abused Children*, the court observed the following regarding the right to dignity:

> Section 10 of the Constitution provides that [e]veryone has inherent dignity and the right to have their dignity respected and protected. While dignity is a cornerstone of our Constitution, it is not easily defined, at least in legal terms. Suffice it to say that dignity recognises the inherent worth of all individuals (including children) as members of our society, as well as the value of the choices that they make. It comprises the deeply personal understanding we have of ourselves, our worth as individuals and our worth in our material and social context. *This Court has found that children’s dignity rights are of special importance and are not dependent on the rights of their parents. Nor is the exercise by children of their dignity rights held in abeyance until they reach a certain age*.[387] (Own emphasis).

In an earlier Constitutional judgment of *Dawood v Minister of Home Affairs*, O’Regan traces a breach of the right to dignity to the right to bodily integrity as follows:

> Section 10, however, makes it plain that dignity is not only a value fundamental to our Constitution, it is a justiciable and enforceable right that must be respected and protected. In many cases, however, where the value of human dignity is offended, the primary Constitutional breach occasioned may be of a more specific right such as the right to bodily integrity.[388]

It is clear that the concept of human dignity remains a special value that must be taken into consideration when the Bill of Rights is applied. This value is tied solely to a person’s humanity and should always be protected. Habermas, a German social theorist whose theories explored the possibility of reason and emancipation and the human capacity to deliberate and pursue rational interests,[389] describes human dignity

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[385] Doris Schroeder, ‘Human rights and human dignity: an appeal to separate the conjoined twins’ (2012) 15 Ethical Theory and Moral Practice 323-335 <https://www.jstor.org/stable/23254292> or <http://0-www.jstor.org.oasis.unisa.ac.za//stable/23254292> accessed on 12 October 2022.

[386] Section 10 of the Constitution.

[387] *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development* 2013 ZACC 35; 2013 (12) BCLR 1429 (CC); 2014 (2) SA 168 (CC); 2014 (1) SACR 327 (CC) para 35.

[388] *Dawood v Minister of Home Affairs* 2000 3 SA 936 (CC) 962.

[389] Jürgen Habermas, *Communication and the Evolution of society*. Beacon Press, 1979, at 18.

as a “fusion of moral content with coercive law”.[390] In support, Beyleveld and Brownsword state that:

> Dignity appears in various guises, sometimes as the source of human rights, at other times as itself a species of human right (particularly concerned with the conditions of self-respect); sometimes defining the subjects of human rights, at other times defining the objects to be protected; and sometimes reinforcing, at other times limiting, rights of individual autonomy and self-determination.[391]

Barrett states that dignity is “inviolable, irreducible, unalienable, [it] cannot be valued or exchanged”.[392] Sachs J on the other hand, describes dignity in general terms as a right that cannot be restricted under any circumstances.[393] Dignity represents a “wide moral view”,[394] and therefore, reflects the essence of what it means to be a human being. It also legalises the notion that the essence of humanity must be recognised and respected in equal *quantum* due to its recognition of a human right.[395]

In the South African case of *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others,* Ackermann J wrote that:

> Human dignity has little value without freedom; for without freedom personal development and fulfilment are not possible. Without freedom, human dignity is little more than an abstraction. Freedom and dignity are inseparably linked. To deny people their freedom is to deny them their dignity.[396]

The decision suggests that dignity should be embraced in all aspects of health and health care, as its link with freedom (which may be seen as autonomy) is essential. Further, treating all persons with respect should become a core goal for all actions within health and health care. A minor’s identity, which includes his or her gender orientation, is part and parcel part of dignity. Consequently, to deny a minor an

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[390] Jürgen Habermas, ‘The Concept of Human Dignity and the Realistic Utopia of Human Rights’ (2010) 41 Metaphilosophy 464-480 <https://www.jstor.org/stable/24439631> accessed on 12 October 2022.

[391] Deryck Beyleveld and Roger Brownsword, ‘Human Dignity, Human Rights, and Human Genetics’ (1998) 61 MLR 661-662.

[392] Jonathan Barrett, ‘*Dignatio* and the Human Body’ (2005) 21 South African Journal for Human Rights 530 <https://www.africabib.org/htp.php?RID=301242658> accessed on 13 October 2022.

[393] *S v Lawrence* 1997 4 SA 1176 (CC) para 168. Judge Sachs echoes Kant’s theory and provide that: “[i]ndeed, there is a core to the individual conscience so intrinsic to the dignity of the human personality that it is difficult to imagine any factors whatsoever that could justify its being penetrated by the state”.

[394] Doron Schultziner, Human Dignity: Functions and Meanings in Jeff Malpas and Norelle Lickiss (eds) *Perspectives on Human Dignity* (Springer Dordrecht 2007) 85.

[395] Schultziner, ‘Human Dignity’ 85.

[396] 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (CC) para 49.

opportunity to make autonomous decisions regarding his or her gender reassignment amounts to a denial of the autonomy to exercise their human dignity. In the case of *National Coalition for Gay and Lesbian Equality v Minister of Justice*,[397] the common law offences of sodomy were decriminalised because they were found to be incompatible with the constitution. The offences of sodomy differentiated between gays, heterosexuals and lesbians, and the differentiation violated their rights to equal protection under the law, human dignity, and privacy in the Constitution. Ackerman J rightly described the effect of these offences on those targeted by the offences as follows:

> There can be no doubt that the existence of a law which punishes a form of sexual expression for gay men degrades and devalues gay men in our broader society. As such it is a palpable invasion of their dignity and a breach of section 10 of the Constitution.[398]

This judgment turned the spotlight on the persisting injustices inflicted upon gay persons, and the way their constitutional rights on grounds of privacy, dignity and equality were systemically violated. The Constitutional Court also declared discrimination based on sexual orientation unfair and prohibited under the Constitution. The inclusion of sodomy in schedule 1 of the Criminal Procedure Act and the Security Officers Act was held to be unconstitutional.[399] This landmark decision played a huge role in realising the inherent dignity of every person within South Africa, including those of a different sexual orientation.

The right to health care services places obligations on the State to respect, promote and fulfil these rights.[400] This obligation requires that the State does not deny anyone their legitimate right to have access to health care services. Section 27(2) obliges the State to realise the right of access to health care in a progressive manner by adopting reasonable legislative and other measures within its available resources.[401] The interpretation of rights embraces two approaches, known as the vertical application and the horizontal approach. The vertical approach places a duty on the State or public bodies, or officers acting under State authority not to violate the rights of individuals.

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[397] *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1998 (6) BCLR 726 (W) (quoting *Shabalala v. Attorney-General of the Transvaal* 1996 (1) SALR 725.

[398] Para 26.

[399] Para 77.

[400] Section 7(2) of the Constitution.

[401] The Constitution of the Republic of South Africa.

In the preamble to its founding Constitution from 1946, the World Health Organization defines *health* as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[402] The WHO has adopted a far more holistic position which embraces an individual's distinct aspects of health. Therefore, the right to health is fundamental to the physical and mental well-being of an individual. Access to health care services is a fundamental human right in South Africa,[403] however, there is still a disparity in access to transition related health care services across the globe. It is important to note that the South African Constitution does not protect the right to health itself, which is an unattainable condition for many individuals due to their inherent and diverse health situations and needs, yet the Constitution protects those tangible aspects that will promote and support the right to health, in other words, the relevant health care services.

2.5.12 Limitation of rights

In *Harksen v Lane*,[404] the test for unfair discrimination establishing the so-called three stage enquiry was laid down. The Constitutional court decision sets out the test as follows:

> (a) Does the provision differentiate between people or categories of people? If so ...
>
> (b) Does the differentiation amount to unfair discrimination? This requires a two-stage analysis:
>
> (i) Firstly, does the differentiation amount to 'discrimination'? If it is on a specific ground, the discrimination will have been established. If it is not on a specific ground, then whether or not there is discrimination will depend upon whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner.
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> (ii) If the differentiation amounts to 'discrimination', does it amount to 'unfair discrimination'? If it has been found to have been on a specific ground, then unfairness will be presumed. If on an unspecific ground, unfairness will have to be

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[402] World Health Organization (1946), 1946 constitution of the World Health Organization. <https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf> accessed on 07 October 2022.

[403] 1946 constitution of the World Health Organization. In its preamble it provides as follows: "The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all".

[404] *Harksen v Lane* [1997] ZACC 12; 1997 (11) BCLR 1489 (CC); 1998 (1) SA 300 (CC).

> established by the complainant. The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation. If, at the end of the enquiry, the differentiation is found not to be unfair, then there will be no violation ...
>
> (a) If the discrimination is found to be unfair then a determination will have to be made as to whether the provision can be justified under the circumstances of the limitations clause.[405]

The human rights and duties enshrined in Chapter 2 of the Constitution are not absolute. The Constitution provides through section 36 the limitation of rights. Children's rights are, however, also not absolute, as Sachs J emphasised:

> The fact that the best interests of the child are paramount does not mean that they are absolute. Like all rights in the Bill of Rights their operation has to take account of their relationship to other rights, which might require that their ambit be limited.[406]

The above paragraph highlights that the limitation is necessary in a situation where rights are in tension, requiring choices to be made between competing interests. This occurs where the boundary of a right in the Bill of Rights will affect the scope of another protected right.[407] Section 36(1) provides that rights may be limited only "in terms of law of general application' in so far as it is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account: (i) the nature of the right; (ii) the importance of the purpose of the limitation; (iii) the nature and extent of the limitation; (iv) the relation between the limitation and its purpose; and (v) less restrictive means to achieve the purpose".

This section lists a strict set of requirements that the limitation must meet. It explicitly states that any right in the Bill of Rights may be limited provided it is "in terms of law

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[405] *Harksen v Lane* para 50.

[406] *S v M* para 26.

[407] *Ferreira v Levin NO* 1996 (1) SA 984 (CC). Para 82 provides as follows: "If a limitation is sought to be made at the first stage of the enquiry, it requires, at best, an uncertain, somewhat subjective and generally constitutionally unguided normative judicial judgment to be made. The temptation to, and danger of, judicial subjectivity is great. This Court would, in my view, be discharging its interpretative function best, most securely and most constitutionally, if, as far as is judicially possible, it seeks for any limitation of an entrenched right through s 33(1). It may well be that the Constitution itself, either because of the descriptive ambit of one or more of the many other rights entrenched in chap 3, or in some other way, expressly or by clear implication, indicates a limitation of an entrenched right at the first stage of the enquiry. Absent such an indication, the Court would be on safer constitutional ground if it were to find any limitation on the basis of the prescribed criteria in s 33(1). This approach will afford a better guarantee against the Court, however unwittingly, reading its own subjective views into the Constitution".

of general application".[408] It should further be noted that the notion of an open and democratic society based on human rights, equality and freedom is normative. Every limitation of the right must, therefore, be justifiable against these constitutional norms and values. Subsequently, section 28 of the Constitution, section 129 of the Children's Act and other relevant sections referred to above can be lawfully limited whenever a fundamental right is interpreted or arguably limited. This means that both informed consent (and autonomy) may justifiably be limited, especially in situations where these rights conflict with other rights, taking into account the constitutional norms and values.

In *Holomisa v Argus Newspapers*,[409] dealing with the problem of definitional limitations of competing rights, Cameron J held as follows:

> When two competing rights are both recognised, and both specially protected, but one is shielded by common-law rules which bear on the enjoyment and exercise of the other . . . [t]he Court must determine the meaning and content of the right sought to be asserted. It must then assess whether rules, of the common-law or otherwise, which protect the one right, curtail or infringe upon the enjoyment of the other. If so, it must determine whether, in the light of the constitutional scheme overall, and the relative place of each competing right in it, that infringement can be justified under the limitation provision. At both stages, there will necessarily be an assessment of competing values.[410]

The decision asserts that in cases where there is a conflict without the benefit of an intervening rule of the common law, courts should seek to resolve the tension by means of the general limitation clause as enshrined in the Constitution.

2.5.12.1 Law of general application

The Constitutional Court has not yet provided a definition of the term "law of general application". It has however, made it clear through judgements that a law of general application encompasses the common law and statutory law.[411] In *President of the Republic of South Africa v Hugo,* Mokgoro J, considered the phrase broadly, holding that to qualify as a law of general application, the rule in question should be accessible,

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[408] Section 36 Constitution.

[409] *Holomisa v Argus Newspapers* 1996 (2) SA 588 (W).

[410] *Holomisa v Argus Newspapers* 1996 (2) SA 588 (W), 607.

[411] *Du Plessis v De Klerk* 1996 (3) SA 850 (CC) para 136, Kriegler J, in a separate concurrence held that all common law, regardless of its origin, including statutory, regulatory and tribal custom, would qualify as a law of general application.

precise and generally applicable.[412] A law of general application according to De Waal means a law that is "sufficiently clear, accessible and precise that those who are affected by it can ascertain the extent of their rights and obligations".[413] Upon determining that the rule that limits the right is of a general application, there should be a further examination to determine whether the limitation is "reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom taking into account all relevant factors", as listed in s 36(1).

Common knowledge dictates that the provisions of both the Constitution and the Children's Act are a law of general application. It is further clear that the provisions relating to the rights of children are clear, accessible, and precise. Those provisions apply to *every child* who wish to exercise their constitutional rights, including the right to gender reassignment procedures. The provisions allow children to ascertain their rights and obligation.

The Children's Act, as referred to above, contains a specific provision that guarantees a child's right to consent to the performance of a surgical operation on him or her provided the child meets certain requirements. The Act creates a safeguard in that it explicitly provides that the child must be of sufficient maturity and have the "mental capacity to understand the benefits, risks, social and other implications of the surgical operation".[414]

If one considers the right more closely, the right may be limited if it is determined that the child lacks sufficient maturity that enables him or her to comprehend and understand the nature and extent of the harm or risk of the surgical procedure. Consequently, a proportionality approach must be used to measure the reasonableness and justifiability of the provisions relating to children's consent in the health care decision-making, including the limitations placed on their consent. There must, therefore, be a "sufficient proportionality between the harm done by the law (the infringement of the fundamental right) and the benefits it is designed to achieve (the

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[412] Paras 96-104.

[413] De Waal, *The Bill of Rights Handbook* 148, citing *Dawood* case para 47.

[414] Section 129(3)(b).

purpose of the law, which may point to the protection of children in health care services delivery)".[415]

2.5.12.2 The nature of the right

In a constitutional dispensation, a child's ability to participate in matters affecting him or her is extremely important. The exercise of such an ability without restrictions signifies a clear break from the segregation which characterised the past. The Constitutional Court seems to have introduced the phrase "the nature and importance of the right" in the 1995 case of *S v Makwanyane*.[416] This case was decided under the interim Constitution of 1993. Ackermann J, when handing down the majority judgement, held that "[a]lthough s 36(1) does not expressly mention the importance of the right, this is a factor which of necessity must be taken into account in any proportionality enquiry".[417] In this instance, the nature of the right under infringement is overlooking the child's participation in matters that affect him/her. One hurdle is that the child's competence to consent becomes questionable only in instances where there is a conflict of interests between the child, the parent and/or the practitioner.[418] It is proposed that the restrictions placed upon child participation that strictly requires the child to be "duly assisted" by a parent or guardian, must be weighed against the benefits that the law seeks to achieve.

2.5.12.3 The importance of the purpose of the limitation

De Waal argues that the limitation of the right must serve some purpose, and that purpose should be "worthwhile and important in a constitutional democracy".[419] Furthermore, the limitation must serve a purpose that 'all reasonable citizens' would regard as "compellingly important".[420] Section 129 of the Children's Act accords participation rights to children, however, autonomous rights are restricted with regard to surgical procedures. The approach, therefore, will be to check whether the

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[415] De Waal and others, *The Bill of Rights Handbook* 155.

[416] *S v Makwanyane* 1995 (3) SA 391 (CC) paras 104.

[417] *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* para 34.

[418] Priscilla Alderson, 'In the genes or in the stars? children's competence to consent' in Michael Freeman, *Children, medicine and the law* (UK: Ashgate 2005) 550.

[419] De Waal and others, *The Bill of Rights Handbook* 157.

[420] De Waal and others, *The Bill of Rights Handbook* 157.

restriction serves a legitimate purpose, and whether it is *compellingly important* to limit a minor's right in the context of *reasonable citizens*.

It may be possible that children experiencing dysphoria may consider gender reassignment as an option. The question to be answered is would ordinary citizens regard the interests of a minor child in such a situation as compellingly important enough to override his or her parents' refusal to consent? Some may be of the view that the purpose of the limitation is significant since it aims to protect a child, who is vulnerable and confused regarding his or her gender. However, given the obvious psychological consequences to the minor child who cannot consent for himself or herself, or who is refused consent by the parent or guardian, the answer would seem to be no. As this chapter has argued, the protection of a minor's wishes would seem to be an important legitimate purpose in an open and democratic society based on human dignity, equality, and freedom. Overriding parental consent where a child is clearly too young and immature to make such an important decision concerning gender reassignment, is clearly not recommended. This thesis argues that the limitation on children's consent should cease in a staggered manner as a child's maturity evolves. A child, with the relevant ability to reflect on his or her situation, wishes, and a real lived experience in his or her body, should not be required to have parents "duly assist" in surgical operations to which he or she is independently able to consent to.

2.5.12.4 The nature and extent of the limitation

The nature and extent of the limitation questions whether the limitation is a "serious or relatively minor infringement" of the right.[421] It also relates to the methods and instruments used to limit the right. The question that should be asked is whether the restrictions placed on minor children in consenting to their own surgical operations constitute serious or a minor infringement of the affected child's constitutional rights. Denying a sufficiently mature child to have a gender reassignment procedure performed on him or her may result in severe damage to the child's mental and physical health. It is therefore submitted that to deny such a child autonomous consent to surgical procedure is an infringement of his or her constitutional rights.

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[421] De Waal and others, *The Bill of Rights Handbook* 160.

2.5.12.5 The relationship between the limitation and its purpose

The proportionality test is central to determining the limitation and its purpose. Consequently, there must be "proportionality between the harm done by the infringement and the beneficial purpose that the law is meant to achieve".[422] What may be the purpose of refusing a minor child's autonomous consent to surgical procedures? The argument may be that the limitation seeks to restrict the child's autonomous consent to surgical operation, and the purpose is to protect the child against harm following from his or her own inexperience and lack of judgement. This purpose, however, has to be balanced against the constitutional rights of the sufficiently mature child as the age restriction not only unduly violates his or her best interests, but it is also arbitrary, unreasonable (too fixed and not taking children's development into account) and unjustified. As a result, the limitation cannot be reasonable if the law does not achieve its purpose.

2.5.12.6 Less restrictive means to achieve the purpose

What should be considered in this instance is whether and to what extent the restriction achieves the purpose of the limitation. The benefits achieved by the limitation of the right must be in proportion to the harm caused by the limitation. If a less restrictive method is available that will equally serve the purpose of the limitation, then that less restrictive method must be preferred.[423] In the instance of the child who is restricted from exercising his/her autonomous decision to have gender reassignment procedures and/or take prescribed hormonal treatment, the less restrictive means by which to achieve the purpose is not clear. The less restrictive means may even be less effective. The legislation must make a bold attempt to establish a regime that protects autonomous decision making for a sufficiently mature child regarding hormonal therapy, including surgical procedures. Legislative reform is proposed which will ensure that sufficiently mature children are not unduly prejudiced due to outdated and incorrect adult and societal expectations and perceptions.

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[422] De Waal and others, *The Bill of Rights Handbook* 161.

[423] Section 36(1)(e). See also De Waal and others, *The Bill of Rights Handbook* 162.

2.5.12.7 Are the restrictions in section 129 of the Children's Act reasonable and justifiable?

The preamble to the Children's Act provides that "every child has a right set out in section 28 of the Constitution", further that the state is obliged to "respect, protect, promote and fulfil those rights".[424] The Act, as stated earlier, was therefore meant to give effect to the rights of the child as enshrined in the Constitution, especially the child's best interests in section 28 of the Constitution. I submit that the limitations in section 129(3)[425] of the Children's Act are not reasonable and justifiable as they infringe on the child's right to autonomous decision-making.

The present restrictions perceive children as unable to make their own decisions regarding surgical procedures. The wording of section 129(3) could operate in an unnecessarily harsh manner in that it seems to ignore the maturity of the child, including his or her understanding of the risks involved in the procedure and the consequences of the intervention that is sought. The provisions of the section are clear that surgical operations on the minor child will not be performed without the consent of the parent or guardian. Labuschaigne, Mahomed and Dhai[426] assert that although parents have a clear obligation to always act in the best interests of a child, parental control over their children's treatment decisions may not always necessarily constitute a justifiable limitation of the children's execution of their decision-making rights. They argue that parental control will be justifiable where the minor children have not met the specified chronological age criteria and have not demonstrated sufficient maturity to make independent decisions. However, a justifiable limitation of a child's right cannot be adequately met where such a child possesses sufficient maturity and competencies. It is therefore submitted that the view of the law as outlined, is inconsistent with the purpose of the Children's Act in giving effect to the rights of the child as contained in the Constitution, especially where a child is sufficiently matured to give an autonomous consent.

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[424] Children's Act.

[425] Children's Act.

[426] Melodie Labuschaigne, Safia Mahomed and Amed Dhai, 'Evolving capacity of children and their best interests in the context of health research in South Africa: An ethico-legal position, [2022] Developing World Bioethics 1-9 <https://doi.org/10.1111/dewb.12383> accessed on 13 December 2022.

2.6 Parental responsibilities and rights

The South African case of *V v V*[427] became instrumental in creating a paradigm shift that is evident from the following remarks by Foxcroft J:

> There is no doubt that over the last number of years the emphasis in thinking in regard to questions of relationships between parents and their children has shifted from a concept of parental power of the parents to one of parental responsibility and children's rights. Children's rights are no longer confined to the common law, but also find expression in s 28 of the Constitution of the Republic of South Africa Act 108 of 1996, not to mention a wide range of international conventions.[428]

It is trite that the common law parental authority was conferred on parents before Chapter 3[429] was entrenched in the Children's Act.[430] The common law parental authority was defined as "… the sum total of rights and duties of parents in respect of their minor children arising out of parentage".[431] The child was considered legitimate when both his or her parents were married, either at conception, birth, or any time in between. Such children were under the control of both their biological mothers and fathers. Illegitimate children (those whose parents were not married) were placed under the control of their biological mothers.[432] Parents were obligated to protect their children, especially, as a vulnerable category of persons. These children were denied full participation in the political, legal and social processes, because they were presumed to lack capacity.[433] Subsequently, legal reform took place and a culture of children's rights shifted the emphasis from parental authority to the recognition of the rights of children.[434] The Children's Act now governs the relationship between a parent and child.[435] The Act defines "parental responsibilities and rights" as the responsibility and the right, including:

(a) to care for the child;[436]

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[427] *V v V* 1998 4 SA 169 (C).

[428] *V v V* case 176C-D.

[429] Parental responsibilities and rights.

[430] Carmel R Matthias, 'Parental responsibilities and rights of unmarried fathers: court decisions and implications for social workers' (2017) 53 Social Work 95-96 <http://dx.doi.org/10.15270/52-2-548> accessed on 13 December 2022.

[431] Jacobus A Robinson, Children and divorce in Davel *Introduction to Child Law in South Africa* (Juta, Cape Town 2000) 68.

[432] Matthias, 'Parental responsibilities and rights of unmarried fathers.'

[433] Ngwena 'Health care in decision-making' 140.

[434] Ngwena, 'Health care in decision-making' 140.

[435] Chapter 3 of the Act.

[436] Section 1(1) of the Children's Act which provides that 'care' "in relation to a child, includes – (a) within available means, providing the child with – (i) a suitable place to live; and (ii) living

(b) to maintain contact with the child;[437]
(c) to act as guardian of the child;[438]
(d) to contribute to the maintenance of the child".[439]

The Children's Act further makes provisions regarding major decisions involving a child. Section 31(1) provides as follows:

> (a) Before a person holding parental responsibilities and rights in respect of a child takes any decision contemplated in paragraph (3) involving the child, that person must give due consideration to any views and wishes expressed by the child, bearing in mind the child's age, maturity and stage of development.
>
> (b) A decision referred to in paragraph (a) is any decision-
>
> (i) in connection with a matter listed in section 18(3)(c);
>
> (ii) affecting contact between the child and a co-holder of parental responsibilities and rights.

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conditions that are conducive to the child's health, well-being and development; (b) safeguarding and promoting the well-being of the child; (c) protecting the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation, and any other physical and moral harm or hazards; (d) respecting, protecting, promoting and securing the fulfilment of, and guarding against any infringement of, the child's rights set out in the Bill of Rights and the principles set out in Chapter 2 of this Act; (e) guiding and directing the child's education and upbringing, including religious and cultural education and upbringing, in a manner appropriate to the child's age, maturity and stage of development; (f) guiding, advising and assisting the child in decisions to be taken by the child, taking into account the child's age, maturity and stage of development; (g) guiding the behaviour of the child in a humane manner; (h) maintaining a sound relationship with the child; (i) accommodating any special needs that the child may have and (j) generally, ensuring that the best interests of the child is the paramount concern in all matters affecting the child".

[437] Section 1(1) defines contact as: 'Contact' "in relation to a child, means – (a) maintaining a personal relationship with the child; and (b) if the child lives with someone else – (i) communication on a regular basis with the child in person, including – (aa) visiting the child; or (bb) being visited by the child; or (ii) communication on a regular basis with the child in any other manner, including – (aa) through the post; or (bb) by telephone or any other form of electronic communication".

[438] Section 18(3) defines the term as follows: 'guardianship' "in relation to a child means – (a) administering and safeguarding the child's property and property interests; (b) assisting or representing the child in administrative, contractual and other legal matters; or (c) giving or refusing any consent required by law in respect of the child, including – (i) consenting to the child's marriage; (ii) consenting to the child's adoption; (iii) consenting to the child's departure or removal from the Republic; (iv) consenting to the child's application for a passport; and consenting to the alienation or encumbrance of any immovable property of the child".

[439] The Children's Act and the Maintenance Act 88 of 1998 do not provide a definition of the term 'maintenance'. However, it should be noted that the objective of the Maintenance Act is to ensure that children receive the necessary maintenance to assist in their upbringing and well-being. Further that, parents should be held accountable to their duty to maintain their children. Section 28(2) of the Constitution on the other hand states that a child's best interest is of paramount importance in every matter concerning the child. Importantly, sections 28(1)(b) and 28(1)(c) stipulates that every child has the right to family care, nutrition, and shelter.

Section 129(3) of the Act strictly requires the child to be “duly assisted” by a parent or guardian in matters relating to surgery. The definition of the phrase “duly assisted” is not provided in the Children's Act.

The confusing aspects are that the Act corresponds with the term ‘assistance’ that is used as an umbrella term for the various actions that a guardian can take to supplement a minor’s limited capacity to act.[440] Kruger,[441] therefore, aligns herself with the view held by Himonga and Cooke[442] which asserts that that the phrase refers to parental help. The words duly assisted therefore, places a responsibility on the child’s parent, guardian or even a caregiver to assist the minor child appropriately and meaningfully in decision-making. This, however, requires the parent to properly apply his or her mind to the matter and advise the child accordingly.[443] The best interests of the child must be determined and even take precedence in situations where there is a clash between the wishes of the child and the parent regarding surgery.[444] Although the literal interpretation of the words duly assisted do not lead to a senseless interpretation, the legislators should replace the phrase “duly assisted” with duly directed and guided.[445] In this instance the phrase will have a clearer meaning and serve as a useful guide. In *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another*,[446] the court recognised the evolving capacities of children and also considered the best interest of the child in its judgement. It placed an obligation on the State to facilitate appropriate guidance for children on the exercise of their rights. The court provided as follows:

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[440] Jacqueline Heaton, *Law of Persons* 5th edn (LexisNexis 2017) 89. The guardian may act on behalf of the minor, the minor may personally conclude the agreement with the guardian's consent, or the guardian may ratify the agreement after its conclusion.

[441] Kruger, ‘The realization of children's rights.’ 94.

[442] Chuma Himonga and Anita Cooke, ‘A Child's Autonomy with Special Reference to Reproductive Medical Decision-making in South African Law: Mere Illusion or Real Autonomy?’ (2007) International Journal of children’s Rights 323-363 <https://doi.org/10.1163/092755607X262784> accessed on 10 February 2023. Also see Slabbert, ‘Parental access to minors' health records’ 171. Slabbert poses a question whether the phrase could possibly refer to "parental advice or supplementary support”.

[443] Basil J Pillay and Jerome A Singh, ‘‘Mental capacity’, ‘sufficient maturity’, and ‘capable of understanding’ in relation to children: how should health professionals interpret these terms? [2017] South African Journal of Psychology <https://doi.org/10.1177/0081246317747148> accessed on 10 February 2023.

[444] Pillay and Jerome, ‘‘Mental capacity’, ‘sufficient maturity’, and ‘capable of understanding’ in relation to children.’

[445] Kruger, ‘The realization of children’s rights’ 100.

[446] 2013 (12) BCLR 1429 (CC); 2014 (2) SA 168 (CC); 2014 (1) SACR 327 (CC).

> Children are precious members of our society and any law that affects them must have due regard to their vulnerability and their need for guidance. We have a duty to ensure that they receive the support and assistance that is necessary for their positive growth and development. Indeed, this Court has recognised that children merit special protection through legislation that guards and enforces their rights and liberties. We must be careful, however, to ensure that, in attempting to guide and protect children, our interventions do not expose them to harsh circumstances which can only have adverse effects on their development.[447]

One of the reasons advanced by Kruger is that the meaning of parental responsibilities and right as enshrined in the Act include the responsibility and right to care for the child.[448] The provision of section 31 of the Children's Act aligns itself with section 28 of the Constitution in that it requires that every decision involving the child must give due consideration to the wishes and views of the child. This resonates also in the wording of section 129 of the Children's Act concerning age and maturity as some of the considerations. Moreover, section 31 of the Children's Act seems to underscore the meaning of section 7 of the Act that refers to the "stage of development" of a child as one of the factors to be considered in determining the competency of the child. Although stage of development is not defined in the Act, it may be accepted that the word generally subscribes to a developmental approach to maturity.[449] Havenga and Temane argues that although these stages are linked to age, there are instances where they are attained beyond the expected norm. This is because children do not develop simultaneously, some are early developers, whilst some are late developers. It is, therefore, important to consider each child's unique circumstances, and desist from applying an umbrella approach.[450]

2.7 Conclusion

This chapter is premised on canvassing the legal-historical development of children's rights, including childhood itself from a range of related perspectives. Research suggests that there is a correlation between autonomy, self-determination, competence, and decision-making capacities. The chapter argued that a sufficiently mature child should be regarded as an active participant in health care decision-making and surgical interventions. Further that, the recognition and acknowledgement

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[447] *Teddy Bear* case para 1.
[448] Section 18(2)(a) of the Children's Act.
[449] Havenga and Temane, 'Consent by children.'
[450] Havenga and Temane, 'Consent by children.'

of children's evolving maturity necessitates legal acknowledgement of children's right to self-determination and autonomy, which are part of their rights to bodily and psychological integrity as enshrined in the Constitution. This change in thinking reflects the beginning of a re-conceptualisation of childhood itself. Whilst liberationists claim that the autonomous child should have a say in matters relating to their health, protectionists, on the other hand, argue that a minor lacks capacity to make decisions. As a result, to protect children from their naivety and lack of experience, the decision-making is conferred on the parent or guardian of the child. An age threshold was established all over the world by legislators exactly because of the protectionist stance.[451] Children are generally believed to be unable to understand the consequences of their decisions. Consequently, they need protection as they develop the skills to become competent decision-makers, and to learn how to exercise sound judgement.[452]

Pragmatists emphasise the importance of striking a fair balance between the protection needed for children and self-determination when considering a child's views. As Freeman states, "… to take children's rights more seriously, requires us to take more seriously both the protection of children and recognition of their autonomy, both actual and potential".[453] Striking a balance between these two ideas recognises children as capable subjects vested with knowledge and rights, whilst at the same time acknowledging that such children may be in need of protection. In a way, there seems to be significant divergence between the views held by some authors referred to in this chapter. A closer look, however, reflects that these deviations have the same goal, which is to assess the factual and legal competence of children.

The notion of the best interests of the child plays a central role in all matters relating to the child. As it has already been indicated, the difficulty arises where there are competing interests that should be considered, and the extent at which those interests must be considered. This led to the best interests principle being criticised by many as

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[451] Prinslean Mahery, 'Consent Laws Influencing Children's Access to health care services' [2006] Children's Institute, University of cape Town 167-180 <https://journals.co.za/doi/pdf/10.10520/EJC35464> accessed on 25 November.

[452] Mahery, 'Consent Law' 167-180.

[453] Michael Freeman, 'Whither Children: Protection Participation, Autonomy?' (1994) 22 Manitoba Law Journal 324.

being too indeterminate. The concept's indeterminacy is attributed to its vagueness and the risk of it becoming manipulated by adults whose views conflict with those of their minor children, and who, because of their authority to decide their children's best interests, have the upper hand when a medical decision needs to be made. This in turn has repercussions on sufficiently mature children's claim to autonomy. Central to a child-centred approach is the notion that children are more rational than what is usually admitted and should be granted more autonomy. This chapter also refers to a specific view that children's abilities evolve with maturation and experience and accepting that children need to develop their decision-making capacities, does not mean accepting that they have a right to autonomy. This is a view that cannot be accepted, for reasons indicated in this chapter.

Providing children with opportunities to participate in decision-making and encouraging their contributions will ensure that they become role players in decisions that concern them. Adults should become advocates in encouraging mature children's voices in medical contexts, emphasising that children are legal subjects as opposed to legal objects. In support of this objective, MacNaughton explains the benefit of such an approach:

> The principles underpinning democratic societies require that everyone—regardless of age—should be able to participate in civic life and so listening to young children is a prerequisite of a vigorous democratic society. By listening to children, adults can assist them to enact their right as citizens to participate in decisions that affect their lives, giving them a stake in those decisions. Listening to young children helps them to build the skills and knowledge they need to be active citizens and gives them experience in participating in decision-making.[454]

Perceptions of the child as incompetent when making decisions regarding surgical operations that affect them should change. Sufficiently mature children should be regarded as human beings in the fullest sense with a voice, not as persons "in the making" that adults can continue to marginalise. Including not only the child's voice in decisions that affect him or her, but also fully recognising and giving effect to his or her decisions, are imperative for child participation. Excluding the sufficiently mature child's view and disregarding his or her autonomy will no doubt result in a child feeling

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[454] Glenda MacNaughton, Kylie Smith and Heather Lawrence, *Hearing young children's voices* Parkville: Centre for Equity and Innovation in Early Childhood, (University of Melbourne 2003). 12.

undervalued. Immanuel Kant has famously cautioned that all rational beings must be treated as ends in themselves, and not as a means to another person's end.[455] This important principle suggests that human beings, including the child's parents or legal guardians, may be inclined to act in their own self-interest or because of entrenched and outdated societal expectations and perceptions. Abusive paternalism may defeat the personal sovereignty of the child, especially where the paternalism is not in the child's best interests.

Understanding the child's views and considering his/her individual needs are essential in decision making and shaping the developing young adult. Furthermore, if consultation with children disregards individuality, that participation fails to contribute to a child's development of individual identity, competence, responsibility, and a child's sense of self-esteem. Such a consultation may, consequently, disempower and tokenise the child, rather than asserting them as active participants in decision-making processes that may affect them.[456]

The sufficiently mature child's wishes, and feelings should form an integral part in determining their best interests. This can progressively be realised through participation and consultation processes that encourages a child's voice to be heard. These processes will reach a point where the child's competence and individual maturity have become strong enough to be exercised completely independently from his or her parents or guardian. The presumption that parents naturally and reliably always act in the best interests of their child need to be scrutinised. This is because evidence and case law reflect that determining the interests of the child are not an instinctual exercise.

This chapter alluded to the reality that the LGBTQIA+ community has suffered a harsh fate during the apartheid era, an aspect which has also been noted by the Constitutional Court. It is for this reason that the constitutionalisation of the right to be protected from unfair discrimination specifically included those discriminated against,

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[455] Samantha Vice, 'Dignity and Equality in *Barnard'* (2015) 7 Constitutional Court Review 141.

[456] Frans M Mahlobogwane, 'Determining the Best Interests of the Child in Custody Battles: Should a Child's Voice be Considered? (2010) 31 Obiter 235-236 <https://doi.org/10.17159/obiter.v31i2.12357> accessed on 27 November 2022.

among others, on the ground of sexual orientation. I would like to conclude this chapter by referring to the words of Sachs J in the *Fourie* judgment, where he highlights at least four features of the context in which the prohibition against unfair discrimination on grounds of sexual orientation must be analysed. They are:

> (1) South Africa has a multitude of family formations that are evolving rapidly as our society develops, so that it is inappropriate to entrench any particular form as the only socially and legally acceptable one; (2) The existence of an imperative constitutional need to acknowledge the long history in our country of marginalisation and persecution of gays and lesbians; (3) Although a number of breakthroughs have been made in particular areas, there is no comprehensive legal regulation of the family law rights of gays and lesbians; and (4) Our Constitution represents a radical rupture with a past based on intolerance and exclusion, and the movement forward to the acceptance of the need to develop a society based on equality and respect across difference. Small gestures in favour of equality, however meaningful, are not enough. At the very least, equality affirms that difference should not be the basis for exclusion and stigma. At best, it celebrates the vitality that difference brings to any society.[457]

Chapter 3 will explore the clinical aspects of gender-affirming health care, which in turn affects how the best interests of the child are carried out in light of transgendered children and adolescents.

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[457] *Fourie* para 59.

CHAPTER 3: THE CLINICAL AND LEGAL ASPECTS OF ADOLESCENT GENDER AFFIRMING CARE IN SOUTH AFRICA

3.1 Introduction

The previous chapter canvassed the recognition of the best interests of the child by the Constitution in 1996. It further postulated that the principles of the best interests of the child and autonomy or self-determination have become twin pillars in childcare related matters. This chapter provides a conceptual examination of these principles by narrowing them down to the perspective of gender reassignment decisions.

Reisner and others argue that gender affirming care should be conceptualised as multidimensional with at least four core constructs:

> Social (choice of name and pronoun, interpersonal and institutional acknowledgement and recognition), psychological (internal felt sense of self-actualization, validation of gendered self, internalised transphobia), medical (pubertal blockers, hormones, surgery, other body modification), and legal (legal name change, legal change of gender marker designation).[458]

The chapter begins with introducing the history of transgenderism with the aim of contextualising the current conditions of trans lives in South Africa. It continues to explore trans people's experiences of discrimination and marginalisation by society. It then builds on the concept of gender reassignment describing hormonal therapy and surgical reconstructions as clinical interventions to promote a change in gender identity. It also points to the physical and psychological challenges in the implementation of gender reassignment procedures at both a systemic and an individual level. The chapter finally explores an up-to-date review of the relevant clinical guidelines relevant to the initiation of gender-affirming procedures for children and adolescents with gender dysphoria.

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[458] Sari L Reisner, Asa Radix, and Madeline B Deutsch, 'Integrated and Gender-Affirming Transgender Clinical Care and Research' (2016) 15 Journal of Acquired Immune Deficiency Syndromes 235-242 <https://doi.org/10.1097/QAI.0000000000001088> accessed on 13 December 2023.

3.2 The social construction of gender

Sex, gender and sexuality are intimately intertwined, as a result they are often placed into binaries[459] of male, female, heterosexual and homosexual.[460] These terms fall short of considering the individual's unique experience, which often does not fit into these classifications.[461] Raley and Bianchi argue that sex and gender are then "primary lenses through which we view ourselves and others."[462] Huggard argues that sex is usually a designation that doctors assign to infants when they are born and is based on whether an infant has a penis or a vagina. The term sex has become scientifically and clinically defined due to its intrinsic focus on biological characteristics and reproductive capabilities.[463] The sex of a baby born with a vulva is assigned as female, whereas the one born with a penis will be labelled a boy. This is also what is usually reflected on their birth records.[464] Accordingly, individuals are expected by virtue of their binary classification of gender, to assume the gender of their assigned biological sex, including the expectations and roles associated with such a classification.

Philosophically, this imply that particular social roles are assigned to an individual at birth. Some babies, however, may display sexual anatomy or chromosomes that are not fitting the typical sex classification of male or female. Doctors usually label these babies as being intersex, which is a socially and a legally constructed category that reflects real biological variation.[465] Sex assigned at birth refers to the biological

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[459] This traditionally refers to the societal or cultural belief that a person is classified as a male or female or a man or a woman following from biological sex. This person is attracted to the opposite sex. However, science is discovering that humans have way more variation than these two options, and that gender may exist beyond a binary measurement and may take many forms. See Martin Eisend and Anna Rößner, 'Breaking Gender Binaries' (2022) 52 Journal of Advertising 557-573 <https://doi.org/10.1080/00913367.2022.2109780> accessed on 15 December 2022.

[460] Sloth-Nielsen, 'Failure to recognise a third gender option.'

[461] John Curra, *The relativity of deviance* (CA: Sage Publications 2000).

[462] Sara Raley and Suzanne Bianchi, 'Sons, daughters, and family processes: Does gender of children matter?' (2006) 32 Annual Review of Sociology 401-421 <https://www.jstor.org/stable/29737745> accessed on 13 December 2022.

[463] Sarah Earle and Gaile Letherby, Reflecting on Reproduction. In: Earle S., Letherby G. (eds) *Gender, Identity & Reproduction* (Palgrave Macmillan, 2003) 225-230.

[464] Ruth Hubbard, 'Gender and Genitals: Constructs of Sex and Gender' (1996) 46/47 Science Wars 157-165 <https://doi.org/10.2307/466851> accessed on 15 December 2022.

[465] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.' See also section 1 of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. In terms of the Act "sex includes intersex", and intersex "means a congenital sexual differentiation which is atypical, to whatever degree".

features of the genitals, but this biological feature may not necessarily be aligned with the person's internal sense of how they feel and how they identify.[466]

Gender is an aspect of the prevailing social and cultural expectations, it includes behaviours and roles associated with being either *masculine* or *feminine*.[467] Gender develops over time, and the social science literature has generally accepted that a coherent gender identity and psychic health develops when a child is around the age of 2 or 2½. This is the period where children become conscious that they align better with one gender than the other.[468] The absolute dichotomous distinction of the sexes into males and females, women and men, is in itself a social construction. This differentiation and insisting that there are no additional sexes beyond male and female as sex is permanent for life, feeds into the notion that persons whose genders are not binary and do not match their genitals are 'abnormal.'[469]

A foundational understanding of sex, gender and identity is crucial for a deeper acknowledgement of LGBTQIA+ identities. LGBTQIA+ persons are also known as persons with diverse gender identities, gender expressions, or sexual orientations. These persons are, however, not a homogeneous population. Kessler and McKenna summarise this as follows:

> Scientists construct dimorphism where there is continuity. Hormones, behavior, physical characteristics, developmental processes, chromosomes, psychological qualities have all been fitted into [sex or] gender dichotomous categories. Scientific knowledge does not inform the answer to "what makes a person either a man or a woman?" Rather it justifies (and appears to give grounds for) the already existing knowledge that a person is either a woman or a man and that there is no problem in differentiating between the two. Biological, psychological, and social differences do not lead to our seeing two genders. Our seeing two genders leads to the "discovery" of biological, psychological, and social differences.[470]

The global rise of social movements and the acceleration of technology, including democratic politics based on ideas of equality, have helped fuel an increased

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[466] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.'

[467] Lauren Costello and Duane Duncan, 'The 'Evidence' of sex, the 'Truth' of gender: Shaping children's bodies' (2006) 4 Children's Geographies 157-172 <https://doi.org/10.1080/14733280600806940> accessed on 16 December 2022.

[468] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.'

[469] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.'

[470] Suzanne J Kessler and Wendy McKenna, *Gender: An Ethnomethodological Approach* (Chicago: University of Chicago Press 1978) 163.

recognition of minority groups.[471] Despite this significant progress, there are still elements of structural inequality based on sexual orientation, and societies worldwide continue to have a considerable presence of gender roles.[472] These gender roles are socially constructed as a result of sociocultural influences based on norms, or standards, created by society.

Social constructions around gender and the prescribed behaviours that are deemed appropriate for women and men socially categorise people and often lead to prejudice, discrimination, and social exclusion.[473] The social construction of gender is bound in those masculine and feminine qualities based upon a binary structure of gender.[474] The origins and determinants of gender differentiation is far from being understood, it has as a result, sparked a debate and various criticisms. Swaab and others asserts that it is more difficult to change gender identity, "probably because... [it is] fixed in the brain".[475] Thorne provides a stark contrast to this view and asserts:

> While many still see gender as the expression of natural differences, the women's movement of the 1970s and 1980s launched a powerful alternative perspective: notions of femininity and masculinity, the gender divisions one sees on school playgrounds--the idea of gender itself--all are social constructions. Parents dress infant girls in pink and boys in blue, give them gender-differentiated names and toys, and expect them to act differently...peer groups...also perpetuate gender-typed play and interaction. In short, if boys and girls are different, they are not born, but made that way.[476]

However, traditional gender role belief systems and the norms relating to sexual orientation, including expression of identity, are starting to change, and have triggered some resistance.[477] Legal developments have been made in ensuring that the law is

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[471] Sloth-Nielsen, 'Failure to Recognise a third gender option.'

[472] Gender roles are defined as '[A]ll those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively. It includes, but is not restricted to, sexuality in the sense of eroticism. Gender role is assessed in relation to general mannerisms, behaviors [sic] and attitudes; preference in games and recreational interests; spontaneous themes of conversation, content of dreams, ramblings and fantasies; response to oblique surveys and projective tests; evidence of erotic practices and, finally, the person's own responses when asked". See Linda Mealey, *Sex differences: Development and evolutionary strategies* (Academic Press 2000) 12.

[473] Frank W Schneider, Jamie A Gruman and Larry M Coutts, (eds.) *Applied social psychology: Understanding and addressing social and practical problems* (Thousand Oaks, CA: Sage Publications 2005).

[474] Schneider and others, *Applied social psychology*.

[475] D F Swaab, L J G Gooren and M A Hofman, 'Gender and Sexual Orientation in relation to hypothalamic structures' (1992) 38 Hormone Research in Paediatrics 52.

[476] B Thorne, *Gender play: Girls and boys in school* (New Brunswick NJ: Rutgers University Press 1993) 2.

[477] Sloth-Nielsen, 'Failure to Recognise a third gender option.'

accommodating and inclusive of the previously ignored and marginalised LGBTQIA+ community.[478] Trans persons are one such group which has been marginalised. Studies, however, indicate that a more radical change has occurred lately. A considerable number of transgender theorists and activists have begun to insist that the myth that gender is binary has reached its expiry date.[479] They argue against gender stereotyped behaviours, including the societal norms and expectations that classify people within a binary. They lobby for an increased fluidity regarding notions of sex and gender, as well as opposing the notion that genitals determine gender. In this instance, they propose that gender should be "unhooked from genitals and speak of a 'rainbow' of genders".[480]

Many trans persons are not only defying rigid, binary gender constructions by strongly identifying with the gender that is opposite to their biological sex or the gender assigned to them at birth, but they may also completely denounce gender altogether. Thus, they may identify as genderqueer, intersex or may decide to live permanently with a more fluid gender identity.[481] They may also advocate for the creation of environments that are gender sensitive, or for flexible, and adaptable environments that fully support the improvement of gender diverse domains.

South African law, however, does not currently make provision for non-binary markers or self-determination of an individual that may legally be recognised as neither female nor male,[482] in other words, South African law does not recognise a third of open-ended number of gender classifications.

A third gender classification, for example, would allow transgender persons who identify as neither female nor male (non-binary) to register a third option in accordance with their non-binary gender identity.[483] Regarding the third gender classification, it is submitted that such a classification may be problematic for some trans persons, as

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[478] Sloth-Nielsen, 'Failure to Recognise a third gender option.'
[479] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.'
[480] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.'
[481] Sloth-Nielsen, 'Failure to Recognise a third gender option.'
[482] Sloth-Nielsen, 'Failure to Recognise a third gender option.'
[483] Sloth-Nielsen, 'Failure to Recognise a third gender option.'

such a category may limit transgender lives within the singular framework of sexuality and gender. Stone explains as follows:

> In the transsexual text we may find the potential to map the refigured body onto conventional gender discourse and thereby disrupt it, to take advantage of the dissonances created by such a juxtaposition to fragment and reconstitute the elements of gender in new and unexpected geometries... I suggest constituting transsexuals not as a class or problematic "third gender", but rather as a genre – a set of embodied texts whose potential for productive disruption of structured sexualities and spectra of desire has yet to be explored.[484]

There is no doubt that trans persons face multiple challenges in South Africa and may consequently require local, evidence based affirming care. In 2019 a group of interested local clinicians mandated and funded by the SAHCS, collaborated with the purpose of developing guidelines on aspects relating to gender-affirming health care (GAHC) in South Africa.[485] These guidelines are considered elsewhere in this chapter.

3.3 The historical concept of transgenderism

Historically, the term 'transsexual' was restricted for individuals who had a "gender identity disorder" and underwent gender reassignment surgery.[486] Currently, however, the phrase *transsexual* refers to anyone who has a gender identity that is incongruent with the sex the person had or was identified with at birth, and therefore currently lives as a person of the opposite sex, regardless of whether they are proposing to undergo,

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[484] Sandy Stone, 'The 'Empire' Strikes Back: A Posttranssexual Manifesto' in *The Transgender Studies Reader*, edited by Susan Stryker and Stephen Wittle (Routledge 2006) 221-235.

[485] A Tomson and others, Southern African HIV Clinicians Society gender-affirming healthcare guideline for South Africa – expanded version October 2021 <https://sahivsoc.org/Subheader/Index/sahcs-guidelines> See also the condensed guidelines, A Tomson and others, Southern African HIV Clinicians Society gender-affirming healthcare guideline for South Africa (2021) 22 South African Journal of HIV Medicine <https://doi.org/10.4102/sajhivmed.v22i1.1299> accessed on 23 February 2023. This are the first national guidelines for Gender-affirming Healthcare for South Africa which were published in October 2021.

[486] The WHO, in the ICD-10 defines the diagnosis as "A disorder, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex. There is a persistent preoccupation with the dress and activities of the opposite sex and repudiation of the individual's own sex. The diagnosis requires a profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behaviour in boys is not sufficient". See World Health Organization, International statistical classification of diseases and related health problems, 10th revision, Fifth edition, (World Health Organization 2016) F64.0–F64.9 <https://apps.who.int/iris/handle/10665/246208> accessed on 17 December 2022.

are undergoing or have undergone medical interventions relevant for transition purposes.[487]

Referring to Etkins and King in their 2006 work, *The Transgender Phenomenon* in which they distinguish four types of transgenderism, Pfäfflin alludes to the complexity of delineating classifications:

> The first one being the traditional transsexual who exclusively wants to be transformed from male to female or vice versa in terms of role behaviour, bodily outfit and legal recognition. The second type oscillates between variably long phases of living a male or female social life. A third type fundamentally negates the gender dichotomy and wants to belong to neither category, neither male nor female, but to an alternative third sex and gender. Finally, there is a fourth type, wanting to escape sex and gender categories. Richard Etkins and Dave King define their attitude as transcending, which may be best defined as an attempt to overcome the gender question altogether. These persons do not want to be called male or female, transsexual or transgender, but only trans or per, derived from the word person.[488]

But, when Freud writes about this lack of sexual demarcations, he observes as follows:

> Man too is an animal with an unequivocally bisexual disposition. The individual represents a fusion with two symmetrical halves; one of these…is purely male, the other female. It is equally possible that half was originally hermaphrodite. Sexuality is a biological fact that is immensely important in our psychical life, but it is hard to comprehend psychologically. We are in the habit of saying that every human being exhibits both male and female impulses, needs and properties, but while anatomy can distinguish between male and female psychology cannot…we do not hesitate to equate active with 'male' and passive with 'female' but these equations are by no means universally confirmed….[489]

Although at the time, modern conceptions of gender had not yet been advanced, Freud began to realise that the concept of gender identity as it is today referred to, could not simply be universalised.

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[487] E Coleman and others, 'Standards of care for the health of transsexual, transgender, and gender nonconforming people, version 7' (WPATH SOC7 2012) 13 International Journal of Transgenderism 165–232 <https://doi.org/10.1080/15532739.2011.700873> accessed on 19 February 2023.

[488] Friedemann Pfäfflin, 'Transgenderism and transsexuality: medical and psychological viewpoints' in Scherpe JM (ed) *The Legal Status of Transsexual and Transgendered Persons* (Cambridge: Intersentia 2015) 19 <https://doi.org/10.1017/9781780685588.003> accessed on 19 February 2023.

[489] Sigmund Freud, *Civilization and its discontents* (London: Penguin Books 2002) 42-43 (Original work published 1930).

In order to update the tenth edition of their diagnostic tool, the WHO created a Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH). This working group was tasked with "reviewing and evaluating clinical and research data informing gender identity diagnoses since the publication of the ICD-10 in 1992".[490] According to Drescher and others, the working group concluded that it would be appropriate to depart from the "psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance" in favour of an alternative model that is:

> (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services.[491]

The 11th revision of the World Health Organization International Classification of Diseases (ICD-11)[492] in 2018 made significant changes to the way in which gender diverse conditions were clinically classified. It removed transsexuality from the list of mental and behavioural disorders. It currently uses the diagnosis of "gender incongruence" describing it in the following terms:

> Gender incongruence of childhood is characterized by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.[493]

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[490] Jack Drescher, Peggy Cohen-Kettenis and Sam Winter, 'Minding the body: Situating gender identity diagnoses in the ICD-11' (2012) 24 International Review of Psychiatry 568-577 <https://doi.org/10.3109/09540261.2012.741575> accessed on 19 February 2013.

[491] Drescher and others, 'Minding the body: Situating gender identity diagnoses in the ICD-11.'

[492] World Health Organization, ICD-11, Classifying disease to map the way we live and die. (WHO: Geneva, 2018) <https://www.who.int/health-topics/international-classification-of-diseases> accessed on 24 February 2023.

[493] Chapter 16: HA61, WHO, International Statistical Classification of Diseases and Related Health Problems 11th edn (Geneva: WHO 2020) <https://www.who.int/standards/classifications/classification-of-diseases> accessed on 03 February 2023. Chapter 17: HA60 further provides as follows: "Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as

Gender incongruence evolved from gender dysphoria,[494] and the diagnosis of “gender incongruence” has now become the preferred term for what was previously described as gender identity disorder.[495] The change in the diagnostic label was influenced by the stigma surrounding the condition “gender identity disorder”. The categorisation of “transsexualism” as a mental disorder also contributed to a variety of human rights violations that trans people faced. The aim of the change in the diagnostic label together with the removal of transsexuality from the list of mental and behavioural disorders, therefore, was to decrease the stigma in order to expand access to health care for transgender persons.[496]

On the other hand, the notion of “gender identity” refers to a subjective sense of belonging to a certain gender category. As Lev puts it, a “person’s self-concept of their gender (regardless of their biological sex) is called their gender identity”.[497] This concept offers the opportunity to understand that an infant’s sex, as determined by their biology might not correspond with the innate gender identity the child develops between birth and the conclusion of adolescence.[498] The expression *gender identity* was coined in the middle 1960s, describing one’s deeply felt internal and individual experience of belonging to either the male and female gender category.[499] The concept of gender identity has existed for many years, though its meaning has changed and evolved over time. Today, this concept includes those people who do not identify either as female or male.

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much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis”.

[494] Gary Butler, ‘Gender Incongruence’ (2020) 30 Paediatrics and Child Health 407-410 <https://doi.org/10.1016/j.paed.2020.09.001> accessed on 25 February 2023.

[495] Gary Butler, ‘Gender Incongruence’ (2020) 30 Paediatrics and Child Health 407-410 <https://doi.org/10.1016/j.paed.2020.09.001> accessed on 25 February 2023.

[496] Jaclyn M White Hughto, Sari L Reisner, and John E Pachankis, ‘Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions’ (2015) 147 Social science and Medicine 222-231 <https://doi.org/10.1016/j.socscimed.2015.11.010> accessed on 18 February 2023.

[497] Arlene Istar Lev, *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and their Families* (New York, NY: Haworth Clinical Practice Press 2004) 397.

[498] Lev, *Transgender Emergence* 397.

[499] J Money, ‘The concept of gender identity disorder in childhood and adolescence after 39 years’ (1994) 20 Journal of Sex and Marital Therapy 163-177 <https://doi.org/10.1080/00926239408403428> accessed on 25 February 2023.

Most attempts to understand the formation of gender identity is based on the neuroanatomical sexual differentiation.[500] Under this theory, gender identity could be related to a different sexual differentiation of the brain and of the genitals. These differences have been found to be associated with the patho-etiology of gender dysmorphic disorder.[501] Sexual differentiation of the genitals takes place early in the evolution of the foetus during the first trimester of pregnancy, whereas sexual differentiation of the brain takes place during the second half of pregnancy. Therefore, it has been hypothesised that these two processes may take different directions of each other as they can be influenced independently.[502] This may result in individuals with male sexual organs experiencing themselves as females and those with female sexual organs experiencing themselves as males.[503] This theory of the two processes that may take different directions of each other seems to have played a significant role regarding present-time research studies.[504] Other research has suggested that whilst it is acknowledged that prenatal and pubertal sex hormones may permanently affect human behaviour, the impact of prenatal hormones on gender identity development is still inconclusive.[505] Rosenthal agrees that gender constructs are influenced in part by innate factors, as there seems to be "[c]ompelling evidence that biology contributes to gender identity development (with the correlate that gender identity, like sexual orientation, is ingrained and not a 'choice')".[506]

Following on the discussion above, one may conclude that the term transgender would fall into the broad category of "gender diverse". It is therefore reflected as an umbrella

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[500] Jiska Ristori and others, 'Brain Sex Differences Related to Gender Identity Development: Genes or Hormones?' (2020) 21 International Journal of Molecular Sciences 2123 <https://doi.org/10.3390/ijms21062123> accessed on 22 February 2023. See also Arthur P Arnold, 'The organizational–activational hypothesis as the foundation for a unified theory of sexual differentiation of all mammalian tissues' (2009) 55 Hormones and Behavior 570-578 <https://doi.org/10.1016/j.yhbeh.2009.03.011> accessed on 25 February 2023.

[501] Ristori and others, 'Brain Sex Differences Related to Gender Identity Development.'

[502] Ristori and others, 'Brain Sex Differences Related to Gender Identity Development.'

[503] Ristori and others, 'Brain Sex Differences Related to Gender Identity Development.'

[504] Ai-Min Bao and Dick F Swaab, 'Sexual differentiation of the human brain: relation to gender identity, sexual orientation and neuropsychiatric disorders' (2011) 32 Frontiers in neuroendocrinology 214-226 <https://doi.org/10.1016/j.yfrne.2011.02.007> accessed on 20 February 2023.

[505] Ristori and others, 'Brain Sex Differences Related to Gender Identity Development.'

[506] Stephen M Rosenthal, 'Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view' (2021) 17 Nature Reviews. Endocrinology 581-591 <https://doi.org/10.1038/s41574-021-00535-9> accessed on 03 February 2023.

term which is mainly referenced as “gender nonconforming”.[507] The etiology of transgenderism remains poorly understood despite the growing amount of research in this area.[508] Despite recent improvements both in social acceptance of transgender persons as well as access to gender affirming therapy, progress in both areas has been hampered by poor understanding of the etiology of gender dysphoria. The WPATH defines the term “gender dysphoria” as:

> [a] state of distress or discomfort that may be experienced because a person’s gender identity differs from that which is physically and/or socially attributed to their sex assigned at birth. Gender Dysphoria is also a diagnostic term in the DSM-5 denoting an incongruence between the sex assigned at birth and experienced gender accompanied by distress. Not all transgender and gender diverse people experience gender dysphoria.[509]

Theisen and others maintain that the poor understanding of gender dysphoria hampers the perceived increasing social acceptance of transgender persons as well as access to hormone therapy and gender-affirming surgery.[510] As far as adolescents are concerned, the WPATH notes that “it may come as a surprise to others (parents, other family members, friends, and community members) when a youth’s gender dysphoria first becomes evident in adolescence”.[511] There is, however, increasing evidence of a biological and/or genetic component.[512]

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[507] Elma de Vries, Harsha Kathard and Alex Müller, ‘Debate: Why should gender-affirming health care be included in health science curricula?’ (2020) 51 BMC Medical Education <https://doi.org/10.1186/s12909-020-1963-6> See also Jack Drescher, ‘Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD’ (2015) 27 International Review of Psychiatry 386-395 <https://doi.org/10.3109/09540261.2015.1053847> accessed on 16 February 2023.

[508] Hiroshi Ujike and others, ‘Association study of gender identity disorder and sex hormone-related genes’ (2009) 33 Progress in Neuro-Psychopharmacology and Biological Psychiatry <https://doi.org/10.1016/j.pnpbp.2009.07.008> accessed on 03 February 2023.

[509] World Professional Association for Transgender Health, Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644> accessed on 03 February 2023. Many jurisdictions, including South Africa, have embraced these guidelines as their point of reference. In its abstract it provides as follows: “The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. One of the main functions of WPATH is to promote the highest standards of health care for TGD people through the Standards of Care (SOC)”.

[510] J Graham Theisen and others, ‘The Use of Whole Exome Sequencing in a Cohort of Transgender Individuals to Identify Rare Genetic Variants’ (2019) 9 Scientific Reports <https://doi.org/10.1038/s41598-019-53500-y> accessed on 03 February 2023.

[511] WPATH SOC7, 12.

[512] Ujike and others ‘Association study of gender identity disorder.’

Meyer-Bahlburg argues that gender dysphoria could be considered a disorder of sex development (DSD) and not a pathological condition or mental disorder.[513] Hughes defines the disorder of sex development as a collection term for problems noted on external genitalia at birth, formerly termed intersex conditions.[514] He further argues that the definition of the disorder of sex development is a genetic condition which can be classified into several categories including chromosomal, gonadal, and anatomic abnormalities. This disorder of sex development may be present in infancy, adolescence and childhood.[515]

Transgenderism includes anyone whose gender identity does not conform with the sex and gender that they were assigned at birth. As such, these individuals do not conform to conventional gender roles of either male or female.[516] This includes both trans women and trans men. A trans female refers to a male who is identified as male at birth, developed the physical characteristics of a male, but self-identifies as female; conversely; trans males are females who are identified as females at birth, have physical characteristics of a female, but self-identify as males.[517]

Although the phenomenon of transgender is uncommon, more media coverage directed toward the subject and gradual acceptance have led to more adolescents and young adults with gender dysphoria coming ‘out of the closet’ at an earlier age.[518] Research has shown that not all trans persons face challenges from the effects of gender dysphoria and as a result, the urgency for the medical intervention required as

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[513] Heino F L Meyer-Bahlburg, ‘From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions (2010) 39 Archives of sexual behavior 461-476 <https://doi.org/10.1007/s10508-009-9532-4> accessed on 21 February 2023.

[514] Ieuan A Hughes, ‘Disorders of sex development: a new definition and classification’ (2008) 22 Best Practice and Research Clinical Endocrinology & Metabolism 119-134 <https://doi.org/10.1016/j.beem.2007.11.001> accessed on the 21 February 2023.

[515] Hughes, ‘Disorders of sex development.’

[516] Wylie C Hembree and others, ‘Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline’ (2009) 94 The Journal of Clinical Endocrinology & Metabolism’ <https://doi.org/10.1210/jc.2009-0345> accessed on 02 February 2023.

[517] Johanna Olson, Catherine Forbes and Marvin Belzer, ‘Management of the Transgender Adolescent’ (2011) 165 Archives of Pediatrics and Adolescent Medicine 171-176 <https://doi.org/10.1001/archpediatrics.2010.275> accessed on 03 February 2023.

[518] Olson and others, ‘Management of the Transgender Adolescent.’

part of their care may vary.[519] Segarra-Echebarría and others echo the WPATH SOC7 provisions and conclude as follows:

> Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate GD. Some patients may need hormones, a possible change in gender role, but not surgery. Others may need a change in gender role along with surgery, but not hormones. In other words, treatment for GD has become more individualized.[520]

For some persons who do not desire procedures, such as hormone therapy and gender-affirming surgeries, social change may be enough without the need for further intervention. In this instance, physical intervention may not be opportune or appropriate.[521] Some prefer to receive medical care from physicians who understand how to approach non-normative gender expression or behaviour. They may prefer physicians with experience in trans-specific care, who have previously treated other gender-variant individuals. There are others, however, who will require medical interventions such as hormone therapy and/or surgery.[522]

Although not all trans adolescents have gender dysphoria, they remain a population with very specific medical and mental health needs, but those who have gender dysphoria may benefit from gender-affirming health care.[523] Children experience drastic changes during their adolescent stage as this stage marks a period where children search for their own identities.[524] Some of the common occurrences during this stage are issues relating to experimentation and risk-taking.[525] It is also during this adolescent stage where children become preoccupied with the physical changes to their bodies and as a result develop an increased interest in their sexuality and gender

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[519] Joshua D Safer and others, 'Barriers to healthcare for transgender individuals' (2016) 23 Current Opinion in Endocrinology, Diabetes and Obesity 168-171 <https://doi.org/10.1097/med.0000000000000227> accessed on 27 February 2023.

[520] WPATH SOC7, 8. See also R Segarra-Echebarría and others, Gender Dysphoria In M. Sáenz-Herrero (ed) *Psychopathology in women: Incorporating gender perspective into descriptive psychopathology* 298 (Springer International Publishing/Springer Nature 2015) <https://doi.org/10.1007/978-3-319-05870-2_3> accessed on 22 February 2023.

[521] Alessandra Lemma and Julian Savulescu, 'To be, or not to be? The role of the unconscious in transgender transitioning: identity, autonomy and well-being' (2023) 49 Journal of Medical Ethics <http://orcid.org/0000-0003-1691-6403> accessed on 24 February 2023.

[522] Lemma and Savulescu, 'To be or not to be?'

[523] Olson, Management of the Transgender Adolescent' 171.

[524] Melinda Jones, 'Adolescent Gender Identity and the Courts' (2005) 13 The international Journal of Children's Rights 121.

[525] Jones, 'Adolescent Gender Identity and the Courts' 121

identity.[526] Jan Morris provides an example of this narrative in the following opening lines of his autobiography *Conundrum:*

> I was three or perhaps four years old when I realized that I had been born into the wrong body and should really be a girl. I remember the moment well, and it is the earliest memory of my life.[527]

Although the documentation of homosexuality dates as far back as the Ancient Greek, many people still consider it to be a modern-day phenomenon.[528] It is argued that the etiology of homosexuality is dictated by genetics. This means that homosexuality is not a choice or "lifestyle", but an "immutable and uncontrollable" aspect of a person.[529] Others suggest that the origin of homosexuality is not biological but a personal choice instead.[530] The ancient Greeks regarded homosexuality as a normal human variance which was part of their lives. Plato wrote that homosexuality:

> [i]s regarded as shameful by barbarians and by those who live under despotic governments just as philosophy is regarded as shameful by them, because it is apparently not in the interest of such rulers to have great ideas engendered in their subjects, or powerful friendships or passionate love-all of which homosexuality is particularly apt to produce.[531]

It is important to note that sexuality and gender identity have not always been differentiated. It was only until the 1950's when psychologists and other professionals working with intersex and transsexual patients found it useful to distinguish between the two terms.[532]

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[526] Jones, 'Adolescent Gender Identity and the Courts' 121

[527] Jan Morris, *Conondru*m (London, Faber 1974) 11.

[528] Gayle Zive, A Brief History of Western Homosexuality (California State University Stanislaus) <https://www.csustan.edu/sites/default/files/honors/documents/journals/sexinstone/Zive.pdf> accessed on 15 December 2022.

[529] Jane P Sheldon and others, 'Beliefs about the Etiology of Homosexuality and about the Ramifications of Discovering Its Possible Genetic Origin' (2007) 52 Journal of Homosexuality 111-150.

[530] Sheldon and others, 'Beliefs about the Etiology of Homosexuality.'

[531] Plato, quoted by John Boswell in 'The Church and the Homosexual: An Historical Perspective, 1979 (Keynote address to the Fourth Biennial International Convention)' <http://www.fordham.edu/halsall/pwh/1979boswell.html> accessed on 15 December 2022.

[532] Toril Moi, *Sex, gender and the body* (New York: Oxford University Press 2005).

3.3.1 Transgenderism: A mental disorder

In the past fifty years, it has been assumed that being a trans person is a mental health disorder.[533] As a result, various editions of the ICD[534] and the Diagnostic and Statistical Manual of Mental Disorders (DSM) used the term “gender identity disorder” as a diagnosis for trans Persons.[535] The term *disorder* was used to describe trans people’s dysphoria. The term “gender identity disorder” was replaced by “gender dysphoria”, a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).[536] Currently, gender incongruence and gender dysphoria are no longer listed as mental health conditions in the revised ICD-11, but rather in a new sexual health chapter.[537] A significant difference between the two diagnostic manuals, ICD-11 and DSM-5, is the diagnostic formulations required for a diagnosis of gender incongruence or gender dysphoria.[538] The DSM-5 requires adolescents and adults to have experienced the symptoms for a minimum duration of approximately 6 months to establish a diagnosis of gender dysphoria. In contrast, the ICD-11 provides that the marked gender incongruence should continuously be present for two years for a diagnosis of gender dysphoria.[539] The diagnose will make it possible for many transgender persons to access vital gender affirming care under medical supervision.[540]

Research suggests that transgender individuals experience multiple health disparities, making them vulnerable to discrimination, which may ultimately affect their psychological health.[541] The discrimination experienced by transgendered persons is not limited to gender identity only, but may include multiple grounds of discrimination,

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[533] Lore M Dickey, History of gender identity and mental health. In E. D. Rothblum (Ed.), *The Oxford handbook of sexual and gender minority mental health* (Oxford University Press 2020) 25 <https://doi.org/10.1093/oxfordhb/9780190067991.013.3> accessed on 22 April 2023.

[534] The WHO, ICD-10.

[535] Wilson and others, ‘Transgender issues in South Africa.’

[536] Wilson and others, ‘Transgender issues in South Africa.’

[537] WHO, ICD-11.

[538] Rebeca Robles and others, ‘Validity of Categories Related to Gender Identity in ICD-11 and DSM-5 Among Transgender Individuals who Seek Gender-Affirming Medical Procedures’ (2022) 22 International Journal of Clinical Health Psychology <https://doi.org/10.1016/j.ijchp.2021.100281> accessed on 03 March 2023.

[539] Robles and others, ‘Validity of Categories Related to Gender Identity in ICD-11 and DSM-5.’

[540] Robles and others, ‘Validity of Categories Related to Gender Identity in ICD-11 and DSM-5.’

[541] Arjee J Restar and Sari L Reisner, ‘Protect trans people: gender equality and equity in action’ (2017) Lancet 390 1933-1935 <http://dx.doi.org/10.1016/S0140-6736(17)31823-8> accessed on 20 February 2023.

such as socioeconomic position, age, and physical and cognitive ability, expanding the range of negative health consequences that they may be subjected to, compared to non-trans persons.[542] The identification of an individual as transgender does not necessarily translate into the existence of mental health concerns.[543] Further, some mental health issues may not necessarily be related to an individual's transgender status, but to the prejudice and social stigma that may accompany the person's status. Stigma is aptly described by Hatzenbuehler and others as "the co-occurrence of labelling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised".[544] These prejudices and stigma-related challenges can inflict serious mental health problems in trans persons, even resulting in major depressive disorders and suicide among trans adolescents.[545] Turban explains that stigma may even have an impact on a trans person's decision to transition:

> While little research has been conducted to systematically examine variables that correlate with a [trans] adult's decision to halt a transition process or to detransition, a recent study found the vast majority of [trans] people who opted to detransition did so due to external factors, such as stigma and lack of social support and not because of changes in gender identity.[546]

Medical sex reassignment procedures began in Western Europe in the 1920s. During this time and until the 1960's, cross-gender identified individuals were classified as homosexuals and their gender non-conformity was regarded as an illness. As a result, initial attempts to perform sex reassignment surgeries in the 1930s were controversial since they seemed to reinforce what many believed to be a psychiatric illness.[547] During the 1950s a few doctors from the United States began performing medical sex

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[542] Restar, 'Protect trans people: gender equality and equity in action.'

[543] Arnold H Grossman, Anthony R D'Augelli, 'Transgender youth and life-threatening behaviors' (2007) 37 Suicide Life Threat Behavior 527-537 <https://doi.org/10.1521/suli.2007.37.5.527> accessed on 16 February 2023.

[544] Mark L Hatzenbuehler, Jo C Phelan, and Bruce G Link, 'Stigma as a fundamental cause of population health inequalities' (2013) 103 American Journal of Public Health 813-821 <https://doi.org/10.2105/AJPH.2012.301069> accessed on 16 February 2013.

[545] Ilan H Meyer, 'Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence' (2003) 129 Psychological Bulletin Journal 674-697 <https://doi.org/10.1037/0033-2909.129.5.674> accessed on 16 February 2023.

[546] Jack L Turban and others, 'Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes' (2021) 61 Journal of Adolescent Health 991-998 <https://doi.org/10.1016/j.jadohealth.2021.06.001> accessed on 16 February 2023.

[547] L Gijs and A Brewaeys, 'Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges' (2012) 18 Annual Review of Sex Research 215 <https://www.tandfonline.com/doi/abs/10.1080/10532528.2007.10559851> accessed on 20 February 2023.

reassignment procedures, with some of them performing sex reassignment surgery for a small number of patients privately.[548]

The first successful gender affirming procedure was performed in the USA in 1952 on Christine Jorgenson.[549] Since then, transsexualism and sex reassignment surgery became increasingly prevalent and more readily available. This development led to a growing understanding of transgender identities and a greater medical and psychiatric awareness of the concepts of gender identity. There was also a growing recognition of an increasing number of people who wish to change their birth-assigned gender to another.[550] Consequently, the medical community's understanding of trans people, their knowledge regarding mental health problems and associated factors, and the role of the mental health professional in gender reassignment surgeries have progressed and evolved since this time.[551]

3.3.2 The concept of gender reassignment

As mentioned in the introduction, gender affirming care covers a spectrum of interventions, including social, psychological, medical and legal interventions. Both binary and non-binary[552] gender identified persons may choose to transition socially, medically, surgically and/or legally. Social transition relates to social changes in the child's appearance. The SAHCS guidelines provide a broader definition of social transition:

> This [social transition] includes elements such as choosing an appropriate name, using appropriate pronouns, wearing appropriate clothes and other social aspects such as hairstyles, toy preferences commonly regarded as appropriate for their expressed gender identity. They often begin their social transition at home, after

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[548] Susan Stryker, *Transgender History* (New York: Seal Press 2017) <http://refhub.elsevier.com/S0090-4295(22)00297-7/sbref0002> accessed on 22 February 2023.

[549] The Danish-American trans woman. This woman became famous for undergoing a gender-affirming surgery in 1952. See Zilavy, Santucci and Gallegos, 'The History of Gender-Affirming Vaginoplasty Technique' 366-372.

[550] Zilavy, 'The History of Gender-Affirming Vaginoplasty Technique.'

[551] Zilavy, 'The History of Gender-Affirming Vaginoplasty Technique.'

[552] The term 'genderqueer' is used interchangeably with 'non-binary'. Gendequeer emerged in the 1990 and can be defined as 'any type of trans identity that is not always male or female. It is [also] where people feel they are a mixture of male and female.' See Surya Monro, 'Non-binary and genderqueer: An overview of the field' (2019) 20 International Journal of Transgenderism 126-131.

> which the social contexts are expanded to include extended family, neighbours and their school.[553] (Own insertion)

Social transition is the recommended intervention for trans children if they opt to undergo such a transition.[554] It is a non-medical intervention that helps bring a child in line with his/her gender identity. This transition may include adopting a child's preferred name and pronouns that they may have communicated to themselves and others.[555] A social transition can include more than just name and pronoun changes, it also extends to letting the adolescents dress in alignment with their gender identity,[556] or legally changing their gender markers on their identification documents.

Gender affirming care may incorporate therapy or other forms of psychological treatment. Medical transition refers to medical interventions that may change a person's body to align with the person's gender identity, including the administration of PBs, hormones and surgery. The aim of all these interventions is to support and affirm the child's gender identity.[557] The WPATH SOC7 recommended and cautioned that "before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken".[558] The SOC8 reiterates the importance of careful diagnostic assessment. It provides as follows:

> Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries.[559]

Often, the word *reassignment* describes the period of transition from one's assigned sex into closer alignment with gender identity. Gender reassignment has been described as follows:

> A medical procedure available to individuals who suffer from a medically recognised psychological condition in which they believe that their physical characteristics should be those of the opposite sex. This procedure is irreversible

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[553] SAHCS GAHC, 42.
[554] SAHCS GAHC, 21.
[555] SAHCS GAHC, 42.
[556] Hughto and others, 'Transgender Stigma and Health.'
[557] Hughto and others, 'Transgender Stigma and Health.'
[558] WPATH SOC7, 18.
[559] WPATH SOC8, S60.

> and includes both surgery and hormonal treatment to achieve a match between the person's physical sex characteristics and their psychological gender profile.[560]

The entire gender reassignment process is based on genital reconfiguration. This reconfiguration entails that trans persons' genitals should be reconstructed to align their external genitalia with their gender identity, resulting in a change of the patient's physical condition.[561] Physical reassignment may also entail surgical, hormonal, or other changes to one's body. Hormonal treatments[562] (often oestrogen and/or anti-androgens for trans women and androgens for trans men) may be referred to as hormone replacement therapy (HRT). The administration of hormonal treatments produces changes that make trans persons relate both physically and psychologically to persons of their preferred gender.[563] Surgical interventions (previously known as "sex change surgery") are now described as gender confirmation or reassignment surgery, which is a medically recognised treatment for gender dysphoria.[564] The surgery[565] itself, alluded to already, relates to possible changes to the primary

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[560] Brenda Grant, 'The Protection of Employees from Discrimination in the Context of Gender Re-assignment' (2011) 23 SA Mercantile Law Journal 82 quoting Jerold Taitz, 'Dismissal of an Employee on Account of a "Sex Change" - An Unfair Labour Practice?' (1989) 10 Industrial Law Journal 578.

[561] Melanie J Adriaansen and others, 'Binary male-female laboratory reference ranges do not reflect reality for transgender individuals on sex-hormone therapy' (2017) 71 New Zealand Journal of Medical Laboratory Science 101-105.

[562] WPATH SOC8, S257 dictates that ALL the following inclusionary criteria must be met in relation to adolescents, defined as from the start of puberty until the legal age of majority (18 years of age):
"Meets diagnostic criteria for gender dysphoria (see Description/Background above for diagnostic criteria); and
Gender dysphoria is marked and sustained; and
Demonstrates emotional and cognitive maturity required to provide informed consent for the treatment; and, particularly when the adolescent has not reached the age of medical consent, the parents/guardians or other legally authorized caretakers have consented to the treatment and are involved in supporting the adolescent throughout the treatment process; and
Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally; and
Onset of puberty to at least Tanner stage 2 has been reached; and
The absence of contraindications to therapy in the judgment of the managing physician; and
One letter of assessment as indicated below***; and
Medications will be prescribed by or in consultation with a pediatric endocrinologist that has collaborated care with a mental health care provider for members less than 18 years of age".

[563] Andriaansen and others, 'Binary male-female laboratory reference ranges.'

[564] Shannon Glick, 'The Ethical Need for a Fertility Decision-Aid for Transgender Adults of Reproductive Age' (2023) 9 Voices In Bioethics <https://doi.org/10.52214/vib.v9i.10309> accessed on 02 March 2023.

[565] WPATH SOC8, S257, guidelines provides as follows: "Genital surgery is considered medically necessary when ALL of the following criteria have been met:
- The individual is at least 18 years of age; and

(genitals) or secondary (hormone related identifiers) sex characteristics. The surgery may either require a penectomy (removal of the penis) and orchidectomy (removal of testes) in male-to-female transsexuals. These changes or removals will be accompanied with the construction of a vagina and labia.[566] Reconstruction in female-to-male transsexuals may include the removal of female organs (ovaries and uterus) and the construction of a penis and scrotum.[567]

3.4 Gender affirming care in terms of the World Professional Association for Transgender Health

The WPATH has developed an internationally recognised manual consisting of guidelines aimed at improving the quality of transgender health care services, in addition to gender transition related treatment. The WPATH's SOCs are globally considered as authoritative and are widely consulted by health care sectors worldwide. Its overall goal is:

> [T]o provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counselling, psychotherapy), and hormonal and surgical treatments.[568]

- The individual has been diagnosed with gender dysphoria (see Description/Background section for diagnostic criteria); and
- Gender dysphoria is marked and sustained; and
- The individual has capacity to make fully informed decisions and consent for treatment; and
- Other possible causes of apparent gender incongruence have been identified and excluded; and
- One letter of assessment as indicated below***; and
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed, with the risks and benefits discussed, before a decision is made regarding treatment; and
- The individual is stable on their gender affirming hormonal treatment regime for at least 12 months, unless a rationale is provided by the HCP that indicates that hormone treatment is either contraindicated or not necessary for the individual's clinical situation; and
- The new gender identity should be present for at least 12 months; and
- The member has a consistent stable gender identity that is well documented by their treating providers and when possible, lives as their affirmed gender in places where it is safe to do so; and
- Pre-operative and post-operative care that addresses both surgical results and possible behavioral health results is highly recommended".

[566] Glick, 'The Ethical Need for a Fertility Decision-Aid for Transgender Adults.'

[567] Glick, 'The Ethical Need for a Fertility Decision-Aid for Transgender Adults.'

[568] WPATH SOC8, S3.

Before the iteration of WPATH's SOCs,[569] trans persons were predominantly assessed within a system that associated them with sexual perversion, they thus, encountered significant barriers in accessing gender-affirming care.[570] As referred to above, a change in the ICD diagnostic criteria opened the door for greater acceptance. In the 1980's, the criteria that were used pathologised identity and conflated sexual and gender identity. As reflected above, the ICD-11 took a more affirmative stance in dealing with transgender issues through the declassification of gender incongruence as a mental health disorder.[571] The chapter on Mental and Behavioural Disorders has been removed in the ICD altogether and replaced with a new chapter titled "Conditions Related to Sexual Health".[572] The ICD-11 recognises that many trans persons do not suffer from gender dysphoria or gender identity disorder, yet they could be perceived as suffering from a mental disorder in order to get approval for treatment.[573] Consequently, in terms of the WPATH SOC7, mental health professionals were tasked with determining whether those interested in gender-affirming treatments meet the eligibility criteria, have capacity for informed consent, and have adequately anticipated the psychosocial impacts of their transition.

The most recent WPATH SOC8, however, acknowledges that a recent "phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years".[574] This sharp increase in the number of adolescents requesting gender care is noticeable globally.[575] The aim of the SOC8 is therefore to assess and provide mental health support to those who need such services. This is taking into consideration that adolescents can have a variety of factors or experiences that contribute to gender incongruence, and that some or all of those feelings may be transitory.[576] Consequently, guidelines recommend that trans children be cared for by a multidisciplinary team.[577] This will provide trans children with

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[569] The WPATH SOC, first published in 1979.
[570] Hughto and others, ''Transgender Stigma and Health.'
[571] WHO, ICD-11.
[572] World Health Organization, International Statistical Classification of Diseases 11th Revision (ICD-11).
[573] WHO, ICD-11.
[574] WPATH SOC8, S45.
[575] WPATH SOC8, S43.
[576] WPATH SOC8, S45.
[577] WPATH SOC8, S7.

access to specialists from different disciplines, who will ensure a reasoned and holistic approach to the individual, as well as contribute to a wider range of services and options being offered to trans persons.

The WPATH SOC8 guidelines recognise that effective patient care depends on the teamwork of multidisciplinary health care professionals:

> The term multidisciplinary team is used to refer to a group of professionals from two or more disciplines who work on the same project, independently or in parallel. The concept of 'collaboration' in the healthcare context is a process of problem-solving, shared responsibility for decision-making and the ability to carry out a care plan while working towards a common goal. Two key elements have been identified: (i) the construction of a collective action that addresses the complexity of patient needs and (ii) the daily team dynamics that help integrate the perspective of each professional and in which team members respect and trust one another.[578]

The role of professionals is to provide a comprehensive clinical assessment on trans persons before a gender reassignment procedure. Since the quality of patient care requires a multidisciplinary approach, the team may comprise of general practitioners, psychologists, psychiatrists, urologists (who specialise in the urinary tract and its abnormalities), gynaecologists, endocrinologists (who specialise in hormonal functions) and surgeons.[579] These professionals' purpose is to serve the scientific evaluation of a person's sex and gender. The purpose of an endocrinologist or hormone-prescribing physicians, for instance, will be needed to conduct pre-operative assessments.[580] These assessments should be conducted both before and after hormone intake.[581] The importance of these tests will be to assist doctors in observing the fluctuations in hormone levels between the trans persons' pre- and post-hormone conditions. The endocrinologists will, based on test results, decide on the required level of hormone intake.[582] They will therefore provide a range of services tailored to each patient's needs.

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[578] Cecilia Saint-Pierre, Valeria Herskovic and Marcos Sepúlveda, 'Multidisciplinary collaboration in primary care: a systematic review' (2018) 35 Family practice 132-141 <https://doi.org/10.1093/fampra/cmx085> accessed on 26 February 2023.

[579] Alessia Celeste Bocchino and others, 'The Role of a Multidisciplinary Approach in Gender Affirmation Surgery: What to Expect and Where Are We Currently?' (2022) 2 Urology 179-190 <https://doi.org/10.3390/uro2030022> accessed on 26 February 2023.

[580] Bocchino, 'The Role of a Multidisciplinary Approach in Gender Affirmation Surgery.'

[581] Bocchino, 'The Role of a Multidisciplinary Approach in Gender Affirmation Surgery.'

[582] Bocchino, 'The Role of a Multidisciplinary Approach in Gender Affirmation Surgery.'

A psychiatrist will provide a comprehensive assessment for all dysphoric adolescents and assess the likelihood of those feelings persisting into adulthood. Their services will also include to help the affected adolescents and their parents process those feelings and determine what medical interventions may be necessary in the circumstances.[583] The guidelines stipulate that:

> We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment. A comprehensive assessment, when requested by a family and/or an HCP can be useful for developing intervention recommendations, as needed, to benefit the well-being of the child and other family members. Such an assessment can be beneficial in a variety of situations when a child and/or their family/guardians, in coordination with providers, feel some type of intervention would be helpful. Neither assessments nor interventions should ever be used as a means of covertly or overtly discouraging a child's gender diverse expressions or identity.[584]

The SOC8 guidelines highlight that being transgender or gender diverse is not a mental health issue, but an incongruence. The guidelines recommend that support can be given by a clinician who holds at least a Master's level degree with sufficient knowledge in treating trans persons.[585] The SOC8 guidelines also aspire to promote the highest standards of health care for trans persons and recognise that "a comprehensive clinical approach is important and necessary".[586] What is required, is a "comprehensive biopsychosocial assessment of adolescents who present with gender-identity concerns".[587] The SOC8 guidelines further emphasise the importance of psychosocial evaluation through its provision that:

> [t]reatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.[588]

Although both the SOC7 and SOC8 guidelines recommend that trans children be cared for by a multidisciplinary team, the two versions vary regarding their preoperative assessments criteria. SOC8 currently require only one letter of referral from a member of a multidisciplinary team when an individual wishes to undergo

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[583] WPATH SOC8, S45.
[584] WPATH SOC8, S71.
[585] WPATH SOC8, S33.
[586] WPATH SOC8, S7 and S46.
[587] WPATH SOC8, S50.
[588] WPATH SOC8, S51.

medical and surgical treatment,[589] but inputs from the medical health practitioners are all considered valuable in determining the individual's readiness for medical or surgical interventions.[590] The number of evaluations has therefore been reduced to a single evaluation prior to gender affirming care. This is different compared to the SOC7, which depending on the nature of the treatment, required reports from one or two mental health providers before gender-affirming surgery.[591] The reduction is apparently an effort to reduce barriers to care for the trans population.

3.4.1 Social transitioning

The SAHCS Gender Affirming Health Care provides that it is the responsibility of parents to request "a psychosocial/mental health evaluation, support and counselling" upon realising that their prepubescent children may be transgender.[592] Once an assessment has been completed and informed consent has been obtained, the findings of the evaluation will be explained to the parents and child "in an age-appropriate way". An evaluation team will advise on the recommended intervention, in this instance, social transitioning. All the factors related to social transition, risks and benefits will be explained and discussed. The guidelines further provide that should the child change his/her mind and no longer wish to continue with the recommended intervention, such a decision should be supported at any stage.[593] The process of social transition will begin when assent has been obtained from the child, and his/her parents or legal guardians have provided their informed consent.[594]

The WPATH SOC7 mandated that mental health professionals "should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes", which would ensure "that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered".[595] It recommended that a mental health professional should provide a careful, psychological assessment and guidance that

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[589] WPATH, SOC8, S57.
[590] WPATH, SOC8, S57.
[591] WPATH, SOC7, 27.
[592] SAHCS GAHC, 21.
[593] SAHCS GAHC, 21.
[594] SAHCS GAHC, 21.
[595] WPATH SOC7, 16.

will enable parents to "weigh the potential benefits and challenges" of a social transition[596] and to "make decisions regarding the timing and process of any gender role changes for their young children".[597] Although the WPATH SOC7 didn't appear to have supported early social transition of adolescents, it acknowledged it because of the paucity of long-term evidence about its effects. This is why such decisions were deferred to the parents and assisting them to weigh "potential benefits and challenges".[598] The parents had to determine whether or not they would "allow their young children to make a social transition to another gender role".[599] Steensma argued against early social transition, he is of the opinion that transitioning back to the child's natal gender identity would be difficult should such a need arise at a later stage. He observes as follows:

> Childhood social transitions were important predictors of persistence, especially among natal boys. Social transitions were associated with more intense GD in childhood but have never been independently studied regarding the possible impact of the social transition itself on cognitive representation of gender identity or persistence.[600]

According to the SOC7 guidelines, social transition in early childhood raised controversial issues as health professionals held "divergent views". In addition, the guidelines concluded that the "evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood"[601] and that "[a] change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part".[602]

The SOC8 guidelines also acknowledge that there is a shortage of "empirical literature regarding best practices related to the social transition process",[603] but acknowledge nevertheless that:

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[596] WPATH SOC7, 14–15, 17.

[597] WPATH SOC7, 17.

[598] WPATH SOC7, 17.

[599] WPATH SOC7, 17.

[600] Thomas D Steensma, 'Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study' (2013) 52 Journal of the American Academy of Child and Adolescent Psychiatry 589.

[601] WPATH SOC7, 17.

[602] WPATH SOC7, 17. WPATH SOC8 also recognises that "[an]other often identified social transition concern is that a child may suffer negative sequelae if they revert to the former gender identity that matches their sex designated at birth". S78.

[603] WPATH SOC8, S76.

> recognition that a child's gender may be fluid and develop over time…is not sufficient justification to negate or deter social transition for a pre-pubescent child when it would be beneficial.[604]

The current guidelines (SOC8) therefore, put more emphasis on the importance of the adolescent's "nuanced and individualised clinical approach to gender assessment".[605] D'Angelo and others explain as follows:

> We believe that exploratory psychotherapy that is neither "affirmation" nor "conversion" should be the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures. This is especially critical now, when we are witnessing an exponential rise in the incidence of young people with GD who have diverse and complex mental health presentations and require careful assessment and treatment planning.[606]

In contrast to the SOC7 guidelines, the SOC8 guidelines recommend that therapeutic professionals should be "gender affirming", especially in situations where a diagnosis is necessary to access the adolescent's health care and to assess whether he/she meets the diagnostic criteria of gender incongruence as per the ICD-11.[607] The early drafts of the WPATH SOC8 guidelines included explicit age guidelines, whereas the final standards are more tailored to the development of the individual adolescent patient. The new criteria stipulate that demonstration of emotional and cognitive maturity is required to provide informed consent.[608] Regarding social transition, the SOC8 guidelines provide that it "should originate from the child and reflect the child's wishes in the process of making the decision to initiate a social transition process".[609] The SOC7 guidelines appeared to have allowed parents to decide whether to allow a social transition for their children, whereas the SOC8 guidelines recognise that "social transition for children typically can only take place with the support and acceptance of parents/caregivers".[610] The SOC8 guidelines thus seem to instruct parents to allow

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[604] WPATH SOC8, S76.

[605] WPATH SOC8, S68.

[606] Roberto D'Angelo and others, 'One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria' (2021) 50 Archives of Sexual Behavior 7-16 <https://doi.org/10.1007/s10508-020-01844-2> accessed on 28 February 2023.

[607] WPATH SOC8 at S6 provides that "WPATH urges health care authorities, policymakers, and medical societies to discourage and combat transphobia among health care professionals and ensure every effort is made to refer TGD people to professionals with experience and willingness to provide gender-affirming care". See also WPATH SOC8, S7, it provides as follows: "[b]ecause of historical and current stigma, TGD people can experience distress or dysphoria that may be addressed with various gender-affirming treatment options".

[608] WPATH SOC8, S48.

[609] WPATH SOC8, S76. SAHCS GAHC guidelines at 42 also provides that "[s]ocial transition is the recommended intervention for TGD children if it is their expressed need to do so".

[610] WPATH SOC8 at S77.

their children to a social transition upon request. It provides that "efforts at blocking reversible social expression or transition [like] choosing not to use the youth's identified name and pronouns" equates to "disaffirming behaviours" which are inappropriate and therefore, not different to conversion therapy.[611] The SOC8 guidelines no doubt still recognises the importance of parents and family support in the social transitioning of their children as a "primary predictor" for their well-being.[612]

3.4.1.1 Effects of marginalisation and discrimination

It is trite that persons with diverse gender are often marginalised by those who are scared or uncomfortable with these identities. It is not surprising that many trans adolescents have psychosocial concerns, including, family rejection and peer rejection. Further, trans persons often experience negative reactions to their gender atypical behaviours, as such, they are vulnerable to high rates of verbal harassment, physical violence, and economic discrimination which mostly occur at home and at school. These experiences are associated with greater psychological distress.[613]

Like discrimination, marginalisation affects trans persons by making them feel less equal than others or even pushed out to the margins of society. The marginalisation and discrimination experienced by the trans population is referred to as transphobia. When trans children try to integrate while seeking to preserve their own identity, they are often faced with acts of intolerance and discrimination from individuals and the societies in which they find themselves.[614] They may find it difficult to express themselves socially, consequently their self-esteem and confidence may be affected. The experiences of minority stress and the impact of social determinants of health[615] contribute to the elevated symptoms of depression, anxiety, high rates of suicidal thoughts and self-harming behaviours in transgender identified youth.[616] They are

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[611] WPATH SOC8, S53.
[612] WPATH SOC8 at S58.
[613] Olson and others, 'Management of the Transgender Adolescent'.
[614] Olson and others, 'Management of the Transgender Adolescent'.
[615] The World Health Organization (WHO) defines social determinants of health as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels". See World Health Organization (WHO). (2014). What are social determinants of health? <http://www.who.int/social_determinants/sdh_definition/en/> accessed on 01 March 2023.
[616] Hatzenbuehler and others, 'Stigma and Minority Stress.'

susceptible to an increased risk of suffering from an inferiority complex. Consequently, many of these young children may be forced to hide their true self and the "coming out" process may be a path to being hurt or ridiculed.[617] As Mikkonen and Raphael observe, social exclusion "creates a sense of powerlessness, hopelessness and depression that further diminish the possibilities of inclusion in society". [618] This social exclusion may arise from the interactions between individuals and their environments, especially, societal values and beliefs relating to how men and women are typically expected to act and behave.[619]

Families should play a protective role in the lives of transgender adolescents. Their support is critical because it protects and safeguards these adolescents from negative outcomes. It will also have a positive effect on the adolescent's mental health and will promote positive health and wellbeing. Abusive families on the other hand, adversely impact a child's mental health, contributing to poor health and mental health outcomes.[620]

Social acceptance, self-acceptance, and validation of minority identity can significantly lessen the stigma against transgender adolescents and improve their psychological health. There is also a need for greater access to transgender-sensitive health care and health resources. A transgender sensitive care approach ensures that the patient is treated in the most respectful manner, which will benefit the overall health outcomes of trans persons.[621] As president Cyril Ramaphosa wrote in the introduction of the National Strategic Plan on Gender-Based Violence and Femicide 2020-2030 of the PATHSA:

> The South Africa we want is a country where all its citizens are able to lead their lives of dignity and freedom, and where the vulnerable and marginalised are protected by our Constitution and Bill of Rights.[622]

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[617] Olson and others, 'Management of the Transgender Adolescent.'

[618] Juha Mikkonen and Dennis Raphael, *Social determinants of health: The Canadian facts* (Toronto ON: York University School of Health Policy and Management 2010).

[619] Hubbard, 'Gender and Genitals: Constructs of Sex and Gender.'

[620] Olson and others, 'Management of the Transgender Adolescent.'

[621] SAHCS GAHC, 8.

[622] Foreword to the National Strategic Plan on Gender-based Violence and Femicide Human Dignity and Healing, Safety, Freedom and Equality in our Lifetime 11 March 2020 5.

Trans persons also suffer significant health disparities, which can be attributed to a lack of access to gender sensitive health care. This lack of transgender sensitive resources, including the lack of access to insurance coverage for gender-affirming care, are barriers to obtaining an effective and good-quality health care. Safer and others provide an analysis of the unique challenges faced by transgender people in health care settings in general:

> Transgender persons suffer significant health disparities in multiple arenas. Real or perceived stigma and discrimination within biomedicine and the healthcare provision in general may impact transgender people's desire and ability to access appropriate care… Although some of these healthcare barriers are faced by other minority groups, many are unique, and many are significantly magnified for transgender persons.[623]

3.4.1.2 Suicide in transgender children

Emerging evidence indicates that the suicide rate is significantly elevated in trans adolescents compared with heterosexual youth.[624] Levine and others argue that as much as trans youth are much more likely to consider suicide, the "transition or die" narrative is inappropriately handled:

> However, the "transition or die" narrative, whereby parents are told that their only choice is between a "live trans daughter or a dead son" (or vice-versa), is both factually inaccurate and ethically fraught. Disseminating such alarmist messages hurts the majority of trans-identified youth who are not at risk for suicide. It also hurts the minority who are at risk, and who, as a result of such misinformation, may forgo evidence-based suicide prevention interventions in the false hopes that transition will prevent suicide.[625]

According to the authors, too many parents have been fed this "transition or die" manipulative false ideology in accommodating their transgender children. Parents are terrified by statistics about high suicide rates for transgender children and this risk of suicide is the strong motivating factor for parents to support their children's wish to

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[623] Safer and others, 'Barriers to healthcare for transgender individuals.'

[624] Natasja M de Graaf and others, 'Suicidality in clinic-referred transgender adolescents' (2020) 31 European child and adolescent psychiatry 67-83 <https://doi.org/10.1007/s00787-020-01663-9> accessed on 28 February 2023.

[625] Stephen B Levine, E Abbruzzeze and Julia W Mason, 'Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults' (2022) 48 Journal of Sex and Marital Therapy 706-727 <https://doi.org/10.1080/0092623X.2022.2046221> accessed on 27 February 2023.

transition. Levine and others argue that “making them an exception falsely promises the parents that immediate transition will remove the risk of suicidal self-harm”.[626]

The critical question is whether transition-related care decreases suicidal ideation and behaviour? This question is relevant, especially because it relates to the treatment of adolescents. Turban and others argue that the administration of puberty blockers on adolescents has mental benefits because it “inhibits endogenous puberty for the duration of the gonadotropin-releasing hormone agonist (GnRHa) use”.[627] He argues that the mental outcome of this pubertal suppression is “associated with lower odds of lifetime suicidal ideation”, especially when compared to trans adolescents who could not receive it.[628] Biggs, on the other hand, maintains that there is low quality research and little evidence to assert that medical transition alleviates suicidality. He, however, argues the same about PBs, especially in improving the psychological well-being and lowering the suicidal ideation of the child. He insists that these conclusions are often drawn based on low-quality research, which consequently elicits unreliable answers and flawed evidence.[629] Concurring with Biggs, Levine emphasises that:

> Despite the precedent of years of gender-affirmative care, the social, medical and surgical interventions are still based on very low-quality evidence. The many risks of these interventions, including medicalizing a temporary adolescent identity, have come into a clearer focus through an awareness of detransitioners. The risks of gender-affirmative care are ethically managed through a properly conducted informed consent process. Its elements—deliberate sharing of the hoped-for benefits, known risks and long-term outcomes, and alternative treatments—must be delivered in a manner that promotes comprehension. The process is limited by: erroneous professional assumptions; poor quality of the initial evaluations; and inaccurate and incomplete information shared with patients and their parents.[630]

Several factors may influence a child’s experience of gender incongruence. Some of the negative emotions, however, may be relatively superficial and transitory.[631] Levine discourages the use of medical treatments that could attend to the discomfort that may be underlying a child’s experiences. He states that “providing treatments with

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[626] Levine, ‘Reconsidering Informed Consent for Trans-Identified Children.’

[627] Turban and others, ‘Pubertal suppression for transgender youth and risk of suicidal ideation.’

[628] Turban and others, ‘Pubertal suppression for transgender youth and risk of suicidal ideation.’

[629] Michael Biggs, ‘Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria’ (2020) 49 Archives of Sexual Behavior 2227-2229.

[630] Levine, ‘Reconsidering Informed Consent for Trans-Identified Children.’

[631] WPATH SOC8, S45.

permanent consequences to address what may be transient identities in youth poses a serious ethical dilemma".[632]

3.4.2 Medical treatment

It is important to note that the WPATH SOCs outline three categories of medical interventions specific for gender affirmation in adolescents. Firstly, (1) fully reversible interventions, such as the use of PBs.[633] The PBs contain stable amounts of GnRHa, which halts the production of oestrogen and testosterone,[634] thus useful for suppressing sex hormones;[635] (2) partially reversible interventions, including hormone therapy, the administration of testosterone which masculinises or oestrogen which feminises the body; and finally, (3) irreversible interventions, which relate to surgical procedures.

In terms of the SAHCS guidelines, children who have been appropriately assessed by a medical health professional and have undergone social transition should be engaged with regard to the option of puberty suppression.[636] Engagement with the child should occur when he or she has reached 'Tanner 2' stage. During this stage, children experience specific pubertal changes that James M Tanner identified as follows:

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[632] Levine, 'Reconsidering Informed Consent for Trans-Identified Children.'

[633] WPATH SOC8, S256, prescribes that an adolescent must meet all of the following inclusionary criteria: "• Meets diagnostic criteria for gender dysphoria (see Description/Background above for diagnostic criteria); and • Gender dysphoria is marked and sustained; and • Demonstrates emotional and cognitive maturity required to provide informed consent for the treatment; and, particularly when the adolescent has not reached the age of medical consent, the parents/guardians or other legally authorized caretakers have consented to the treatment and are involved in supporting the adolescent throughout the treatment process; and • Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally; and • Onset of puberty to at least Tanner stage 2 has been reached; and • The absence of contraindications to therapy in the judgment of the managing physician".

[634] Testosterone is used in biological females or transgender males to suppress feminising characteristics. Whereas oestrogen is used in biological males or transgender females to suppress masculinising features. See also Unger, 'Hormone therapy for transgender patients' 879.

[635] Jack L Turban and others, 'Pubertal suppression for transgender youth and risk of suicidal ideation' (2020) 145 Pediatrics <https://doi.org/10.1542/peds.2019-1725> accessed on 28 February 2023.

[636] SAHCS GAHC 22.

> Stage 2 marks the beginning of physical development. Hormones begin to send signals throughout the body.
>
> Females
>
> Puberty usually starts between ages 9 and 11. Visible changes include:
>
> - First signs of breasts, called “buds,” start to form under the nipple. They may be itchy or tender or one bud may be larger than the other, which is normal.
> - Darker area around the nipple (areola) will also expand.
> - Uterus begins to get larger, and small amounts of pubic hair start growing on the lips of the vulva…
>
> Males
>
> In males, puberty usually starts around age 11. The testicles and skin around the testicles (scrotum) begin to get bigger.
>
> Puberty usually starts around age 11. Changes include:
>
> - Testicles and skin around the testicles (scrotum) begin to get bigger.
> - Early stages of pubic hair form on the base of the penis.[637]

The process of consultation for these children should entail a full disclosure where “the short- and long-term benefits and risks of puberty suppression”[638] are discussed, including gender-affirming hormone therapy. This will be discussed with both the adolescent and the parents or legal guardians. Discussions on these interventions should include a broad range of factors such as emotional, psychological, social, physical, and reproductive factors. [639] In terms of South African law, an adolescent of 12 years or older who is deemed legally competent to make decisions regarding his or her own treatment, can provide informed consent for puberty suppression or hormone therapy.[640]

The WPATH SOC7 dictates that trans persons who requests gender affirming hormones or gender affirming surgery must receive a letter of readiness from a certified psychotherapist or psychiatrist. The letter should state whether the affected trans person is prepared for treatment.[641] This entails that trans persons are obligated

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[637] Carissa Stephens, Navigating Puberty: The Tanner Stages <https://www.healthline.com/health/parenting/stages-of-puberty> accessed on 23 April 2023. See also Mickey Emmanuel and Brooke R Bokor, ‘Tanner stages’ In: StatPearls (StatPearls Publishing, Treasure Island (FL) 2022) <https://europepmc.org/article/NBK/nbk470280> accessed on 23 April 2023.

[638] SAHCS GAHC, 22.

[639] SAHCS GAHC, 22.

[640] SAHCS GAHC, 23.

[641] WPATH SOC7, 26.

to seek out therapy which will serve as a stepping-stone for access to gender affirming care. The SOC8 guidelines also emphasise that:

> [t]reatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.[642]

Therefore, confirmation of the diagnosis of gender dysphoria is the first step for transgender adolescents. This confirmation must be done by the mental health professional with the purpose of helping patients to go through the transition process in a smooth and successful manner.

Traditionally, PBs are not recommended at a prepubertal stage.[643] In terms of eligibility, the SOC7 guidelines recommended that surgical interventions for adolescents should be deferred until they attained the age of consent. The only time an appropriate hormone therapy would commence earlier is when the delay would lead to psychologic and cognitive trauma in a child.[644] The SOC8 and the SAHCS GAHC standards on the other hand, recommend the administration of cross-sex hormonal therapy after Tanner stage 2, which is at the first sign of the child reaching sexual maturity. The cross-sex hormonal therapy may be administered following a shared decision-making process between clinicians, the patient and his/her family.[645] This shared decision making must consider the possible long-term irreversible impact that the treatment can have on fertility.

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[642] WPATH SOC8, S51.

[643] Simona Giordano and Søren Holm, 'Is puberty delaying treatment 'experimental treatment?' (2020) 21 International Journal of Transgender Health 113-121 <https://doi.org/10.1080/26895269.2020.1747768> accessed on 23 April 2023. They assert: "Since the mid-1990s, puberty delaying medications have been prescribed to some adolescents (not prepubertal children) with severe and persistent gender dysphoria, in cases in which such distress was aggravated by pubertal development".

[644] WPATH SOC7, 55. See also Unger, 'Hormone therapy for transgender patients.'

[645] Shared decision making (SDM) has been defined as: "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences". They further provide that "this model rests on supporting a process of deliberation, and on understanding that decisions should be influenced by exploring and respecting 'what matters most' to patients as individuals, and that this exploration in turn depends on them developing informed preferences". See Glyn Elwyn and others, 'Shared Decision Making: A Model for Clinical Practice' (2012) 27 Journal of General Internal Medicine 1361-1367 <https://dx.doi.org/10.1007/s11606-012-2077-6> accessed on 03 March 2023.

The minimum of 12 months on hormone therapy remains the standard that adolescents must meet before surgical treatment, including orchiectomy (surgical removal of one or both testes) and a hysterectomy. This is required to achieve the desired surgical result. Although medical gender transition interventions usually imply the use of hormonal therapies, the SOC8 guidelines provide a more flexible approach by giving transgender persons an option to choose to undergo hormonal therapy or not. The guideline indicates that "unless hormone therapy is either not desired or is medically contraindicated".[646] Hormone therapy may not be desired because of their potential damaging side-effects. These hormones can lead patients to experience lingering health problems that may require ongoing medical assessments.[647] The purpose of assessments and presurgical evaluations is therefore, aimed at determining the medically necessary gender transition-related care. Further, to assess the presence of any relative or absolute contraindications of hormone therapy or the presence of any risk factors that may affect the transgender's decision to take hormone therapy.[648] In practice, hormone therapy prior to surgery has been made flexible, more patient-specific, and its administration is therefore no longer delayed to children who have reached a specific age requirement.

The SOC8 guidelines further stipulate that the role of the multidisciplinary team is to provide transgendered patients with information about risks, side effects, benefits, and possible consequences of undergoing gender affirming care. These risks include informing the adolescent of the reproductive effects, including the potential loss of fertility. Further, the guidelines recommend clinicians to address options that could be available for preserving an adolescent's fertility. This information must have been discussed in the context of the adolescent's stage of pubertal development.[649] The South African guidelines further provide that:

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[646] WPATH SOC8, S48.

[647] Patrice R Jones and others, 'Uncovering the effects of gender affirming hormone therapy on skeletal muscle and epigenetics: protocol for a prospective matched cohort study in transgender individuals (the GAME study)' (2022) 12 BMJ Open < http://dx.doi.org/10.1136/bmjopen-2022-060869> accessed on 04 April 2023. It must, however, be noted that these effects may vary from one person to the other.

[648] Timothy Cavanaugh and others, 'The medical care of transgender persons' (Boston, MA: Fenway Health 2015) 17 <https://www.lgbtqiahealtheducation.org/wp-content/uploads/COM-2245-The-Medical-Care-of-Transgender-Persons-v31816.pdf> accessed on 03 April 2023.

[649] WPATH SOC8, S48. See also Leena Nahata and others, 'Low fertility preservation utilization among transgender youth' (2017) 61 Journal of Adolescent Health 40-44 <https://doi.org/10.1016/j.jadohealth.2016.12.012> accessed on 01 March 2023.

> Fertility preservation should be discussed with adolescents before medical treatment. It is important to note that if puberty is suppressed from its onset, then it is not possible to harvest ova or sperm. This is irreversible unless the GnRHa treatment is stopped in time. This is a complex discussion that should be done in a developmentally appropriate way by a clinician with experience and training.[650]

The SOC7 guidelines provided flexibility in the minimum age requirement for chest reconstruction through its stipulation that individual minors might be candidates for such a reconstruction, especially in male-affirmed adolescents. Those seeking chest/breast surgery had to provide one letter of referral reflecting a more recent assessment by a mental health professional.[651]

The SOC8 guidelines have removed the "age-of-majority" considerations for surgical treatments and replaced it with the "demonstration of emotional and cognitive maturity"[652] yardstick required for giving informed consent.[653] The guidelines, therefore, draw attention to the importance of balancing risks and benefits for the adolescents regardless of age, and to obtain informed consent from the patient. This may allow trans adolescents to start gender transition treatment, including sex hormones and surgeries, prior to the age of 18. The patient must, however, have sufficient mental capacity to give informed consent. The SOC8 guidelines are therefore, tailored to the development of the individual patient by recognising that every patient is unique and requires individualised care based on his/her maturity, not age.[654]

The SOC8 guidelines also recommend coverage of other surgical procedures, such as feminising or masculinising facial surgery. As far as gender affirming surgical procedures, the WPATH SOC8 guidelines provide that:

> As the field's understanding of the many facets of gender incongruence expands, and as technology develops which allows for additional treatments, it is imperative

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[650] SAHCS GAHC, 58.

[651] WPATH SOC7, 16.

[652] WPATH SOC8, S48.

[653] The guidelines provides that "[t]he subsequent 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions divided medical-affirming treatment for adolescents into three categories and presented eligibility criteria regarding age/puberty stage—namely fully reversible puberty delaying blockers as soon as puberty had started; partially reversible hormone therapy (testosterone, estrogen) for adolescents at the age of majority, which was age 16 in certain European countries; and irreversible surgeries at age 18 or older, except for chest 'masculinizing' mastectomy, which had an age minimum of 16 years". WPATH SOC8 S43.

[654] WPATH SOC8, S68.

> to understand this list is not intended to be exhaustive. This is particularly important given the often-lengthy time periods between updates to the SOC, during which evolutions in understanding and treatment modalities may occur.[655]

Although facial surgery has been listed as a gender affirming procedure, many medical aid schemes currently regard this procedure as cosmetic modification of a person's facial characteristics and refuse to cover the costs for this procedure.

The SOC7 guidelines recommended at least 12 months of hormone therapy prior to most surgeries.[656] This "real test" required patients to live full-time as their self-affirmed gender for a period of 12 months prior to starting medical therapy. The SOC8 guidelines, however, recognise individual differences and have thus based the length of hormone therapy prior to surgery on the specific individual's situation. The SAHCS GAHC is silent on how long hormonal therapy should last. This may be because the needs of transgender individuals are unique, accordingly, also the reason why both international and national expert guidelines support transition in carefully evaluated individuals. Notwithstanding the support, the health care systems in few countries cover the costs required for hormonal and surgical interventions.[657]

3.4.2.1 Negative effects of delaying trans-surgery

There is a growing body of research which suggests that access to gender-affirming care in trans children is associated with better mental health outcomes. As previously mentioned, puberty delaying hormones should be administered to children who meet the criteria for gender identity disorder, children who suffer strong and persistent gender dysphoria.[658] The lack of access to such care potentially has a negative effect on many aspects of a child's life as it is associated with heightened risk for depression, self-harm and suicide. Bearing in mind the potential risks, the appropriate and multifaceted gender affirming care is recommended at both the international and national level. SOC8 guidelines further recommend that the gender affirming care

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[655] WPATH SOC8, S138.

[656] WPATH SOC7, 21.

[657] Jack Drescher, Gender identity diagnoses: History and controversies in B P C Kreukels, T D Steensma, & A L C de Vries (eds.), *Gender dysphoria and disorders of sex development: Progress in care and knowledge* 137–150 (Springer Science and Business Media 2014). <https://doi.org/10.1007/978-1-4614-7441-8_7> accessed on 17 February 2023.

[658] Giordano, 'Is puberty delaying treatment 'experimental treatment?'

must be evidence based and medically necessary for children.[659] Delaying gender-affirming hormone therapy will increase the probabilities of later medical transition. Without the hormonal interventions, children will not benefit from puberty delay and may as a result be distressed during the pubertal development of their sex characteristics.

The 2001 Harry Benjamin International Gender Dysphoria Association's Standards of Care for gender identity disorders provided valuable insight into the effects of this valuable health enhancing hormones on the (then) gender identity disorder patients:

> Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender.[660]

Therefore, to lessen the child's stress levels (which may worsen his or her mental health symptoms) access to gender affirming hormones must be prioritised due to their protective effect on children.[661]

Gender affirming care at both national and international level is administered pursuant to the WPATH's operative guidelines. As mentioned above, medical intervention can have lifesaving effects on transgender children. The medical options, however, may vary, based on the stages of pubertal development, namely pre-pubertal, pubertal and post-pubertal.[662] The guidelines do not recommend any medical intervention prior to puberty (pre-pubertal). During this time the child must undergo mental health assessments by a mental health provider with expertise in gender identity issues. Further, the patient must be diagnosed with gender dysphoria, meaning that he or she must have questioned their gender identity for "several years".[663] The assessment may

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[659] WPATH SOC8, S5. See also Giordano, 'Is puberty delaying treatment 'experimental treatment?'

[660] The Harry Benjamin International Gender Dysphoria Association, The Harry Benjamin International Gender Dysphoria Association's Standards Of Care For World Professional Association for Gender Identity Disorders (6th Version 2001) 13 <http://www.wpath.org/documents2/socv6.pdf> accessed on 28 February 2023.

[661] Giordano, 'Is puberty delaying treatment 'experimental treatment?'

[662] Caroline Salas-Humara and others, 'Gender affirming medical care of transgender youth' (2019) 9 Current Problems in Pediatric and Adolescent Health Care <https://doi.org/10.1016/j.cppeds.2019.100683> accessed on 15 March 2023.

[663] Salas-Humara and others, 'Gender affirming medical care of transgender youth.'

result in the child navigating to a social transition. The child is only eligible for gender affirming hormones once puberty has commenced (Tanner stage 2). Breast development, which is the manifestation of puberty for cisgender females (referring to females whose gender identity corresponds with the sex registered for them at birth) begins between the ages of 8-13 years. For cisgender males, the manifestation of puberty is testicular enlargement which occurs between 9-14 years. Accordingly, these stages of development also require an assessment by a qualified mental health provider. PBs are the first line of intervention for transgender children, and their function is to postpone puberty. These blockers effectively delay hormones that cause the physical changes of puberty,[664] which is potentially irreversible. They further allow the child an opportunity to explore his or her gender identity before commencing hormones with long-term consequences. In its 2021 statement regarding medical affirming treatment, PsySSA's Sexuality and Gender Division (SGD) expressed the following opinion:

> The SGD thus stands firmly in support of the statement from WPATH and others, noting that irreversible harm could come to young people denied puberty blockers. As always, our first guiding ethical principle should be to 'do no harm'. In this instance, harm is surely to come, and this harm is preventable.'[665] The South African Society of Psychiatrists stated: 'For parents whose children display gender non-conforming attributes and behaviours, or state that they wish to transition to their preferred gender … it was vital to understand and accept that this was not "just a phase.

Trans children are eligible for feminising and masculinising hormone regimens during the post pubertal stage. Masculinising hormone therapy is used to treat trans men who wish to suppress their secondary sex characteristics and develop more masculine physical traits. This is a widely used treatment for men with hypogonadism or men who fails to produce enough testosterone.[666] Trans women on the other hand are treated with cross-sex hormones using oestrogen therapy. The goal of feminising hormone therapy is to develop more feminine physical traits.[667]

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[664] Sex characteristics for males may include the deepening of the voice, growth of pubic hair, and facial hair in addition to the testicular enlargement. Whereas for females it may include hips widening, and the growth of pubic hair in addition to the growth of the breasts.

[665] PsySSA, Statement regarding medical affirming treatment, including puberty blockers, for trans adolescents (2021) <https://www.psyssa.com/wp-content/uploads/2021/01/2021-PsySSA-SGD-Statement-Statement-regarding-medical-affirming-treatment-including-puberty-blockers-for-trans-adolescents..pdf> accessed on 24 March 2023.

[666] Unger, 'Hormone therapy for transgender patients.'

[667] Unger, 'Hormone therapy for transgender patients.'

The changes with masculinising hormone therapy become noticeable after 3 months of hormone therapy. This may include cessation of menstruation, increased muscle mass and body strength, especially upper body, increased facial and body hair, skin changes, including more oily skin and acne. Later changes may include, voice deepening, enlargement of the clitoris, the thinning and shrinking of vaginal tissue and decreased lubrication.[668] Feminising hormone changes on the other hand are estimated to occur between 18 and 24 months. They include amongst others, decreased muscle mass, thinning facial pattern and body hair, breast tissue growth, decreased testicular size and decreased spontaneous erections.[669]

The administration of these hormones has been found to be safe and improve mental health and increase the quality of life in trans patients.[670] Hormonal therapy is typically prescribed to adolescents who suffer strong and persistent gender dysphoria, and children who are denied this treatment resorts to self-administered hormones and other chemicals aimed at body modification. These chemicals are associated with the risk of long-term health effects in transgender children.[671]

There are multiple medical and surgical interventions that may be required by trans patients in order to affirm their gender identity. It is therefore important that health care professionals should be aware that all these interventions play a vital role in the care of individuals with diverse gender identities. Even minor medical care can effectively reduce gender dysphoric feelings and improve other health problems, including the patients' self-concept and self-esteem.[672] Gender affirming care is not a one size fits all for adolescents, it is therefore, important to be aware of their differences or even their developmental pathways, in order to be able to find appropriate treatment options relevant to their different situations. As recommended by WPATH, an individualised

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[668] Unger, 'Hormone therapy for transgender patients.'

[669] Unger, 'Hormone therapy for transgender patients.'

[670] Salas-Humara and others, 'Gender affirming medical care of transgender youth.'

[671] Hembree and others, 'Endocrine treatment of gender-dysphoric/gender-incongruent persons' 3869-3903.

[672] Joseph K Canner and others, 'Temporal Trends in Gender-Affirming Surgery Among Transgender Patients in the United States' [2018] JAMA Surgery <https://doi.org/10.1001/jamasurg.2017.6231.> accessed on 05 January 2023.

rather than a “blanket” or a “one size fits all” approach to surgical options is recommended.[673]

Conventionally, the age of 16 was the age cut-off to start cross-sex hormonal treatment.[674] The SOC8 guidelines, however, support a more flexible age of initiation as already indicated above. It is my submission that the benefits of gender-affirming care outweigh the risks, especially considering that the lack of access to care is associated with devastating consequences on trans and gender diverse adolescents and children. I, therefore, firmly support an individualised approach to gender affirming health care, which acknowledges the child’s decision-making capacity. While surgical procedures are not in the transition plan of all individuals with transgender experience, I recommend that surgery must be prioritised in situations where it is necessary to resolve a medical emergency or where a delay in treatment can lead to irreversible physical health risks.

3.4.2.2 Medical de-transition

The WPATH recommends a postponement of non-urgent surgeries as it acknowledges the possible complications that may be associated with surgery (including the possibility that a child may be dissatisfied with their treatment as they age, and eventually regret having transitioned). These are situations where a child’s gender reassignment post-surgery may not ultimately line up with their gender identity, which, depending on the circumstances, may constitute gross negligence and medical malpractice based on a lack of informed consent. Many of these youth express regret about their prior transition.[675] There are unfortunately no large-scale studies that have adequately quantified how many remained satisfied and how many eventually regretted transitioning.[676] It should be noted that not all de-transitions are based on regret from the physical effects of the surgery itself. Some discontinue gender affirming health care because of physical or mental health concerns, whilst others de-transition rather as a result of the stigma that trans children face within the society due to their

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[673] WPATH SOC8. See also Salas-Humara, ‘Gender affirming medical care of transgender youth.’

[674] Salas-Humara and others, ‘Gender affirming medical care of transgender youth.’

[675] WPATH SOC8, S47.

[676] Michael S Irwig, ‘Detransition Among Transgender and Gender-Diverse People-An Increasing and Increasingly Complex Phenomenon’ (2022) 107 Journal of Clinical Endocrinology and Metabolism 4261 <https://doi.org/10.1210/clinem/dgac356> accessed on 07 March 2023.

surgical affirmation. Lack of family support is strongly associated with a history of de-transition.[677] The WPATH's SOC8 guidelines alert that "de-transitioning may occur in young transgender adolescents and health care professionals should be aware of this".[678]

3.4.3 Criticism against Standard of Care 8 (SOC8)

Most of the gender reassignment facilities reference the WPATH as the most widely recognised guidelines used to treat trans youth. The WPATH provides no age limit for hormone treatment and also no hard and fast age recommendation for gender reassignment surgeries. However, its guidelines indicate that certain gender affirming surgeries, including vaginoplasty and double mastectomy *could* be considered in minors. [679] The challenge may, however, be that medical guidelines generally do not recommend gender reassignment surgeries before the age of 18. Children under the age of 18 will in most extenuating circumstances be permitted to have gender reassignment surgeries on condition that they meet set standards and guidelines to do so.[680]

The SOC8 guidelines are criticised for undermining the safeguarding of some of the most marginalised and vulnerable members of society. The standard may be said to fail most children and adolescents because it does not place any weight on a nuanced situational concern for the welfare and wellbeing of children and young people. It does not classify transgender health issues, including gender dysphoria as a mental-health symptom.[681] It does not recommend requiring a mental health exam before gender affirming therapy, but recommend mental health support for individuals who need it. Operationally, the mandatory assessments for children and adolescents which have for a long time been an integral part of the child's treatment before obtaining medical

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[677] Irwig, 'Detransition Among Transgender and Gender-Diverse People.'

[678] WPATH SOC8, S47.

[679] WPATH SOC8, S64.

[680] The South African Constitution prescribes the age of 18 for surgical interventions. In other countries like Austria, Czechia, Croatia, Denmark, Finland, Italy, Latvia, Lithuania, the Netherlands, Poland, Portugal, Spain and Sweden the minimum age requirement to request sex reassignment surgery is explicitly set at the age of 18. See European Union Agency for Fundamental Rights 'Access to sex reassignment surgery' <http://fra.europa.eu/en/publication/2017/mapping-minimum-age-requirements-concerning-rights-child-eu/access-sex-reassignment-surgery> accessed on 26 February 2023.

[681] WPATH SOC8, S7.

or surgical procedures, have been made optional. SOC8 thus, ignore that many young people have a range of comorbid disorders such as autism and mental-health diagnoses. It recommends psychotherapy for younger children through its recommendation that:

> [P]arents/caregivers and health care professionals [should] respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.[682]

The guidelines have further lowered the recommended minimum age for a child to be given puberty blockers, cross-sex hormones or gender-reassignment surgery. The condition is that the particular child must have reached 'Tanner Stage 2'[683] of puberty, which can be as young as 9 years old.[684] "Chest masculinization surgery" may be considered for minors in accordance with the guidelines.[685] However, the complete assessment from the multidisciplinary team should reflect that it is "clinically and developmentally appropriate" for a specific minor.[686] The guidelines go even further by recommending that "vaginoplasty" may be considered for children under the age of 18.[687] So, in effect, age is removed as a barrier to surgery. The guidelines recommend much greater flexibility in the administration of hormone therapy. In principle, although it has removed an age threshold, it uses a staged approach that supports a patient's autonomous decision-making. This is despite its acknowledgement that many adolescents may lack the "skills for future thinking, planning, big picture thinking, and self-reflection: which are important aspects of informed decision-making.[688] Again, adolescence is a period of life during which a number of factors will influence their decision-making, such as "a sense of urgency that stems from hypersensitivity to reward", a "heightened focus on peer relationships", and "increased risk-taking behaviours".[689] There are therefore no clearer eligibility criteria, except the physiological and psychological development of the child. The generous discretion

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[682] WPATH SOC8, S69.

[683] WPATH SOC8 at S64 provides as follows: "The use of puberty-blocking medications, such as GnRH analogues, is not recommended until children have achieved a minimum of Tanner stage 2 of puberty because the experience of physical puberty may be critical for further gender identity development for some TGD adolescents".

[684] WPATH SOC7, 18. See also Emmanuel and Bokor, 'Tanner Stages-StatPearls.'

[685] WPATH SOC8, S66.

[686] WPATH SOC8, S66.

[687] WPATH SOC8, S48.

[688] WPATH SOC8, S62.

[689] WPATH SOC8, S44.

given to individual clinical team regarding adolescents who have reached Tanner Stage 2 may impact negatively on the gender-affirming care that is medically necessary for the child. This discretionary power gives much room for confusion and misuse, especially when conflicting recommendations relating to gender affirming care arise. This is the reason why "in most settings, for minors, the legal guardian is integral to the informed consent process".[690]

The guidelines make it clear that there should be no requirement for a child to have received cross-sex hormones prior to surgery "if not desired", and in addition, that it is not mandatory to undergo therapy or counselling before medical treatment. Clinicians have a prerogative to "challenge" parents who are unsupportive of their children's medical transition, and hormone treatment can be prescribed for children without parental involvement if such involvement would be "harmful or unnecessary".[691] Although the SOC8 guidelines do not explicitly recommend parental consent,[692] the guidelines expect parents to consent with the child in standard situations.[693] The guidelines state as follows:

> We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.[694]

It is acknowledged that in situations where an adolescent lacks emotional development and cognitive maturity, "the legal guardian is integral to the informed consent process".[695] However, the parental responsibilities and rights seem to be excluded in that clinicians are advised to prescribe hormone treatment to children without the need for parental support. Further, the advice that parents who are considered unsupportive should be challenged by the clinicians, is problematic, as it potentially infringes on the parent-child relationship and the legal rights that parents and guardians have in this regard. Some parents may justifiably be concerned about

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[690] WPATH SOC8, S61.

[691] WPATH SOC8, S111.

[692] WPATH SOC7, 17. It did not only require parental consent for the provision of PBs, but it also considered such a consent 'ideal' for the provision of cross-sex hormones.

[693] WPATH SOC8, S62.

[694] WPATH SOC8, S48.

[695] WPATH SOC8, S61.

their children's health and well-being, specifically regarding a matter as serious and invasive as medical transitioning procedures. The SOC8 guidelines takes a paternalistic stance by assuming that parents are incapable of providing informed consent pertaining to these complex medical decisions. This is particularly troublesome if one considers that "gender-affirming" interventions are administered to youth "based on very limited data", as such, the long-term outcomes of the transition are unknown.[696]

It is my submission that as much as it is assumed that the age requirement places an added protection for the informed consent process, true protection for the child's best interest lies in the shared decision-making approach between the health care professional, the child and his or her parents or guardians. As Hudson and others highlight:

> For all patients, shared decision-making strategies that facilitate dialogue between families, providers, and patients while taking into account the patient's level of maturity and individual decision-making capacity have been shown to facilitate informed consent and decisions in the best interest of the patient.[697]

3.5 Transgender care in South Africa

South Africa, unlike the greater of its counterparts on the African continent, accept sexually and gender diverse individuals. Its progressive law[698] states that anyone who wishes to change their gender may do so legally, with or without having undergone surgery.[699] Those who wish to change their gender are afforded the same rights and privileges as any other South African citizen.[700] Spencer, commenting on the provision of gender affirming care in South Africa, refers to seven South African public hospitals

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[696] Johanna Olson-Kennedy and others, 'Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study' (2019) 8 JMIR Research Protocols 1-10 <https://doi.org/10.2196/14434> accessed on 25 February 2023.

[697] Janella Hudson and others, 'Fertility counseling for transgender AYAs' (2018) 6 Clinical practice in pediatric psychology 84.

[698] Section 2(1), the Alteration of Sex Description and Sex Status Act (Act No. 49 of 2003).

[699] Liesl Theron, 'When a progressive constitution is not enough, and other challenges.' Presentation given in July at the 13th conference of the International Association for the Study of Forced Migration (Kampala, Uganda 2011) <https://genderdynamix.org.za/wp-content/uploads/2013/04/When-the-Constitution-is-Not-Enough.pdf?x91330> accessed on 23 February 2023.

[700] Juan A Nel, 'South African can and should provide leadership in advancing understanding of sexual and gender diversity on the African continent' (2014) 44 South African Journal of Psychology 145-148 <https://doi.org/10.1177/0081246314530834> accessed on 23 February 2023.

providing gender affirming care. These hospitals are the Groote Schuur Hospital in Cape Town; Chris Hani Baragwanath Hospital in Johannesburg; Helen Joseph Hospital in Johannesburg; Steve Biko Academic Hospital in Pretoria; Charlotte Maxeke Hospital in Johannesburg, Greys Hospital in Pietermaritzburg, and Universitas Academic Hospital in Bloemfontein. Three of these hospitals provide endocrinology, psychiatric and surgical services at the same facility, namely Chris Hani Baragwanath Hospital, Steve Biko Academic Hospital, and the Groote Schuur Hospital.[701]

One may argue that the effective realisation of the right of persons to access health care services is inhibited by the limited number of state facilities providing this form of care. All seven hospitals are based in urban areas and not spread across all provinces.[702] This means that individuals based mainly in rural areas, including provinces where gender-affirming care is not available, have to travel unreasonable distances to access gender-affirming care from these hospitals.[703] Spencer argues further that despite the availability of psychosocial support, hormone therapy and gender-affirming surgical interventions in the private sector, they are generally not covered by medical aid schemes and/or health insurance.[704] The range of obstacles that trans persons may face when trying to access gender affirming care, point to a violation of their constitutionally protected rights, notably the rights to equality, dignity and access to health care services.

It must be noted that gender affirming care in South Africa accords with the WPATH's international standards and the NHA in relation to its status in the medical and ethico-legal practice.[705] The WPATH makes it clear that its standards of care are intended as a guide to good clinical practice, therefore, "individual health professionals may modify them".[706]

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[701] Sarah Spencer, Talia Meer and Alex Müller, '"The care is the best you can give at the time": Health care professionals' experiences in providing gender affirming care in South Africa' (2017) 12 PloS One e0181132 <https://doi.org/10.1371/journal.pone.0181132> accessed on 23 February 2023.

[702] Spencer and others, 'The care is the best you can give at the time.'

[703] Spencer and others, 'The care is the best you can give at the time.'

[704] Spencer and others, 'The care is the best you can give at the time.'

[705] National Health Act 61 of 2003. See also Spencer and others, 'The care is the best you can give at the time.'

[706] WPATH SOC7, 104.

South Africa's national guidelines for gender-affirming care are the SAHCS GAHC.[707] As part of the executive summary, the guidelines provide as follows:

> This guideline has been developed primarily with the intention of centering and amplifying voices of TGD individuals in order to facilitate access to healthcare that is sensitive, skilled and respectful. We recognise that there are significant gaps in the knowledge and skills of healthcare providers, and there is a lack of understanding of the unique experiences faced by TGD persons. The prevailing sentiment that many healthcare providers hold around TGD individuals, informed by ignorance and conditioning within social and societal structures, are malevolent towards this community, and often include harmful assumptions and generalisations. We believe that healthcare providers have an ethical obligation to interrogate these notions, and we promote an attitude of respect for diversity that upholds human rights.[708]

Prior to the SAHCS GAHC in 2019, the Psychological Society of South Africa (PsySSA)[709] developed practice guidelines for professionals working in the field of sexual and gender diversity.[710] The PsySSA also has a comprehensive affirmative

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[707] SAHCS GAHC, developed in 2021. Its scope is to "[p]rovide evidence-informed best practice recommendations to enable South African healthcare providers, including psychosocial and allied healthcare professionals, and to offer quality, affirming services to TGD clients." Further, to "[p]rovide a support to TGD clients when accessing healthcare services". See the scope and purpose, 9.

[708] SAHCS GAHC's executive summary, 8.

[709] Psychological Society of South Africa, Sexual and gender diversity position statement (2013) <http://www.psyssa.com/documents/PsySSA_sexuality_gender_position_statement_2013.pdf> accessed on 18 February 2023.

[710] PsySSA' statement on sexual and gender diversity was adopted on 24 September 2013. It affirms the following: "1. Respect the human rights of sexually and gender diverse people, and are committed to non-discrimination on the basis of sexuality and gender, including, but not limited to, sexual orientation, gender identity, and biological variance; 2. Subscribe to the notion of individual self-determination, including having the choice of self-disclosure (also known as 'coming out') of sexual orientation, gender diversity, or biological variance; 3. Acknowledge and understand sexual and gender diversity and fluidity, including biological variance; 4. Are aware of the challenges faced by sexually and gender diverse people in negotiating heteronormative, homonormative, cisgendered (see section 'Glossary'), and other potentially harmful contexts; 5. Are sensitised to the effects of multiple and intersecting forms of discrimination against sexually and gender diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty, and unemployment; race, culture, and language; age and life stage; physical, sensory, and cognitive–emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality; 6. Have an understanding of stigma, prejudice, discrimination and violence, and the potential detrimental effect of these factors on the mental health and well-being of sexually and gender diverse individuals; 7. Recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age; 8. Understand the diversity and complexities of relationships that sexually and gender diverse people have, which include the potential challenges (a) of sexually and gender diverse parents and their children, including adoption and eligibility assessment; (b) within families of origin and families of choice, such as those faced by parental figures, caregivers, friends, and other people in their support networks, for example, in coming to terms with the diversity, non-conformity,

practice guidelines regarding sexual and gender diversity concerns.[711] The PsySSA aims to support the well-being and facilitate the recognition of human rights for all sexually and gender-diverse people by utilising the application of its knowledge as a tool to achieve its aims.[712] McLachlan and Nel correctly observe that these guidelines cannot be restricted to the field of trans health care, as they are "becoming an important guide for not only psychological professionals but also other health care professionals".[713] The year 2020 has seen the establishment of an organisation referred to as PATHSA.[714] PATHSA is an interdisciplinary organisation advocating for the dignity, equality, and access to health care of sexually and gender diverse people. Its objectives are as follows:

> a) Facilitate networks and foster supportive environments for health professionals working with and for trans and gender diverse people.
>
> b) Develop, advocate for and promote best practices and clinical resources for gender affirming health care.

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and/or minority status of their sexually and gender diverse significant other; and (c) for people in different relationship configurations, including polyamorous relationships. 9. Adhere to an affirmative stance towards sexual and gender diversity in policy development and planning, research and publication, training and education (including curriculum development, assessment, and evaluation of assessment tools), and intervention design and implementation (including psychotherapeutic interventions); 10. Support best practice care in relation to sexually and gender diverse clients by (a) using relevant international practice guidelines in the absence of South African–specific guidelines; (b) cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy; (c) opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by the WPATH; and (d) encouraging parents to look for alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons. 11. Are, if it be the case, aware of their own cultural, moral, or religious difficulties with a client's sexuality and/or gender identity, in which case they should disclose this to the client and assist him or her in finding an alternative psychology professional should the client so wish; and 12. Are committed to continued professional development regarding sexual and gender diversity, as well as to promoting social awareness of the needs and concerns of sexually and gender diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals".

[711] Cornelius J Victor and others, 'The Psychological Society of South Africa sexual and gender diversity position statement: contributing towards a just society' (2014) 44 South African Journal of Psychology 292-302.

[712] PsySSA 2017.

[713] C McLachlan and J A Nel, Que(e)ring models of accessing gender affirming healthcare in the Southern African context. Paper presented at the World Professional Association for Trans Gender Health bi-annual symposium (Buenos Aires, Argentina 2018).

[714] The Professional Association for Transgender Health South Africa (PATHSA) 2020 [cited 2021 Aug 21] <https://pathsa.org.za/constitution> accessed on 25 February 2023. PATHSA in its position statement, takes a clear and consistent position on gender-affirming healthcare for children and adolescents, it provides as follows: 'PATHSA regards gender affirmation of transgender children and adolescents as evidence based, internationally recognised and in the best interest of the child and adolescent.' See also SAHCS GAHC Guidelines.

> c) Encourage, promote, conduct and disseminate research, which is done in a respectful way towards the community, to expand knowledge and deepen understanding about trans and gender diversity.
>
> d) Advocate for institutional, policy, and legislative change by utilizing our collective knowledge and expertise.
>
> e) Provide education on holistic gender-affirming healthcare promoting the health, wellbeing, and supporting the self-actualisation of trans and gender diverse people.
>
> f) Develop leadership skills amongst trans and gender diverse health professionals and promote indigenous perspectives.
>
> g) To disseminate awareness around power dynamics that are typically inherent to all healthcare seeker/provider interactions involving people who are part of the trans and gender-diverse communities, to acknowledge the damage that has been done by such dynamics, and to insist that gender-affirming clinicians must take steps to dismantle these typical power hierarchies.
>
> h) Generally, to do such other things as may be incidental or conducive to the attaining of the above objectives.

Before, the SAHCS guidelines, South Africa, like many parts of the world, required individuals who seek treatment to obtain approval from mental health professionals before they could undergo hormonal or surgical intervention. These medical professionals included a psychotherapist, a counsellor, or family therapist, or a diagnostician/assessor.[715] Both the WPATH SOC8 and PATHSA guidelines acknowledge that an evaluation and support of a transgender youth must be conducted by a suitably skilled mental health practitioner. Both sets of guidelines are aligned regarding the issue that gender-diverse children should be put on hormone blockers after having reached Tanner Stage 2, which marks the beginning of physical development. The purpose of hormone blockers, explained elsewhere in this chapter, is to delay further physiological development of the child. The guidelines do not force patients to seek a referral by medical professionals before accessing gender affirming care, instead, a more individualised assessment of the patient's best interests is considered.[716] The guidelines recognise that transitioning can be different for each transgender individual.[717]

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[715] WPATH SOC7, 23.

[716] SAHCS GAHC, 31.

[717] SAHCS GAHC, 10. It provides that "[e]ach individual has unique needs, and the gender affirming process is rarely linear".

Legal and ethical requirements expect medical practitioners to furnish potential patients with adequate information to make an informed decision and provide proper informed consent.[718] Informed consent is an integral part of the psychotherapy process. This implies that although individuals may still need to provide a written report from a mental health professional to access gender affirming care, this must be done in terms of an informed consent model. Snyder and Barnett provide that the model of informed consent should be:

> [P]romoting client autonomy and self-determination, minimizing the risk of exploitation and harm, fostering rational decision-making, and enhancing the therapeutic alliance.[719]

This model therefore, requires a medical professional to inform a patient about both the potential benefits and risks of the proposed treatments in detail, including what is yet unknown regarding these treatments, and to provide alternative gender affirming care to the patient, where relevant and indicated.[720] Therapy is not required to initiate a medical transition but psychological services are beneficial and as such, encouraged to address any concerns that may arise during the process or that arise as a result of transitioning.[721] A challenge with psychotherapy is that it is expensive and consequently not affordable to all transgenders. The cost implications place unnecessary and unfair hurdles on some transgender individuals. As such, it could be perceived as a gatekeeping model. Tabenkin and Gross explain gatekeeping as:

> the authority to decide upon referrals to specialists, to implement the diagnostic workup and patient management in the primary care clinics, to consider finances when deciding about medical care, and to co-ordinate the actions of other caregivers, thus guaranteeing continuity of care.[722]

Campbell and others correctly observe that limited funding and resources continue to present considerable public health challenges in South Africa.[723] These contributes

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[718] SAHCS GAHC, 13.

[719] T A Snyder and J E Barnett, 'Informed consent and the process of psychotherapy' (2006) 41 Psychotherapy Bulletin 37-42.

[720] Psychological Society of South Africa (PsySSA) Practice guidelines for psychology professionals working with sexually and gender-diverse people (Johannesburg, South Africa: 2017).

[721] PsySSA 2017.

[722] H Tabenkin and R Gross, 'The role of the primary care physician in the Israeli health care system as a 'gatekeeper'-The viewpoint of health care policy makers' (2000) 52 Health Policy 73-85 <https://doi.org/10.1016/S0168-8510(00)00070-1> accessed on 27 February 2023.

[723] Megan M Campbell and others, 'Experiences of gender incongruence and the relationship between social exclusion, psychological distress, and dysfunction among South African transgender adults: A field-study for ICD-11' (2018) 30 Annals of Clinical Psychiatry 168-174.

substantially to the misfunctioning and inefficient health care. Consequently, the current waiting period for gender transition surgical interventions is estimated at between 15-20 years.[724] These extremely lengthy waiting periods are but one of the many unique challenges that South African trans persons experience. In addition, many South Africans face extreme poverty and unemployment which further hamper their efforts to access treatment. Muller notes that access to the South African health care services may be attributed to the country's economic disparities. He explains the consequences of this as:

> [...] where the vast majority of the population depend on health services in the under-resourced and overburdened public sector [...] in this highly unequal system, sexual and gender minority people face the general challenges of service and supply unavailability, long waiting times, and a lack of specialized personnel and services, but also encounter homo-and transphobic discrimination and prejudice on top of these other barriers.[725]

Moreover, most South African medical aid schemes do not cover the gender affirming care costs.[726] The main cost drivers in gender affirming care include drug costs, diagnostics and monitoring where applicable, hospitalisation during surgical interventions and support services. It is my submission that one way to overcome the challenge regarding costs, is that the Department of Health's PMB[727] list be updated to include trans affirming care as one of the treatments on the list of prescribed minimum benefits.[728] The term "prescribed minimum benefits" is defined as follows:

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[724] Campbell and others, 'Experiences of gender incongruence.'

[725] Alex Müller, 'Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa' (2017) 17 BMC International Health and Human Rights 10.

[726] Human Science Research Council (HSRC), Policy guidance: Improving access to gender-affirming healthcare for transgender women (28 September 2022) <https://hsrc.ac.za/news/impact-engagement/policy-guidance-improving-access-to-gender-affirming-healthcare-for-transgender-women/> accessed on 02 March 2023.

[727] The Medical Schemes Act (Act 131 of 1998) effective from January 2000 provided for the definition of Prescribed Minimum Benefits (PMB), which stipulate a package of services or care a medical scheme must provide for in its benefit design. It regulated medical scheme coverage for certain defined health conditions in terms of prescribed minimum benefits (PMBs) which were introduced on 1 January 2004 into the health care sector. Annexure A to the regulations defined the prescribed minimum benefits (PMBs) in terms of some 270 diagnosis - treatment pairs and were published initially on 20 October 1999 (the 1999 regulations) with subsequent amendments. See Medical Schemes Act, 1988 (Act no. 131 of 1998) Amendment to the general regulation made in terms of the Medical Schemes Act, 1998 (Act No. 131 of 1998), Government Notice 540, Government Gazette No. 23379 (30 April 2002). See also B Rayner, 'Prescribed minimum benefits or minimum pre-scribed benefits?' (2004) 94 South African Medical Journal 623-624.

[728] South African Government (1999), Regulations in Terms of the Medical Schemes Act, 1998, Government Notice, Regulation Gazette No. 6652, Vol. 412, 20 October 1999. Further Regulations published on 5 June 2000 and 30 June 2000. See also Therese Fish and others,

> Prescribed minimum benefits' means the benefits contemplated in section 29(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of-
>
> (a) The Diagnosis and Treatment Pairs listed in Annexure A,
>
> subject to any limitations specified in Annexure A; and
>
> (b) Any emergency condition.[729]

Section 29(1)(o) of the Medical Schemes Act provides as follows:

> Matters for which rules shall provide
>
> (1) The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters:
>
> …(o) The scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed.[730]

In terms of regulation 7,[731] the benefits contemplated in section 29(1)(o) of the Act "consist of the provision of the diagnosis, treatment and care costs" of the Diagnosis and Treatment Pairs listed in Annexure A to the Regulations.[732] It must, however, be

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'The Costing of Existing Prescribed Minimum Benefits in South African Medical Schemes in 2001' (2002) 5. It provides that: "[t]he objective of specifying a set of Prescribed Minimum Benefits was given in the 1999 Regulations as:
(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.
(ii) To encourage improved efficiency in the allocation of Private and Public health care resources".

[729] Section 7 of the Medical Schemes Act.

[730] Section 29(1)(o) of the Medical Schemes Act. See also regulation 7 Government Notice 540, Government Gazette No. 23379 (30 April 2002).

[731] Government Notice 540, Government Gazette No. 23379 (30 April 2002).

[732] HSRC, Policy guidance: Improving access to gender-affirming healthcare. The 1999 Regulation 8 of the Medical Schemes Act 131 of 1998 deals with the PMB's for the already listed medical conditions. It provides as follows: '(1) From the date of commencement of these regulations, the prescribed minimum benefits that medical schemes must offer in terms of the Act consist of the provision of treatment for all the categories of Diagnosis and Treatment Pairs listed in Annexure A subject to any limitations specified in Annexure A.
(2) Any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in Annexure A in at least one provider or provider network which must at all times include the public hospital system.
(3) Cover in the public hospital system must include all the costs of diagnosis, treatment and care for the prescribed minimum benefit Diagnosis-Treatment Pairs in Annexure A to a level and entitlement that is not different in terms of quality and intensity to the services provided to publicly funded patients.
(4) Medical schemes may offer enhanced options to their members through additional cover for any specific entitlements: Provided that diagnosis, treatment and care under the prescribed minimum benefits is provided.

noted that psychotherapy treatment is available at state funded health services such as clinics and hospitals, although the waiting period in these state-run institutions may be lengthy.

Another challenge faced by transgender persons is that many clinicians and other health care professionals, such as psychologists, may have limited training and experience in providing care for gender diverse individuals.[733] Transgender education in both psychological and clinical settings is lacking, as such, professionals who interact with the patient may be unaware of the sensitivity required when treating a transgender person.[734]

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(5) The options referred to in subregulation (4) may include the use of alternative providers or provider networks and could incorporate member co-payments, or enhanced options for other benefits that fall outside of the prescribed minimum benefits or both.
(6) If cover for a prescribed minimum benefit as defined in Annexure A under an enhanced option is exhausted while the patient still requires diagnosis; care or treatment for that prescribed minimum benefit, that patient may be transferred to a lower cost provider or provider network, but the medical scheme must continue to be fully liable for all costs incurred in delivering the prescribed minimum benefit care that is required.
(7) A member or dependant shall not lose his or her entitlement to any prescribed minimum benefit, regardless of any enhanced option they may choose or as a result of any condition associated with that enhanced option.
(8) Medical schemes may employ appropriate interventions aimed at improving the efficiency and effectiveness of health care provision provided that every option offered by a medical scheme must at least provide full cover for prescribed minimum benefits in at least the public hospital system.
(9) These regulations must not be construed to prevent medical schemes from employing techniques such as the designation of preferred providers, requirements for Pre-Authorization and the application of Treatment Protocols: Provided that in the case of Pre-Authorization a medical scheme must not refuse authorization for the delivery in a public hospital of standard treatment for a prescribed minimum benefit as defined in Annexure A.
(10) Every Medical Scheme must make provision in its rules for the reimbursement of the cost of care that is considered to fall within the Prescribed Minimum Benefits prescribed under these Regulations within all the membership options that the medical scheme offers.
(11) Medical schemes must refer to these Regulations in their rules and such reference may not be a full reproduction of these Regulations.
(12) Medical schemes must specify in their rules whether they restrict the provision of the prescribed minimum benefits under specific membership options to a named network of providers.
(13) The Registrar must determine whether a medical scheme's rules are consistent with the provisions of the Act and these Regulations before approving such rules.
(14) Disputes and complaints between a member or a provider and the medical scheme in relation to minimum prescribed benefits must be dealt with in terms of Chapter 10 of the Act".

[733] PsySSA 2017. See also Wilson and others, 'Transgender issues in South Africa.'

[734] Alexandra Müller, 'Teaching lesbian, gay, bisexual and transgender health in a South African health sciences faculty: addressing the gap' (2013) 13 BMC Medical Education <http://dx.doi.org/10.1186/1472-6920-13-174> accessed on 28 February 2023.

3.5.1 Lack of access to care

The discussion above has alluded to the difficulties experienced by trans persons who wish to access gender affirming surgery. What becomes clear is that these obstacles are multifaceted and not only limited to accessing medical services.[735] Hughto describes the structural barriers to trans patients' lack of access to care as follows:

> Structural barriers to transgender healthcare include high uninsured rates or lack of coverage for transgender-related services, inadequate training of physicians on transgender-sensitive care, and limited access to providers who offer transgender-related care. [736]

The argument advanced in literature is that there is lack of access to trans-inclusive care. This is linked to lack of providers with expertise in transgender medicine.[737] Transgender treatment is not taught in conventional medical curricula, as such, some health professionals lack knowledge about the concerns and medical needs of the transgender community. [738] This lack of the required specialist knowledge contributes greatly to transgender individuals having difficulties in accessing quality care. Some have reported experiences of verbal and physical harassment in several settings, including medical offices and hospitals.

As indicated above, the WPATH considers gender affirming care necessary because it promotes the overall well-being of trans persons.[739] Access to health care services includes considering the consequences of the cost barrier of gender affirming care for trans individuals. This lack of affordability often leads to trans persons skipping health care because of considerable financial obstacles based on the high costs involved. Research shows that the majority of South Africans do not belong to a medical insurance, as such, they are not in a position to afford the high costs of private hospital

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[735] T Nkoana and M Nduna, 'Engaging primary health care providers in transgender community health care: Observations from the field' (2012) 8 New Voices in Psychology 120-129.

[736] Hughto and others, ''Transgender Stigma and Health.'

[737] Jason van Heesewijk and others, 'Transgender health content in medical education: a theory-guided systematic review of current training practices and implementation barriers & facilitators' (2022) 27 Advances in Health Sciences Education 817–846 <https://doi.org/10.1007/s10459-022-10112-y> accessed on 17 March 2023.

[738] Van Heesewijk and others, 'Transgender health content in medical education.' See also SR Vance, BL Halpern-Felsher, SM Rosenthal, 'Health care providers' comfort with and barriers to care of transgender youth' (2015) 56 Journal of Adolescent Health 251–253 <https://doi.org/10.1016/j.jadohealth.2014.11.002> accessed on 20 February 2023.

[739] WPATH SOC8, S6.

care.[740] Private medical care treatment is often not achievable for the indigent and working-class trans persons within South Africa. They often have no choice, but to depend on the already overburdened public health facilities, not to mention the impact of this on the quality of health care that they may expect.[741]

PATHSA has taken a stance that it will support the application of transgender and gender diverse persons, especially regarding the role of medical aids in covering the costs for gender-affirming surgery. The most obvious reason is because gender affirming surgeries are medically necessary and not merely cosmetic procedures.[742] It is therefore recommended that medical cover should include gender affirming treatment and should align with the cover provided to other medical patients. Further, it should be explicitly clear what coverage benefits are included in the different insurance plans, and/or the defined exclusion clauses. This will provide a reasonable basis for the denial of transition related services which are considered cosmetic or experimental. In addition, as I have submitted above, the Department of Health's PMB list should be updated to include transgender health care.

Although there are state hospitals that are providing gender-affirming health care as an essential service, the waiting periods are unacceptably long. As argued in this chapter, all the impediments preventing trans persons from accessing the relevant trans gender care, including gender reassignment surgery, constitute unjustifiable limitations on the rights of trans persons.

3.5.2 The Alteration of Sex Description and Sex Status Act 49 of 2003

Despite its dark history, South Africa is frequently lauded as having one of the most progressive Constitutions in terms of the advancement of human rights. The South African Constitution is the only one in Africa offering constitutional protection against

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[740] Stats SA, General Household Survey, 2016. Table 7 <https://www.statssa.gov.za/> accessed on 20 February 2023.

[741] Nkoana and Nduna, 'Engaging primary health care providers.'

[742] PATHSA, Letter of motivation for medical aid payment for gender-affirming surgery, 16 September 2022 <https://pathsa.org.za/News/12921932> accessed on 22 February 2023.

discrimination based on sex, gender and sexual orientation.[743] The Constitution advances and protects the rights of sexual and gender minorities within the country. It further allots trans persons the same legal rights as those of cisgendered individuals. The protection of the rights of trans persons is also evident in the promulgation of the Alteration of Sex Description and Sex Status Act, which aims to protect the rights of trans persons seeking legal gender recognition. In terms of the Act, it is not mandatory that a person applying to change the gender marker should have undergone gender reassignment. The provisions of section 2(2)(b) suggests that a person who has had medical treatment to alter their hormonal patterns for the purpose of gender change can also apply to change their gender marker.[744] However, applicants who have not undergone surgery are turned away by officials at the Department of Home Affairs.[745] This is mostly as a result of an incorrect understanding and application of the Act. Consequently, applicants may sometimes wait 2 years longer to get a response.[746] The Births and Deaths Registration Act,[747] read together with the Alteration Act, provide for the amendment of the personal information. Section 27A of the Births and Deaths Registration Act empowers the Director-General to alter the sex description of the applicant on condition that an application was "made in the prescribed manner". The sex description may also be altered by the Director-General when a magistrate has issued an order in terms of section 2 of the Alteration Act.

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[743] Statista Research Department, 'Countries with laws against discrimination based on sexual orientation 2020' (9 January 2023) <https://www.statista.com/statistics/1269887/countries-laws-against-discrimination-based-sexual-orientation/>. See also European Parliamentary Research Service, LGBTI in Africa Widespread discrimination against people with non-conforming sexual orientations and gender identities (May 2019) <https://www.europarl.europa.eu/thinktank/en/document/EPRS_BRI(2019)637949> accessed on 22 April 2023. It provides as follows: "Some African countries have partly decriminalised LGBTI persons or given them better protection. However, across the continent – with the notable exception of South Africa – such persons are still far from fully enjoying the same rights as other citizens" 1.

[744] Section 2(2) of the Alteration Act.

[745] Jennifer Sanasie, 'Transgender SA Woman Speaks out about Prejudice and Public Humiliation' News24 27 June 2016 <https://www.news24.com/news24/video/southafrica/news/watch-a-transgender-life-in-south-africa-20160627> accessed on 23 April 2023. See also Liberty Matthyse and others, 'Keeping the Promise of Dignity and Freedom for All: A Position Paper on Legal Gender Recognition in South Africa' (Gender DynamiX and Legal Resources Centre 2020) 69 <https://lrc.org.za/wpcontent/uploads/Position-paper-on-legal-gender-recognition.pdf> accessed on 23 April 2023. The paper reflects as follows: "In some instances, trans and gender diverse persons have been sent from one official to another or one Home Affairs office to another reflecting uncertainty, active obstruction or unwillingness on the part of officials".

[746] Matthyse and others, 'Keeping the Promise of Dignity and Freedom for All' 59.

[747] Act 51 of 1992.

As stated earlier, gender incongruence can manifest from early childhood onward. Some children, depending on the varying degrees of their responses to their situation, may express discomfort with their assigned gender and manifest strong cross-gender interests from as early as age 3.[748] These children may also express a desire to have the genitalia of the opposite sex. The Alteration Act defines gender reassignment as:

> [a] process which is undertaken for the purpose of reassigning a person's sex by changing physiological or other sexual characteristics, and includes any part of such a process …[749]

The wording of the section suggests that medical processes in general, and psychiatry, are promoted to achieve the reassignment goal. Levine and others observe that previously, many physicians and psychiatrists were sceptical and critical of using surgery and hormone therapy. This is because they perceived transgenderism to be a psychological distress and/or delusional condition in need of psychotherapy and "reality testing".[750] The modern clinical practice, however, assists the LGBTQIA+ patients to live their lives according to their own natures and desires. As Levine and others explain, despite this, some professionals "continue to treat youth with gender-affirmative interventions despite lingering doubts".[751]

As outlined in chapter 2, the Alteration Act provides for a legal name change and changes to gender markers on legal documents after the transition.[752] It makes provision for the amendment of a person's gender in the population registry. The new gender marker will thus be reflected on birth certificates, smart ID cards and passports. Section 2 of the Act[753] stipulates that only three categories of people are eligible to

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[748] Stephen B Levine, 'Reflections on the Clinician's Role with Individuals Who Self-identify as Transgender' (2021) 50 Archives of Sexual Behavior 3531 <https://doi.org/10.1007/s10508-021-02142-1> accessed on 23 February 2023.

[749] Definition clause.

[750] Eric Yarbrough, *Transgender Mental Health* (Washington, DC: American Psychiatric Association Publishing 2018) online book.

[751] Levine, 'Reconsidering Informed Consent for Trans-Identified Children.'

[752] Section 1 of the Alteration Act. Section 24 (1) of Births and Deaths Registration Act 51 of 1992 provides as follows: "Any parent of a minor, or a person of age, may apply in the prescribed manner to the Director-General for the alteration of his or her forename under which his or her birth is registered, and the Director General may alter such forename accordingly in the prescribed manner".

[753] The section provides as follows: "(1) Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register.

apply for the alteration of their gender marker. These are persons: (i) whose sexual characteristics have been altered by surgical or medical treatment; (ii) whose sexual characteristics have been altered through natural development resulting in gender reassignment; and (iii) persons who are intersexed. Section 2 of the Alteration Act, read with section 27A of the Birth and Registrations Act,[754] provides that the transition must relate to an identified gender which will be opposite to the gender that was assigned at birth. Further, an application must provide proof that the applicant has been medically altered, or alternatively, that they were born with a condition resulting in conflicting or ambiguous biological gender markers, meaning being intersexed. Two medical reports are required in such cases: one by the medical practitioner who performed the procedure or medical treatment or by a medical practitioner who has experience in such procedures or treatments; and a report by a second medical practitioner who has independently examined the application to establish the applicant's gender.[755]

This Act is however criticised for being "inherently medicalised".[756] It requires a medical diagnosis and an intervention as preconditions, whilst a vast majority of transgender and gender diverse individuals cannot afford such gender affirming care. The Act may not benefit transgender individuals who lack equitable access to medical and surgical care due to the associated costs. The Act is further criticised for its failure to recognise fluid or non-conforming identities.[757]

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(2) An application contemplated in subsection (1) must- (a) be accompanied by the birth certificate of the applicant; (b) in the case of a person whose sexual characteristics have been altered by surgical or medical treatment resulting in gender reassignment, be accompanied by reports stating the nature and results of any procedures carried out and any treatment applied prepared by the medical practitioners who carried out the procedures and applied the treatment or by a medical practitioner with experience in the carrying out of such procedures and the application of such treatment; (c) in every case in which sexual characteristics have been altered resulting in gender reassignment, be accompanied by a report prepared by a medical practitioner other than the one contemplated in paragraph (b) who has medically examined the applicant in order to establish his or her sexual characteristics;…"

[754] This section has been inserted in the Act, after section 27. It provides as follows: "(1) If the Director-General grants an application or a magistrate issues an order in terms of section 2 of the Alteration of Sex Description and Sex Status Act, 2003, the Director-General shall alter the sex description on the birth register of the person concerned.
(2) An alteration so recorded shall be dated and after the recording of the so-called alteration the person concerned shall be entitled to be issued with an amended birth certificate".

[755] S2 of the Alteration Act.

[756] HSRC, Policy guidance: Improving access to gender-affirming healthcare.

[757] HSRC, Policy guidance: Improving access to gender-affirming healthcare.

3.5.3 The possible effect of the implementation of the National Health Insurance

Chapter 2 has already mentioned that South Africa's health system is severely biased and fragmented due to the legacy of apartheid. Because the health system was designed along racial lines, inequity and inefficiency became entrenched in the health system through apartheid's discriminatory laws and practices.[758] Shortly after the dawn of democracy and the coming into effect of the Constitution every person's right of access to health care services was prioritised.[759] In order to achieve this constitutionally protected right, the government had to revise existing laws and policies, as well as introduce new laws and policies with the objective of transforming the health system to give effect to the constitutional imperatives regarding access to health care services. These documents included the 1994 National Health Plan,[760] the 1997 White paper for Transformation of the Health System in South Africa,[761] and the National Health Act, 2003.[762]

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[758] South African National Department of Health, National Health Insurance in South Africa (Pretoria: NDoH 2011). National Health Insurance in South Africa policy paper. Government Gazette 554: 34523 <https://www.greengazette.co.za/documents/national-gazette-34523-of-12-august-2011-vol-554_20110812-GGN-34523.pdf> accessed on 19 March 2023.

[759] Section 27(1) of the Constitution.

[760] In its foreword, it stated as follows: "The challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, reduce waste, increase efficiency and to promote greater control by communities and individuals over all aspects of their lives. In the health sector this will involve the complete transformation of the national health care delivery system and all relevant institutions. All legislation, organisations and institutions related to health have to be reviewed with a view to attaining the following:
- ensuring that the emphasis is on health and not only on medical care.
- redressing the harmful effects of apartheid health care services.
- encouraging and developing comprehensive health care practises that are in line with international norms, ethics and standards.
- emphasising that all health workers have an equally important role to play in the health system and ensuring that teamwork is a central component of the health system.
- recognising that the most important component of the health system is the community and ensuring that mechanisms are created for effective community participation, involvement and control.
- introducing management practises that are aimed at efficient and compassionate health care delivery.
- ensuring respect for human rights, and accountability to the users of health facilities and the public at large.
- reducing the burden and risk of disease affecting the health of all South Africans".

[761] It stated as follows in its preface: "We advance a wide range of policies that will fundamentally transform our health care delivery system. Some significant steps have already been taken in this direction, but a lot still needs to be done. We intend to decentralise management of health services, with emphasis on the district health system- increase access to services by making primary health care available to all our citizens; ensure the availability of safe, good quality essential drugs in health facilities; and rationalise health financing through budget reprioritization".

[762] Chapter 2 provided a detailed discussion of this Act.

The South African government introduced its first piece of Policy Paper on the National Health Insurance (NHI) to help in improving access to health care for lower income citizens. In the White paper, the NHI is defined as:

> [a] health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families.[763]

The NHI seeks to bridge existing health inequalities and aims to make affordable health care available to all South Africans regardless of their financial circumstances. The goal is to achieve universal health coverage for all South African citizens. This goal was launched in 2012 and is estimated to be completed by 2026.[764]

The reference to the term "universal coverage" is in line with the WHO Constitution which envisages "…the highest attainable standard of health as a fundamental right of every human being." It further supports vision 2030 of the National Development Plan which aims to reduce inequality in the health sector by 2030.[765] By implication, it seeks to achieve equitable access to health care, regardless of a person's income. Accordingly, people should be protected from financial hardships of paying for health services, and this should be applied in a non-biased and non-discriminatory manner. The words "based on their health need" is of importance. This imply that meeting health care needs has a special importance. In this regard, Kutzin concludes that:

> [u]niversal coverage with the health insurance function may be defined as physical and financial access to necessary healthcare of good quality for all persons in a society. It implies protection against the risk that if expensive (relative to an individual's or family's means) healthcare services are needed, services of adequate quality will be physically accessible, and the costs of these services will not prevent persons from using them or impoverish their families.[766]

It should be noted that the South African health care system is still fragmented and needs to be de-fragmented.[767] It is, however, evident that in order to achieve equitable

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[763] Department of Health, National Health insurance for South Africa: Towards Universal Health Coverage <https://www.gov.za/documents/national-health-act-national-health-insurance-policy-towards-universal-health-coverage-30> accessed on 20 March 2023.

[764] Slabbert and Labuschaigne, 'Legal reflections on the doctor-patient relationship.'

[765] National Planning Commission, National Development Plan 2030: Out Future-make it work (Pretoria: Government Printer 2011) 339.

[766] Joseph Kutzin, *Towards Universal Health Care Coverage: A Goal-oriented Framework for Policy Analysis* (The World Bank Washington, DC 2000) 2.

[767] Maphumulo and Bhengu, 'Challenges of quality improvement in the healthcare.'

universal coverage, health care services must be accessible to all, necessary, and accommodate individuals' different health needs, including their financial circumstances.

The implementation of the NHI presents an opportunity to flag the situation of transgender persons, including their challenges in accessing health care services relevant to their unique situation. The National Department of Health recently developed the NHI Service Benefits Framework which details the conditions, services, and care pathways captured in existing national clinical policy, and the minimum or average required resources associated with their delivery.[768] It is important that gender affirming care interventions be included in the NHI's Benefits Service Network.

3.6 Conclusion

This chapter highlights that the multi-component gender affirming care interventions have a positive effect on the mental and physical well-being of trans persons, including the self-concept and self-esteem for trans adolescents. In correlation, it leads to improved health outcomes for trans adults and adolescents.[769] Exposure of children to both the social transition and puberty blocking interventions points to a positive effect in reducing suicide deaths among trans adolescents. Despite the concerns of some authors regarding early social transition of children in support of a "watchful waiting" approach, Rafferty cautions as follows:

> The approach [watchful waiting] is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD [transgender and gender diverse] and, by adolescence, did not seek further treatment ("desisters").[770]

Rafferty argues in favour of the usefulness of multidisciplinary gender affirming care as the most effective way to meet the unique needs of transgender adolescents and their families.[771] As it has been outlined in this chapter, gender dysphoria has varying

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[768] Jeanne-MarieTucker , Kalipso Chalkidou and Yogan Pillay, 'Establishing the NHI Service Benefits Framework:Lessons learnt and stakeholder engagement' (2019) 1 South African Health Review 43 <https://journals.co.za/doi/epdf/10.10520/EJC-1d2aad4a4c> accessed on 21 April 2023.

[769] Canner, 'Temporal Trends in Gender-Affirming Surgery.'

[770] Jason Rafferty, 'Ensuring Comprehensive Care and Support for Transgender' (2018) 142 Pediatrics 2162 <https://doi.org/10.1542/peds.2018-2162> accessed on 24 March 2023.

[771] WPATH SOC8, S7. See also Rafferty, 'Ensuring Comprehensive Care and Support'.

degrees of severity.[772] As a result, gender reassignment is recommended for severely affected children. The diagnosis and treatment of gender dysphoria in childhood and adolescence has become a specialised and rapidly evolving interdisciplinary field.

Trans persons require high quality lifelong access to a wide scope of transgender competent health care. Health care professionals must be mindful that trans persons are at a higher risk of developing psychological trauma associated with intersections of social marginalisation. Their support should, therefore, extend beyond the process of gender transition. This chapter emphasises that because de-transitioning often happens because of a lack of support provided to trans persons by their family members and communities, clinicians must be aware of and explore the increasing impacts of social discrimination.

Regarding the first line treatment for gender dysphoric minors, I am of the opinion that they must undergo psychotherapy prior to the administration of PB's. As far as PBs for adolescents are concerned, research has shown that in addition to PB's being reversible, they may prevent the child's body from developing sex characteristics that may eventually lead to feelings of body discomfort. Further, they present more time for the adolescent to explore the social and emotional issues that accompany physical transitioning. The chapter highlighted the importance of finding a gender-affirming health care provider who is experienced and competent in transgender and gender diverse field. A qualified assessment is beneficial in a variety of situations as the concerned child and his or her family, coupled with clinicians, may come up with an appropriate and well-informed intervention. Longitudinal studies have also demonstrated significant improvement of mental health on adolescents following hormone treatment. This refers to adolescents whose gender dysphoria persisted post the administration of puberty blockers.

Regarding the marginalisation of transgender and gender diverse individuals, much remains to be done to protect the rights of these minorities. There is a huge need to change the systems and practices that perpetuate it. This is not only the government's responsibility, but the general public as well. Society must be sensitised on the

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[772] Levine, 'Reflections on the Clinician's Role with Individuals Who Self identify as Transgender.'

challenges that transgender and gender diverse individuals face, with the objective of changing stereotypes and stigma. Education regarding gender variance should be included in school curricula for age-appropriate learners. The better the injustices of those who discriminate against trans persons are understood, the more likely the entrenched social systems and practices that perpetuate the discrimination may be prevented. One suggestion is that the static recognition of gender identity should be broadened and replaced with respect for the dignity of transgender and gender diverse individuals.

Failure to provide gender affirming care to children in need of it has a negative impact on the best interests of these children. It further, undermines and overlooks their practical needs for which the Children's Act was promulgated. Gender affirming care should also not be constrained by access barriers such as exorbitant costs. As medical schemes remain an integral part of the South African health care, they must prioritise a gender affirming model of care. This affirming model of care should be integrated in their PMB at least pending the implementation of the NHI. The NHI need to make provision for gender affirming health care in its comprehensive benefits. The NHI's Service Benefits Framework should also include a treatment pathway for transgender individuals, including transgender children. Regarding state funded gender affirming care, the challenge is to maintain sustained funding which could assist in strengthening the health systems. Existing insufficient resources in supplies, infrastructure, material, and staff, should be addressed as a matter of priority and urgency, together with strategies to increase health funding. Consequently, there is a need to introduce innovative approaches to allocate more health funds for continuous improvement in patient value. One may only hope that an ostensible lack of political will to consider the rights of transgender persons in the health care context may not compromise the already dire position of these vulnerable group.

Chapter 4 will discuss some of the relevant regional and international human rights instruments that have provisions addressing the best interests of the child in medical decision-making, particularly, issues related to gender-affirming health care and legal recognition of gender marker change. The purpose will be to identify opportunities for law reform within the South African health care system, where applicable.

CHAPTER 4: REGIONAL AND INTERNATIONAL LEGAL FRAMEWORKS

4.1 Introduction

Chapter 2 presented an evaluation on the right to have access to health care services as entrenched in the Constitution. It has further demonstrated how the provisions of the Bill of Rights have been applied in the health care context of South Africa. The chapter also articulated the measures the state put in place to ensure the progressive realisation of the right of access to health care services.

This chapter aims to comparatively assess the regional and international obligations to respect, protect and fulfil children's right of access to health care services, including gender affirming care. It explores children's participation in decisions regarding their health care from the perspective of the children, their parents, and health care professionals in gender reassignment issues. In addition to the arguments presented in chapter 2, this chapter argues that participation and decision-making autonomy are the underlying ethical foundations for the provision of gender reassignment surgery in competent transgender adolescents. Accordingly, the legislative requirements for consent by children are examined, especially the law relating to youth seeking treatment for gender dysphoria. It examines whether the South African national framework that provides for the child's right to health care services and participation is aligned with relevant regional and international law instruments and directives. This exercise is justified by the directive in the Constitution which compels a court, tribunal or forum to consider international law when interpreting legislation, particularly regarding the interpretation of human rights.[773]

South Africa is a member state of the African Union (AU) and has ratified the regional ACRWC, including the UNCRC. Through ratification, South Africa has committed itself to observe obligations arising from these instruments. While South Africa is free to develop its child reform initiatives in its National Development Plan and to ensure that children's rights are protected and respected as a means to achieve its goals, this

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[773] Section 39(1) of the Constitution of the Republic of South Africa, 1996. The Section provides as follows: "[w]hen interpreting the Bill of Rights, a court, tribunal or forum—(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom; (b) must consider international law; and (c) may consider foreign law".

must take place within the parameters of the applicable domestic, regional, and international legal frameworks.

This chapter further explores the legal frameworks governing children's consent to medical procedures and a rights-based approach to children's issues in English law as influenced by the landmark case of *Gillick v. West Norfolk and Wisbech Area Health Authority*,[774] as well as in four international jurisdictions namely Australia, New Zealand, Canada and Denmark. Both Australia and Canada are, like South Africa, jurisdictions influenced by a common law tradition. Australia has a National Children's Commissioner and has ratified the UNCRC in December 1990, also following the best interest of the child standard. Canada, despite ratifying the UNCRC in 1991, adhering to the best interest of the child standard and having a Charter on Rights and Freedoms, it came under criticism recently for not having a central independent mechanism for monitoring children's rights.[775] The legal position in Denmark, on the other hand, will be considered as Denmark has taken a progressive approach towards gender recognition reform.

4.2 A historical perspective on child protection in western countries

Ekundayo correctly observes the value of a historical retrospect for expounding the various stages that the rights of children have passed through, and to show that human rights instruments and documents are a living reality that has acceptance by the vast majority of states in various parts of the world today.[776] Since the beginning of the twentieth century, developments in international law on the rights of the child have taken place more than the last 90 years ago.

Historically, children were marginalised and viewed as passive individuals who were not entitled to exercise a wide variety of rights. Thus, there were a lack of laws upholding and protecting the rights of children.[777] The protections afforded to children

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[774] [1986] AC 112.

[775] Levesque, 'Are the kids alright?'

[776] Osifunke Ekundayo, 'Does the African Charter on the Rights and Welfare of the Child (ACRWC) only Underlines and Repeats the Convention on the Rights of the Child (CRC)'s Provisions?: Examining the Similarities and the Differences between the ACRWC and the CRC' (2015) 5 International Journal of Humanities and Social Science 145.

[777] Lothar Krappmann, 'The weight of the child's view (Article 12 of the Convention on the Rights of the Child)' (2010) 18 International Journal of Children's Rights 502.

were justified based on their physical and psychological immaturity.[778] This approach was challenged through the emerging children's rights movement in the eighteenth century.

The twentieth century is characterised by an advanced dramatic recognition of the need for special care and prevention of cruelty to children. The industrial revolution exploited child labourers since there were no legal safeguards to protect them. They worked long hours of physically hazardous labour which consequently had adverse effects on their health and overall well-being.[779] Critics launched an attack on this injustice and gradually there was a response from states and society. The movement aimed at protecting the rights of children commenced at the end of the First World War (from 1914-1918).[780] One such critic was Eglantyne Jebb, a British woman who founded the 'Save the Children' movement that had a vision to achieve and protect the rights of children worldwide.[781] The increasing recognition of the vulnerability and developmental needs of children became instrumental in paving a way for better child protection policies and treaties around the world. In spurring action toward this vision, the movement drafted the first international standards of protection for children as an initiative to prioritise the rights and welfare of children around the world.[782] This immediate sequence of events led to the adoption of the 1924 Geneva Declaration on the Rights of the Child.[783] The Geneva Declaration consisted of a set of rights drafted

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[778] Sheila Varadan, 'The Principle of Evolving Capacities under the UN Convention on the Rights of the Child (2019) 27 International Journal of Children's Rights 306. See also John Tobin, 'Justifying Children's Rights' (2013) 21 International Journal of Children's Rights 395-441 <https://doi.org/10.1163/15718182-02103004> accessed on 12 April 2023.

[779] Sarah Grossman-Greene and Chris Bayer, History of child labor, child rights and the Harkin-Engel protocol (Payson Center for International Development Tulane University 2009) <https://studylib.net/doc/8375401/a-history-of-child-rights--child-labor--and-the-harkin#> accessed on 10 April 2023.

[780] Dejo Olowu, 'Children's Rights, International Human Rights and the Promise of Islamic Legal Theory' (2008) 12 Law, Democracy & Development 63.

[781] Zoe Moody, 'The United Nations Declaration of the Rights of the Child (1959): Genesis, transformation and dissemination of a treaty (re)constituting a transnational cause' (2015) 45 Prospects 18 <https://doi.org/10.1007/s11125-015-9343-4.> accessed on 11 April 2023.

[782] Moody, 'The United Nations Declaration of the Rights of the Child.'

[783] Geneva Declaration of the Rights of the Child of 1924 (also known as the Geneva Declaration). In its opening statement it provided as follows: "[B]y the present Declaration of the Rights of the Child, commonly known as 'Declaration of Geneva,' men and women of all nations, recognizing that mankind owes to the Child the best that it has to give, declare and accept it as their duty that, beyond and above all considerations of race, nationality or creed".

by Jebb,[784] providing for the most basic needs of the child.[785] The Declaration states that children are vulnerable and incapable of caring for themselves.[786] It thus became the first Declaration consisting of elaborative provisions to give effect to the protection of the child, including being known as the first international instrument to use the word 'rights' when dealing with child protection.[787] Although not legally binding, the Geneva Declaration became the most comprehensive foundation of child protection due to its recognition and affirmation of the existence of rights specific to children. It further described the responsibility of adults in safeguarding and promoting the welfare of children.[788]

The traumatic events and casualties of World War II that left thousands of children in dire situations sparked an international desire for peace which led to the creation of the United Nations (UN) in 1945. Its central mission was to foster international peace and prevent conflict. Consequently, in 1948, the UN adopted the Universal Declaration of Human Rights (UDHR), an internationally regulating human rights instrument. The UDHR, however, was inadequate in respect of the broad range of children's rights that needed to be promoted, developed and protected. As Ofodile writes, the UDHR did not "clearly espouse the idea of children as rights holders but merely [drew] attention to their need for special protection".[789] The adoption of the 1959 Declaration of the Rights of the Child became a response to address limitations that plagued the 1948

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[784] Save the Children International, Children's participation: Moving forward together: Promising practices from save the children thematic priorities and the EVERY ONE campaign (London: Child Rights Governance Initiative, Save the Children International 2011a) <https://resourcecentre.savethechildren.net/document/childrens-participation-moving-forward-together-promising-practices-save-children-thematic/> accessed on 10 April 2023.

[785] Esther Elizabeth Suson, 'The History of children's Rights' <https://hankeringforhistory.com/the-history-of-childrens-rights/> accessed on 10 April 2023. She writes that the Geneva Declaration "mandated that children be fed adequately, nursed in times of sickness, encouraged to advance in education, reclaimed from delinquency, and that orphan and beggar children should be cared for. It also affirmed the right of children to be attended first in times of disaster, to be trained to an occupation, and to be protected from exploitation".

[786] Chapter 1 Declaration of the Rights of the Child 1924.

[787] Olowu, 'Law, Democracy and Development' 64.

[788] UNICEF, The state of the world's children: Special edition, celebrating 20 years of the Convention on the Rights of the Child (New York: United Nations Children's Fund 2009). <https://www.unicef.org/media/61751/file/SOWC%20Spec.%20Ed.%20CRC%20Main%20Report_EN_090409.pdf> accessed on 10 April 2023.

[789] Uché Ewelukwa Ofodile, 'The Universal Declaration of Human Rights and the African Child Today: Progress or Problems?' (2009) 25 American University International Law Review <https://ssrn.com/abstract=2312602> accessed on 11 April 2023.

UDHR.[790] The provisions of this Declaration were also criticised for being very general in nature as it called for "the protection and [individual] development of children and aiming for the improvement of children's health, nutrition, safety, and education".[791]

Although both the 1924 and 1959 Declarations laid a very important foundation in establishing an international standard for the promotion of children's rights, both were non-binding international agreements.[792] Consequently, they failed to provide a follow-up and an implementation mechanism.[793] The failure of implementation was attributed to the documents being of "an aspirational and moral and political nature, lacking legal teeth".[794] The first legally binding international agreements were only adopted by the UN in 1966. These two human rights covenants are the International Covenant on Civil and Political Rights (ICCPR)[795] and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[796] These documents contain some explicit protections relating to children and family.[797] For example, Article 24(1) of the ICCPR states as follows:

> Every child shall have, without any discrimination as to race, colour, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.[798]

The ICESCR places the burden on the state to ensure economic, social, and cultural rights to individual citizens. It provides furthermore in Article 10 as follows:

> Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions.[799]

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[790] Christian Tomuschat, International Covenant on Civil and Political Rights (2008) <http://untreaty.un.org/cod/avl/pdf/ha/iccpr/iccpr_e.pdf.> accessed on 10 April 2023.

[791] Hafen and Hafen, 'Abandoning Children to Their Autonomy' 449-450 (quoting U.N. Dep't of Pub. Info., Convention on the Rights of the Child: World Campaign for Human Rights at 1, U.N. DOC. DPI/1101, U.N. Sales No. E.91.I.51 (1991).

[792] Van Bueren, 'The International Law on the Rights of the Child' 8.

[793] Van Bueren, 'The International Law on the Rights of the Child' 8.

[794] Fitzgibbon, 'The United Nations Convention on the Rights of the Child.'

[795] International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR].

[796] International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

[797] Tomuscat, International Covenant on Civil and Political Rights.

[798] Article 24, ICCPR.

[799] Article 10, ICESCR.

The ICESCR also "recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[800] Despite these two Covenants being landmarks in international law,[801] the need remained for a more expansive children's rights approach that recognises the child as a person with his/her own individuality and inherent dignity.[802] This explains the subsequent movement towards a comprehensive child's rights treaty.[803] In 1978, the government of Poland initiated the drafting of the UN Convention on the Rights of Child (UNCRC) through its proposal to the UN Commission on Human Rights, for the creation and adoption of a Convention that prioritises the fundamental rights of the child.[804]

The UN declared the year 1979 as the International Year of the Child. Van Bueren argues that the Year of the Child was an important event as it ushered in a period of change, particularly because states started withdrawing their opposition to the idea of a child rights convention.[805] This paved a way for the drafting of a legally binding

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[800] Article 12(1) ICESCR. The human right to health is also recognised in Article 25(1) of the Universal Declaration of Human Rights which affirms that: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". On the other hand, the World Health Organization in its founding constitution provides as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
The achievement of any State in the promotion and protection of health is of value to all.
Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures". The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946.

[801] Lauren M Spitz, 'Implementing the U.N. Convention on the Rights of the Child' (2005) 38 Vanderbilt Journal of Transnational Law 862.

[802] Rochelle D Jackson, 'The War Over Children's Rights: And Justice for All? Equalizing the Rights of Children' (1999) 5 Buffalo Human Rights Law Review 225.

[803] UNICEF, The state of the world's children.

[804] Anna Holzscheiter, *Children's rights in international politics: The transformative power of discourse* (Springer 2010) 143.

[805] Geraldine Van Bueren, *The International Law on the Rights of the Child* (The Hague: Martinus Nijhoff 1998) 13.

Convention on the Rights of the Child. [806] After a decade of fierce debate, technical reviews and revisions, the draft was ready to be tabled for adoption in the UN General Assembly following the satisfaction of those who were directly involved.[807]

4.3 The United Nations Convention on the Rights of the Child

> Historically, the embryonic development of children not merely as citizens, but as active citizens of the world, participating in helping develop global legislation regarding their own autonomy, began with the drafting of the CRC.[808]

The UNCRC is said to be the most comprehensive human rights treaty and legally binding document. It is further, the most widely ratified international treaty in history[809] aimed at respecting, protecting, and promoting the rights and wellbeing of every child across the globe.[810] The current status reflects that nations of the world belonging to the UN have signed, and all have ratified the treaty, with the exception of the United States of America.[811] This document is widely cited in relation to children's rights. It promotes the rights of children from birth to 18[812] years in 54 articles. Its adoption reaffirmed children as rights-holders, as well as promoting the development and the existence of children's rights as a particular set of human rights. Cranston defines a human right as:

> [a] human right by definition is a universal moral right, something which all men, everywhere, at all times ought to have, something of which no one may be

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[806] Ann Quennerstedt, Carol Robinson and John I'Anson, 'The UNCRC: The Voice of Global Consensus on Children's Rights?' (2018) 36 Nordic Journal of Human Rights 38-54 <https://doi.org/10.1080/18918131.2018.1453589> accessed on 12 April 2023.

[807] Quennerstedt and Others, 'The UNCRC: The Voice of Global Consensus on Children's Rights?'

[808] Geraldine Van Bueren, Acknowledging Children as international Citizens: A Child-Sensitive Communication Mechanism for the Convention on the Rights of the Child in A Invernizzi and J Williams (eds), *The Human Rights of children: From Visions to Implementation* (Farnham: Ashgate 2011) 117.

[809] "The United Nations Convention on the Rights of the Child, or UNCRC, is the basis of all of Unicef's work. It is the most complete statement of children's rights ever produced and is the most widely-ratified international human rights treaty in history". See UNICEF, How do We Protect Children's Rights With the UN Convention of the Rights of the Child, (UNICEF online) <https://www.unicef.org.uk/what-we-do/un-convention-child-rights/> accessed on 05 April 2023.

[810] Jeffrey Goldhagen and others, 'Thirtieth anniversary of the UN Convention on the Rights of the Child: advancing a child rights-based approach to child health and well-being' (2020) 4 BMJ Paediatric Open <https://doi.org/10.1136/bmjpo-2019-000589> accessed on 05 April 2023.

[811] Convention on the Rights of the Child, United Nations Treaty Collection, Human Rights Chapter IV (2023) Retrieved from <https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-11&chapter=4> accessed on 05 April 2023.

[812] Article 1 of the UNCRC defines a child as "every human being below the age of 18 years unless under the law applicable to the child, the majority is attained earlier".

> deprived without a grave affront to justice, something which is owing to every human being simply because he is human.[813]

The preamble to the UNCRC calls on everyone to take into account that "the child by reason of his physical and mental immaturity needs special safeguards and care, including appropriate legal protection."[814] It further expects everyone to recognise that world-wide, "there are children living in difficult conditions and such children need special consideration." It recognises the importance of accelerating international cooperation to improve the living conditions globally, particularly in developing countries.[815] The UNCRC considers the importance of the child's rights, the urgency of ensuring children's well-being and promotion of their development, protection and participation. It further considers why children should be viewed as rights-holders. Goodin and Gibson, in supporting the interest theory in ascribing rights to the immature young, alludes as follows:

> [i]t does not matter that right-holders are not in a position to assert rights - or, indeed, even to conceptualize them as rights capable of being exercised. All that matters on this Interest Theory of rights is that right-holders have interests to be protected by such rights. What it is to be a right-holder, on this theory, is merely to be a direct intended beneficiary of someone else's duty-bound performance. Rights are claims, to be sure. But to qualify as a right-holder one need not necessarily be in a position to press those claims oneself, either directly (by claiming them oneself) or indirectly (by authorizing someone else to claim them on one's behalf). All that is strictly required is that one have interests which are recognisable by others who are duly empowered, by the moral community more generally, to press those claims on one'[816]

The UNCRC operates on four foundational principles that underpin the protection of children's rights. These are: non-discrimination; the best interest of the child; the right to life, survival and development; and respect for the views of the child".[817]

The UNCRC further imposes obligations on the state parties to provide the basis for legal protection of a wide range of human rights offered to children by virtue of respect

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[813] Maurice W Cranston, *What are human Rights?* (Taplinger Publishing Co, New York 1973) 36.

[814] UNCRC.

[815] UNCRC.

[816] Robert E Goodin and Diane Gibson, 'Rights, Young and Old' (1997) 17 Oxford Journal of Legal Studies 188.

[817] United Nations Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 44/25 2 (CRC) <http://www.unhcr.org/refworld/docid/3ae6b38f0.htm> accessed on 05 April 2023. It provides as follows: "The Convention rests on a foundation of four general principles that express its philosophy and offer guidance to national programs for putting that philosophy into effect. Key provisions focus on, Non-discrimination, best interests of the child, right to life, survival and development, and views of the child".

for their inherent human dignity.[818] More significantly, the UNCRC Committee has set out what it describes as a child rights approach, which is fundamental to safeguarding and promoting the welfare of every child. It provides as follows:

> [A] child rights approach is one which furthers the realization of the rights of all children as set out in the Convention by developing the capacity of duty bearers to meet their obligations to respect, protect and fulfil rights (art. 4) and the capacity of rights holders to claim their rights, guided at all times by the rights to non-discrimination (art. 2), consideration of the best interests of the child (art.3, para.1), life, survival and development (art. 6), and respect for the views of the child (art. 12). Children also have the right to be directed and guided in the exercise of their rights by caregivers, parents and community members, in line with children's evolving capacities (art. 5). This child rights approach is holistic and places emphasis on supporting the strengths and resources of the child him/herself and all social systems of which the child is a part: family, school, community, institutions, religious and cultural systems.[819]

The UNCRC provides children with the right of the highest attainable standard of health (article 24). The UNCRC also established a Committee on the Rights of the Child to supervise the implementation of the UNCRC by state parties.[820] The Committee monitors ratifying countries that undertook to apply the UNCRC in their national laws. It monitors the measures adopted by ratifying countries in order to fulfil the obligations set out in the treaty, including the progress that has been made. The Committee seems to presuppose that a determinant for effective implementation is the ability of children's rights to be invoked before the courts.[821] To monitor the performance of ratifying countries, the Committee receives, and reviews state reports submitted by state parties. The reports include an initial report submitted by the state parties 2 years after ratification, and subsequent periodic reports every 5 years.[822] Article 45(a) affords non-governmental organisations (NGOs) and other specialised

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[818] Eugeen Verhellen, 'The Convention on the Rights of the Child: Reflections from a historical, social policy and educational perspective' in Vanderhole (ed.), *Routledge International Handbook of Children's Rights Studies* (2015) 43.

[819] Committee on the Rights of the Child, General Comment No 13: Article 19: The right of the child to freedom from all forms of violence, 18 April 2011 at para 59.

[820] Article 43(1) UNCRC. See also Judith Ennew, *Monitoring Children's Rights: Indicators for Children's Rights Project* (Suffolk, United Kingdom: Global Gutter Press 1997). According to Judith Ennew, the ongoing monitoring of children's rights is set to achieve dual objectives: "[T]o fulfil the government's obligations as a state party to the Convention on the Rights of the Child (CRC), to show the progressive achievement of children's rights - and in South Africa's case this will include the African Charter on the Rights and Welfare of the Child; and; [T]o maintain systematic information systems on the national conditions of children's lives in order to plan, implement and evaluate interventions for their welfare".

[821] General Comment 5 para 21.

[822] United Nations Human Rights Office of the High Commissioner 'Monitoring Children's Rights' OHCHR <https://www.ohchr.org/en/hrbodies/crc/pages/crcintro.aspx> accessed on 12 April 2023.

agencies a direct role in monitoring implementation.[823] The Committee has made it clear that it is of utmost importance to consult children in the formulation of legislation and policy and that they should be involved in the drafting, development and implementation of related plans and programmes.[824]

4.3.1 The 'best interests of the child' standard in terms of the UNCRC

The 'best interests of the child' concept was not created by the drafters of the UNCRC but has rather been a longstanding principle of domestic and international law.[825] The concept, however, arose in matters related to family law disputes such as custody, guardianship, maintenance, adoption of the child and other related issues.[826] Thus, the principle of the best interest of the child had limited application.

The UNCRC acknowledges this important standard by stating that:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.[827]

The concept of the best interests of the child is used across many disciplines when different sectors respond to issues affecting children. This means that the best interests assessment should be made "at every stage of the process in preparation for

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[823] UNCRC. Article 45(a) states that: "The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities".

[824] UNCRC Committee, General Comment No. 12 (2009) on the Rights of the Child to be Heard (UN Doc.CRC/C/GC/12 1 July 2009) [122] <https://www.refworld.org/docid/4ae562c52.html> accessed on 10 April 2023.

[825] Ursula Kilkelly, The Best Interests of the Child: A Gateway to Children's Rights? In E. Sutherland & L. Barnes Macfarlane (eds.), *Implementing Article 3 of the United Nations Convention on the Rights of the Child: Best Interests, Welfare and Well-being* pp. 51-66 (Cambridge: Cambridge University Press 2016) <https://doi.org/10.1017/9781316662977.004> accessed on 10 April 2023.

[826] Stephen Parker, 'The Best Interests of the Child: Principles and Problems; The Best Interest of the Child; Reconciling Culture and Human Rights' (1994) 8 International Journal of Law, Policy and the Family 27.

[827] Article 3(1) UNCRC.

any decision that impacts the child's life".[828] Van Bueren argues that while the best interests principle did not originate from the UNCRC, it has transformed the UNCRC beyond its initial boundaries.[829] According to Hammarberg, the best interest concept has been referred to as the primary focus of the UNCRC.[830] The Committee highlighted that article 3(1) requires active measures through governments and the judiciary. It provides that:

> Every legislative, administrative and judicial body or institution is required to apply the best interests principle by systematically considering how children's rights and interests are or will be affected by their decisions and actions — by, for example, a proposed or existing law or policy or administrative action or court decision, including those which are not directly concerned with children, but indirectly affect children.[831]

The UNCRC transformed the best interest concept in three important ways, that is through: broadening the scope of the concept; making the best interest a primary consideration; and finally, by establishing a dual relationship between best interests and human rights.[832]

4.3.2 A child's right to participation

The history of child protection includes a history of children becoming more publicly visible. The inclusion of children's right to be heard in the UNCRC relating to matters that affect them is considered as one of the most prominent developments.[833] Michael

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[828] Lena Karlson, 'The Rights of All Children in the Context of International Migration' 2012 <https://resourcecentre.savethechildren.net/pdf/6715.pdf/> accessed on 11 April 2023.

[829] Van Bueren 'International law on the Rights of the Child' 7 para 4.

[830] Thomas Hammarberg, 'The UN Convention on the Rights of the Child – And How to Make It Work' (1990) 12 Human Rights Quarterly 99.

[831] Committee on the Rights of the Child, Thirty-fourth session (19 September – 3 October 2003) General comment No 5 (2003) (General measures of implementation of the Convention on the Rights of the Child) CRC/GC/2003/527 November 2003 <http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/3bba808e47bf25a8c1256db400308b9e/$FILE/G0345514.doc> accessed on 13 April 2023.

[832] Children have rights as human beings, on the other hand, they have also been guaranteed child-specific rights. Amongst these special rights is the concept of the best interests of the child, a child rights principle which may arguably be the most well-known concept in the framework for promoting and mainstreaming children's rights. In international human rights law, children are the only group whose 'best interests' are protected in every possible way. See Helen Stalford, 'The broader relevance of features of children's rights law: the "best interests of the child" principle' in Eva Brems, Ellen Desmet and Wouten Vandenhole (eds), *Children's Rights Law in the Global Human Rights Landscape Isolation, inspiration, integration?* (Routledge 2017) 40.

[833] Laura Lundy, John Tobin and Aisling Parkes, 'Article 12: The Right to Respect for the Views of the Child' 398-434 in John Tobin (ed), *The UN Convention on the Rights of the Child: A Commentary* (Oxford University Press, 2019) 411.

Freeman describes article 12 as the "linchpin"[834] of the UNCRC as it recognises children's autonomy to which every child is entitled to for the simple reason of being human.[835] The UN's International Children's Emergency Fund (UNICEF) refers in its guiding document to the UNCRC to a child's right to participate as one of the core values of the UNCRC:

> In 1989, governments across the world adopted the United Nations Convention on the Rights of the Child (UNCRC), recognising that all children have the right to be treated with dignity and fairness, to be protected, to develop to their full potential and to participate.[836]

The Committee's description of the term "participation":

> [i]s now widely used to describe ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes.[837]

The rights of children to freedom of expression and to receive information are underpinned by articles 12 and 13[838] of the UNCRC. These provisions afford children the rights to express their views in matters that affect them, and have those views given due weight. Article 12 is recognised as a general principle for any consideration of children's participation in the UNCRC, and provides as follows:

> 1. State 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.
>
> 2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent

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[834] Freeman, 'Whither the Children: Protection, Participation and Autonomy' 319.

[835] Freeman, 'Whither the Children: Protection, Participation and Autonomy' 319.

[836] UNICEF, 'The Rights of Every Child: A summary of the United Nations Convention on the Rights of the Child' (undated) (UNICEF UK) 1 <https://www.unicef.org.uk/child-rights-partners/wpcontent/uploads/sites/3/2016/08/CRC_summary_leaflet_Child_Rights_Partners_web_final.pdf> accessed on 09 May 2023.

[837] The UN Committee on the Rights of the Child 'General Comment No. 12: The Right of the Child to be heard' (2009) CRC/C/GC/12 1 July 2009, 3.

[838] It provides as follows: "1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
(a) For respect of the rights or reputations of others; or
(b) For the protection of national security or of public order, or of public health or morals".

with the procedural rules of national law.[839]

The article purposely uses the word *shall* to impose a strict obligation on state parties to implement this right for all children.[840] Article 12 also stipulates specific conditions under which a child has the right to be heard. Firstly, states are under the duty to assure the right to be heard to every child that is capable of forming his/her own views.[841] Secondly, the child's views should be given due weight in accordance with the operating criterion of sufficient age and maturity of the child.[842] Consequently, age and maturity are integral in analysing how to implement the right of participation, but not whether a child possesses the right.[843] Furthermore, with regard to the right to be heard,[844] the UNCRC discourages state parties from introducing age limits in law and practice when determining a child's capacity.[845] While recognising that children's levels of understanding are not uniformly linked to age,[846] there is acknowledgement that the introduction of an age limit would restrict the child's right to be heard.[847]

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[839] UNCRC. See also Aoife Daly, Sandy Ruxton and Mieke Schuurman, *Challenges to Children's Rights Today: What Do Children Think?* (Council of Europe 2015) 5. In their evaluation of Article 12 they note: "Article 12 of the UNCRC, the right of children to be heard, is arguably the most ground-breaking provision in that instrument. It is, at least in part, due to this provision that there is acceptance by many states, organisations and others that legal standards and policies concerning children should be informed by their views".

[840] Aisling Parkes, *Children and International Human Rights Law: The Right of the Child to be Heard* (Routledge, 2013) 312.

[841] The UN Committee 2009 also underlined that children are "able to form views from the youngest age, even when [they] may be unable to express them verbally. Consequently, the full implementation of article 12 requires recognition of, and respect for, non-verbal forms of communication" para 21.

[842] Article 12 of the Convention.

[843] Article 12 of the Convention.

[844] Article 12 of the Convention.

[845] UN General Comment para 28. It stipulates as follows: "The views of the child must be given due weight in accordance with the age and maturity of the child. This clause refers to the capacity of the child, which has to be assessed in order to give due weight to her or his views, or to communicate to the child the way in which those views have influenced the outcome of the process. Article 12 stipulates that simply listening to the child is insufficient; the views of the child have to be seriously considered when the child is capable of forming her or his own views".

[846] UN General Comment para 29 which provides that: "[B]y requiring that due weight be given in accordance with age and maturity, article 12 makes it clear that age alone cannot determine the significance of a child's views. Children's levels of understanding are not uniformly linked to their biological age. Research has shown that information, experience, environment, social and cultural expectations, and levels of support all contribute to the development of a child's capacities to form a view. For this reason, the views of the child have to be assessed on a case-by-case examination".

[847] UN Committee on the Rights of the Child, General Comment No. 12 para 21. It provides as follows: "The Committee emphasizes that article 12 imposes no age limit on the right of the child to express her or his views and discourages States parties from introducing age limits either in law or in practice which would restrict the child's right to be heard in all matters affecting him or her. In this respect, the Committee underlines the following:

Consequently, the UNCRC obliges authorities to determine the child's capability to express views as well as how those views and preferences should be considered.[848] State parties are thus under an obligation to assess the capacity of the child to form an autonomous opinion to the greatest extent possible.[849] Against this backdrop, the state has to ensure that mechanisms are put in place to effectively solicit the views of the child in all matters affecting him/her, further, to ensure that those views are heard.[850]

It must, however, be noted that even though the UNCRC Committee's interpretations gives recognition to the child's right to make autonomous decisions, it also expresses a need to assess the maturity of the child in question. The need to develop good practice guidelines for assessing the capacity of the child to form his or her own views is hence essential.[851] In this instance, article 12 of the UNCRC mandates an assessment of a child's decision-making capacity in consideration of his/her age and

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− First, in its recommendations following the day of general discussion on implementing child rights in early childhood in 2004, the Committee underlined that the concept of the child as rights holder is '... anchored in the child's daily life from the earliest stage'. Research shows that the child is able to form views from the youngest age, even when she or he may be unable to express them verbally. Consequently, full implementation of article 12 requires recognition of, and respect for, non-verbal forms of communication including play, body language, facial expressions, and drawing and painting, through which very young children demonstrate understanding, choices and preferences;
− Second, it is not necessary that the child has comprehensive knowledge of all aspects of the matter affecting him or her, but that she or he has sufficient understanding to be capable of appropriately forming her or his own views on the matter;
− Third, States parties are also under the obligation to ensure the implementation of this right for children experiencing difficulties in making their views heard. For instance, children with disabilities should be equipped with, and enabled to use, any mode of communication necessary to facilitate the expression of their views. Efforts must also be made to recognize the right to expression of views for minority, indigenous and migrant children and other children who do not speak the majority language;
− Lastly, States parties must be aware of the potential negative consequences of an inconsiderate practice of this right, particularly in cases involving very young children, or in instances where the child has been a victim of a criminal offence, sexual abuse, violence, or other forms of mistreatment. States parties must undertake all necessary measures to ensure that the right to be heard is exercised ensuring full protection of the child".

[848] Aoife Daly, No Weight for 'Due Weight'?: A Children's Autonomy Principle in Best Interest Proceedings (January 24, 2018). Available at SSRN: <https://ssrn.com/abstract=3254112> or <http://dx.doi.org/10.2139/ssrn.3254112>.accessed on 01 May 2023.

[849] General Comment No. 12 'The right of the child to be heard' CRC/C/GC/12 (2009) para 20.

[850] General Comment No. 12.

[851] General Comment 12 para 44. It provides as follows: "The child's views must be given due weight, when a case-by-case analysis indicates that the child is capable of forming her or his own views. If the child is capable of forming her or his own views in a reasonable and independent manner, the decision maker must consider the views of the child as a significant factor in the settlement of the issue. Good practice for assessing the capacity of the child has to be developed".

maturity (by adult decision makers). Fortin has argued that the child's right as entrenched in article 12(1) of the UNCRC is about consultation and participation, not about self-determination.[852]

4.3.3 Evolving capacities of the child

Article 5 of the UNCRC introduces, for the first time, the concept of "evolving capacities" of the child.[853] The appearance of the phrase "evolving capacities of the child" is closely related to the recognition of a child as a rights-holder under international law.[854] The phrase "evolving capacities of the child" is meant to inform the manner in which children receive appropriate guidance and direction.[855] In addition, the Committee reiterated the following view stated in 2016:

> The Convention on the Rights of the Child defines a child as every human being below the age of 18 years unless under the law applicable to the child majority is attained earlier and emphasizes that States should respect and ensure the rights embodied in the Convention to each child within their jurisdiction without discrimination of any kind. While the Convention recognizes the rights of all persons under 18 years, the implementation of rights should take account of children's development and their evolving capacities.[856]

Article 5 of the UNCRC does not establish a minimum age for children's participation, but instead emphasises the notion of the evolving capacities[857] of children which is central to the discourse on children's rights.[858] Article 5 provides as follows:

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[852] The UN Committee 2009, para 21 states as follows: 'it is not necessary that the child has comprehensive knowledge of all aspects of the matter affecting him or her, but … has sufficient understanding to be capable of appropriately forming her or his own views on the matter.' See also Jane Fortin, *Children's rights and the developing law* (3rd ed). (New York: Cambridge University Press 2009) 236.

[853] Gerison Lansdown, The Evolving Capacities of the Child (Florence: UNICEF Innocenti, 2005) 6 <https://www.unicef-irc.org/publications/384-the-evolving-capacities-of-the-child.html> accessed on 03 May 2023.

[854] Lansdown, The Evolving Capacities of the Child 6.

[855] Varadan, 'The Principle of Evolving Capacities under the UN Convention.'

[856] United Nations Committee on the Rights of the Child, (2016). General comment No. 20 (2016) on the implementation of the rights of the child during adolescence. (CRC/C/GC/20) <https://www.refworld.org/pdfid/589dad3d4.pdf> accessed on 01 May 2023.

[857] Margaret Brazier and Caroline Bridge, 'Coercion or caring: analysing adolescent autonomy' (1996) 16 Legal Studies 84-109 <https://doi.org/10.1111/j.1748-121X.1996.tb00401.x> accessed on 11 May 2023. They note that "[f]ocusing on chronological age alone ignores the development of that individual and flies in the face of notions of evolving autonomy".

[858] Inter-Agency Working Group on Children's Participation (IAWGCP), Children's participation in decision making: Why do it, When to do it, How to do it (Bangkok 2007) 8 <https://plan-international.org/uploads/2022/01/2007_childrens_participation_in_decision_making_en.pdf> accessed on 11 May 2023.

> States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.[859]

It further places emphasis on the appropriateness of expanding children's participation as active agents in accordance with their relative immaturity and youth.[860] The WHO expresses the following view on the evolving capacities of children:

> The capacity of an adolescent to understand matters that affect changes in their life and health with age and maturity. The more an adolescent knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for him or her can transform direction and guidance into reminders and advice, and later into exchange on an equal footing.[861]

The child's rights under article 5 of the UNCRC thus recognises that parents' role is to offer appropriate direction and guidance, consistent with the child's evolving capacities. The wording of the provision acknowledges, given the historic context, that a child may be judged to lack sufficient maturity and decisional capacity to determine their best interests in relation to various matters. Thus, parents must make important decisions on behalf of their child or children, however, they are to operate within the scope of the evolving developmental capacities of their children. The goal is to support the child's assertion and exercise of their rights.

The provisions of the UNCRC require that with regard to a child's evolving capacities, the phrase 'capable of forming his or her own views' should not be construed as a limitation when assessing capacity, "but rather an obligation to assess the capacity of the child to form an autonomous opinion to the greatest extent possible".[862] Daly proposes that a rights-based model consisting of four basic components should be considered when assessing children's capacity or understanding, namely: autonomy,

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[859] Article 5 UNCRC.

[860] Holly Doel-Mackaway, *Indigenous Children's Right to Participate in Law and Policy Development* (Routledge, 2022) 88.

[861] World Health Organization. (2021). Assessing and supporting adolescents' capacity for autonomous decision-making in health care settings: a tool for health-care providers. World Health Organization p(v) <https://apps.who.int/iris/handle/10665/350208> accessed on 11 May 2023.

[862] UN Committee on the Rights of the Child, General Comment No. 12 (2009), The Right of the Child to Be Heard, 20 July 2009, CRC/C/GC/12 para 20.

evidence, capacity and protection.[863] Autonomy recognises that children have the capacity to take part in decisions affecting them to some extent, and to deny them the right to practice their autonomy consciously and freely should be considered a matter of utmost seriousness.[864] For this reason, assessing the ability of children should be evidence-based and decision-makers must be sufficiently competent to make decisions about childhood, in other words, decision-makers should have a clear understanding of children's decision-making ability.[865] Since children's abilities evolve with maturation and experience to varying degrees, it is thus crucial for children to be given opportunities to practise decision-making and weighing the alternatives, which will enable them to eventually become autonomous.[866] As Bielby stipulates, "[t]his epitomises the growing trend in law and social policy towards nurturing children's eventual independence by supporting autonomous choices in the spheres in which they are capable of exercising such choices".[867]

During the assessment of a child's maturity and mental capacity, the person conducting an assessment must consider children's unique position of relative vulnerability. This position of vulnerability underlines the need to extend special care and protection to children by reason of their physical and mental immaturity.[868] This view has likely influenced the common view that children's views must be respected in accordance with the age and maturity of the child.[869]

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[863] Aoife Daly, 'Assessing Children's Capacity: Reconceptualising our Understanding through the UN Convention on the Rights of the Child' (2020) 28 International Journal of Children's Rights 471.

[864] Daly, 'Assessing Children's Capacity' 472 referring to Article 12 of the UNCRC.

[865] Daly, 'Assessing Children's Capacity' referring to Article 2 of the CRC. See also B Wright B and others, 'Clinical dilemmas in children with life-limiting illnesses: decision making and the law' (2009) 3 Palliative Medicine 238-247 <https://doi.org/10.1177/0269216308099958> accessed on the 02 May 2023.

[866] Simon N Whitney and others, 'Decision making in pediatric oncology: who should take the lead? The decisional priority in pediatric oncology model' (2006) 24 Journal of Clinical Oncology 160-165 <https://doi.org/10.1200/JCO.2005.01.8390> accessed on 02 May 2023. See also Mary Ann McCabe, 'Involving children and adolescents in medical decision making: developmental and clinical considerations' (1996) 21 Journal Pediatric Psychology 505-516 <https://doi.org/10.1093/jpepsy/21.4.505> accessed on 02 May 2023.

[867] Philip Bielby, 'The Conflation of Competence and Capacity In English Medical Law: A Philosophical Critique' (2005) 8 Medicine, Health Care and Philosophy 362 <https://doi.org/10.1007/s11019-005-0537-z> accessed on 02 May 2023.

[868] Daly, 'Assessing Children's Capacity' referring to Article 3 of the UNCRC.

[869] Lansdown 'The Evolving Capacities of the Child.'

In line with this idea, parents supporting autonomy help their children take a more active role and encourage them to assume responsibilities and make choices. As children's capacities evolve, the extent to which a parent or legal guardian can decide on their behalf, will transform the direction of parental guidance. The UN General Comment 20 emphasises this point and clarifies that:

> Article 5 of the Convention 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 his or her parents will have to transform direction and guidance into reminders and gradually to an exchange on an equal footing.[870]

As a result of the above, as children mature, they no longer require the right to appropriate parental direction and guidance. By implication, they should receive less direction and protection from their parents, which will enable them to obtain a more equal role in relationships with adults, including a greater opportunity to think and act independently.[871] It is concluded that assessing children's decision-making capacity may not be straightforward, as it requires an individual assessment of the child's age and his/her maturity in determining the extent of his/her participation.[872] For this purpose and in recognition that children's participation and capacity are integral to their protection, the Committee emphasises that this provision is applicable in all judicial and administrative proceedings affecting the child.[873]

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[870] The UN General Comment 20 (2016) para 18. See also General Comment No. 12, para 84 where the Committee elaborated on this point as follows: "The more the child himself or herself knows, has experience and understands, the more the parent, legal guardian or other persons legally responsible for the child have to transform direction and guidance into reminders and advice and later to an exchange on an equal footing. This transformation will not take place at a fixed point in a child's development but will steadily increase as the child is encouraged to contribute her or his views".

[871] Lansdown, 'The Evolving Capacities of the Child.' See also Beal and others, 'The role of shared decision-making in shaping intent to access services for adolescents in protective custody' (2019) 25 Child Care in Practice 64-78 <https://doi.org/10.1080/13575279.2018.1521379> accessed on 03 May 2023. They note that "when adults have supportive, warm, and nurturing relationships with adolescents and are less controlling, adolescents provide more voice in decision-making" 67.

[872] Daly, Assessing Children's Capacity 493.

[873] UN General Comment 12 para 32. It provides as follows: "Article 12, paragraph 2, specifies that opportunities to be heard have to be provided in particular 'in any judicial and administrative proceedings affecting the child'". The Committee emphasizes "that this provision applies to all relevant judicial proceedings affecting the child, without limitation…"

To explain this in more detail, the UNCRC advises that:

> Evolving capacities should be seen as a positive and enabling process, not an excuse for authoritarian practices that restrict children's autonomy and self-expression … Parents and (others) should be encouraged to offer "direction and guidance" in a child-centred way through dialogue and example, in ways that enhance young children's capacities to exercise their rights…[874]

Hanson and Lundy suggest that given the importance attached to the concept of the child's evolving capacities, article 5 be widely recognised as "a cross-cutting standard" of interpreting international children's rights law under the UNCRC.[875]

4.4 The African Charter on the Rights and Welfare of the Child (African Children's Charter)

The African Children's Charter (ACRWC) was adopted in 1999 and deals with the rights of children in the African context. South Africa became a signatory to the ACRWC in 2000, as such, it is impelled to comply with the obligations imposed on states by the UNCRC.[876] It should be noted that the ACRWC is not opposed to the UNCRC, as it recognises the UNCRC in its preamble:

> Reaffirming adherence to the principles of the rights and welfare of the child contained in the declaration, conventions and other instruments of the United Nations and in particular the United Nations Convention on the Rights of the Child.[877]

The ACRWC further refers to certain rights and freedoms in the preamble that are significant to children, such as:

> Recognising that the child occupies a unique and privileged position in the African society and that for the full and harmonious development of his personality, the child should grow up in a family environment in an atmosphere of happiness, love and understanding.

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[874] UN Committee on the Rights of the Child, General Comment No. 7 (2005), Implementing child rights in early childhood, 20 September 2006, CRC/C/GC/7/Rev.1 para 17.

[875] Karl Hanson, and Laura Lundy, 'Does Exactly What it Says on the Tin? A Critical Analysis and Alternative Conceptualisation of the So-called 'General Principles' of the Convention on the Rights of the Child' (2017) 25 The International Journal of Children's Rights 301-302. <https://doi.org/10.1163/15718182-02502011> accessed on 03 May 2023. See also Lansdown, 'The Evolving Capacities of the Child.'

[876] BD Mezmur, 'The African Children's Charter versus the UN Convention on the Rights of the Child: A zero-sum game?' (2008) 23 SA Publiekreg/ Public Law 1.

[877] Preamble, African Charter on the Rights and Welfare of the Child.

The development of the ACRWC and all processes that led to its adoption were driven by the objective of ensuring that the UNCRC and children's rights were given specific application across the African continent.[878] This was because some member states of the AU believed that the UNCRC does not recognise some of the most important social, cultural, and economic realities of children in the African continent.[879] The ACRWC recognises the importance of human rights and that children are equally entitled to rights and freedoms inherent to all, regardless of their race, sex, ethnic group, religion or other status.[880] It further acknowledges that children require special protection and care due to their physical and intellectual immaturity.[881] It recognises that African children are substantially more likely to experience several forms of human rights violations than adults, they are thus, more vulnerable than children in other continents.[882] There was hence a need for a more elaborate legal framework that can provide "better protection to the African child" encompassing the need for "an African touch to the overall concept of children's rights".[883] This made the ACRWC the first legal instrument at the regional level to comprehensively provide for the rights of the child, especially addressing African children's unique problems.[884] Although the UNCRC and the ACRWC were formulated against different backgrounds, the two treaties are complementary to each other,[885] as they contain several provisions which are more or less similar.[886] Regarding the African child's autonomy, Article 7 of the ACRWC stipulates that:

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[878] Amanda Lloyd, 'Evolution of the African Charter on the Rights and Welfare of the Child and the African Committee of Experts: Raising the gauntlet' (2002) 10 The International Journal of Rights 179-80.

[879] See the ACRWC, Preamble. It must however be noted that child survival was included in the provisions of the Charter. Article 5(2) provides as follows: "State parties to the present Charter shall ensure, to the maximum extent possible, the survival, protection and development of the child".

[880] Preamble, ACRWC.

[881] ACRWC.

[882] Frans Viljoen, The African Charter on the Rights and Welfare of the Child in Boezaart *Child Law in South Africa* (Juta Claremont 2009) 332.

[883] Aron Degol and Shimelis Dinku, 'Notes on the Principle "Best Interest of the Child": Meaning, history and its place under Ethiopian Law' (2011) 3 Mizan Law Review 329.

[884] DM Chirwa, 'The merits and demerits of the African Charter on the Rights and Welfare of the Child' (2002) 10 The International Journal of Children's Rights 157.

[885] Dejo Olowu, 'Protecting children's rights in Africa: A critique of the African Charter on the Rights and Welfare of the Child' (2002) 10 The International Journal of Children's Rights 128.

[886] Ekundayo, 'Does the African Charter on the Rights and Welfare of the Child (ACRWC) only Underlines and Repeats the Convention on the Rights of the Child (CRC)'s Provisions?' 148.

> Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate his opinions subject to such restrictions as are prescribed by laws.[887]

This provision is part of the ACRWC's attempt to eradicate the notion that children in many African countries "are considered incapable of making decisions" and that the responsibility to decide ultimately lies with their parents or male elders.[888] As has already been mentioned, the inclusion of article 7 was motivated by the fact that some African States felt that the UNCRC fell short of adequately addressing African concerns. It must, however, be noted that there is a slight difference between article 7 of the ACRWC and article 12 of the UNCRC in relation to children expressing their views. The UNCRC does not only establish the right of the child to freely express opinions, but also employs the term "due weight" to be given to the views expressed by children. In other words, children's views must not only be heard, but they must be given serious consideration in alignment with the age and maturity of the child. The ACRWC, on the other hand, does not contain a phrase indicating the significance that should be accorded to the opinions of the child. It simply stipulates that such opinions will be subject to such restrictions as are prescribed by laws,[889] thus making it unclear how those views should be regarded or treated. Kassan[890] alleges that it may be inferred that the use of the words "to be heard" in reference to the views of the child places a duty on the relevant person or authority to ensure that the child's expressed view is considered in conformity with the provision, irrespective of age and maturity.

The "best interests" standard is one of the grounding principles of the ACRWC.[891] Article 4(1) asserts that:

> In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.[892]

Some scholars have concluded that although the ACRWC adopts a similar approach to the UNCRC in requiring that "in all actions concerning the child undertaken by any

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[887] Article 7 of the ACRWC.

[888] Admark Moyo, Balancing Child Participation Rights, Parental Responsibility and State Intervention in Medical and Reproductive Decision Making under South African Law (PhD thesis Cape Town 2014).

[889] Article 7 of the ACRWC.

[890] Daksha Gaman Kassan, How can the voice of the child be adequately heard in family law proceedings? (LLM Thesis University of the Western Cape, South Africa 2004).

[891] Viljoen, 'The African Charter on the Rights and Welfare of the Child' 219.

[892] Article 4 of ACRWC.

person or authority, the best interests of the child shall be *the* primary consideration" (own emphasis),[893] the ACRWC's provisions offer a slightly higher standard of protection to the rights of children than the UNCRC's.[894] They argue that the use of the phrase, "a" primary consideration in the UNCRC, requires the best interests to be simply "a consideration" or one consideration among others,[895] meaning that other principles can be taken into account alongside it. On the other hand, "the" primary consideration elevates the best interests principle to an overriding consideration, meaning that it will take priority over others, thus setting a higher level of protection to children.[896] Parker comes to a similar conclusion:

> I only need to emphasize that whilst [article 3(1)] binds a broader group of decision-makers than typically do the stronger formulations, the best interests of the child are only 'a primary' consideration. Clearly "a" is weaker than "the" and, arguably, "primary" is weaker than "paramount".[897]

It is worth noting that although the UNCRC and the ARCWC employ the words "a primary" and "the primary" consideration respectively, section 28 of the South African Constitution does not refer to the word "primary" with regard to children's best interests but uses the word "paramount". The Constitution hence treats children's interests with utmost seriousness as the word "paramount" suggest that "nothing except the best interests of the child matters".[898]

Another striking deviation between the UNCRC and the ACRWC is regarding the concept of "a child". A child is defined as "every human below the age of 18 years"[899] with no exceptions provided. Consequently, unconditional protection is afforded to all people under the age of 18 without limitations in terms of the ACRWC.[900]

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[893] Article 4 of the ACRWC.

[894] Skelton, 'Too much of a good thing?'

[895] Rachel Murray, *Human Rights in Africa: from the OAU to the African Union* (Cambridge University Press 2004) 167.

[896] Murray, *Human Rights in Africa* 167.

[897] Parker, 'The best interests of the child-principles and problems' 28.

[898] Admark Moyo, 'Reconceptualising the 'paramountcy principle': Beyond the individualistic construction of the best interests of the child' (2012) 12 African Human Rights Law Journal 143.

[899] Article 2, ACRWC.

[900] Michael Gose, The African Charter on the Rights and Welfare of the Child: An assessment value of its substantive provisions by means of a direct comparison to the Convention on the rights of the Child (Mini Thesis LLM, University of the Western Cape, 2002) 11.

4.5 Medical decision-making for children

Article 24 of the UNCRC sets out that the right of children to health care should be as best as possible. It obligates states to recognise the right of the child to the enjoyment of the "highest attainable standard of health". It further stresses that ensuring the well-being of the child requires state parties to "ensure that no child is deprived of his or her right of access to such health care services".[901] Article 14 of the ACRWC similarly provides that "[e]very child shall have the right to enjoy the best attainable state of physical mental and spiritual health".[902]

It is important to note that both the UNCRC and the ACRWC recognise children as rights-holders and autonomous beings. They further guarantee children several participatory rights entrenched in articles 7[903], 8[904] and 9[905] of the ACRWC as a routine focal point.

Autonomy is a widely valued key ethical principle in health care. Chapter 2 of this thesis has pointed to the inclusion of respect for autonomy as a key concern in biomedical ethics.[906] Respect for autonomy is compatible with human rights, as it enables patients to freely and voluntarily make their own decisions on medical treatment preferences.[907] Health care providers are obligated to allow patients to

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[901] Article 24 of the UNCRC.

[902] Article 14 of the ACRWC.

[903] It accords the child's right to expression by providing as follows: "Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate his opinions subject to such restrictions as are prescribed by laws."

[904] Freedom of association. Its provision states as follows: "Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law".

[905] Freedom of thought, conscience and religion. It stipulates as follows:
"1. Every child shall have the right to freedom of thought, conscience and religion.
2. Parents, and where applicable, legal guardians shall have a duty to provide guidance and direction in the exercise of these rights having regard to the evolving capacities, and best interests of the child.
3. States Parties shall respect the duty of parents and where applicable, legal guardians to provide guidance and direction in the enjoyment of these rights subject to the national laws and policies".

[906] Susan Sherwin, A relational approach to autonomy in health care. In E. Boetzkes & W. J. Waluchow. (Eds.), *Readings in health care ethics* (2000) 69-87.

[907] Jianli L Song, 'Autonomy and Intervention in Medical Practice' (2018) 8 Open Journal of Philosophy 294-307 <https://doi.org/10.4236/ojpp.2018.83021> accessed on 08 May 2023. See also V A Entwistle and others, 'Supporting patient autonomy: the importance of clinician-patient relationships' (2010) 25 Journal of General Internal Medicine 741-745 <https://doi.org/10.1007/s11606-010-1292-2> accessed on 08 May 2023 .

practice their autonomy and make informed decisions about their health care. Varkey explains this as follows:

> Respecting the principle of autonomy obliges the physician to disclose medical information and treatment options that are necessary for the patient to exercise self-determination and supports informed consent, truth-telling, and confidentiality.[908]

It must be conceded that not all children are meaningfully participating in their health care decisions. A child's decision to the preferred medical intervention is often overridden. A child's decision in this context is often subject to the oversight or to restrictions laid down by their parents and sometimes other adults. In this instance, the values and beliefs of the decision-makers are used to validate and justify the choices made for the child. This may be one of the factors which may obstruct the realisation of the child patient's autonomy. Some are of the view that parents should have total control, as children are considered immature and cannot be responsible for making decisions.[909] James and Prout argue that adults are, from a cognitive and developmental perspective, predominantly considered 'mature, rational, competent, social and autonomous' unless there is evidence to the contrary. On the other hand, children are viewed as "immature, irrational, incompetent, asocial and acultural".[910] Children are, as a consequence, regarded as vulnerable, dependent and lacking competency, and generally seen as having not reached a mature capacity to express their autonomy. This position has historically been the accepted practice in health care ethics.

The inclusion of children may fluctuate, as some children may not desire complete autonomy but mere involvement in decisions affecting their health. In such circumstances, the child may completely trust in his or her parents' ability to make sound decisions.[911] This view is supported by Diekema who maintains that parents

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[908] Varkey, 'Principles of Clinical Ethics and Their Application to Practice.'

[909] Erica K Salter, 'Deciding for the child: a comprehensive analysis of the best interest standard' (2012) 33 Theoretical Medicine and Bioethics 179-198. He argues that "Decisions about a child's course of treatment affect not only the life and welfare of that child, but they often involve very significant financial, relational, and emotional consequences for the rest of the family".

[910] Allison James and Alan Prout, Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood (1st edn, Routledge 2014) 11.

[911] Maya Sabatello and others, 'Pediatric Participation in Medical Decision Making: Optimized or Personalized?' American Journal of Bioethics (2018) 18 1-3 <https://doi.org/10.1080/15265161.2017.1418931> accessed on 08 May 2023.

"[w]ill usually be better situated than others to understand the unique needs of their children, desire what's best for their children, and make decisions that are beneficial to their children".[912]

Diekema's views are that because parents are better placed to know their children's preferences; they should thus, be allotted a degree of authority over their children's health care decisions.[913] As discussed earlier in this thesis, others regard children as subjects with rights and not merely as subjects in need of protection. Some children, like adults, may feel resentful when decisions are imposed upon them.[914] In the health care context, the imposer often decides that the patient "should" only take up the imposer's preferred treatment option. As one young patient once observed:

> [I]f you don't put your point across, then they make the decision, and if you don't like the decision, it just blows up in your face, and in their face too, and causes more trouble. It's better to have a say when it's needed.[915]

Autonomy, however, does not exist in isolation, as there are other medical principles currently in the health care ethics domain that may assist in guiding medical care. Chapter 2 of this thesis has explained that Childress and Beauchamp became pioneers in the health care sector with their 1979 publication *Principles of Biomedical Ethics.* They developed and advocated a framework of the four influential principles in bioethics: respect for autonomy, nonmaleficence, beneficence, and justice.[916] Whilst, autonomy has been discussed above, it is useful to reiterate that beneficence requires that actions taken by health care providers must be in the best interests of the patient, thus taking all appropriate actions for the benefit of the patient.[917] Non-maleficence is the principle that involves an ethical and legal duty to desist from harming a patient.

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[912] Douglas S Diekema, 'Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention' (2004) 25 Philosophy of Medical Research and Practice 244 <https://doi.org/10.1007/s11017-004-3146-6> accessed on 08 May 2023.

[913] Cressida Auckland and Imogen Goold, 'Parental Rights, Best Interests and Significant Harms' (2019) 78 Cambridge Law Journal 287-323. <https://doi.org/10.1017/S0008197319000382> accessed on 08 May 2023.

[914] Judy Cashmore, 'Promoting the participation of children and young people in care' (2002) 26 Child Abuse and Neglect 26 (2002) 837-847 <https://doi.org/10.1016/S0145-2134(02)00353-8> accessed on 08 May 2023.

[915] P Spall, P Testro and R Matchett, Having a say (Sydney: New South Wales Child Protection Council 1998) 113.

[916] Beauchamp and Childress, Principles of Biomedical Ethics.

[917] Robert M Taylor, 'Ethical principles and concepts in medicine' (2013) 118 Handbook of Clinical Neurology 1-9 <https://doi.org/10.1016/B978-0-444-53501-6.00001-9> accessed on 08 May 2023.

This principle is based on the Latin phrase, *primum non nocere*, which translated means "First do no harm". Justice includes the general principle of fairness and equality under the law. It requires that the benefits and risks associated with health care should be equitably shared in society without bias.[918] Beauchamp and Childress explain that justice is "fair, equitable, and appropriate treatment in light of what is due or owed to persons". They further state that injustice involves a wrongful act or omission that denies people resources or protections to which they have a right".[919] These principles also apply to children as patients or health research participants.

In 2003, UNICEF developed a program aimed at strengthening and promoting children's rights in the 21st century. With reference to child participation, the program provides as follows:

> Children and adolescents are resourceful citizens capable of helping to build a better future for all. We must respect their right to express themselves and to participate in all matters affecting them, in accordance with their age and maturity.[920]

Vedasto and others also value and respect the participation of children in decisions that impact them, including health care decisions. They hold that "shared decision making empowers patients with ability of voicing their preferences, participation in self-management and adherence to chosen treatment plans".[921]

4.5.1 Gillick and West Norfolk and Wisbech Area Health Authority and Another[922]

The *Gillick* case concerns a 15-year-old girl in the UK who consulted her general practitioner (GP), seeking access to contraception. This English House of Lords case became a landmark decision for establishing the legal position regarding a minor's capacity to consent. The girl in this case tried to obtain access to contraception to the exclusion of her parents' knowledge and permission. The treating GP was, however,

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[918] Taylor, 'Ethical principles and concepts in medicine.'

[919] Beauchamp and Childress, *Principles of Biomedical Ethics.*

[920] UNICEF, 'A World Fit For Children' (UNICEF, July 2008) at 16. <https://www.unicef.org/serbia/media/7321/file/A%20world%20fit%20for%20children.pdf> accessed on 11 May 2023.

[921] Osward Vedasto, Baraka Morris and Francis F Furia, 'Shared decision-making between health care providers and patients at a tertiary hospital diabetic Clinic in Tanzania' (2021) 21 BMC Health Services Research <https://doi.org/10.1186/s12913-020-06041-4> accessed on 10 May 2023.

[922] [1986] A.C. 112.

uncertain as to the legal requirements of providing such a young girl access to contraception without her parent's knowledge or consent. Victoria Gillick, the mother of this 15-year-old girl, lodged an application challenging the legality of the Memorandum of Guidance issued by the UK's Department of Health and Social Security (DHSS) to National Health Service (NHS) authorities. This Guidance recommended that doctors may in exceptional circumstances be legally permissible to give contraceptive advice and to prescribe treatment to children under 16 years without their parents' consent or knowledge.[923]

Victoria Gillick raised an argument that a physician, legally cannot "prescribe contraception for a girl under 16 years of age without the consent of her parents".[924] She challenged the assumption that children under the age of 16 could be treated without parental consent under common law, and thus wanted the DHSS guidance to be declared unlawful. The issue that the court had to determine was whether a medical practitioner in the UK is ever legally allowed to provide contraceptive advice and prescribe contraceptives to a person under the age of 16, without parental knowledge or consent. In his leading judgment, Lord Fraser stated that to the extent permitted by the welfare of the child, parental consent may be forsaken in order to give effect to the child's consent.[925] He outlined five pre-conditions regarding when it would be in the interests and welfare of the child to provide advice to a person under the age of 16 regarding contraception and sexual health without parental knowledge and consent. These conditions are: (i) the maturity and intelligence of the child to understand the nature and implications of the treatment proposed; (ii) if it is impossible for the doctor to persuade the child to inform her parents about the advice sought; (iii) the likelihood that the girl is to begin or to continue having sexual intercourse with or without contraceptive treatment; (iv) the likelihood of the girl suffering physical or mental health or both, unless she receives contraceptive advice or treatment; and (v) it is in the child's best interests to be given contraceptive advice, treatment or both without parental consent.[926]

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[923] 179-180; HN(80)46, section G

[924] *Gillick* case

[925] Lord Fraser at 162. Lord Fraser continues at 173 that "It is notorious that children of both sexes are often reluctant to confide in their parents about sexual matters, and … to abandon the principle of confidentiality … might cause some of them not to seek professional advice at all, with the consequence of exposing them to 'the immediate risks…"

[926] Lord Fraser at 162.

The matter was heard in three courts, following Victoria Gillick's unsuccessful attempt in the court of first instance. The matter was thereafter taken to the Court of Appeal, which found in Ms Gillick's favour. The DHSS subsequently appealed to the House of Lords where the Guidance was found *not* to be unlawful. In his judgement, Lord Scarman explained that:

> […] the parental right yields to the child's right to make his [sic] own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.[927]

The Lordships declared a child under 16 as having legal competence to consent to a medical examination and treatment depending on the maturity and intelligence to understand what is involved.[928]

Broadly, therefore, it is required that the decision maker must have (a) the capacity to understand the information, (b) the decision must be based on adequate information provided and (c) the consent must be voluntarily given.[929] In this context, the child must possess sufficient maturity and intelligence to understand and appraise the nature and implications of the treatment. The court, exercising its authority on the grounds of *parens patriae*,[930] recognised that in certain circumstances and under certain conditions being met, it is in the best interests or the welfare of the child to consent to medical treatment without parental knowledge or consent. Lord Fraser held that a doctor is in certain and exceptional circumstances entitled to provide contraceptive or sexual health advice and treatment in the absence of parental

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[927] Lord Fraser at 186.

[928] *Gillick* case.

[929] Pieter Carstens and Debbie Pearmain, *Foundational Principles of South African Medical Law* (LexisNexis South Africa 2007) 465. See also *Halushka v University of Saskatchewan* [1965] 52 WWR 608 Canada [para 705]. Hall J argued that: "In order for consent to be effective, it must be informed consent, freely given and it is the duty of the doctor to give a fair and reasonable explanation of the proposed treatment including the probable effect thereof and any special or unusual risks. Such being the duty owed by a physician to his patient in ordinary medical practice…"

[930] Graeme T Laurie, 'Parens Patriae Jurisdiction in the Medico-legal Context: The Vagaries of Judicial Activism' (1999) 3 Edinburgh Law Review 95-107 <https://doi.org/10.3366/elr.1999.3.1.95> accessed on 15 May 2023. He sketches the history of the courts' parens patriae doctrine as the legal basis for courts' jurisdiction. He traces it back to feudal times, emanating from: "the monarch as the ultimate superior, empowered with jurisdiction … over the administration of justice in those lands and, indeed, with jurisdiction over the very "person" of those who inhabited the land. In this latter respect the monarch was parens patriae -- parent of the country--and, as such, had the right and duty to care for those not able to care for themselves".

consent. There is hence a clear overlap between the child's autonomous consent and parental rights and duties that the court had to untangle in reaching its decision. In his judgment, Lord Scarman stated that:

> [a]s a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law.[931]

With this case quickly becoming a benchmark for children's consent to medical treatment under English law, the term *Gillick competent* was coined. This term is used by judges and health professionals as an objective test to identify children aged under 16 who have the necessary legal competence to consent to medical interventions.[932] The conditions, however, are that those children should demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of action.[933]

The notion of *Gillick competent* quite clearly considers the developmental stages and varying levels of maturity and intelligence that normal children may demonstrate, including their particular needs.[934] Lord Scarman, however, in his judgement in the *Gillick* case, rejected the idea of fixed guidelines outlining the exact age of capacity to consent. He held as follows:

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[931] At 188 and 189. See also the case of *Re R* (1992), where Lord Donaldson in appreciating the different aspects of maturity involved, said the following in reference to Gillick: "[w]hat is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age … It should be added that in any event what is involved is not merely an ability to understand the nature of the proposed treatment…but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and equally important, the anticipated consequences of failure to treat".

[932] Malcolm K Smith, 'Leading Gillick Astray? An Analysis of the Law of Consent Relevant to Trans and Gender Diverse Minors and the Commencement of Gender-Affirming Hormone Treatment' (2023) 12 Laws 26.

[933] At 189, Lord Scarman addresses a variety of things a girl needs to understand in relation to contraceptive advice and treatment. "[T]here is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice that is being given: she must also have sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate".

[934] Paula Boddington and Maggie Gregory, 'Adolescent Carrier Testing in Practice: The Impact of Legal Rulings and Problems with "Gillick Competence"' (2008) 17 Journal of Genetic Counselling 509-521 <https://doi.org/10.1007/s10897-008-9168-x> accessed on 13 May 2023.

> If the law should impose upon the process of growing up fixed limits where nature knew only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.[935]

Lord Fraser suggested a balanced approach between parental decision-making powers and the *Gillick competent* child's decision-making, thus recognising that a child's decision-making capacity should occur in exceptional circumstances.[936]

It would be fair to conclude that the *Gillick competent* test moved beyond an arbitrary age of consent towards respect for individual children's abilities.[937] The standard used in the *Gillick competent* tests may be seen as a yardstick that is proportionate to the child's competence and not one that is achieved by age or adulthood.

4.5.2 When should a child be deemed to be 'Gillick competent'?

The notion of *Gillick competent* has become a medico-legal term and a key platform for medical decision making in the case of children.[938] It is used mostly to assess a functional ability of a child to consent to their own medical treatment.[939] This notion presupposes that the consent of a child who is considered *Gillick competent* carries the same weight and effect as that of an adult and cannot be overridden by the child's parents.[940] Consequently, the child will have the same entitlements as an adult to exercise the right of self-determination. In this regard, Sheriff McGowan stated the following *In Re Houston*:

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[935] At para 186. Lord Fraser further stated that "[P]rovided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises. After all, a minor under the age of 16 can, within certain limits, enter into a contract. He or she can also sue and be sued and can give evidence on oath. I am not disposed to hold now, for the first time, that a girl aged less than 16 lacks the power to give valid consent to contraceptive advice or treatment, merely on account of her age.''

[936] *Gillick* case at 162.

[937] Priscilla Alderson, 'Competent children? Minors' consent to health care treatment and research' (2007) 65 Social Science and Medicine 2272-2283 <https://doi.org/10.1016/j.socscimed.2007.08.005> accessed on 14 May 2023.

[938] Nigel Zimmermann, 'Gillick Competence: An Unnecessary Burden' (2019) 25 A Multidisciplinary Journal of Biotechnology and the Body 78-93 <https://doi.org/10.1080/20502877.2019.1564004> accessed on 14 May 2023.

[939] Richard Griffith, 'What is Gillick competence?' (2016) 12 Human Vaccines and Immunotherapeutics 244-247 <https://doi.org/10.1080/21645515.2015.1091548> accessed on 14 May 2023.

[940] Griffith, 'What is Gillick Competence.'

> It seems to me illogical that, on the one hand a person under the age of 16 should be granted the power to decide upon medical treatment for himself while, on the other hand, his parents have the right to override his decision […] [L]ogic demands that the minor's decision is paramount.[941]

The *Gillick competent* test is also firmly entrenched in the UNCRC. This is because the UNCRC provisions recognises the right of a child to be heard in legal matters affecting him/her.[942] The UNCRC further recognises that the decision makers must consider the wishes of the child, with the weight determinate on the child's age, capacity and maturity.[943] In *Re T*[944] Lord Justice Butler-Sloss concurred with the judgment of Mr. Justice Robins in *Malette v Shulman*,[945] and stated as follows:

> The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.

The court, in the case of *In Re Marriage of Doyle*,[946] decided in 1993, considered the issue of how the wishes of the child should be heard by applying the *Gillick competent* test. The court observed as follows:

> If the court is satisfied that the wishes expressed by the child are soundly based and founded upon proper considerations as well thought through as the ability and state of maturity of the child will allow, it is appropriate to have regard to those wishes and give such weight to them as may be proper in the circumstances.[947]

As mentioned above, the *Gillick competent* test does not necessarily reflect on the child's chronological age to assess his/her level of maturity. *Gillick competent* acknowledges that the measure of the extent to which a child's input is considered, depends on the competency of the chid to maturely express wishes and feelings that are central to the decision-making process.

Some courts during the 1990s demonstrated some reluctance to recognise certain minors as competent, thus narrowing the scope and application of the *Gillick* ruling.

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[941] *Re Houston* (1996) SCLR 943, para O.
[942] Article 12(1) of the UNCRC.
[943] Article 12(1) of the UNCRC.
[944] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112E.
[945] *Malette v Shulman* (1990) 67 DLR (4th) 321, 336b.
[946] *Re Marriage of Doyle* (1993) 106 FLR.
[947] *Re Marriage of Doyle* at 125.

For example, in *Re J (A Minor) (Wardship: Medical Treatment)*,[948] Lord Donaldson noted that "there will be cases in which ... it is not in the best interests of the child to subject it to treatment which will cause it increased suffering and produce no commensurable benefit".[949] He emphasised in his judgement that there are situations where the wishes of a young person can be overruled, including the wishes of the child who is found to be *Gillick competent*.[950]

In the matter of *An NHS Trust v MB* (*A Child Represented by CAFCASS as guardian ad litem*),[951] Lord Holman summarised the role of the court as follows:

> The role and duty of the court is to exercise its own independent and objective judgment. The right and power of the court arises only because the child lacks the capacity to make a decision for himself. The matter must be decided by the application of an objective test and that test is the best interests of the patient. Best interests include medical, emotional, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations. Considerable weight must be attached to the prolongation of life but it is not an absolute. All these cases depend entirely on the facts of the individual case. The views and opinions of both the doctors and the parents must be carefully considered. Parental views may have particular value because they know the patient and how he reacts so well, but parental wishes, however understandable in human terms, are wholly irrelevant to the consideration of the objective best interests of the child save to the extent that they may illuminate the quality and value to the child of the child/parent relationship.

In these cases, although the courts accepted the children's capacities to make independent decisions, they however, curtailed the endorsement of what both the courts and those caring for the child perceived as "irrational" choices.[952] Consequently, these cases suggests that the *Gillick competent* principle can be restricted in relation to those cases where (i) the child's rationality is in question (and where the capacity of the child would consequently be in doubt), or where (ii) the child is deemed too

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[948] *Re J (A Minor) (Wardship: Medical Treatment)* [1990] 3 All ER 930.

[949] *Re J* case 939.

[950] In this case, Lord Donaldson argued that in the Gillick ruling: "Lord Scarman was discussing the parent's right to determine whether or not their minor child below the age of 16 will have medical treatment … a right of determination is wider than a right of consent… I do not understand Lord Scarman to be saying that, if a child was 'Gillick competent' … the parents ceased to have a right of consent as contrasted with ceasing to have a right of determination, i.e. a veto. In a case in which the 'Gillick competent' child refuses treatment, but the parents' consent, that consent enables treatment to be undertaken lawfully".

[951] *An NHS Trust v MB* (A Child Represented by CAFCASS as guardian ad litem) [2006] EWHC 507 (Fam).

[952] Caroline Bridge, 'Adolescents and mental Disorder: Who consents to treatment?' (1997) 3 Medical Law International 51-74 <https://doi.org/10.1177/096853329700300103> accessed on 15 May 2023.

young, thus incapacitated to make informed decisions. In this context, the UK's Children Act[953] makes provision for situations where a person who is said to have "parental responsibility" is entitled to take decisions on behalf of the child, with the overarching principle being consideration of the child's best interests. The Act further, highlights specific elements that should be considered when determining the child's best interest, referred to as a "welfare checklist".[954] Section 22(4)[955] of the Act is aligned with Article 12 of the UNCRC. They both impose a duty on authorities and decision-makers to ascertain the child's wishes and feelings as reasonably practicable, before making any decision with respect to a child. In accordance with section 22(5),[956] due consideration must be given to those wishes and feelings, however, the decision-makers ought to have regard to the context of the child's age and understanding.

4.5.3 Application of the Gillick Competent in Bell v Tavistock and Portman NHS Foundation Trust

The British case of *Bell v Tavistock and Portman NHS Foundation Trust*[957] raised controversial issues relating to young persons' capacity to consent to PB's for gender dysphoria. This case concerned a judicial review proceeding brought by two claimants, Keira Bell and Mrs A. Mrs A was the mother of a child presenting with gender dysphoria

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[953] The Children Act 1989.

[954] Section 1 (3) of the Act. It provides that "In the circumstances …, a court shall have regard in particular to—
(a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);
(b) his physical, emotional and educational needs;
(c) the likely effect on him of any change in his circumstances;
(d) his age, sex, background and any characteristics of his which the court considers relevant;
(e) any harm which he has suffered or is at risk of suffering;
(f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;
(g) the range of powers available to the court under this Act in the proceedings in question".

[955] Section 22(4) states that "Before making any decision with respect to a child whom they are looking after, or proposing to look after, a local authority shall, so far as is reasonably practicable, ascertain the wishes and feelings of— (a) the child;
(b) his parents;
(c) any person who is not a parent of his but who has parental responsibility for him; and
(d) any other person whose wishes and feelings the authority considers to be relevant, regarding the matter to be decided".

[956] Section 22(5) provides that "In making any such decision a local authority shall give due consideration— (a)having regard to his age and understanding, to such wishes and feelings of the child as they have been able to ascertain…"

[957] *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274.

and who had been referred to Tavistock for treatment, yet she did not receive such treatment. Keira Bell on the other hand, had previously been a patient of the Tavistock's Gender Identity Development Service (GIDS). She launched a legal action against the GIDS in 2019. Keira Bell was born female and had been prescribed PB's to halt the process of developing female sexual characteristics at 16. She eventually transitioned into a male after having taken the male hormone testosterone to promote male characteristics and underwent surgery to remove her breasts. She was initially happy with the treatment she received, however, she had regrets later about her decision to transition and wished to revert back to being female. She was quoted as saying: "I was treated like an experiment" and "I want the message of cases like mine to help protect other kids from taking a mistaken path".[958] She expressed her disapproval and critiqued the Tavistock Clinic for failing to properly challenge her original decision to transition. The defendant, Tavistock and Portman NHS Foundation Trust, provided specialist medical treatment for children and young people experiencing gender dysphoria through GIDS and had been in operation since 1989. The NHS Trust conducted proper assessments before the administration of certain hormone or PB's prescribed to those aged 12 to 15.

The provision of *Gillick competent* assessments would require, in the context of those clinicians providing the treatment, that they (the clinicians) had enough understanding about a proposed treatment, and the consensual requirements relating to the prescribing of PB's. The prescription of cross-sex hormones would only be possible to patients from around the age of 16 years. The NHS Foundation Trust's practice was to require the informed consent of children and young persons recommended for such treatment through its service. The legal action relating to the case above was to challenge the practice of prescribing PB's treatment to children, as well as to determine whether the information provided to children can be considered sufficient enough to enable them to make informed decisions and provide valid consent to the proposed treatment. The applicants, therefore, sought confirmation of their argument that children under the age of 16 years and those between 16 and 17 years old were not capable of legally providing informed consent to trans health care.

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[958] Keira Bell, 'Keira Bell: My Story' 7 April 2021 Persuasion <https://www.persuasion.community/p/keira-bell-my-story> accessed on 16 May 2023.

In December 2020, the court ruled in Keira Bell's favour, thus modifying the *Gillick competency* test.[959] The court expressed considerable doubt as to whether a person as young as ten years old could possess sufficient understanding and intelligence to be considered legally *Gillick competent* in order to consent to medical treatment.[960] The court subsequently held that it was highly unlikely that children aged 13 or younger could be considered *Gillick competent* to consent to PB treatment. The court furthermore observed that:

> It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences. It is highly unlikely that a child aged 13 or under would be competent to give consent.[961]

In respect of persons between 16 and 18, the court held that:

> […] there is a presumption that they have the ability to consent to medical treatment […] [W]e recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.[962]

The court concluded that a legal presumption operates for children between the ages of 16 and 18, unless there is significant evidence to suggest otherwise, thus creating a rebuttable presumption. The presumption can be rebutted in terms of sections 2(1)[963] and 3(1)[964] of the Mental Capacity Act 2005 (MCA 2005), which applies to persons of

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[959] *Bell* case.

[960] *Bell* case at 105.

[961] *Bell* case at 151.

[962] *Bell* case at 152.

[963] It provides that "For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

[964] It provides as follows: "For the purposes of section 2, a person is unable to make a decision for himself if he is unable— (a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means)".

the age of 16 and above.[965] These children may be treated, based on an assessment of their best interests, set out in section 4 of the MCA 2005.[966]

As can be garnered from the court's findings, Bell's evidence to the effect that PB's were considered *experimental* was significant for the Divisional Court and played a

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[965] *An NHS Trust v X* [2021] 4 WLR 11 at [77]. Sir James Munby provides that: "In relation to the 2005 Act, as before, the Donaldson analysis continues to apply, subject only to the refinement referred to in paragraph 57 above: (1) Until the child reaches the age of 16 the relevant inquiry is as to whether the child is Gillick competent. (2) Once the child reaches the age of 16: (i) the issue of Gillick competence falls away, and (ii) the child is assumed to have legal capacity in accordance with section 8, unless (iii) the child is shown to lack mental capacity as defined in sections 2(1) and 3(1) of the Mental Capacity Act 2005".

[966] The section stipulates as follows: "(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of— (a) the person's age or appearance, or
(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
(3) He must consider— (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
(b) if it appears likely that he will, when that is likely to be.
(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
(6) He must consider, so far as is reasonably ascertainable—
(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
(b) the beliefs and values that would be likely to influence his decision if he had capacity, and
(c) the other factors that he would be likely to consider if he were able to do so.
(7) He must take into account, if it is practicable and appropriate to consult them, the views of—
(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b) anyone engaged in caring for the person or interested in his welfare,
(c) any donee of a lasting power of attorney granted by the person, and
(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—
(a) are exercisable under a lasting power of attorney, or
(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.
(10) 'Life-sustaining treatment' means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
(11) 'Relevant circumstances' are those—
(a) of which the person making the determination is aware, and
(b) which it would be reasonable to regard as relevant".

role in the court's decision.[967] The ruling that children under 16 are unlikely to be able to legally consent to gender affirming care treatment led to the suspension of PB's prescribed by clinicians to children under the age of 16. These children could henceforth not be treated for gender dysphoria with PB's and cross-sex hormones.

In September 2021, following the Divisional Court's judgement barring treatment to under 16-year-old children, the NHS appealed the ruling.[968] The appeal was successful and the Divisional Court's decision was subsequently overturned. The Court of Appeal acknowledged "the difficulties and complexities" involved in determining whether a child under 16 is capable to consent to the prescription of PB's, especially if the child seeks to obtain treatment without parental consent and involvement. In its conclusions, the court observed as follows:

> We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in Gillick, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As Gillick itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested. [969]

Although the Court of Appeal did not find GIDS's policies and procedures to be unlawful, it held that the High Court was "not equipped" to decide on the capacity of trans children to consent to their own medical treatment. The court maintained that the Divisional Court "was not in a position to generalise about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of PBs".[970] The Court of Appeal's decision re-established the *Gillick competent* test and re-affirmed that it is for the clinicians, together with the patient and the family, to make health care decisions that align with the patient's

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[967] At para 147, the court found that puberty blockers and cross-hormones treatment had such significant and long-term effects and it should be described as 'experimental' in nature, "it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to … the long-term best interests of a 16 or 17 year old".

[968] *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363.

[969] *Bell & Anor* case at 92.

[970] *Bell & Anor* case at 85.

individual circumstances.[971] Not only was the Divisional Court cautioned that it is not in its position to make generalisations about minors' capacity to consent at different ages, the Court of Appeal also held that the court should not routinely be part of the consent process for PBs:

> The ratio decidendi of Gillick was that it was for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment. Nothing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception in Gillick and of puberty blockers in this case bearing in mind that, when Gillick was decided 35 years ago, the issues it raised in respect of contraception for the under 16s were highly controversial in a way that is now hard to imagine. A similar conclusion was reached by Silber J in connection with abortion in R (Axon) v. Secretary of State for Health [2006] QB 539 at para [86].[972]

The Court of Appeal also held that it was inappropriate for the Divisional Court to provide guidance in the terms it had done,[973] as this amounted to an improper restriction on the *Gillick* test of competence. By implication, no unique restrictions should be placed on a person's ability to consent by virtue of him/her being trans. The court concluded that:

> [t]he effect of the guidance was to require applications to the court in circumstances where the Divisional Court itself had recognised that there was no legal obligation to do so. It placed patients, parents and clinicians in a very difficult position. In practice the guidance would have the effect of denying treatment in many circumstances for want of resources to make such an application coupled with inevitable delay through court involvement.[974]

The court further held that:

> We conclude that it was inappropriate for the Divisional Court to give the guidance concerning when a court application will be appropriate and to reach general age-related conclusions about the likelihood or probability of different cohorts of children being capable of giving consent. That is not to say that such an application will never be appropriate. There may be circumstances where there are disputes between one or more of clinicians, patients and parents where an application will

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[971] The Court of Appeal at para 81 indicated that the statement of "law is found in the first sentence but the second recognises that the question whether valid consent is given in any case is a question of fact. That depends upon the individual circumstances of any child and the surrounding circumstances of the clinical issues".

[972] *Bell & Anor* case at 72.

[973] This is despite the fact that the court recognised that the provision of guidance "stemmed from the understandable concern of the Divisional Court for the welfare of children suffering from gender dysphoria who, it is common ground, are deeply distressed and highly vulnerable". 85.

[974] *Bell & Anor* case at 86.

> be necessary, even if they are difficult to envisage under the service specification and SOP with which this case is concerned.[975]

The Court of Appeal's ruling dictated that there was no "real distinction" between minors being prescribed PBs and minor children being *Gillick competent* to receive contraception, hence, there was no justification for the modification of the *Gillick competent* test.[976] The Divisional Court was found to have erred in its application of the law relating to *Gillick competence*.

It is clear from the *Bell* case that the Divisional Court gave much consideration to the effects of PBs, including their 'irreversible' effect. Disappointingly, these judgments did not take into consideration other relevant issues which could affect minors experiencing persistent gender dysphoria who cannot receive PBs. The Tavistock Clinic omitted to put forward an argument that trans children would be at a disadvantage if they are denied access to PBs puberty. The substantial negative impact of denying them access to PBs is that the growth of sexual characteristics cannot be halted, and consequently the child will suffer irreversible body changes that can be emotionally and mentally distressful and potentially harmful for them.

4.5.4 AB v CD and others

In March 2021, in another English case, *AB v CD and others*,[977] parents sought a declaration to lawfully consent to their child receiving PBs, including a determination whether PBs should be classed as a *special* category of medical intervention requiring court authorisation. The case of *Bell* did not consider the question whether parents could consent to the administration of PBs or any related treatment on behalf of their children. Lieven J re-affirmed the *Gillick's* ruling that parents' rights cannot trump the decision of a child who is *Gillick competent*. However, in situations where the child cannot make the decision, parents have the legal right to provide consent on behalf of such a child.[978] Lieven J also clarified that hormone treatment that suppresses puberty

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[975] *Bell & Anor* case at 89.

[976] *Bell & Anor* case at 76. The court stated that: "Nothing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception in Gillick and of puberty blockers in this case".

[977] *AB v CD and others* [2021] EWHC 741 (Fam).

[978] Lieven J noted at para 68: "Therefore, the issue here is whether the parents' ability to consent disappears once the child achieves Gillick competence in respect of the specific decision even

should not "be placed in a special category making it impossible for parents to give legal consent".[979] This meant that parents retained the right to consent to PBs on behalf of their children.

4.5.5 Re W, Re E and Re M

In *Re W*,[980] the local authority (in *loco parentis*) decided that a 16-year-old girl suffering from anorexia nervosa should be transferred against her will to a hospital specialising in eating disorders.[981] In *Re E*,[982] a boy of almost 16 years old refused to consent to the required blood transfusion treatment on account of subscribing to the Jehovah's Witness Faith. Similarly, the parents withheld their consent on religious grounds. Ward J ordered transfusion to go ahead. In *Re M*,[983] a girl of almost 16 years refused a life preserving heart transplant. The judge ordered the surgeons to treat her in accordance with their clinical judgment, despite her refusal.

These cases reflect a matrix of competing interests between children, their parents and relevant professionals as to what would be in their best interests. These decisions seem to re-establish parental control over children's rights and have thus been criticised and viewed as a "retreat from *Gillick*".[984] Another important aspect to consider is that the proposed courses of treatments were for very serious and life-threatening medical conditions. It is, however, apparent that the courts took an approach that regarded the best interests of the child as paramount and rendered the children's objections to treatment invalid on account of their best interests.[985] In the

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where both the parents and child agree. In my view it does not. The parents retain parental responsibility in law and the rights and duties that go with that. One of those duties is to make a decision as to consent in medical treatment cases where the child cannot do so. The parent cannot use that right to 'trump' the child's decision, so much follows from Gillick, but if the child fails to make a decision then the parent's ability to do so continues. At the heart of the issue is that the parents' 'right' to consent is always for the purpose of ensuring the child's best interests. If the child does not, for whatever reason, make the relevant decision then the parents continue to have the responsibility (and thus the right) to give valid consent".

[979] At para 128.

[980] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 3 WLR 758.

[981] Lord Donaldson in his judgement.

[982] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

[983] *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.

[984] Gillian Douglas, 'The Retreat from Gillick' (1992) 55 The Modern Law Review 569-576 <https://doi.org/10.1111/j.1468-2230.1992.tb00934.x> accessed on 16 May 2023.

[985] The Family law Reform Act, 1969.

case of *In Marriage of Harrison and Woollard*,[986] Fogarty and Kay JJ referred to *Gillick* as a useful "analogy":

> [W]here a court is concerned with the welfare of a child no question of 'self-determination' by a mature child can arise. In the ultimate, whether by a statute or at common law, whilst the wishes of children are important and should be given real and not token weight the court is still required to determine the matter in the child's best interests and that may in some circumstances involve the rejection of the wishes of the child.[987]

It would thus seem that the *Gillick competent* test is limited to non-life-threatening conditions.[988]

Despite the seemingly legal complications and uncertainties that derive from the *Gillick* decision, the *Gillick competent* test was also adopted into Australian common law.[989] As was indicated above, a minor is declared capable of consenting to medical treatment when he/she "achieves a sufficient understanding and intelligence to enable him/her to understand fully what is proposed".[990] *Gillick* was accepted into Australian law by the High Court of Australia in 1992 in the case of *Secretary of the Department of Health and Community Services v JWB and SMB*, commonly known as *Marion's* case.[991]

4.6 Minors' consent to medical treatment in other jurisdictions

4.6.1 Australia

Australian law defines a minor as a person who has not attained the age of 18 years, which is the age of majority.[992] While New South Wales (NSW) has specific legislation

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[986] (1995) 126 FLR 159.

[987] At para 173 (Fogarty and Kay JJ)

[988] Caroline Bridge, 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 Modern Law Review 585-594.

[989] Pip Trowse, 'Refusal of medical treatment: a child's prerogative?' (2010) 10 Queensland University of Technology Law Review 191-212.

[990] Para 189. This has been adopted into Australian law in *Secretary, Department of Health and community Services v JWB* (1992) 175 CLR 218 (HC).

[991] *Secretary of the Department of Health & Community Services v JWB & SMB* ("Marion's case") [1992] HCA.

[992] Ffion Humphries-Hart and others, 'Consent for gynaecological imaging in Australian and New Zealand adolescent patients: A discussion of legal considerations in sonography' [2023] Sonography <https://doi.org/10.1002/sono.12360> accessed on 16 May 2023. See also Section 1(1) of the Family Law Reform Act 1969 provides that "As from the date on which this section

pertaining to a minor consenting to medical treatment,[993] other states do not have specific legislation regarding a minor's ability to consent to medical treatment. These states rely on the common law to determine the issue.[994] The understanding is however, that common law recognises that a parent/guardian can concurrently consent to medical treatment until the adolescent reaches the age of 18 years.[995] The case of *Secretary of the Department of Health and Community Services v JWB and SMB* developed the Australian common law position. This case involved a 14-year-old girl who had multiple disabilities, including intellectual disability. The High Court of Appeal ruled that the child's parents have no power to authorise the sterilisation of a child and that it was within the court's powers to make orders relating to the welfare of children. The ruling specified certain limitations of parental responsibilities and powers in alignment with *Gillick* - ''parental rights are derived from parental duty…exist only so long as they are needed for the protection of…the child.''[996] Accordingly, the *Gillick* case was subsequently considered as persuasive, and thus it "should be followed in this country as part of the common law".[997]

Under the current position, there is no fixed age at which minors are automatically deemed incapable of consenting to medical procedures. Common law further recognises that a minor has an ability to consent to medical treatment when he/she achieves a sufficient understanding and intelligence to be able to understand fully what is proposed.[998] This common law position is based on the immensely influential English House of Lords judgment, the *Gillick* case[999] as discussed above. Despite the absence of specific legislation in some states and territories, children may still be

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comes into force a person shall attain full age on attaining the age of eighteen instead of on attaining the age of twenty-one; and a person shall attain full age on that date if he has then already attained the age of eighteen but not the age of twenty-one".

[993] Section 49(1) of the Minors (Property and Contracts) Act (Act No 60 of 1970). This section covers persons aged 14 years and above. See also Humphries-Hart and others, 'Consent for gynaecological imaging.'

[994] Consent to Medical Treatment and Palliative Care Act 1995 (SA).

[995] *Marion's* case at 240.

[996] *Gillick* case at 420.

[997] *Marion's* case at 237-238.

[998] *Secretary of the Department of Health & Community Services v JWB & SMB* ("Marion's case") [1992] HCA at 395.

[999] *Marion's* Case at 395. It reflects *Gillick* judgement's endorsement as part of Australian common. See also section 12(b)(ii) of the Consent to Medical Treatment and Palliative Care Act 1995 (SA).

determined a “mature minor” or *Gillick competent*. These children will be deemed competent to consent to their own medical care and treatment.[1000]

In the 2004 Australian case of *Re Alex: Hormonal Treatment for Gender Identity Dysphoria,*[1001] the issue before the court was whether it was in the best interests of the child to be granted permission to have permanent physical surgery before reaching the age of consent.[1002] Alex was born as an anatomically female infant with no apparent signs of ambiguity in sexual characteristics. Although he had an estranged relationship with his mother, the relationship with his father was characterised by affection and closeness. When he lost his father between the ages of 5 and 6 years, he lived in foster care for a few months and thereafter stayed with his paternal aunt, as the Child Protection Services found that he was rejected by his mother. Alex was diagnosed with gender dysphoria when he was 13 years old, and an application was made to the court for Alex to officially adopt a male name and start hormone treatment. The court had to consider whether it should authorise the requested medical treatment, especially considering Alex’s age. A number of medical experts were requested to give their opinions regarding whether the procedure was in the *best interests* of Alex. The court subsequently granted permission that the gender reassignment process may commence after careful consideration of the reports from medical specialists and those who had direct dealings with Alex.[1003] Although the first stage of the reversible hormonal treatment was authorised, the court ruled that the second stage consisting of hormonal therapy which induces partially irreversible physical changes, could only begin when Alex attains the age of 16 years. Alex would hence only be eligible for irreversible surgical intervention upon turning 18 years old, when he would be legally competent to make his own decisions. The court ruled that both stage one and stage two treatments necessitate approval by the Family Court of Australia, since these treatments were considered types of “special medical procedures”.[1004] Although the court noted the depth of Alex’s maturity and the

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[1000] Sara Bird, ‘Consent to medical treatment: the mature minor’ (2011) 40 Australian Family Physician 159-60.

[1001] [2004] FamCA 297.

[1002] Kim Atkins, ‘Re Alex Narrative Identity and the Case of Gender Dysphoria’ (2005) 14 Griffith Law Review 1-16 <https://doi.org/10.1080/10383441.2005.10854545> accessed on 12 July 2023.

[1003] *Re Alex* at [49].

[1004] *Re Alex* at [6], [8], [201]. See also *Re Jamie* at [150]-[153]).

consistency of his stated wishes, he was found not competent to consent to the treatment on his own behalf. The court held as follows:

> […] [T]he evidence does not establish that Alex has the capacity to decide for himself whether to consent to the proposed treatment. It is one thing for a child or young person to have a general understanding of what is proposed and its effect, but it is quite another to conclude that he/she has sufficient maturity to fully understand the grave nature and effects of the treatment.[1005]

The court's conclusion seems to suggest that there are serious medical interventions that even a sufficiently mature child, with full comprehension of the nature of the treatment and the consequences of his/her decision, should not be permitted to autonomously consent to. This may include situations where a child has to decide on the gender affirming treatment that he/she wishes to undergo. Under the circumstances, both the partially reversible treatment and gender reassignment surgery would probably fall into this category.

It must, however, be noted that the court's decision in *Re Alex* received some criticisms, with some opinions stating that Alex should not have received the much-sought hormone treatment. Beh and Diamond writes in this regard that:

> Critics of Alex's treatment were unlikely bedfellows. Some critics of treatment argued that such life-altering elective treatment on children should be avoided until the child has full decisional capacity. Still others questioned the moral and medical legitimacy of sex change treatment for gender dysphoria generally. And some in the lesbian and gay community argued that sex reassignment is necessary only because society is intolerant to gender-blending. Those in the feminist and other communities voiced one of the major arguments against the judgment. They argued that the decision was the result of patriarchal thinking.[1006]

In the case of *Re Lucy*,[1007] however, it was held that court authorisation was not required for stage one treatment due to it being reversible and therapeutic in nature. The parents in this case were permitted to consent on behalf of their child.[1008] The Family Court of Australia echoed the same judgement in the case of *Re Sam and Terry.*[1009] Both children were 16 and had been diagnosed with gender dysphoria. The

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[1005] *Re Alex* at [168].

[1006] Hazel Beh and Milton Diamond, 'Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia' (2005) 15 Health Matrix 239.

[1007] [2013] FamCA 518.

[1008] *Re Lucy* at [99].

[1009] *Re: Sam and Terry (Gender Dysphoria)* [2013] FamCA 563 (31 July 2013).

court reiterated that parental consent was enough for stage one treatment, but that court authorisation was mandatory for stage two treatment.

In South Australia, section 6 of the Consent to Medical Treatment and Palliative Care Act defines the age of consent as follows:

> A person of or over 16-years-of-age may make decisions about his or her own medical treatment as validly and effectively as an adult. This means that a child aged 16 or over has the capacity to refuse treatment as well as consent to it.[1010]

A child under 16 may validly consent to treatment if:

> The medical practitioner is of the opinion that the child capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being, and
>
> That opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced.[1011]

It is clear from the above provisions that the South Australian Consent to Medical Treatment and Palliative Care Act treats medical decisions made by children of 16 years and older in relation to their own treatment as if they were an adult.[1012] Children aged 16 and younger may still provide valid consent, provided that their assessments display the characteristics of *Gillick competence*.

In the case of *Re Anita*,[1013] the parents of a 16 years old made an application to declare their child, Anita, competent to consent to Stage 2 treatment for gender dysphoria. The court considered the evidence provided by both Anita's parents and the consultant psychiatrist. The court concluded that Anita was *Gillick competent* and could consent to stage two treatment.

In NSW, consent to medical treatment appears *prima facie* to be governed by the Minors (Property and Contracts) Act.[1014] Section 49 of the Act provides as follows:

> (1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of

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[1010] Section 6, Consent to Medical Treatment and Palliative Care Act 1995.
[1011] Section 12, Consent to Medical Treatment and Palliative Care Act 1995.
[1012] Section 6, Consent to Medical Treatment and Palliative Care Act 1995.
[1013] [2016] FamCA 1137.
[1014] Minors (Property and Contracts) Act 1970.

> the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.
>
> (2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged twenty-one years or upwards.

Pursuant to section 49 of the Minors (Property and Contracts) Act, a child of 14 years and older may consent to medical or dental treatment. The condition, however, is that such a minor must display enough understanding and maturity to understand the proposed treatment. The minor's consent may acquit a medical practitioner from a charge of assault or battery.[1015] Treatment of a minor below the age of 16 may proceed with the consent of the parent(s) or guardian(s). Parental consent provides a legal defence against a claim for assault or battery that may arise in respect of such a child's treatment.[1016]

The NSW Law Reform Commission commenced with the review on the Guardianship Act 1987 on 7 February 2017. In 2018, the Commission's recommendations included replacing the Guardianship Act 1987 with a new Assisted Decision-Making Act. This proposed law would formally move away from substitute decision making to a regime of supported decision-making.[1017]

The Australian Family Law Act,[1018] as amended, preserves the concept of the best interests of the child as the primary consideration and the key reference point for decision-making in children's matters.[1019] Section 68F of the Act stipulates:

[1015] Section 49(2).

[1016] Section 49(1).

[1017] Nola M Ries and Elise Mansfield, 'Supported Decision-Making: A Good Idea in Principle but We Need to Consider Supporting Decisions about Voluntary Assisted Dying' in Daniel J Flemming and David J Carter (eds) *Voluntary Assisted Dying* (ANU Press 2022) 49-74.

[1018] Family Law Act 1975.

[1019] Georgina Dimopoulos, 'Embracing Children's Right to Decisional Privacy in Proceedings under the Family Law Act 1975 (Cth): In Children's Best Interests or a Source of Conflict?' RAIS Conference Proceedings - The 11th International RAIS Conference on Social Sciences <https://dx.doi.org/10.2139/ssrn.3303395> accessed on 20 May 2023.

> (1) […] in determining what is in the child’s best interests, the court must consider the matters set out in subsection (2).
> (2) The court must consider:(a) any wishes expressed by the child and any factors (such as the child’s maturity or level of understanding) that the court thinks are relevant to the weight it should give to the child’s wishes […].[1020]

The Act further provides statutory guidelines on how to determine what would be in the child’s best interests.[1021] Before the amendment, the Act stipulated additional considerations that the court should take into account in determining what is in a child’s best interests, namely “any views expressed by the child and any factors (such as the child’s maturity or level of understanding) that the court thinks are relevant to the weight it should give to the child’s views”.[1022] Chisholm argues that the intention of shifting of attention to the word *views* instead of *wishes* was “to direct the courts to have regard to children's viewpoint and understanding in a general sense”.[1023] Santow J in the case of *Director General of Department of Community Services v “BB”* puts emphasis on how the best interests of the child should be the primary consideration in the determination of their interests. He lists various factors that must be considered in objectively ascertaining those best interests, including:

> [t]he particular condition of the child which requires the procedure or treatment; (ii) the nature of the procedure or treatment proposed; (iii) the reasons for which it is proposed that the procedure or treatment be carried out; (iv) the alternative courses of treatment that are available in relation to that condition; (v) the desirability of and effect of authorising the procedure or treatment proposed rather than the available alternatives; (vi) the physical effects on the child and the psychological and social implications for the child of: authorising the proposed procedure or treatment, or not authorising the proposed procedure or treatment; (vii) the nature and degree of any risk to the child of: authorising the proposed procedure or treatment, or not authorising the proposed procedure or treatment; and (viii) the views (if any) — expressed by the guardian(s) of the child, a person who is entitled to the custody of the child, a person who is responsible for the daily care and control of the child, and the child — to the proposed procedure or treatment and to any alternative procedure or treatment.[1024]

While countries do not have the exact same requirements, the Australian experience is found to be highly relevant to medical decisions regarding gender reassignment

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[1020] Section 68F(2)(a).

[1021] Section 60CC.

[1022] Section 60CC(3)(a).

[1023] Richard Chisholm, ‘The meanings of ‘meaningful’ within the Family Law Act Amendments of 2006: A legal perspective’ (2009) 15 Journal of Family Studies 60-66 <https://doi.org/10.5172/jfs.327.15.1.60> accessed on 20 May 2023.

[1024] *Director General of Department of Community Services v “BB”* [1999] NSWSC 1169 at 23.

issues in South Africa. As mentioned in chapter 2, the common law general principle was that children were legally incompetent to give consent to medical treatment and operations, parents were afforded the responsibility to make important decisions on their behalf.[1025] However, the limitation of younger children's ability to consent was gradually relaxed.[1026] Before *Gillick*, Australian courts' *parens patriae* was vested with power to make medical decisions on behalf of incompetent and competent minors.[1027] The Australian legal position is similar to that of South Africa, particularly because the best interest of the child is paramount, although it had a fairly limited application.

Australia's most significant change to minors' decision-making about medical treatment, was the adoption of the *Gillick competent* test. The shift in focus brought about a change in the way in which young persons may have capacity to consent to their own medical treatments, in some instances, without their parents' knowledge. The requirements, however, are that the minor child must have "sufficient understanding and intelligence to enable him/her to fully understand what is proposed".[1028] As indicated in this chapter, the *Gillick competent* or "mature minor" principles were endorsed as part of Australian common law in the *Marion's* case.[1029]

The 2013 case of *Re Jamie*,[1030] an Australian case involving issues of gender dysphoria, dealt with the application of *Gillick competence*. The court had to determine whether it is the parent of the child who should consent to potentially irreversible stage two treatment. The Full Family Court held that a trans young person does not need court authorisation to undergo stage one (puberty suppression) treatment. Williams and others view this as a positive and important step in de-pathologising gender dysphoria and removing the financial burdens that stems from expensive legal

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[1025] Kruger, 'The protection of children's right to self-determination.'

[1026] Kruger, 'The protection of children's right to self-determination.'

[1027] Nicholas J Lennings, 'Forward, Gillick: Are competent children autonomous medical decision makers? New developments in Australia' (2015) 2 Journal of Law and Biosciences 459-468 <https://doi.org/10.1093/jlb/lsv028> accessed on 14 June 2023. See also the case of In *AMS v AIF* (1999) 199 CLR 160 at 189 [86] The court in this case indicated that: 'If there is a risk to the welfare of a child, the *parens patriae* jurisdiction will support a great variety of orders and orders of great width.'

[1028] *Gillick* case at para 122.

[1029] *Marion's* case.

[1030] *Re Jamie* [2009] 248 FamLR 312; [2013] FAMCAFC 110.

proceedings.[1031] The court further held that the minor can proceed with stage two treatment (oestrogen or testosterone) if he/she is found to be *Gillick competent*. However, the court's authorisation is required where the child is found to be incompetent, and the determining factor will be the child's best interests. It must be noted that court attendance is mandatory because the Full Court has accepted the Australian Human Rights Commission's submissions that "the nature of the treatment at stage two requires that the court determine *Gillick competence".*[1032] The judgment has been criticised for narrowing down the "boundaries of parental decision-making".[1033] By contrast, Australia became the only country in the world to have an arrangement of requiring Court authorisation before commencing cross-sex hormone treatment for trans children.[1034] Australia, like South Africa, deems any person above the age of 18 years competent to make decisions about their own medical treatment. The treatment, however, varies slightly for persons under 18.

In the case of *Re Kelvin*,[1035] a Family Court of Australia's ruling deviated from the above *Re Jamie* ruling that required court authorisation before embarking on stage two gender affirming hormones prior to the age of 18. The Full Court of the Family Court of Australia held that where consent to stage two treatment has been obtained from a child diagnosed with gender dysphoria, and the child's treating medical practitioners have determined the child to be *Gillick competent* and there is no lack of consensus between the child and his or her parents, then the Family Court should have no role to play in the determination of the child's competence to consent.[1036] In light of this ruling, the Australian legal position concerning minors and treatment for

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[1031] Michael Williams, John Chesterman and Phil Grano, 'Re Jamie (No 2): A positive development for transgender young people' (2014) 22 Journal of Law and Medicine 90.

[1032] *Re Jamie* case at para 137.

[1033] Malcolm K Smith, 'The Boundaries of Parental Decision-Making and the Requirement to Obtain Court Approval for "Special Medical Procedures": The Recent Decision of *Re Jamie* [2013] FAMCAFC 110' (2013) 33 Queensland Lawyer 186.
They argue that "If the treatment is deemed to be therapeutic, it could be stated that the court has no authority to narrow the boundaries of parental decision-making in the way that it did, as the classification of the treatment as therapeutic was itself a critical factor in distinguishing [Marion's Case] from previous jurisprudence on special medical procedures".

[1034] Fiona Kelly, 'The Court Process Is Slow but Biology Is Fast': Assessing the Impact of the Family Court Approval Process on Transgender Children and Their Families (2016) La Trobe Law School - Law and Justice Research Paper Series Paper No. 16-4 <https://ssrn.com/abstract=2793664> or <http://dx.doi.org/10.2139/ssrn.2793664> accessed on 14 June 2023.

[1035] *Re Kelvin* [2017] FamCAFC 258.

[1036] *Re Kelvin* at [177]-[184]

gender dysphoria advanced significantly, particularly with courts deviating from a particularly cautious approach previously adopted about treatment decisions.[1037] The elimination of the Family Court's involvement has importantly removed the daunting, time consuming and costly process of applying to court for authorisation of stage two treatment. It is also worth mentioning that the minority judgment held that the ruling in *Re Jamie* was "plainly wrong".[1038]

The case of *Re Imogen*,[1039] on the other hand, seems to have diminished the concept of *Gillick competent*. The decision in *Re Imogen* seems to be forcing health professionals working with trans children to seek an informed consent of both parents even when the adolescent is considered to be sufficiently competent to provide informed consent. This decision will result in delays in treatment, thus, negatively impacting on the trans adolescents, their families and treating health professionals. In this case, Imogen, born male, was diagnosed with gender dysphoria at the age of 16, and was given a treatment plan and commenced stage one treatment. Clashing interests between the mother and the father arose when the mother objected to stage two treatment. The court authorised stage two treatment upon an application by the father to deem Imogen as an absolute decision-maker in the process.

The *Re Imogen* ruling determined that court application is mandatory when there is a dispute between parents or the treating medical practitioner regarding:

(i) The *Gillick competence* of an adolescent; or
(ii) a diagnosis of gender dysphoria; or
(iii) proposed treatment for gender dysphoria.[1040]

The court further stated that treatment cannot commence without first ascertaining the expressed consent from both parents in relation to the proposed treatment.[1041] Some commentators have been critical of this decision as the judgment marks a backward step.[1042] By implication, children who have not attained the age of 18 and whose

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[1037] Smith, 'The Boundaries of Parental Decision-Making' 186.
[1038] *Re Kelvin* at [171]-[177] as per Ainslie-Wallace and Ryan JJ.
[1039] *Re Imogen* [2020] FamCA 761.
[1040] *Re Imogen* at [35].
[1041] *Re Imogen* at [35].
[1042] Stephanie Jowett and Fiona Kelly, 'Re Imogen: A Step in the Wrong Direction' (2021) 34 Australian Journal of Family Law 31.

parents or guardians do not give consent to initiate PBs or hormone treatment, have to seek the involvement of the Family Court. The downside of this decision is that a lack of consent from parents in these circumstances would mean that trans persons should wait until they are 18 years old to access gender affirming care. Unfortunately, this decision may also push the child to seek unsupervised treatment outside of medical care.

In the 2022 case of *Re A*,[1043] a dispute arose between the mother and the father of the minor child, with the father denying that *A* had gender dysphoria. The Queensland Supreme Court distanced itself from the decision in *Re Jamie* and *Re Imogen* and held that:

> The conclusion that there is no need, once the child is Gillick competent, for Court authorisation means that it is unnecessary to consider a further aspect of the Applicant's application which was the making of declarations authorising the treatment.[1044]

The Court had to consider whether the child was *Gillick competent* to undergo the treatment, and further whether it was in the best interests of the child to receive gender-affirming treatment for gender dysphoria without parental consent. The court considered an overwhelming amount of evidence submitted by practitioners and concluded that *A* was capable of consenting to the proposed treatment. Accordingly, *Gillick competent* children in Australia do not require parental consent in order to receive treatment anymore. Denying them gender affirming care without the consent of both parents would be inconsistent with the child's human rights.[1045]

In 2018, the Royal Children's Hospital Gender Service published Australia's first guidelines on medical treatment for gender dysphoria in children and adolescents.[1046] It is worth noting that these guidelines were published following the Family Court of Australia's judgement in *Re Kelvin.*[1047] Amongst others, these guidelines note that

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[1043] *Re A* [2022] QSC 159.

[1044] *Re A* at [28].

[1045] *Re A* at [24].

[1046] M Telfer and others, Australian standards of care and treatment guidelines for trans and gender diverse children and adolescents version 1.1. Melbourne, Vic: The Royal Children's Hospital, 2018. See also Calina Ouliaris, 'Models of care for gender dysphoria in young persons: How Psychiatry lost and is finding its voice' (2022) 318 Psychiatry Research <https://doi.org/10.1016/j.psychres.2022.114923> accessed on 13 July 2023.

[1047] *Re Kelvin* [9].

there is a lack of a reliable empirical rationale for the recommendation of an age threshold. The adolescent, and ideally his/her parents or guardians, may provide informed consent.[1048] The guidelines further recommend adopting a more individualised approach to determine when to initiate stage two treatment.[1049] On the same note, the guidelines advise that caution should be exercised in relation to the initiation of stage two treatment, due to it being generally irreversible, combined with the potential complexity of autism spectrum disorder-related deficits.[1050]

Regarding stage three treatments, the 2018 Australian Guidelines acknowledge the variation in surgeons' attitudes and opinions regarding the performing of vaginoplasty. The Guidelines, therefore, recommend that planned genital surgery in patients should be delayed until adulthood because this type of surgery is more complex, and the risk factors have the potential to impact on sexual function and fertility.[1051]

The South African HIV Clinicians Society Gender-Affirming Guidelines and the Australian Standards of Care and Treatment Guidelines have several provisions in common and in alignment with those of the World Professional Association for Transgender Health. These first-mentioned two sets of guidelines encourage and support the historically controversial pre-pubertal social transition in adolescents where such a need has been expressed by the affected child.[1052] Medical treatment in both the guidelines comprises a three-stage approach to treating transgender children: stage one (pubertal suppression), stage two (gender-affirming hormones), and stage three (surgical interventions).[1053] Both sets of guidelines explicitly recommend a multidisciplinary effort to care.[1054] Instead of age thresholds, these guidelines recommend that PBs be administered when a child has achieved a minimum of Tanner

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[1048] Telfer and others, 'Australian Standards of Care and Treatment Guidelines' 17.

[1049] Telfer and others, 'Australian Standards of Care and Treatment Guidelines' 17.

[1050] John F Strang and others, 'Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents' (2018) 47 Journal of Clinical Child and Adolescent Psychology 105-115 <https://doi.org/10.1080/15374416.2016.1228462> accessed on 13 July 2023.

[1051] Telfer and others, 'Australian Standards of Care and Treatment Guidelines' 25.

[1052] SAHCS GAHC 5.3.1.2 p42. See also Telfer and others, 'Australian standards of care and treatment' 9.

[1053] SAHCS GAHC. See also Telfer and others, 'Australian standards of care and treatment' 14.

[1054] SAHCS GAHC 6.8 58. See also Telfer and others, 'Australian standards of care and treatment' 10.

stage 2, the first sign of puberty.[1055] The Australian Guidelines, however, go further, and require that the child must have been diagnosed with gender dysphoria and must have undergone medical assessment, including fertility preservation counselling. The child must further have provided consent in addition to the informed consent from legal guardians.[1056] The Guidelines further recommend that the decision regarding the timing and initiation of hormone treatment should be "individualised".[1057] In terms of the Australian Guidelines, the following factors should be taken into account:

> [t]he nature of the history and presentation of the person's gender dysphoria, duration of time on puberty suppression for those undertaking such treatment, co-existing mental health and medical issues and existing family support.[1058]

The South African Guidelines provide that consideration should be given to "family support, likely time on GnRHa,[1059] potential impacts on height, risks of delaying hormonal treatment and the adolescent's ability to consent".[1060]

Despite many commonalities between the guidelines, there are some differences. In terms of terminology, the South African Guidelines utilises the word "puberty blocking" whilst the Australian Guidelines utilises "puberty suppression". The Australian Guidelines explicitly recommend that the treating team must agree that both puberty suppression, oestrogen and testosterone treatments should be in the best interests of the adolescent before commencement.[1061] The South African Guidelines recommend that the medical health practitioner should work with the adolescent and his/her caregivers in facilitating access to PBs which should then be appropriate.[1062]

In South Africa, it is important for the child's treating medical professionals, the parents and the child to have a mutual responsibility to make decisions about treatment.[1063] It is my submission that this collaborative approach to decision-making is essential when

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[1055] SAHCS GAHC 2.2.3 p22. See also Telfer and others, 'Australian standards of care and treatment' 10.

[1056] Telfer and others, 'Australian standards of care and treatment' 23.

[1057] SAHCS GAHC 6.8 p57. See also Telfer and others, 'Australian standards of care and treatment' 17.

[1058] Telfer and others, 'Australian standards of care and treatment' 17.

[1059] Gonadotrophin-releasing hormone agonists (GnRHa) are used to suppress puberty. See SAHCS GAHC 6.8 57.

[1060] SAHCS GAHC 6.8 57.

[1061] Telfer and others, 'Australian standards of care and treatment' 23.

[1062] SAHCS GAHC 2.2.4, 23.

[1063] SAHCS GAHC 2.2.4, 23.

making health decisions. It is further patient-centred, as it views patients as equal partners in assessing care and determining the best treatment plan,[1064] which is thus, a vital component of effective health care.

In the specific context of South Africa, children and adolescents of over 12 years and older may legally consent to their own medical treatment. The requirement, however, is that that they must be sufficiently matured with the “mental capacity to understand the benefits, risks, social and other implications of the treatment”.[1065] By implication, a minor who desires to transition to the other gender through PBs and cross sex hormones has the legal autonomy to have access to health care without parental consent. The SAHCS guidelines recommend that both parents and legal guardians must be involved in the process, where possible.[1066] In situations where surgical intervention is required, it is a statutory requirement that the minor of 12 years or above, but below the age of 18, must be assisted by his/her parents or legal guardians.[1067] Thus, the medical practitioners, parents and the child must be included in the process of informed consent.

It must, however, be noted that in all matters or decisions pertaining to children, the best interest of the child should be of paramount consideration.[1068] The High Court as the upper guardian of all children in South Africa may in exceptional circumstances and as a last resort always be approached to ensure that the best interests of the child are considered in all situations and decisions affecting the child.[1069] The best interests standard is no doubt a significant standard used to measure actions and interventions that concern and affect a child. International instruments to which South Africa subscribes, also emphasise the best interest of the child, notably the UNCRC and the ACRWC.[1070] The best interests standard thus, underpins the interpretation of children’s rights in all actions concerning them.

[1064] Tammy C Hoffmann and others, ‘Shared decision making: what do clinicians need to know and why should they bother?’ (2014) 201 The Medical Journal of Australia 35-39 <https://doi.org/10.5694/mja14.00002> accessed on 15 June 2023.

[1065] Section 129(2) of the Children’s Act, 2005.

[1066] SAHCS GAHC Guidelines 4.

[1067] Section 129(3) of the Children’s Act, 2005.

[1068] See the Constitution of the Republic of South Africa, 1996.

[1069] Section 45(4) of the Constitution of South Africa provides that “Nothing in this Act shall be construed as limiting the inherent jurisdiction of the High Court as upper guardian of all children”.

[1070] See articles 3 and 4 of the UNCRC and the ACRWC respectively.

4.6.2 New Zealand

In New Zealand, the legal age for minors to consent to medical treatment is 16 years of age. This is also reflected in the New Zealand Guidelines for Gender Affirming Health care for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa.[1071] The Guidelines provide as follows:

> Gender affirming healthcare may include provision of puberty blockers in children and adolescents, and hormone therapy in older adolescents and adults. The criteria for access to gender affirming hormones are persistent well-documented gender dysphoria, the capacity to make a fully informed decision and to consent for treatment, 16 years of age or older, and significant medical or mental health concerns must be reasonably well controlled. However, it is increasingly recognised that there may be compelling reasons, such as final predicted height, to initiate hormones prior to the age of 16 years for some individuals, although there is as yet little published evidence to support this.[1072]

Atkin concludes that New Zealand does not have a "one neat code" pertaining to children and that the key rules relating to the law of children are located in different sets of legislation.[1073] The Guardianship Act[1074] provides for a young person of 16 years or older to consent to their own medical or dental procedure as if they were adults. [1075] The Act's explicit omission to address consent relating to children under

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[1071] Jeannie Oliphant and others, Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa, New Zealand (Transgender Health Research Lab, University of Waikato, 2018).

[1072] Oliphant and others, Guidelines for Gender affirming Healthcare 86.

[1073] Nessa Lynch, 'Children's Rights in Aotearoa New Zealand: Reflections on the 30th Anniversary of the Convention on the Rights of the Child.' In Children's Rights in Aotearoa New Zealand: Reflections on the 30th Anniversary of the Convention on the Rights of the Child. 2019 5.

[1074] Guardianship Act 1968.

[1075] Section 25 provides the following with reference to consents to operations:
'(1) Subject to subsection (6) of this section, the consent of a child of or over the age of sixteen years to any donation of blood by him, or to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on him, for his benefit by a person professionally qualified to carry it out, shall have the effect as if he were of full age.
(3) Where the consent of any other person to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on a child is necessary or sufficient, consent may be given
a) By the guardian of the child; or
b) If there is no guardian in New Zealand or no such guardian can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent; or
c) If there is no person in New Zealand who has been so acting, or if no such person can be found with reasonable diligence or is capable of giving consent, by a District Court Judge or the Director-General.
(5) Nothing in this section shall limit or affect any enactment or rule of law whereby in any circumstances-
(a) No consent or no express consent is necessary; or
(b) The consent of the child in addition to that of any other person is necessary; or
(c) ...the consent of any other person instead of the consent of the child is sufficient.

the age of 16 appears to suggest that those children lack capacity to consent and that the required consent should be obtained from persons other than the child before any treatment commences.[1076] The consent can be provided by a parent, including a person acting *in loco parentis*, in situations where the necessary consent cannot be obtained from a parent. Consent may also be obtained from the District Court Judge or the Director of Social Welfare in circumstances where there is no available parent or guardian.[1077]

Section 25 of the Guardianship Act, one of the statutes that preceded the current Care of Children Act[1078] was the most important provision relating to medical care and procedures for several decades. The question whether the provisions of section 25 were aligned with the *Gillick competency* test may seem rather pointless, considering that the *Gillick* case was decided in 1985 and that the Guardianship Act was promulgated in 1968. It is relevant, however, for tracing the legislative development regarding children's consent to the current position, discussed below. Although the section did not explicitly make provision for children under 16 to consent to their own medical treatment, it did not rule out the possibility. The provision of subsection 5(a) appears to have expressly preserved common law rules whereby "no consent or no express consent is necessary".[1079] Atkin, however, argues that the subsection should not be construed as having expressly referred to any rule by which the consent of the child alone would have been sufficient. He argues that the subsection should be understood to have constituted a possible exception to "a rule about the non-necessity of parental consent".[1080] Consequently, the silence of the subsection regarding whose consent had to be obtained could arguably have been interpreted as being broad

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(6) Except to the extent that this section enables a blood transfusion (as defined in subsection (1) of section 126B of Health Act 1956) to be administered to a child without the consent of any other person, nothing in this section shall affect the provisions of the said section 126B".

[1076] Lucy Thomson, 'Whose Right to Choose? A Competent Child's Right to Refuse Medical Treatment in New Zealand' (2001) 8 Canterbury Law Review 145.

[1077] Section 25(3) of the Act.

[1078] Care of Children Act 2004.

[1079] Although the legal age for consent is 16, at common law, an adolescent under 16 may be able to give consent to medical procedures and treatment, depending on the level of understanding of the child and the nature of the treatment involved. See Kathryn McLean, 'Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand' (2000) Victoria University of Wellington Law Review 551 <https://doi.org/10.26686/vuwlr.v31i3.5943> accessed on 20 May 2023.

[1080] WR Atkin, 'Parents and Children: Mrs Gillick in the House of Lords' [1986] New Zealand Law Journal 92.

enough to have included the *Gillick* standard, especially where parental consent was not necessary because the child was sufficiently capacitated to consent.

New Zealand law has to date not expressly endorsed nor expressly rejected the application of the *Gillick* test. It has indirectly, albeit in an *ad hoc* manner and through effective mechanisms such as case law, policy and guidelines, adopted the *Gillick* test.[1081]

The Guardianship Act was replaced by the Care of Children Act in 2004. However, prior to this replacement, the Children, Young Persons and their Families Act,[1082] enacted in 1989, gave recognition to the ability of children to make autonomous decisions.[1083] Through this Act's adoption of the UNCRC provisions, the yardstick of the paramountcy of the welfare and best interests of the child became recognised.[1084] This standard suggested that the government's intervention was crucial in circumstances where a child's best interests were not met. In the case of *Capital and Coast District Health Board v DRB*,[1085] Whitehead J ordered the immunisation of a child to proceed, despite parental objection, because he believed that the child's life was in direct risk of contracting Hepatitis-B.

The current Care of Children Act[1086] makes provision for the child's consent in the context of medical decision-making. Section 36 provides as follows:

> (1) A consent, or refusal to consent, to any of the following, if given by a child of or over the age of 16 years, has effect as if the child were of full age:
>
> (a) any donation of blood by the child:
>
> (b) any medical, surgical, or dental treatment or procedure (including a blood transfusion, which, in this section, has the meaning given to it by section 37(1)) to

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[1081] McLean, 'Children and competence to consent: Gillick guiding medical treatment in New Zealand' 553.

[1082] The Children, Young Persons and their Families Act 1989.

[1083] Section 5(d) of this Act provides: "The principle that consideration should be given to the wishes of the child or young person, so far as those wishes can reasonably be ascertained, and that those wishes should be given such weight as is appropriate in the circumstances, having regard to the age, maturity, and culture of the child or young person".

[1084] Section 6 of the Act states that: "In all matters relating to the administration or application of this Act…the welfare and interests of the child or young person shall be the first and paramount consideration, having regard to the principles set out in sections 5 and 13".

[1085] *Capital and Coast District Health Board v DRB* FAM-2010-085-000595, 26 May 2010.

[1086] Care of Children Act 2004.

> be carried out on the child for the child's benefit by a person professionally qualified to carry it out.[1087]

Section 36 appears to be consistent with the *Gillick* standard. The section does not undermine the autonomy of the child and recognises that a minor of over the age of 16 may consent to medical treatment that serves his/her best interests. The section acknowledges the importance of the standard of competence adopted in *Gillick*. Section 36 does not make provision for children below the age of 16 to consent or refuse treatment. Section 38 of the same Act accords a female child "of whatever age" the right to independently authorise or refuse consent for an abortion "as if she were of full age." The practical effect of this provision is that the girl is not only entitled to give an autonomous consent to an abortion, but this process can take place without her parents' knowledge, thus waiving parental consent. The distinction between consent to abortion and other medical interventions, including gender reassignment, is not unique to New Zealand. In South Africa, for instance, a female child of any age may also independently consent to the termination of an early pregnancy (less than 12 weeks' gestation) without her parents' or guardian's consent or knowledge.[1088]

In a relative manner, in the England and Wales High Court, in the matter of *Axon, R* (*on the application of*) *v Secretary of State for Health*, the judge confirmed '*Gillick* competence' as a well-established principle relating to the interpretation of the case and decided that a medical practitioner is:

> entitled to provide medical advice and treatment on sexual matters without the parents' knowledge or consent provided he or she is satisfied of the following matters:
>
> that the young person although under 16 years of age understands all aspects of the advice… that understanding includes all relevant matters and it is not limited to family and moral aspects as well as all possible adverse consequences which might follow from the advice;
>
> that the medical professional cannot persuade the young person to inform his or her parents or to allow the medical professional to inform the parents that their child is seeking advice and/or treatment on sexual matters;
>
> that (in any case in which the issue is whether the medical professional should advise on or treat in respect of contraception and sexually transmissible illnesses)

[1087] Section 36 of the Act.

[1088] Section 2(1)(a) Choice on Termination of Pregnancy Act.

> the young person is very likely to begin or continue having sexual intercourse with or without contraceptive treatment or treatment for a sexually transmissible illness;
>
> that unless the young person receives advice and treatment on the relevant sexual matters, his or her physical or mental health or both are likely to suffer; and
>
> that the best interests of the young person require him or her to receive advice and treatment on sexual matters without parental consent or notification.[1089]

The Gillick competency test has also been applied in cases other than medical decision-making of minors. The test was applied in the case, *In Re Marriage of Doyle*,[1090] that dealt with a custody dispute involving two boys aged 9 and 13 years old as indicated above. In this case, the court found it appropriate to give regard to the child's wishes upon satisfaction that they are "soundly based and founded upon considerations" in alignment with the "ability and state of maturity" of the child.[1091]

The Care of Children Act 2004, however, accords the power to consent to "medical, surgical, or dental treatments or procedures (including a blood transfusion)" to guardians.[1092] The guardian's power to consent on the child's behalf is limited to children under the age of 16.[1093] Although children over the age of 16 are deemed as fully capacitated to consent as if they are of full age,[1094] those younger than 16 may also be deemed capable of consenting if they are found to possess the *Gillick* level of maturity and understanding.[1095] In the case of *Re SPO FC Wellington FAM*,[1096] after having considered relevant information from the public health nurse, the general practitioner and the 15 year-old boy's older brother, Judge Ullrich referred to the often

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[1089] *Axon, R (on the application of) v Secretary of State for Health* [2006] EWHC 37 (Admin).

[1090] *In Marriage of Doyle* (1993) 106 FLR.

[1091] *Doyle* case at 125.

[1092] Care of Children Act 2004 (COCA), s 36(3).

[1093] Care of Children Act 2004, s 36(3). See *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190; 196-197 where the court held that: "... Lord Scarman was discussing the parents' right to determine whether or not their minor child below the age of 16 will have medical treatment and this is 'parental right'… A right of determination is wider than a right to consent. The parents can only have the right of determination if either the child has no right to consent, i.e. is not a key holder, or the parents hold a master key which could nullify the child's consent. I do not understand Lord Scarman to be saying that, if a child was 'Gillick competent' ... the parents ceased to have an independent right of consent as contrasted with ceasing to have a right of determination, i.e. a veto. In a case in which the 'Gillick competent' child refuses treatment, but the parents consent, that consent enables treatment to be undertaken lawfully, but in no way determines that the child shall be so treated. In a case in which the positions are reversed, it is the child's consent which is the enabling factor and again the parents' refusal of consent is not determinative".

[1094] COCA, s 36(1).

[1095] *Gillick* case 184, per Lord Scarman.

[1096] *Re SPO FC Wellington FAM* 2004-085-1046, 3 November 2005 at 25.

quoted citation by Lord Scarman in the *Gillick* case, and decided that the 15-year-old child in question was competent to consent to vaccination.[1097] The judge did not dwell on the conflicting parental wishes in the case, but instead decided that the 15 year-old's growing autonomy should be recognised, thus ensuring that the boy's decision would prevail over parental views.[1098] This decision is in alignment with the *Gillick competency* test. Although the general practice in New Zealand presumes that children under the age of 16 are incapable of giving consent to medical treatment, a rebuttable presumption exists in terms of the common law if the child is found to be *Gillick competent*.[1099] That being said, New Zealand has set the statutory age threshold for medical consent, both treatment and surgery at 16 years. This is much higher than that in South Africa, where children of 12 years and older are competent to consent independently to their own medical treatment.

It has already been mentioned that gender affirming health care in New Zealand is governed by the Professional Association for Transgender Health Aotearoa (PATHA) guidelines.[1100] Interestingly, both New Zealand and South Africa share common barriers to this care, including unavailability of this type of care. Increased demands for gender affirming health care have led to shortage of resources in the public health care systems.[1101] As a result, trans people often need to pay exorbitant health care costs to access gender affirming health care through private health care services. This dire situation leaves many trans people unable to access the care they need. In instances where services are available in the public health care system, another barrier often encountered relates to capacity limitations, including the lack of trained health care professionals.[1102] This results in long waiting lists at health care facilities, which remains a pervasive barrier to gender affirming care. Delays in diagnosis results in delayed access to gender affirming hormones or puberty-delaying medication. As

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[1097] *Re SPO* case 27.

[1098] *Gillick* case 189 per Lord Scarman.

[1099] Chantelle Murley, 'Does the Gillick competency test apply in New Zealand, given the special nature of sexual health care services?' (2014) 19 Public Interest Law Journal of New Zealand 92.

[1100] Oliphant and others, Guidelines for Gender Affirming Healthcare.

[1101] Jaimie F Veale and others, 'PATHA's vision for transgender healthcare under the current health Reforms' (2023) 136 The New Zealand Medical Journal 24-31 <https://hdl.handle.net/10289/15717> or <https://journal.nzma.org.nz/> accessed on 11 July 2023.

[1102] Veale and others, 'PATHA's vision for transgender healthcare.'

pointed out earlier in this thesis, these delays may negatively affect health outcomes for both transgender children and adults.[1103]

It is worth noting that although the New Zealand Guidelines are recent, it is noticeable that they do not recommend gender reassignment surgery in adolescence at all, including masculinising chest reconstruction and feminising chest reconstruction, also known as "top surgery".[1104] The current practice in New Zealand requires a person to be 18 years or older in order to access the publicly funded surgeries.[1105] In contrast, the South African guidelines recommend breast surgery with chest reconstruction on condition that an agreement on the timing of the surgery should involve the adolescent, his or her parents or legal guardians, together with the medical health practitioner.[1106] Both South Africa and New Zealand explicitly provide support for social transitioning as part of this process.[1107] The New Zealand guidelines also establish fertility counselling as a prerequisite for the initiation of PB treatment.[1108] Regarding the initiation of stage two treatment, the New Zealand guidelines propose an individualised approach, taking into account the adolescent's stage of development, the effects of prolonged administration of *GnRHa* on the body, and especially on the adolescent's bone health, amongst others.[1109] Like South Africa, New Zealand faces similar obstacles in providing equitable and accessible gender affirming health care services. There is hence also a need for improvement regarding current practices in New Zealand.

It should be noted that New Zealand has also adopted a set of new guidelines, the Primary Care Gender Affirming Hormone Therapy Initiation Guidelines,[1110] endorsed by the Royal New Zealand College of General Practitioners. The guidelines, however,

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[1103] Veale and others, 'PATHA's vision for transgender healthcare.'

[1104] Rebecca Duncan and Charlie Eggleton, 'Mainstream media discourse around top surgery in Aotearoa New Zealand: a qualitative analysis' (2022) 5 Australasian Journal of Plastic Surgery 29-36 <https://doi.org/10.34239/ajops.v5n2.343> accessed on 26 July 2023.

[1105] Jeannie Oliphant and others, Guidelines for Gender Affirming Healthcare 37.

[1106] SAHCS GAHC 7.3.1, 60.

[1107] Oliphant and others, Guidelines for Gender Affirming Healthcare 46.

[1108] Oliphant and others, Guidelines for Gender Affirming Healthcare 28.

[1109] Oliphant and others, Guidelines for Gender Affirming Healthcare 31.

[1110] Rona Carroll and others, Primary Care Gender Affirming Hormone Therapy Initiation Guidelines: Aotearoa New Zealand guidelines for commencing GAHT for adults in primary care 2023 <https://blogs.otago.ac.nz/rainbow/> accessed on 21 May 2023.

are irrelevant for this study as they have been crafted for adults in a primary care setting.

4.6.2.1 Change of a gender marker

The Births, Deaths, Marriages, and Relationships Registration Act[1111] made significant changes to New Zealand's register of Births. It has accorded New Zealanders the right to dignity by abolishing the requirement that applicants should prove that they have undergone complex, intimidating, and often inaccessible medical treatment to align their sex and gender identity before they could amend the sex on their birth certificates. Section 24 of the Act states that:

> (1) An application by an eligible person for registration of the person's nominated sex must—
>
> (a) specify male, female, or any other sex or gender specified in regulations for the purposes of this paragraph as the person's nominated sex; and
>
> (b) include a statutory declaration by the eligible person verifying that—
>
> (i) the eligible person identifies as a person of the nominated sex; and
>
> (ii) the eligible person understands the consequences of the application; and
>
> (c) if the eligible person is 16 or 17 years old and has never been in a marriage, civil union, or de facto relationship, be accompanied by—
>
> (i) the written consent of their guardian; or
>
> (ii) a letter of support from a suitably qualified third party that confirms that the third party believes that—
>
> (A) the eligible 16- or 17-year-old understands the consequences of the proposed registration of the nominated sex; and
>
> (B) the eligible 16- or 17-year-old's preference is for the nominated sex to appear as their registered sex on any birth certificate issued under this Act; and
>
> (d) if the Registrar-General has previously registered a nominated sex for the person under section 26, meet any additional requirements set out in regulations; and
>
> (e) be accompanied by the prescribed fee.
>
> (2) An eligible person may apply for registration of a nominated sex at the same time as the person applies for a name change under section 69.

[1111] Births, Deaths, Marriages, and Relationships Registration Act 2021.

This section of the Act does not only remove the medical-laden processes that were required under section 28[1112] of the former Birth, Deaths, Marriages and Relationships Registration Act 1995 regarding the alignment of an individual's sex and gender identities. It also makes an allowance for individuals to change the sex recorded on their birth certificates with a simple declaration to the effect that one self-identifies as any other sex or gender specified. In terms of the former Act, a person's sex could only be described as 'male, 'female' or 'indeterminate' on a person's birth certificate. The new 2021 Act, however, covers "any other sex or gender specified".[1113] By implication, other sexes other than male, female, gender diverse, and indeterminate could be included.[1114]

[1112] Births, Deaths, Marriages, and Relationships Registration Act 1995 as repealed and replaced. This Act provided as follows: "(1) Subject to subsection (3), the Family Court may, on the application of an eligible adult (the applicant), declare that it is appropriate that birth certificates issued in respect of the applicant should contain the information that the applicant is a person of a sex specified in the application (in subsection (3) referred to as the nominated sex).
(2) The court must cause a copy of the application to be served on—
(a) the Registrar-General, if the applicant's birth is registered or is registrable under this Act but is not yet registered; and
(b) any other person who, in the court's opinion, is interested in it or might be affected by the granting of the declaration.
(3) The court shall issue the declaration if, and only if, —
(a) it is satisfied either that the applicant's birth is registrable under this Act but is not yet registered, or that there is included in the record of the applicant's birth—
(i) information that the applicant is a person of the sex opposite to the nominated sex; or
(ii) information that the applicant is a person of indeterminate sex; or
(iii) no information at all as to the applicant's sex; and
(b) it is satisfied that the applicant is not a person of the nominated sex, but—
(i) has assumed and intends to maintain, or has always had and intends to maintain, the gender identity of a person of the nominated sex; and
(ii) wishes the nominated sex to appear on birth certificates issued in respect of the applicant; and
(c) either—
(i) it is satisfied, on the basis of expert medical evidence, that the applicant—
(A) has assumed (or has always had) the gender identity of a person of the nominated sex; and
(B) has undergone such medical treatment as is usually regarded by medical experts as desirable to enable persons of the genetic and physical conformation of the applicant at birth to acquire a physical conformation that accords with the gender identity of a person of the nominated sex; and
(C) will, as a result of the medical treatment undertaken, maintain a gender identity of a person of the nominated sex; or (ii) it is satisfied that the applicant's sexual assignment or reassignment as a person of the nominated sex has been recorded or recognised in accordance with the laws of a State for the time being recognised for the purposes of this section by the Minister by notice in the Gazette".

[1113] Section 24(1).

[1114] Gender identity classification in New Zealand is the distinction between male, female, and indeterminate. See Frank Pega and others, 'Transgender Health: New Zealand's Innovative Statistical Standard for Gender Identity' American Journal of Public Health (2017) 107 217-221 <https://doi.org/10.2105/AJPH.2016.303465> accessed on 22 May 2023.

Under the new provisions, registration of a person's nominated sex may be done through an application to the Registrar-General for registration of their nominated sex. The person applying for this must be 16 years of age or older.[1115] The consent of the child is a statutory requirement in the case where a guardian applies for registration of a child's nominated sex.[1116] The application must "specify male, female, or any other sex or gender specified".[1117] If the eligible person is 16 or 17 years old, the application for registration must be accompanied by "the written consent of their guardian; or a letter of support from a suitably qualified third party" confirming that the minor "understands the consequences of the proposed registration of the nominated sex",[1118] and further that it is his or her preference to have the nominated sex registered "on any birth certificate issued under this Act".[1119]

Unlike the position in New Zealand, South African law still requires people to have medically transitioned into their identified gender which will be opposite to the one assigned at birth, before changing their gender marker and or names.[1120] This is, however, not limited to alterations made to a person's genitals.[1121] South Africa still lacks behind as it only recognises a binary gender marker system of male or female. These binary sex categories fail to encompass the full variety of sexual identities. Despite a progressive Constitution that includes gender identity provisions, South African law does not recognise non-binary gender markers, limiting the scope of the right to self-determination of persons regarding the expression of their gender identity. This also exposes transgender persons to potential discrimination. It also constitutes a violation of other rights entrenched in the Constitution, including the right to equality and the right to dignity.[1122]

[1115] Section 23(1).

[1116] Section 23(2).

[1117] Section 24(1).

[1118] Section 24(1)(c)(ii)(A).

[1119] Section 24(1)(c)(ii)(B).

[1120] Section 1 of the Alteration of Sex Description and Sex Status Act.

[1121] This is taking into account the definition of gender reassignment in s 1 of the Act. The definition is as follows: "… gender reassignment means a process which is undertaken for the purpose of reassigning a person's sex by changing physiological or other sexual characteristics, and includes any part of such a process …"

[1122] A Meerkotter (ed), *Laws and Policies Affecting Transgender Persons in Southern Africa* (Southern Africa Litigation Centre 2016) 11.

4.6.3 Canada

Canada has adopted explicit human rights legislation to secure the protection of trans people. The human rights legislation is aimed at ensuring equal treatment and preventing discrimination and harassment based on gender identity or expression. Section 3(1) of the Canadian Human Rights Act is an additional tool at the federal level which prohibits discrimination. It provides as follows:

> For all purposes of this Act, the prohibited grounds of discrimination are race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability and conviction for an offence for which a pardon has been granted or in respect of which a record suspension has been ordered.[1123]

The Criminal Code further provides that “every person who advocates or promotes genocide is guilty of an indictable offence and liable to imprisonment for a term of not more than 5 years”.[1124] The amendment of the Ontario’s Education Act[1125] additionally ensured protection for transgender and gender diverse individuals by inclusion of the provision that seeks to discourage bullying based on sexual orientation and also gender identity or expression.[1126] In the 2019 case of *A.B. v. C.D. and E.F*,[1127] the British Columbia Supreme Court prohibited a father from expressing his rejection on the child’s gender identity as that constituted a form of family violence against the child. The court stated that:

> It is declared under the Family Law Act that: … Attempting to persuade A.B. to abandon treatment for gender dysphoria; addressing A.B. by his birth name; referring to A.B. as a girl or with female pronouns whether to him directly or to third

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[1123] Section 3(1) of the Canadian Human Rights Act, RSC 1985. Additionally, Section 718.2 proves that: “[A] court that imposes a sentence shall also take into consideration the following principles: (a) a sentence should be increased or reduced to account for any relevant aggravating or mitigating circumstances relating to the offence or the offender, and, without limiting the generality of the foregoing,
(i) evidence that the offence was motivated by bias, prejudice or hate based on race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, sexual orientation, or any other similar factor”.

[1124] Section 318(1) of the Criminal Code (R.S.C., 1985, c. C-46).

[1125] Education Act RSO 1990. Accepting Schools Act, 2012 introduced the definition of bullying by amendment into the Education Act. Accepting Schools Act focuses on addressing bullying in schools across Ontario.

[1126] Section 1(1) states that ‘bullying’ “means aggressive and typically repeated behaviour by a pupil where, (b) the behaviour occurs in a context where there is a real or perceived power imbalance between the pupil and the individual based on factors such as ... sexual orientation ... gender, gender identity, gender expression ...”

[1127] 2019 BCSC 604.

> parties; shall be considered to be family violence under s. 38 of the Family Law Act.[1128]

In this case, the judge found it necessary to grant a protection order restraining a father from “attempting to persuade his son to abandon treatment for gender dysphoria”.[1129]

In Canada, children are subject to their parents’ authority and protection. It is generally the parents’ prerogative to make medical treatment decisions on behalf of their children. The Canadian common law, however, recognises the ‘mature minor’ doctrine which essentially accepts that children who are sufficiently mature may consent to their own medical treatment and procedures. In *Walker (Litigation Guardian of) v. Region 2 Hospital Corp.*,[1130] the New Brunswick Court of Appeal provided an analysis of the mature minor doctrine and its relevance on consent:

> In Canada, the common law recognizes the doctrine of a mature minor, namely, one who is capable of understanding the nature and consequences of the proposed treatment. Accordingly, a minor, if mature, does have the legal capacity to consent to his or her own medical treatment. […] At common law, where a minor is mature, no parental consent is required.[1131]

The right is applicable so long as the minor understands and appreciates the proposed medical treatment.[1132] In examining capacity, the test involves:

> [...] the ability to understand the reasonably foreseeable consequences of a treatment decision in a mature and comprehensive way. The significance and repercussions of a decision are relevant in assessing capacity. Capacity is presumed at the age of sixteen. An individual may have sufficient maturity and judgment at a younger age.[1133]

The mature minor doctrine has been recognised since 1986, in the case of *C. v. Wren.*[1134] The case involved a pregnant 16-year-old girl who left her parental home and decided to obtain an abortion. The parents were opposed to their child having an abortion and sought to prevent the procedure by relying on the premise that the child lacks capacity to give consent. The court disagreed with the parents and concluded that the girl understood the nature of the procedure and extent of the harm and risks

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[1128] 2019 B.C.S.C. 604 [10].

[1129] 2019 B.C.S.C. 604 [64].

[1130] *Walker (Litigation Guardian of) v. Region 2 Hospital Corp.,* 1994 CanLII 4470 (NBCA).

[1131] *Walker* case [487].

[1132] Lucinda Ferguson, ‘The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions’ 2004 <https://doi.org/10.2139/ssrn.998227.2.> accessed on 25 May 2023.

[1133] *Tarin Hand Children's Aid Society of Metropolitan Toronto* 10 O.F.L.R. 82, 88.

[1134] *C. v. Wren* (1986) 35 DLR (4th) 419 (Alta CA).

involved. Consequently, her parents' wishes were disregarded as the girl was found competent enough to provide consent. The court aligned itself with the *Gillick* test and stated that although parents have a legal right and are typically viewed as best suited to make treatment decisions for their child, such right expires if and when the child is considered to possess sufficient understanding to enable him or her to comprehend fully the proposed medical intervention.

The right to bodily integrity is also relevant in this context, as was formulated in the case of *Ciarlariello v Schacter*, where Cory J stated the following:

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent.[1135]

The Canadian provinces and territories all have legal frameworks governing consent to medical treatment. These jurisdictions have adopted different approaches regarding the consent of children to treatment. Some jurisdictions do not explicitly address children's consent to treatment, whilst others rely on legislation that is flexibly applied to both adults and children.[1136]

In Ontario, the Health Care Consent Act[1137] (HCCA) was passed in 1996 to specifically address the issues of consent to medical treatment.[1138] Section 4(2) of the HCCA stipulates that "a person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services". The section seems to be in alignment with section 15(1) of the Canadian Charter of Rights and Freedoms which states:

[1135] *Ciarlariello v Schacter* [1993] 2 SCR 119, 135. See also the case of *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.). The Ontario Court of appeal found that: "[T]he common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7. Indeed, in my view, the -common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of the individual, can be treated as coextensive".

[1136] David C Day, 'The Capable Minor's Healthcare: Who Decides?' (2007) 86 Canadian Bar Review 379.

[1137] Health Care Consent Act, 1996, S.O. 1996, c. 2.

[1138] John Philippe Schuman, 'When Worlds Collide: The Legal Rights of Minors in Ontario to Direct Medical Treatment' (1999) 5 Appeal Law Journal 38-53.

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The Charter refers to the phrase ‘every person’ which includes citizens of all ages, meaning that minors cannot be treated differently because of their age. It can thus, be argued that denying minors the ability to fully participate in their own medical treatment decisions would be interfering with their right to dignity. By implication, in terms of the HCCA and the Charter, children would be presumed capable of consenting to treatment, unless the presumption can be rebutted. Importantly, the legislation does not mention any specific age of consent. However, according to section 7(1) of the Consent to Treatment and Health Directives Act,[1139] this presumption can be rebutted where:

> (1) [a] patient is capable with respect to treatment if the patient is, in the health practitioner’s opinion, able
>
> (a) to understand the information that is relevant to making a decision concerning the treatment;
>
> (b) to understand that the information applies to his or her particular situation;
>
> (c) to understand that the patient has the right to make a decision; and
>
> (d) to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

Section 11 of the HCCA contains additional requirements to determine whether consent has been given:

> (1) The following are the elements required for consent to treatment:
>
> 1. The consent must relate to the treatment.
> 2. The consent must be informed.
> 3. The consent must be given voluntarily.
> 4. The consent must not be obtained through misrepresentation or fraud.
>
> (2) A consent to treatment is informed if, before giving it,

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[1139] Consent to Treatment and Health Care Directives Act, S.P.E.I. 1996, c. 10.

> (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
>
> (b) the person received responses to his or her requests for additional information about those matters.
>
> (3) The matters referred to in subsection (2) are:
>
> 1. The nature of the treatment.
>
> 2. The expected benefits of the treatment.
>
> 3.The material risks of the treatment.
>
> 4. The material side effects of the treatment.
>
> 5. Alternative courses of action.
>
> 6. The likely consequences of not having the treatment.

Section 10(1)[1140] of the HCCA requires health care providers to respect the patient's wishes whether or not to receive specific treatment, unless they have reasonable cause to believe that the patient lacks sufficient maturity to understand the proposed treatment, or the possible risks involved. Treatment decisions must be made in the best interests of the patient. Section 7 of the Charter also guarantees specific rights to everyone, including the right to "liberty and security of the person". The section makes it explicitly clear that any deprivation of these rights should strictly be "in accordance with the principles of fundamental justice".[1141]

In the province of British Columbia, the Infants Act[1142] governs the right of children to consent to medical treatment.[1143] This is consistent with the Canadian common law

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[1140] The section provides that "[A] health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act".

[1141] Section 7 of the Canadian Charter of Rights and Freedoms.

[1142] Infants Act, Revised Statutes of British Columbia 1996.

[1143] Section 17 provides that "(1) Subject to subsection (3), an infant may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the infant's person, and if an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian.

that recognised that children could consent to their own medical treatment. The judgment of the Ontario High Court of Justice in the case of *Johnston v Wellesley Hospital*[1144] held that there is no specified minimum age threshold at which children accumulate decisional capacity to provide their own consent regarding medical treatment.[1145] The condition for decisional capacity is that children should understand the nature and consequences of the proposed medical treatment which is in alignment with the *Gillick* standard. The Supreme Court, in the case of *A. C. v. Manitoba (Director of Child and Family Services*[1146] emphasised that the best interests of the child standard must be applied in a manner that seriously considers children's views in accordance with their level of maturity as far as treatment decisions are concerned. The best interest principle was also emphasised in the case of *AB v CD and EF*,[1147] which involved a 14-year-old transgender boy who sought gender-affirming medical treatment at age 13. In this instance, the child's endocrinologist recommended that the child should receive puberty-delaying hormone therapy, with the father opposing the treatment. The matter went to court and a ruling was made in favour of the child, ordering the treatment to proceed.

Justice Marzari based his ruling on section 41(f) of the Family Law Act.[1148] This section has incorporated the provisions of section 17 of the Infants Act,[1149] thus making

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(2) A request for or consent, agreement or acquiescence to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care.
(a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and
(b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests".

[1144] *Johnston v Wellesley Hospital* (1970) 17 DLR (3d) 139.

[1145] *Johnston* 144-145. The court held that: "But, regardless of modern trend, I can find nothing in any of the old, reported cases, except where infants of tender age or young children were involved, where the Courts have found that a person under 21 years of age was legally incapable of consenting to medical treatment. If a person were unable to consent to medical treatment, he would also be incapable of consenting to other types of bodily interference. A proposition purporting to establish that any bodily interference acquiesced in by a youth of 20 years would nevertheless constitute an assault would be absurd… I feel that the law on this point is well expressed in the volume on Medical Negligence (1957) by Lord Nathan (pl 76): 'It is suggested that the most satisfactory solution of the problem is to rule that an infant who is capable of appreciating fully the nature and consequences of a particular operation or of particular treatment can give effective consent thereto, and in such cases the consent of the guardian is unnecessary; but that where the infant is without the capacity, any apparent consent by him or her will be a nullity, the sole right to consent being vested in the guardian".

[1146] *A. C. v. Manitoba (Director of Child and Family Services*, 2009 SCC 30, [2009] 2 S.C.R. 181.

[1147] *A.B. v. C.D. and E.F.*, 2019 BCSC 254.

[1148] Family Law Act, SBC 2011.

[1149] Infants Act, 1996.

the specific provision of the Family Law Act subject to section 17 of the Infants Act. In terms of section 17 of the Infants Act, the minor's effective consent to medical care is determined by his or her understanding of the proposed treatment and its consequences. Further, the health care provider must have found the minor capable of exclusive consent and that the nature of the treatment is in the minor's best interest. The court therefore made it clear that *AB* has the exclusive right to consent to the exclusion of his father's intervention.[1150]

In other jurisdictions, such as Manitoba[1151] and Newfoundland,[1152] the age of 16 is set as a yardstick where a child is generally presumed as having the capacity to consent to treatment. The legislations that are applicable in these provinces makes it explicitly clear that children below the age of 16 are presumed incapable of making health care decisions. Competent adults are, however, permitted to make decisions on behalf of minors who are incompetent of consenting.[1153]

In situations where a child lacks the mental ability to make treatment decisions, someone with appropriate mental capacity should be appointed as proxy to make decisions on a child's behalf.[1154] Guidelines on substitute consent have been adopted

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[1150] *A.B.* case. The court stated as follows: "Having considered the form of consent signed by A.B. and the evidence of [his psychologist, his physician, and his psychiatrist] I am satisfied that A.B.'s health care providers have explained to A.B. the nature and consequences as well as the foreseeable benefits and risks of the treatment recommended by them, that A.B. understands those explanations and the health care providers have concluded that such health care is in A.B.'s best interests".

[1151] Section 4(2) of the Health Care Directives Act CCSM c H27 provides that "[I]n the absence of evidence to the contrary, it shall be presumed for the purpose of this Act
(a) that a person who is 16 years of age or more has the capacity to make health care decisions; and
(b) that a person who is under 16 years of age does not have the capacity to make health care decisions".

[1152] Section 7 of the Advance Health Care Directives Act, SNL 1995, c A-4.1 states that". For the purpose of this section, there shall, in the absence of evidence to the contrary, be a presumption
(a) that an advance health care directive was made immediately prior to the maker losing the competency to make health care decisions;
(b) that a person who is 16 years of age or older is competent to make health care decisions; and
(c) that a person who is younger than 16 years of age is not competent to make health care decisions".

[1153] Section 5 of the Health Care Directives (applicable in Manitoba) and Section 9 of the Advance Health Care Directives as it is applicable in Newfoundland and Labrador.

[1154] Sarah MacKenzie, 'Informed Consent: The Right of Psychiatric Patients to Refuse Treatment' (1993) 2 Dalhousie Journal of Legal Studies 59.

in some Canadian provinces,[1155] and they are based strictly on the ‘best interest’ standard. The Alberta legislation, the Mental Health Act provides as follows:

> Sec. 28 (3) A person authorized by subsection (l)(b) to make treatment decisions on behalf of a formal patient shall make the decisions in accordance with what the person believes to be the best interest of the patient.
>
> (4) In order to determine the best interest of the formal patient in relation to treatment, a person referred to in subsection (l)(b) shall have regard to the following:
>
> (a) whether or not the mental condition of the patient will be or is likely to be improved by the treatment;
>
> (b) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment; (c) whether or not the anticipated benefit from the treatment outweighs the risk of harm to the patient;
>
> (d) whether or not the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c).[1156]

Invoking the best interests is purposed to ensure that the decision will in principle, benefit the patient. An authorised person must thus satisfy himself or herself that the benefit will reasonably be achieved through the intervention. It therefore, falls on the authorised person to ensure that the interests of the patient are respected.

In the province of Québec, consent may legally be given directly by patients from the age of 14 years.[1157] Québec seem to recognise an age specific threshold to medical consent, rather than the one based on the child’s development. It should be noted that Quebec does not have a legislative definition of capacity and has adopted the five criteria for capacity as stipulated in the Nova Scotia Hospitals Act.[1158] Such consent is

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[1155] Ontario, New Brunswick, and Alberta, with Alberta and New Brunswick using the ‘best interests’ model test.

[1156] Section 28 of the Mental Health Act, RSA 2000, c M-13 <https://canlii.ca/t/55zj6> accessed on 26 May 2023.

[1157] Civil Code of Québec: Bill 125 (1991, chapter 64). Québec: Québec Official Publisher, 1991 <https://www.legisquebec.gouv.qc.ca/en/pdf/cs/CCQ-1991.pdf> accessed on 27 May 2023. Article 17 provides that “A minor 14 years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor and may cause him grave and permanent effects”.

[1158] Nova Scotia Hospital Act, RSNS 1989, c 313 <https://canlii.ca/t/jpnk> accessed on 06 June 2023. Section 52 stipulates as follows:
“(1) Every adult person in a hospital or a psychiatric facility is presumed to have capacity to make all treatment decisions with respect to the person’s health care and to be competent to administer the person’s estate.

subject to certain limitations associated with the severity of the illness and the risk of harm. This is because although a minor is entitled to give individual consent to health care that is not required by the state of his or her health, parents must generally consent if the health care involves any serious risks or may potentially lead to grave and permanent effects to the child.[1159] It is hence doubtful that minors can provide their own consent to gender reassignment treatments in Québec, particularly concerning the risks involved with these procedures.[1160]

It is important to note that laws that protect transgender children in Canada differs from province to province. Despite the role of the Canadian Association for Transgender Health (CPATH), each province is responsible for implementing its own health care system and responding to persons' health needs within a framework of universal coverage.[1161] As a result, access to transgender health care for children and young adults remains disparate because of a lack of consistency in the Canadian laws across the provinces, with some provinces not having any transgender-specific health care policies.[1162] These disparities create a solid barrier for transgender individuals to get full access to transgender health care in Canada. There is a need for harmonisation of laws to protect transgender individuals across Canada, particularly adolescents.

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(2) A person in a hospital or a psychiatric facility may be found, after examination by a psychiatrist, not to be capable of consenting to treatment or competent to administer the person's estate.
(2A) In determining whether or not a person in a hospital or a psychiatric facility is capable of consenting to treatment, the examining psychiatrist shall consider whether the person understands and appreciates
(a) the condition for which the specific treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing the specific treatment; and
(d) the risks and benefits involved in not undergoing the specific treatment".

[1159] Section 17 of the Civil Code provides "A minor 14 years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor and may cause him grave and permanent effects".

[1160] Canadian Medical Protective Association. Can a child provide consent? Canadian Medical Protective Association. 2018. Updated 2021 May. <https://www.cmpa-acpm.ca/en/advicepublications/browse-articles/2014/can-a-child-provide-consent> accessed on 30 May 2023.

[1161] Gerald Hunt and Michael Pelz, Transgender Rights in Canada: Legal, Medical and Labour Union Activities' in: Köllen T (eds), *Sexual Orientation and Transgender Issues in Organizations* (Springer, Cham 2016) 133-147 <https://doi.org/10.1007/978-3-319-29623-4_8> accessed on 14 July 2023.

[1162] Hunt and Pelz, Transgender Rights in Canada.

In Québec, the fixed age where a minor patient can give a direct consent to medical treatment is set at 14 years and older. However, an exception applies in circumstances where a minor is required to remain in a health establishment for more than 12 hours. In such a situation, an additional requirement is that the person with parental authority or guardianship must be informed about the arrangement.[1163] However, should the physician or another health care provider determine that the child has the decisional capacity, parental consent is not required. In such circumstances, the autonomous consent of the child will be sufficient, even when he or she is accompanied by both the biological parents or legal guardians.

Some provinces, such as Ontario, does not have an age-specific requirement for consent to medical treatment. In terms of their domestic legislation,[1164] all persons are presumed capable of giving consent[1165] in respect of their medical treatment.[1166] The Act[1167] requires health care practitioners to rely on this presumption of capacity,[1168] the only exception however, would be where there are reasonable grounds to believe that the person lacks the required capacity to consent.[1169] The onus is placed on the health care practitioner to prove that the person is incapable of making a decision, owing to specific conditions. The Act requires the consent of the substitute decision-maker where the patient is incapable of consenting. The Supreme Court of Canada (SCC) set out the test as to whether someone had decisional capacity under the

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[1163] Article 14 of the Civil Code of Québec provides that: "A minor 14 years of age or over, however, may give his consent alone to such care. If his state requires that he remain in a health or social services establishment for over 12 hours, the person having parental authority or tutor shall be informed of that fact."

[1164] Health Care Consent Act, 1996.

[1165] Section 4(1) of the HCCA defines capacity as follows: "A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision". See also S 45 of the Substitute Decisions Act, 1992, S.O. 1992, c. 30.

[1166] Section 4(2) of the Health Care Consent Act.

[1167] Healthcare consent act, 1996.

[1168] Loren H Roth and others, 'Tests of competency to consent to treatment' (1977) 134 American Journal of Psychiatry 279-282 <https://doi.org/10.1176/ajp.134.3.279> accessed on 06 June 2023. The author at 281 writes "what matters in [the ability to understand test of capacity] is that the patient is able to comprehend the elements [of benefits and risks that] are part of treatment decision making. How the patient weighs these elements, values them, or puts them together to reach a decision is not important.".

[1169] Section 4(3) of the HCCA, it provides as follows: "A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be."

Ontario HCCA. The leading authority involving treatment capacity is the judgment in the case of *Starson v. Swayze*[1170] where Chief Justice McLachlin held that:

> [T]he issue in the [capacity] hearing is not the merits of medication or other treatment, but the patient's ability to understand and appreciate the benefits and drawbacks of treatment or lack thereof.[1171]

The Supreme Court further argued that:

> [...] if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.[1172]

In this instance, *Starson* was found to have met this relevant criterion and was therefore, deemed to have sufficient capacity to make his own treatment decisions.[1173] The 2004 case of *M.B. c. Centre Hospitalier Pierre-LeGardeur*[1174] upheld the finding of incapacity as determined in *Starson*, where the Court of Appeal's majority judgement held that:

> [T]he principles laid down in Starson do not prohibit an analysis using the five-question test [for capacity] set forth [under the Nova Scotia Hospitals Act.] They are simply there to guide the judge in a review of these questions.[1175]

Like Ontario, Prince Edward Island and the Yukon also do not prescribe the minimum age requirements in terms of their health consent legislations. The requirements are that a child must be *Gillick competent*. Van Rooyen and others have argued that "age

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[1170] *Starson v Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722.

[1171] *Starson* case para 36.

[1172] *Starson* case para 79. Again, in the case of *Roy v. Furst* 1999 O.T.C. Uned. 333 (S.C.), at para 10, the court held that "[I]t is not sufficient that a person have an intellectual understanding of the nature of his or her illness and the treatment proposed. [...] A person is not mentally capable if delusions render him or her incapable of understanding the information that is relevant to making a decision about the treatment and/or unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

[1173] *Starson* case at para 78, Justice Major wrote "…Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. There is no doubt the respondent satisfied this criterion. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof."

[1174] *M.B. c. Centre hospitalier Pierre-de-Gardeur* (2004), 238 D.L.R. (4th) 312 (Que. C.A.).

[1175] *M.B. c. Centre hospitalier* case para 43. At para 45-46 the court continued and stated that "[T]he criteria contained in the five questions adopted [from the Nova Scotia Hospitals Act] are not cumulative. The court must consider these criteria as a whole in order to determine whether … the patient actually understands the parameters of the decision that he or she is making."

has been shown to be an inaccurate marker of the level of children's competence".[1176] The legal position in these Canadian provinces[1177] is that minors can make their own health care decisions without interference if and when they are deemed to have sufficient capacity.[1178] As already indicated, age considerations are not applicable and thus not relevant and determinative. Although Canada is lagging behind with the implementation of the rights and protocols of the UNCRC, some provinces seem to have aligned themselves with the UNCRC by not imposing a specific age under which a child's capacity is determined.[1179] Although the ACRWC is a regional instrument that is relevant to African countries, the similarities that it has with the UNCRC have been discussed earlier. Like the UNCRC, it enables children to express their views, thus conceptualising them as autonomous beings. It also does not subscribe to a specific age of determining the child's capacity. The general rules of consideration require a child to understand the information relevant to deciding about the proposed treatment, and further, to appreciate the reasonably foreseeable benefits and risks of his or her decision. Although the patient is required to have the ability to appreciate the consequences of his or her decision, Major J of the Supreme Court of Canada observed the following regarding the ability to appreciate:

> However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences […].[1180]

As indicated above, each country has its own legal requirements for determining whether a child has the capacity to consent to medical interventions, regardless of their age. Some countries have incorporated the competency-based approach into their domestic law as the sole determining factor. Rather than focusing only on the age of the child, the main focus is placed on how competent each child is. This means

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[1176] Amanda van Rooyen and others, 'What makes a child a 'competent' child?' (2016) 128 The New Zealand Medical Journal 88-95.

[1177] Ontario, Prince Edward Island and Yukon.

[1178] Reyes Boceta, Olga Martínez-Casares and Marta Albert, 'The Informed Consent in the Mature Minor: Understanding and decision-making capacity' (2021) 95 Anales de Pediatría (English Edition) 413-422 <https://doi.org/10.1016/j.anpede.2020.10.011> accessed on 11 June 2023.

[1179] General Comment No 12 para 21. It provides as follows: "[T]he Committee emphasizes that article 12 imposes no age limit on the right of the child to express her or his views and discourages States parties from introducing age limits either in law or in practice which would restrict the child's right to be heard in all matters affecting him or her".

[1180] *Starson* case para 81.

that children can make informed decisions only when they demonstrate maturity and capacity to make treatment decisions that are congruent with their own values and preferences. In this context, minors who are considered to have the capacity to make particular treatment decisions, are recognised as competent adults who have the right to provide free and informed consent.[1181] Reyes Boceta and others argue that:

> The assessment of this competence is complex, as maturity is a developmental process that involves the maturation of moral judgment, cognitive development, emotion and the health condition of the minor.[1182]

Competence in the medical context typically refers to the legal *ability* to understand the proposed treatment, consider the risks and benefits of treatment options, and make an informed decision.[1183] The basis for the decision is the detailed medical information which would have been provided by the health care provider as morally and legally required.[1184]

In the context of Article 12 of the UNCRC[1185] as discussed earlier, capacity entitles a child to a higher level of responsibility and allows him or her to express his/her views in all areas that affect his/her life, in a reasonable and independent manner.[1186] The Convention further states that due weight must be placed on the child's viewpoint "in accordance with the age and *maturity* of the child". Phillip Crosby first introduced the concept of maturity in his conceived Quality Management Maturity Grid (QMMG),[1187] but this term is now used in the health care settings as well. This notion of *maturity* is defined as "the state of being complete, perfect, or ready".[1188] Although the concept maturity is one of the central values and frequently discussed in legal settings that

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[1181] Elias Baumgarten, 'The concept of "competence" in medical ethics' (1980) 6 Journal of medical ethics 180-184 <https://www.jstor.org/stable/27715897> accessed on 08 June 2023.

[1182] Boceta, 'The Informed Consent in the Mature Minor.'

[1183] Victoria A Miller, Dennis Drotar and Eric Kodish, 'Children's competence for assent and consent: a review of empirical findings' (2004) 14 Ethics Behaviour 256 <https://doi.org/10.1207/s15327019eb1403_3> accessed on 08 June 2023.

[1184] Baumgarten, 'The concept of "competence" in medical ethics.'

[1185] See the UNCRC.

[1186] UNCRC General Comment No. 12 2009, para. 85. It provides that: "This requirement is stimulated by article 12 of the Convention, which stipulates that the child's views must be given due weight, whenever the child is capable of forming her or his own views. In other words, as children acquire capacities, so they are entitled to an increasing level of responsibility for the regulation of matters affecting them".

[1187] The QMMG is used by a business or organization as a diagnostic tool to assess the level of maturity of their operations and processes, with respect to service or product quality management. See JA Schmele and SJ Foss, 'The quality management maturity grid: a diagnostic method' (1989) 19 Journal of Nursing Administration 29-34.

[1188] Phillip Crosby, *Quality is free* (New York: McGraw-Hill, 1979).

involve children, it does not have a universal definition within health care settings. The Committee on the Rights of the Child attempted to provide clarity and practical guidance to the concept maturity in the context of article 12 of the UNCRC. As part of this attempt, they defined the concept within a cognitive framework. They proposed that maturity "is the capacity of a child to express her or his views on issues in a reasonable and independent manner".[1189] Generally, this developmental approach to maturity has received support from health care professionals.[1190] Against this background, the objective of article 12 is to encourage adults to recognise that maturity is a developmental process and that they should listen to the opinions of children and involve them in decisions that affect them. It is worth noting that although Articles 3 and 12 of the UNCRC relate to a child's right to be heard, specific protection is accorded to these children by ensuring that their best interests have a "primary consideration" in any decision-making process.

According to the UNCRC, the right to be heard is determined through the age and maturity of the child. In terms of Article 12(1), member states have the primary responsibility to assure the right to be heard to every child 'capable of forming his or her own views.'[1191] For this reason, some jurisdictions like South Africa have adopted legislation which recognises a legally fixed age and an assessment of a child's maturity and mental capacity respectively.[1192] My submission is that the respective recognition of both approaches allows for more fluidity and flexibility in issues relating to consent. It has already been mentioned that in other jurisdictions such as Newfoundland in Canada, the age at which minors are deemed legally competent to consent to health care decisions is 16, with those below 16 presumed incapable. The Advanced Health

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[1189] UNCRC General Comment No. 12 2009, para 30. It provides as follows: "Maturity refers to the ability to understand and assess the implications of a particular matter and must therefore be considered when determining the individual capacity of a child. Maturity is difficult to define; in the context of article 12, it is the capacity of a child to express her or his views on issues in a reasonable and independent manner. The impact of the matter on the child must also be taken into consideration. The greater the impact of the outcome on the life of the child, the more relevant the appropriate assessment of the maturity of that child".

[1190] Pillay and Singh, ''Mental capacity', 'sufficient maturity', and 'capable of understanding' in relation to children.'

[1191] UNCRC was ratified by Canada on 13 December 1991. Canada has legally committed itself to ensuring that they meet the standards of the Convention, however, it is lagging far behind on implementing the rights and protocols under the UNCRC.

[1192] Section 10 and section 129 of the Children's Act, 2005.

Care Directives Act has a provision for competency-based approach.[1193] This requires health care providers to satisfy themselves that the minor understands the information conveyed regarding the options (such as a surgical procedure), consequences, benefits and risks of the health care before agreeing to it. In the case of a complex treatment, a careful assessment of competency is required to determine whether or not it is the right decision for the minor to make.[1194] South African law requires adolescents to be duly assisted by parents in respect of surgical operations, and thus the same will be required for gender affirming operations.[1195]

4.6.4 Denmark

The law in Denmark makes provision for health care issues related to gender identity under the provisions of the Danish Health Law.[1196] The Danish Health Act[1197] empowers patients in securing participation rights in medical decision-making. Section 1 of this Act provides for a fixed age limit for minors to make independent health care decisions at 15 years:

> A patient who has reached the age of 15 can provide informed consent to treatment. The custodians must be informed as well, in accordance with § 16 (see above: A. Right to informed consent as a basic requirement) and be included in the decision of the minor.[1198]

The Act further stipulates that physicians should not initiate or continue with the provision of medical treatment without the informed consent of the patient. The only exception is when such treatment has been established by law or regulation in

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[1193] Section 14 of the Advanced Health Care Directives Act states that "A maker shall be considered competent to make an advance health care directive where he or she is able to understand the information that is relevant to making a health care decision and able to appreciate the reasonably foreseeable consequences of that decision".

[1194] Govert den Hartogh, 'Do we need a threshold conception of competence?' (2016) 19 Medicine, Health Care and Philosophy 71-83 <https://link.springer.com/content/pdf/10.1007/s11019-015-9646-5.pdf> accessed on 13 June 2023.

[1195] Section 129 of the Children's Act, 2005.

[1196] Guide on healthcare related to gender identity (Danish Health Authority 2018) 6. See also section 3 of the Health Act No. 546 of 24/06/2005 which provides as follows: "According to the rules in this act, regions and municipalities are responsible for the health service offering a population-oriented effort regarding prevention and health promotion as well as treatment of the individual patient".

[1197] The Health Act (No. 546 of 2005).

[1198] Section 1 of the Health Act.

accordance with sections 17-19 of the Act.[1199] Informed consent is defined as "consent that has been given on the basis of adequate information on the part of the health care professional, according to section 16".[1200] The requirement of informed consent in terms of the Act is that information must be provided continuously to the patient regarding his/her options for treatment, including the risk of complications and side effects.[1201] The provision specifically requires that the provided information must take into account the capabilities of the minor with respect to several factors, including, but not limited to age, maturity, and experience.[1202]

Although minors at the age of 15 years are generally considered to be capable of giving an informed consent, it is essential for parents to be kept informed and included in the decisions taken by the minors.[1203] This means that consent would have been procured from both the parents and their children. Nys and others[1204] argue that a minor of 15 years and older has the ultimate say when the parents have extremely different feelings that clash with his or hers, thus resulting in a disagreement.[1205] However, informed consent of a person holding parental authority will be required if the physician, based on an individual assessment, has found a person of 15 years and older incapable of taking autonomous health care decisions.[1206]

The Danish Health Act's requirement on informed consent is consistent with Article 5 of the Convention on Human Rights and Biomedicine of the Council of Europe which provides as follows:

[1199] Section 15(1) provides that "No treatment may be initiated or continued without the patient's informed consent, unless otherwise determined by law or regulations in accordance with the law or sections 17-19".

[1200] Section 15(3).

[1201] Section 16(3) states as follows: "The information must be provided continuously and provide an understandable presentation of the disease, the examination and the intended treatment. The information must be given in a considerate manner and be adapted to the individual requirements of the recipient in terms of age, maturity, experience, etc".

[1202] Section 16(3). In terms of Section 16(4): "The information must include information about relevant prevention, treatment and care options, including information about others, medically sound treatment options, as well as information about the consequences of no treatment being initiated. The information must be more extensive when the treatment entails a near risk of serious complications and side effects."

[1203] Section 17(1).

[1204] Herman Nys and others, "Patient Rights in the EU. Denmark", European Ethical-Legal Papers No 2 (Leuven 2007).

[1205] Nys and others, 'Patient Rights in the EU. Denmark' 17.

[1206] Section 17(2). See also Nys and others, 'Patient Rights in the EU. Denmark' 11.

> An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.[1207]

It is given that in some instances, minors may be found incapable of exercising their right to give autonomous consent in a health care setting due to factors including age or their cognitive capabilities. Therefore, the Convention contains a specific provision addressing the protection of persons who are considered having no capacity to consent or who are not fully capable of acting independently.[1208] In this instance, a treatment of a minor who lacks the competence to consent to medical treatment may only be carried out after "his/her representative or an authority or a person or body provided by law" has granted its authorisation. Such an authorisation must be for the minor's "direct benefit".

In addition, the Convention embodies the idea that the opinion of the minor shall be taken into account "as an increasingly determining factor in proportion to his or her age and degree of maturity".[1209] The Explanatory Report to the Convention states that the Convention's intention is not to introduce a single system for the whole of Europe. It thus, gives discretion to each country's domestic law to determine with certainty if a person is capable of consenting to medical treatment.[1210] The principles of the

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[1207] Article 5 of the Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. Brussels: European Treaty Series-No 164, 1996. The Convention was adopted by the Council of Europe in Oviedo, on 4 April 1997 and entered into force in 1999 <http://conventions.coe.int/treaty/en/treaties/html/164.htm> accessed on 01 June 2023. The Explanatory notes on Article 5 (Strasbourg 1997) further explains that: "Human beings must therefore be able to give or refuse their consent to any intervention involving their person. This rule makes clear patients' autonomy in their relationship with healthcare professionals and restrains the paternalistic approaches which might ignore the wish of the patient…"

[1208] Article 6(2) of the Council of Europe Convention states that: "Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law".

[1209] Article 6(2) of the Council of Europe Convention.

[1210] See section 42 of the Explanatory Report to the Convention on human rights and biomedicine (ETS 164) which provides as follows: "The incapacity to consent referred to in this article must be understood in the context of a given intervention. However, account has been taken of the diversity of legal systems in Europe: in some countries the patient's capacity to consent must be verified for each intervention taken individually, while in others the system is based on the institution of legal incapacitation, whereby a person may be declared incapable of consenting to one or several types of act. Since the purpose of the Convention is not to introduce a single system for the whole of Europe but to protect persons who are not able to give their consent, the reference in the text to domestic law seems necessary: it is for domestic law in each country to determine, in its own way, whether or not persons are capable of consenting to an intervention

Convention are binding on the member states that have ratified it, including Western Europe's Denmark.[1211]

In order to ensure that respect is afforded to the dignity, integrity[1212] and self-determination of the patients, the Act on Patients' Rights[1213] was introduced in Denmark. Regarding self-determination of the patient, the Act provides that:

> The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.[1214]

As mentioned above, Denmark has set a statutory fixed age at which minors of a certain age may independently take health care decisions. It must be borne in mind that the age of consent usually does not correspond with the legal age of majority. It has already been indicated that minors are considered incapable of giving consent, and in such circumstances, the consent of the child's representative is required.

Although the fixed-age approach presumes minors as legally capable of making medical decisions and views them as competent because of their age, some countries have formulated some additional requirements or exceptions. In Denmark, puberty blockers may be prescribed to a 12-year-old subject to parental consent. The same position is applicable in South Africa where the age of consent to medical treatment is fixed at 12 years.[1215] However, considering the nature of puberty blockers, South African guidelines require that "the short- and long-term benefits and risks of puberty

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and taking account of the need to deprive persons of their capacity for autonomy only where it is necessary in their best interests" <https://rm.coe.int/16800ccde5> accessed on 02 June 2023.

[1211] Oviedo Convention in Central and Eastern European Countries. Medicínska etika & Bioetika - Medical Ethics and Bioethics. Vol. 16, 2009, Supplementum p 10 <http://www.bioetika.sk/files/casopis/Suppl%201%202009%20brief.pdf#page=23> accessed on 02 June 2023.

[1212] Section 482.13(a)(c) provides as follows: "(1) The patient has the right to personal privacy.
(2) The patient has the right to receive care in a safe setting.
(3) The patient has the right to be free from all forms of abuse or harassment".

[1213] Patients' Rights Act No. 482 of 1 July 1998. See also Maria Olejaz and others, 'Denmark: Health system review' (2012) 14 Health Systems in Transition 48 <https://apps.who.int/iris/bitstream/handle/10665/330321/HiT-14-2-2012-eng.pdf?sequence=5&isAllowed=y> accessed on 10 June 2023.

[1214] Section 482.13(b)(2) of the Patients' Rights.

[1215] Section 129(2) of the Children's Act.

suppression and gender-affirming HT are discussed with both the adolescent and their parents/legal guardians".[1216]

In Denmark, health care professionals play a more important role in the process of evaluating competence and maturity of the minor child. Any determination of the child's cognitive ability and maturity is done on a case-by case basis.[1217] In 1991, Denmark ratified the UNCRC. This ratification indicates a commitment by Denmark to be bound by the Convention or to carry out obligations under this Convention.[1218] In terms of the UNCRC, due weight should be given to the views of the child 'in accordance with the age and maturity of the child.'[1219] Several Danish laws have incorporated this aspect, although legislation may specify different age limits[1220] governing children's consent.[1221] Section 2(1) of the Danish Act on Parental Responsibility[1222] provide rules under which the custody holder is obliged act on behalf of the child. In terms of this Act, parental authority entails both the right to decide and a duty to care for the child.[1223] This being so, the fundamental understanding in the Danish law is that parents must make decisions from the perspective of the child's interests, and the expectation is thus, that parents must be capable of ascertaining the best interest of the child.[1224] In situations where this assumption has been violated or in the context of great uncertainty, the social authorities may legally intervene, subject to the Danish Social Services. It is worth noting that the parent's right to act on behalf of the child is

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[1216] SAHCS GAHC at 2.2.3, 23.

[1217] World Health Organization, 'Assessing and supporting adolescents.'

[1218] Per Schultz Jørgensen, Ingrid Leth and Edith Montgomery, 'The Children's Rights Convention in Denmark: A Status Report on Implementation' (2011) 22 Early Education and Development 839-862 <https://doi.org/10.1080/10409289.2011.597026> accessed on 11 June 2023.

[1219] Article 12 of the UNCRC.

[1220] The age of medical consent without parental 15-17 years, whereas abortion is only allowed without parental consent from the age of majority, which is mostly 18 years. It seems as if this norm is likely to change in the immediate future with abortion without parental consent being authorised at age 15. See Christian Wienberg, 'Denmark Will Allow Under-18s Right to Abortion Without Parental Consent' Børsen Pro international (Published on 24 May 2023) <https://borsen.dk/nyheder/prointernational/politics/article3372397.ece> accessed on 13 June 2023.

[1221] Hanne Hartoft, "Chapter 15 Children's Right to Participation in Denmark: What Is the Difference between Hearing, Co-Determination and Self-Determination?". In *Children's Constitutional Rights in the Nordic Countries* (Leiden, The Netherlands: Brill Nijhoff 2019) <https://doi.org/10.1163/9789004382817_016> accessed on 14 June 2023.

[1222] Parental Responsibility Act 1417 of 2017.

[1223] Commission report No. 985/1983, 24-25.

[1224] Caroline Adolphsen, "Chapter 19 Children's Right to Family Life in Denmark". In *Children's Constitutional Rights in the Nordic Countries* (Leiden, The Netherlands: Brill Nijhoff 2019) <https://doi.org/10.1163/9789004382817_020> accessed on 15 June 2023.

usually terminated when the child reaches the age of 18 in most countries, or alternatively, when a minor acquires the right to self-determination on a specific area in earlier years.[1225] In accordance with section 17 of the Danish Health Act, a minor may acquire this right at the age of 15. It should be noted that although the regulation of children's rights has a long history in Danish legislation, not a lot of focus was placed on these rights. The recognition of the UNCRC has paved a way for children's rights to be rooted in the Danish legislation, case law and institutions.[1226]

4.6.4.1 Denmark on legal gender recognition

One of the reasons for the inclusion of Denmark in this thesis was for its progressive view towards gender recognition reform. The Danish Parliament has passed the most progressive LGBTQIA+ legislation that makes it possible for citizens to legally change their gender to match their identified gender.[1227] This step has made Denmark the first European country to give effect to the LGBTQIA+ rights through legal gender reassignment.[1228] This was also an attempt from the Danish government to enhance sexual equality. Therefore, consideration was given to the risks related to surgery and those who wish to change their gender legally without having to undergo surgery to have the same rights. This 2014 Act, the *Det Centrale Personregister* (Central Personal Registry)[1229] does not require applicants to have taken hormones or having undergone sex-reassignment surgery or even psychological evaluation. Section 3(6) of the Act provides:

> PCS. 6. The Ministry of the Economy and the Interior assigns, upon written application, a new social security number to a person who identifies as belonging to the other sex. Allocation of a new social security number is conditional on the person concerned making a written statement that the desire for a new social security number is based on an experience of belonging to the other gender, and that the person concerned confirms his application in writing after a reflection period of 6 months from the time of application. It is also a condition that the person in question is 18 years old at the time of application.[1230]

[1225] Adolphsen, "Chapter 19 Children's Right to Family Life in Denmark".

[1226] Hartoft, 'Children's Right to Participation in Denmark.'

[1227] Chris Dietz, 'Self-declaration of legal gender status in Denmark' (2018) 30 Age 8.

[1228] Dietz, 'Self-declaration of legal gender status in Denmark.'

[1229] Act no 752 of 25/06/2014 amending the Civil Registration System Act. This law was passed on 11 June 2014 and came into effect on the 01 September 2014.

[1230] Section 3(6) of the Act amending the Civil Registration Act 2014.

The trans citizen only needs to file a written application to the Ministry of Economic Affairs and the Interior for a new social security number. The application must indicate that the desire for change is based on a sense of having a gender identity that is incongruent to the recorded gender details. The minimum age for legal gender application is 18 years. Persons under the age of 18 are excluded from this dispensation. However, there is currently a new proposal which has a broad political support, and which recommends a change in the law to allow transgender and non-binary children (as suggested by the Danish Ethics Council, the age limit should be lowered to 10 to 12 years) to legally change their gender.[1231]

It should be noted that most countries require transgender persons to undergo sterilisation surgeries prior to receiving gender-affirmative treatment and legal gender reassignment. However, the provisions of the International Commission of Jurists (ICJ) and the International Service for Human Rights in their Yogyakarta Principles Plus 10 provide as follows:

> 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.[1232]

[1231] 'No easy ride for Danish bill legislating gender change from birth' Northern Europe CNE.news Published on 20-08-2022 <https://cne.news/article/1584-no-easy-ride-for-danish-bill-legislating-gender-change-from-birth> accessed on 23 June 2023.

[1232] International Commission of Jurists (ICJ), The Yogyakarta Principles Plus 10 - Additional Principles and State Obligation on the Application of International Human Rights Law in Relation to Sexual Orientation, Gender Expression and Sex Characteristics to Complement the Yogyakarta Principles, 10 November 2017 <https://www.refworld.org/docid/5c5d4e2e4.htm> accessed on 30 July 2023. In terms of principle 31, the states shall: "A. Ensure that official identity documents only include personal information that is relevant, reasonable and necessary as required by the law for a legitimate purpose, and thereby end the registration of the sex and gender of the person in identity documents such as birth certificates, identification cards, passports and driver licences, and as part of their legal personality;
B. Ensure access to a quick, transparent and accessible mechanism to change names, including to gender-neutral names, based on the self-determination of the person;
C. While sex or gender continues to be registered:
i. Ensure a quick, transparent, and accessible mechanism that legally recognises and affirms each person's self-defined gender identity;
ii. Make available a multiplicity of gender marker options;
iii. Ensure that no eligibility criteria, such as medical or psychological interventions, a psycho-medical diagnosis, minimum or maximum age, economic status, health, marital or parental

It is worth noting that these principles have no legal force or binding effect. They however, typically give rise to an expectation of compliance due to their affirmation of the binding international human rights standards[1233] applicable for all human beings regardless of their sexual orientation or gender identity.[1234] In 2003, South Africa became the first African country to give recognition to the rights of trans persons through the enactment of the Alteration of Sex Description and Sex Status Act.[1235] The provisions of this Act, however, requires applicants to furnish reports from medical practitioners, psychologists or social workers to the effect that their sexual characteristics have been altered.[1236] Such reports should accompany the applications for alteration of sex description. I believe that South African law falls short with regard to the protection of the rights and interests of the LGBTQIA+ individuals, and in promoting the constitutional right to equality as entrenched in section 9 of the Constitution.[1237]

4.7 Conclusion

This chapter has examined the legal frameworks regulating various aspects relating to the capacity of children to consent to their own medical treatment, including the *best interests* principle. The objective of the legal comparative overview of relevant provisions in the different jurisdictions selected for the comparison, was to assess the different frameworks with the purpose of improving the identified gaps in the existing South African legal framework governing the participation of children in gender reassignment procedures.

The comparison has pointed to different approaches to health care decisions involving minors, especially given the varied and complex nature of determining the competency

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status, or any other third party opinion, shall be a prerequisite to change one's name, legal sex or gender;

iv. Ensure that a person's criminal record, immigration status or other status is not used to prevent a change of name, legal sex or gender".

[1233] The Convention on the Rights of the Child is an example.

[1234] Oscar Schachter, 'The Twilight Existence of Nonbinding International Agreements' (1977) 71 American Journal of International Law 299.

[1235] Act 49 of 2003. See also B Camminga, 'The Stigma of Western Words": Asylum Law, Transgender Identity and Sexual Orientation in South Africa' (2018) 8 An Interdisciplinary Journal of Current Affairs and Applied Contemporary Thought 452-469 <https://doi.org/10.1080/23269995.2018.1521045> accessed on the 05 June 2023.

[1236] Section 2 of the Alteration Act.

[1237] Constitution of the Republic of South Africa, 1996.

of children to make independent medical decisions. In some jurisdictions, a fixed-age approach for children's decision-making was followed, whereas in others, the common law has developed to a point of recognising the growing maturity of children regarding medical decision-making. Children's decision-making in these jurisdictions was determined with reference to the following: (i) a fixed-age of consenting to health care intervention; (ii) competency-based approach to consent; and (iii) a hybrid consent approach which combines fixed age with competency-based approaches.[1238]

It is common knowledge that adults are generally presumed to be competent to make decisions, unless proven otherwise. This presumption regarding adults may be rebutted when an adult suffers in terms of a diagnostic criterion from an impairment or disturbance of the mind. On the other hand, minors have conventionally been presumed to have capacity to give informed consent to a particular treatment when they reach the legal age of majority. Therefore, owing to the presumed immaturity of minors in relation to age and understanding, minors have traditionally been considered incompetent of appreciating the nature as well as consequences of the proposed interventions. These limitations have clearly impacted negatively on the minor's capacity to consent.

The jurisdictions considered in this chapter, are all member states that have signed and ratified the UNCRC, have committed themselves to ensuring that children's voices are heard and listened to as is required by the UNCRC. The different legal approaches to children's consent regarding medical treatment and surgical procedures in the jurisdictions selected in this chapter reflect attempts to balance the interests and autonomy of children in the context of medical decision-making in varying degrees.

This chapter has also discussed the application of the *Gillick competence* test in some of the jurisdictions. Despite the usefulness of the test, it appears that several legal ambiguities still exist amongst clinicians when applying the *Gillick* test. Cave adds that

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[1238] Karine Sénécal and others, 'Legal approaches regarding health-care decisions involving minors: implications for next-generation sequencing' (2016) 24 European Journal of Human Genetics 1559-1564.

these ambiguities "are compounded by subsequent interpretation of *Gillick* in the law courts".[1239]

South Africa has made progress in ensuring that the rights of adolescents are protected. The protection of these rights is firmly entrenched in the Constitution and other relevant legislation, including the Children's Act.

Despite the appreciable progress made by South Africa in ensuring the realisation of children's rights, the South African legal framework relating to gender affirming care still remains inadequate. Legal developments regarding children's consent to medical decision-making should move towards an increased recognition of children's autonomy and participation in medical procedures involving them. This will result in better decisions being made,[1240] as decisions will be made *with* children and not *for* them. Children should, as far as possible, be provided with opportunities to contribute to discussions and decision-making processes without any fear of their ideas or views being rejected. Children who have sufficient understanding and the ability to grasp or understand the nature of the treatment in question, including risks and benefits as explained by health care professionals, should be heard and their views should be taken into consideration as much as reasonably possible. In addition, there should be clear guidelines to be used by health care providers who assess medical decision-making capabilities. The guidelines must apply to all assessment procedures and provide clarity on what determines decision-making capacity.[1241] This can be accomplished through legal reform, starting with an amendment to section 129 of the Children's Act.

The next chapter, chapter 5, will provide the conclusions and recommendations that follow from the preceding chapters.

[1239] Emma Cave, 'Goodbye Gillick? Identifying and resolving problems with the concept of child competence' (2013) 34 The Journal of the Society of Legal Scholars 103-122 <https://doi.org/10.1111/lest.12009> accessed on 20 June 2023.

[1240] Belinda Garth and others, 'Perceptions of participation: Child patients with a disability in the doctor–parent-child partnership' (2009) 74 Patient Education and Counseling 50.

[1241] Pillay and Singh, ''Mental capacity', 'sufficient maturity.''

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

In the case on *Bell*, Burnett LCJ in the Court of Appeal conceded that:

> The treatment of children for gender dysphoria is controversial. Medical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood. The question raises not only clinical medical issues but also moral and ethical issues, all of which are the subject of intense professional and public debate. Such debate, when it spills into legal proceedings, is apt to obscure the role of the courts in deciding discrete legal issues.[1242]

5.1 Introduction

The aim of this doctoral thesis was to address issues relating to child and adolescent participation in medical and gender reassignment interventions. In South Africa, child participation in medical decision-making is strengthened by relevant provisions in the Constitution, the Children's Act, as well as the National Health Act. Moreover, regarding gender reassignment procedures, the thesis has drawn from the useful comparison of the 2022 WPATH and the SAHCS GAHC clinical approaches in treating trans adolescents. The overriding reason to draw a distinction between the current WPATH and the SAHCS GAHC guidelines is that they vary, amongst others, in terms of the age threshold for providing gender-affirming medical care.

Importantly, this thesis has presented divergent views, which, when properly understood and analysed, will provide context on the current and ongoing debates pertaining to approaches to care for children and adolescents with gender dysphoria, including how medical interventions should be provided. The comparative approach has highlighted both proactive and restrictive approaches in the provision of gender affirming care in South Africa, Australia, New Zealand, Canada and Denmark. The different ways of approaching issues relating to the provision of gender affirming care offer us valuable insight on why guidelines have to be developed setting out the management of gender affirming care and for implementing a plan to assess the needs and treatment of gender dysphoric children.

[1242] *Bell and Another v Tavistock and Portman NHS Trust and others* [2021] ECiv 1363: [4].

My analysis of the varying approaches in relation to the way in which medical interventions are considered for children and adolescents focused on the autonomy of gender diverse children and adolescents. This is not limited to the issue of paying attention to an individual, but to encourage more collaborative approaches on how the government and institutions must promote and ensure the autonomy of transgender children and adolescents. I have further argued the importance of considering the best interests of the child as a key concept in influencing the provision of clinical care for transgender children and adolescents, which may not always be an easy exercise, especially when the wishes of transgender children and their parents or guardians differ.

Parental consent is generally required for any form of gender-affirming care. Yet, not all parents are willing to consent due to misconceptions, misinformation and a misguided hypothesis about gender dysphoria, including the fear that gender-affirming medical care on adolescents might be regretted later in life. Kopelman and Kopelman set out the reasonable approach in which the best interests of the child should be ascertained. They argue that:

> […] decision makers should use the best available information to assess the incompetent or incapacitated person's immediate and long-term interests and set as their prima facie duty that option (or from among those options) that maximizes the person's overall or long term benefits and minimizes burdens. (2) Second, decision-makers should make choices for the incompetent or incapacitated person that must at least meet a minimum threshold of acceptable care; what is at least good enough is usually judged in relation to what reasonable and informed persons of good will regard to be acceptable were they in the person's circumstances. (3) Third, decision makers should make choices compatible with duties to incompetent or incapacitated individuals (those unable to make decisions for themselves).[1243]

Parents' direct knowledge and affection of their children makes them particularly well suited to make decisions about their child's interests. In the English case of *Re C (HIV Test)*,[1244] the court considered parents' views in relation to the child as important, however, Mr Wilson, a judge in this matter, describes "[…] a rebuttable presumption that the united appraisal of both parents will be correct in identifying where the welfare

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[1243] Loretta M Kopelman and Arthur E Kopelman, 'Using a new Analysis of the Best Interests Standard to address Cultural Disputes: Whose data, Which values? (2007) 28 Theoretical Medicine and Bioethics 377 <https://doi.org/10.1007/s11017-007-9050-0> accessed on 21 July 2023.

[1244] *Re C (HIV test)* [1999] 2 FLR 1004.

of the child lies".[1245] Although the parents in this case refused testing and medication, the court endorsed the child's rights and granted an order authorising tests on the baby. While there is a legitimate justification that parents are better suited to make decisions about the interests of their children, ironically, that may not always be the case as parents may sometimes be mistaken regarding their child's interests. In the past, the health care professional was considered ethically justified to override the parent's decision, particularly in circumstances where the parent's decision "significantly increase[s] the likelihood of serious harm"[1246] to the child. There has however, been a shift in recent years from the physician-directed decision-making approach into an approach that recognises the importance of shared decision-making between the health care professional, patient and the parents.[1247] By law in South Africa, a child as a developing person with evolving capacities must be involved in decisions relating to their health, with consideration being given only to the options that are in the best interests of the child.[1248]

5.2 Developments in the South African Law

Chapter 2 highlighted the South African legal principles governing issues of consent for minor children's medical treatment, including how these legal principles have developed over time. Against the backdrop of colonialism and apartheid, legal developments that led to the inclusion of children's rights in the Constitution were traced. The chapter also considered the existing framework governing children's rights, particularly, the Children's Act and the Constitution. Within this context, specific reference was given to section 129 of the Children's Act which governs children's consent to medical treatment. This section provides for a lower threshold for age of consent. However, this thesis argues that the age threshold as encapsulated in the Children's Act does not fully promote children's access to health care services. It further does not fully acknowledge and promote participation of children in health care decisions affecting them, a key issue being a child's capacity to make autonomous decisions. Chapter 2 further considered section 28(2) of the Constitution that requires

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[1245] *Re C (HIV test)* [58].

[1246] Diekema, 'Parental refusals of medical treatment' 252.

[1247] J Thomas, 'Parent Refusal: legal and ethical considerations' (2015) 21 Southern African Journal of Anaesthesia and Analgesia 36.

[1248] Section 28(2) of the Constitution.

a child's best interests to always be of paramount importance in every matter concerning the child. The chapter has argued that although the best interests of the child in gender affirming health care cannot be determined with an absolute certainty, it however, remains a valuable yardstick in respect of a position of a child in health care matters. These interests should be established as the need arises in each child’s individual case.

5.3 Gender identity in children and adolescents

Chapter 3 provided a philosophical view upon which an individual's identity is constructed. From a sociocultural perspective, gender identity is influenced largely by socially constructed gender roles imposed on an individual from early childhood extending into adulthood.[1249] As previously indicated, the sociocultural norms exhibit its stereotypes by requiring men and woman to fit into their gender binary respective roles. Stereotypes and categories that are harmful for our society, particularly trans and gender diverse children and adolescents, must be unlearned for the opening of new possibilities, particularly, the different needs of a continually evolving social landscape.

These norms are to some extent, still influencing the way in which individual identity in children and adolescents is conceptualised clinically. This is despite the fact that, due to the developing nature of the gender field, trans and gender diverse identities are no longer conceptualised as abnormal and pathological, especially through the changing of the diagnosis from “gender identity disorder” to “gender dysphoria”.[1250] Consequently, there are interventions that focuses on medical pathway for younger adolescents, particularly, the emergence of physical treatment to arrest puberty in its early stages. These developments, however, invoke a considerable debate.

Although hormone replacement therapy may be in the best interests of minors for the purpose of a successful gender transition as it delays pubertal changes, it also pose a risk of harm to minors. It is criticised as having a lifelong adverse impact upon adolescents and children due to its significant risks, including eating disorders and

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[1249] Smith, ‘Gender as a Socially Constructed Phenomenon.’

[1250] Drescher, ‘Gender identity diagnoses: History and controversies’ 137-150.

bone health.[1251] This means that the clinical provision of medical interventions for trans children and adolescents should always be treated with caution. There are also concerns around potential de-transitioning and regret experienced by those who had transitioned. It is therefore, suggested that degrees of caution in the clinical management of gender affirming health care treatment be applied.

5.3.1 Identifying gender incongruence

From a purely medical perspective, evidence suggests that children may experience gender incongruence that could, in some instances, lead to gender dysphoria. The identification of gender dysphoria is made through the marked and persistent gender incongruence experience of the child or adolescent. In this instance, an adolescent will express feelings of gender incongruence through specific behaviour that may develop at an early stage. Due to experiencing a sense of unease regarding the mismatch between the gender assigned at birth and gender identity, they may also have contrasting emotions and behaviour that show discomfort or distress. Feelings of gender incongruence when they reach adolescence stage or even adulthood are also common.

Because of the unobservable nature of gender dysphoria, or lack of reliable indicators, children may encounter several barriers to medical treatment even when they reflect significant and persistent distress. This is in part because there is no pathophysiological evidence to show the deficiency related to gender incongruence. Problems involving a medicalised approach is that although treatment can be assigned to a given individual once a gender dysphoria diagnosis is confirmed, the absence of observable evidence can potentially result in lack of consideration for the child's views and expressed wishes, his/her experienced distress, including the assessment of his/her best interests.

[1251] Amy D DiVasta and Catherine M Gordon, 'Hormone replacement therapy for the adolescent patient' (2008) 1135 The Menstrual Cycle and Adolescent Health 204-211 <https://doi.org/10.1196/annals.1429.012> accessed on 31 July 2023.

5.3.2 The diagnostic evaluation

It is worth noting that the evaluations are meant to assess self-understanding and confirm the necessity of medical intervention. Whilst chapter 3 has highlighted a few changes that have been made to the WPATH SOC7 in relation to the assessment process,[1252] SOC8 no longer requires a second letter of evaluation and the requirement that the letter be written by a mental health provider prior to initiating gender-affirming medical interventions. Therefore, SOC8 recommends only a single evaluation in contrast to SOC7 that required a trans individual to undergo two evaluations. The guidelines further recommend that the assessing health care professional should hold at least a Master's degree and have competencies in assessing trans individuals, an aspect not required in terms of the SOC7 guidelines.

It is worth noting that the SOC8 recognises that "a comprehensive clinical approach is important and necessary".[1253] The guidelines further, recommends "a comprehensive biopsychosocial assessment of adolescents who present with gender-identity concerns".[1254] Thus, the guidelines recognise that the complexity of the assessment process may differ from patient to patient, therefore, a patient-centred approach for patient care is crucial.[1255] Barry and Edgman-Levitan define patient-centred care as the "care that is respectful of and responsive to individual patient preferences, needs, and values…[that] guide all clinical decisions".[1256] SOC8 places much heavier emphasis on shared decision making and informed consent through a multidisciplinary approach.[1257] It is my submission that shared decision-making is important because this will mitigate the risk that whilst assessing competence, the rights of the child may be curtailed by parental opinions and views which are not in alignment with those of the child.

[1252] Coleman and others, Standards of care for the health of transgender and gender diverse people, version 8 S1–S259.

[1253] WPATH SOC8 S45.

[1254] WPATH SOC8 S45, S50.

[1255] WPATH SOC8 S118.

[1256] Michael J Barry and Susan Edgman-Levitan, 'Shared decision making - The pinnacle of patient-centred care' (2012) 366 New England Journal of Medicine 780-781 <https://doi.org/10.1056/NEJMp1109283> accessed on 08 August 2023.

[1257] WPATH SOC8 S64.

Although few still subscribe to the notion of reclassifying gender dysphoria as a mental health disorder, ICD-11 has redefined the term as a condition related to sexual health,[1258] as explained in chapter 3. This change is welcomed, as a mental disorder continues to be stigmatised in some societies. A similar shift is seen in terminology from gender identity disorder to gender incongruence.[1259] This clinical classification focuses on the early symptoms, thus, acknowledging the legitimacy of gender incongruence. It further shapes and solidifies the understanding of appropriate medical treatment and promote access to gender-affirming health care in a variety of contexts. It has been mentioned that not all adolescents seeking help with gender incongruence experience persistent gender dysphoria.

Because childhood is often associated with a child's exploration of his or her gender identity, some form of gender ambivalence may be common, but this does not necessarily mean that these children may seek gender affirming treatment or surgery. Some of those with gender dysphoria may outgrow this form of distress by the end of puberty, with clearer indication of whether they are homosexual, heterosexual or bisexual. These children will need the psychosocial support that is helpful for their wellbeing and that makes them feel certain about their identity.

Diagnosing a child with gender incongruence means that the individual child's experience is clinically recognised. The notion that a child should be diagnosed as a prerequisite for gender affirming health care, is criticised by others who believe that such practice carries the risk that it may perpetuate the oppression of trans and gender diverse patients.[1260] It is my argument that diagnoses should be required for clinical purposes as it is necessary to exclude other conditions that may not be associated with gender dysphoria. It is further necessary for the determination of the treatment that is in the best interest of that particular child.

[1258] Larissa Dias de Freitas and others, 'Psychiatric disorders in individuals diagnosed with gender dysphoria: A systematic review' (2020) 74 Psychiatry and Clinical Neurosciences <https://doi.org/10.1111/pcn.12947> accessed on 08 August 2023.

[1259] ICD-11 Conditions Relating to Sexual Health.

[1260] Tonia Poteat and others, History and prevalence of gender dysphoria. In: Poretsky L, Hembree W (eds), *Transgender Medicine: A Multidisciplinary Approach* (Humana Press 2019) 1-24.

5.4 An affirming approach in children and adolescents

The WPATH's SOC8 observes that there has recently been a "sharp increase in the number of adolescents requesting gender care" internationally.[1261] Chapter 3 has explained that transgender children who presents with a distress related to gender incongruence seek support and potential affirmation of their experienced gender. The chapter has also highlighted that there are those who argue that gender dysphoria is transitory and does not persist, and that transition related services for children with gender dysphoria should therefore not be encouraged.[1262] Some argue that in this era of acceptance and tolerance and increasing gender fluidity, children should be advised to grow up acknowledging their gender incongruence, they can thus, decide to have gender affirming treatments once they have matured into adulthood.[1263] It is however, my contention that competent children should be given PBs, hormone replacement therapy and transition surgeries as this would not only promote their autonomy in making choices and decisions, but it is part and parcel of their constitutional rights, as discussed in 3.4.2.1 of this thesis.

While it is argued that safeguarding is more important than *validation*, I believe that an affirming approach regarding trans children is crucial for healthy child development. Trans children and adolescents need support and care from the family and society in order to be themselves and live a normal life. Trans children and adolescents can become acutely depressed and suicidal should they fail to get validation and support. It is worth noting that the South African Department of Health appears to hold the view that gender affirming care is medically necessary, safe and effective for trans minors, despite the lack of any announcement or directive recognising GAHC as a medical specialty.[1264] At the time of writing this thesis, seven public hospitals have been identified as providing components of GAC, discussed in 3.5 above. Evidence suggests that children whose gender dysphoria has been confirmed as being persistent were much more likely to continue into adulthood as transgender.[1265]

[1261] WPATH SOC8 S43.

[1262] James M Cantor, 'Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy' (2020) 46 Journal of Sex and Marital Therapy 307-313 <https://doi.org/10.1080/0092623X.2019.1698481> accessed on 02 August 2023.

[1263] Stephen B Levine and E Abbruzzese, 'Current Concerns About Gender-Affirming Therapy in Adolescents' (2023) 15 Current Sexual Health Reports 118.

[1264] Spencer and others, 'The care is the best you can give at the time.'

[1265] Smith, 'Gender as a Socially Constructed Phenomenon.'

Access to gender affirming care will therefore, more likely be in the best interests of children who needs this.

Whilst it is true that there are individuals who transitioned and later regretted their decision, these cases are isolated. Research further shows that most de-transitions are based, for the most part, on lack of acceptance in the environment. Unfortunately, the de-transitioning cases are invalidating the significant benefits of the gender affirming care that has helped thousands of minors, as highlighted in 3.4.2.2 above.[1266]

As reflected under 3.4.2.1 above, gender affirming care is critical to children's health, safety and well-being, reaching the age of maturity must, therefore, not be a threshold. The thesis has reflected how the restriction of timely access to PBs and hormone therapy has been associated with significant negative effects on children's mental health, including the increased risk for suicidal ideation and other negative mental health outcomes. It has further reflected how failure to halt an adolescent's unwanted bodily changes through hormone replacement therapy is likely to cause transition to be more complicated, thus leading to more medical expense in the future.[1267] It is therefore my argument that clinical guidelines should recommend gender affirming care, including surgery for competent minors. Failure to recommend the required GAHC can lead to these minors resorting to an unsupervised self-treatment despite its associated risks.[1268] This may be exacerbated by the lack of access to specialised care due to long waiting lists at the hospitals providing GAHC. To limit these risks, it is important that countries maintain and expand the provision of gender affirming care for trans and gender diverse individuals.

5.5 Major gender reassignment decisions

This thesis has emphasised that the nature of the provision of medical interventions for trans adolescents is highly controversial, as gender reassignment is a major decision that can potentially have adverse effects on the child's living conditions,

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[1266] Irwig, 'Detransition Among Transgender and Gender-Diverse People.'

[1267] Eliza Chung, 'Trans Adults Deserve a Right to Sue for Gender-Affirming Care Denied at Youth' (2021) 24 The City University of New York Law Review 148.

[1268] Self-prescription of sexual hormones for gender affirmation may pose significant health hazards as it will not be medically controlled.

health and well-being. In this regard, section 31(1)(a)[1269] of the Children's Act states that prior to taking a decision that involves the child in accordance with the provisions of section 31(1)(b), a person holding parental responsibilities and rights in respect of a child is required to "give due consideration to any views and wishes expressed by the child". It is further, necessary to bear "in mind the child's age, maturity and stage of development". In terms of section 31(1)(b), a decision referred to in paragraph (a) include any decision:

> (iv) which is likely to significantly change, or to have an adverse effect on, the child's living conditions, education, health, personal relations with a parent or family member or, generally, the child's well-being.[1270]

It is apparent that medical interventions, particularly those relating to the treatment of trans adolescents, are considered to be more contentious than other areas of health care. A key argument against the medical intervention for trans children is the view that vulnerable children may be permanently harmed and that it is therefore incumbent on society to protect them.[1271] The case of *Bell*[1272] however, has a far-reaching impact for both the treating physician and the patient equally. In this case, the Court of Appeal highlighted that the law should be careful not to impose further restrictions on an area of care that has existing restrictions already in place and is subjected to professional and clinical scrutiny.[1273] The danger of professional and clinical scrutiny is that it exacerbates the shifting away from the clinical judgement that is individual-based to the age-related criteria that mandates court authorisation. It may further be detrimental to the medical decision-making that might be in the best interests of some trans children and adolescents.

The SAHCS GAHC guidelines recognises the provision of medical interventions for transgender adolescents.[1274] Access to safe and legal gender reassignments should also be considered a fundamental rights matter. It is my submission that while it can be argued that continuation of an unwanted pregnancy can take a heavy toll on a woman's physical and emotional well-being, the same argument resonates with

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[1269] Children's Act.

[1270] Section 31 of the Children's Act.

[1271] Para 4.6.3 above. See also Levine and Abbruzzese, 'Current Concerns About Gender-Affirming Therapy in Adolescents' 116.

[1272] Para 4.5.3 above.

[1273] *Bell and Another v Tavistock and Portman NHS Trust and others* [2021] ECiv 1363: [94].

[1274] Paras 3.3.2 and 3.4.2 above.

people with gender incongruence as well.[1275] Therefore, setting age limits for gender reassignment surgery where a parent or legal guardian can have an absolute veto over their child's decision to have gender reassignment, violates the fundamental rights of people with gender incongruence. Gender-affirming care must, therefore, be made available as a legal right to all people who request it. South Africa should remain steadfast in its determination to ensure that the rights of every child, including those with gender incongruence, are fully observed and enjoyed.

In the case of *McCall v McCall*, which dealt with the issue of the best interests of the child in custody dispute, it was stated that:

> With reference to the child's preference above, if the Court is satisfied that the child has the necessary intellectual and emotional maturity to give in his/her expression of a preference a genuine and accurate reflection of his feelings […], in other words to make an informed and intelligent judgment, weight should be given to his/her expressed preference.[1276]

The counter argument is often that the views and voice of the child in gender reassignment cases are problematic since children cannot fully comprehend what the reality would be like to transition to another gender. However, in the case of *F v F*, the court reiterated its position on the voice of the child and stated as follows:

> If the court is satisfied that the child in question has the requisite intellectual and emotional maturity to make an informed and intelligent judgment, then the court should give serious consideration to the child's expressed preference.[1277]

The court in this case also cautioned that courts should guard against the common practice where "too ready an assumption that the [custodian's] proposals are necessarily compatible with the child's welfare".[1278] This being said, the danger is that the parent's differing views may potentially unjustifiably restrict the child's fundamental rights to privacy and dignity, thus, causing a severe impact in the welfare of any child seeking gender affirming care. Although every decision pertaining to the child is guided by the principle of the child's best interests, medical professionals must assist in scrutinising the parent's refusal to consent, the best interests of the child to transition to another gender, and the extent to which the child has properly understood and

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[1275] Para 2.5.2 above.

[1276] *McCall v McCall* 1994 3 SA 201 (C) at 207H. See also para 2.5.6 above.

[1277] *F v F* 2006 (3) SA 42 (SCA) [10].

[1278] *F v F* case at [31].

weighed the potential advantages and disadvantages of the proposed treatment. An expert opinion will ensure that interests of the parents or legal guardians are not put before the best interests of their children. This will also serve to balance the motivation of the refusing parent, the views of the child and the impact that the gender reassignment procedure will have on the child. These competing interests will have to be carefully considered before gender reassignments procedures are performed.

In *Jackson v Jackson*, also a case regarding the best interests of the child in relocation decision, Scott JA stated that:

> No two cases are precisely the same and, while past decisions based on other facts may provide useful guidelines, they do no more than that. By the same token care should be taken not to elevate to rules of law the *dicta* of Judges made in the context of the peculiar facts and circumstances with which they were concerned.[1279]

Although it is generally accepted that the best interest of the child "are the first and paramount consideration",[1280] there is no consistent approach in practice to follow, especially when trying to balance the competing interests between the child and his or her parents.

5.6 Parents

Children's rights are entrenched in both the national and international legal instruments, which include the right of a child to make their own medical decisions.[1281] While these rights have been accorded to adolescents, parental consent or parental assent, depending on the context, is also recognised in law in the context of medical treatment and interventions of children. In terms of the Children's Act, full parental responsibilities and rights[1282] are generally accorded to parents or legal guardians of the child. As such, the ability to consent to medical treatment rests with parents or legal guardians, although a caregiver[1283] can perform functions of consenting to medical treatment of children under his or her care. Holders of parental responsibilities

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[1279] 2002 (2) SA 303 (SCA) [2].

[1280] *LW v DB* 2015 JR 2617 (GJ) [20].

[1281] S 129 of the Act and Article 12 of the UNCRC. See paras 2.5.1 and 4.3.2 above.

[1282] In terms of section 18(2) it includes a duty to care for the child; maintain contact with the child; act as guardian of the child and contribute to the maintenance of the child.

[1283] Section 129(4).

and rights should, however, listen to views and wishes of the child before they make decisions affecting the child.[1284]

Parental responsibilities and rights are however, generally limited where the parents refuse medical procedures to be undertaken in the best interests of the child as it has been highlighted in chapter 2.[1285]

5.7 Best interests

Chapter 2 and 4 have dealt with the child's best interests standard in detail as required by both the national and international legal frameworks. It has also been highlighted that is some situations, the best interests of the child are open to debate, thus making it difficult to determine, particularly where parents refuse to allow their children to access gender affirming care. It has been argued that determining the best interests of a child or adolescent needs a carefully balanced decision. In terms of the WPATH and the SAHCS GAHC guidelines, such decisions should involve the minor child, parents or legal guardians or carers and the clinicians. In chapter 2 and 4 I have suggested that potential access to gender-affirming surgery may be in the best interests of certain transgender adolescents. It will, therefore, be justified to allow access to gender affirming care, particularly to minors who are competent to give consent to treatment. This is best demonstrated by the United Kingdom case of *Gillick,*[1286] which has been analysed in chapter 4. The concept *Gillick competence* recognises that older children may consent to medical treatment on their own behalf on condition that they have sufficient maturity and judgement to enable them to understand what is proposed.[1287] It is further supported by WPATH SOC 8 which repeatedly "emphasizes the importance of a nuanced and individualized clinical approach to gender assessment",[1288] particularly for trans children and adolescents.

A child gender reassignment dispute occurs when a child wishes to transition to another gender and the parents or legal guardians reject the idea. Although these

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[1284] Section 31(1)(a) of the Act.
[1285] Para 2.6 above.
[1286] [1986] AC 112.
[1287] *Gillick* case.
[1288] WPATH SOC8 S68 and S45.

cases are generally decided on a case-by-case basis, there is no set formula that the decision-making process should follow. Sachs J in the case of *S v M*, however, does not support an idea of applying a pre-determined formula as that would certainly be contrary to the best interests of the child.[1289]

5.8 The High Court as the upper guardian of all minors

This thesis has explored in chapter 4 how disputes regarding treatment choices between parents, health care providers, and the relevant child in the context of gender affirming care and interventions should be addressed.[1290] In situations where there is a disagreement between parents, the health care providers, public authorities or the child regarding recommended course of treatment, the court's intervention may be sought in relation to decisions concerning a child's medical treatment. The court has an inherent discretion to make decisions concerning a child's medical treatment under either the doctrine of *parens patriae* or the provisions of section 45(4) of the Children Act.[1291]

It is also worth noting that the SAHCS GAHC guidelines provide that if a reason exists that the parents/legal guardians are not acting in the child's best interest, a court order may be obtained if it is believed that the child is at the risk of harm. The evoking of the court order will be for purposes of allowing the child to access the gender affirming health care.[1292] It is further worth noting that parental responsibilities and rights can be limited or terminated by the High Court as the upper guardian of all minor children in situations where the interests of the minor child are not served.[1293]

5.9 How Should We Approach issues of medical consent?

The conclusion from the thesis thus far is that trans children and adolescents are simply part of the full tapestry of human diversity. Gender diversity reflects a vast number of ways by which human being express themselves in the world. Since the contemporary approach does not view gender diversity as a mental illness requiring

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[1289] (Centre for Child Law as Amicus Curiae) [2007] ZACC 18 [16].
[1290] Para 4.5 above.
[1291] Para 2.3.3 and 4.5.1 above.
[1292] SAHCS GAHC 2.2.2 p 21.
[1293] Section 45(4) of the Children's Act.

correction or treatment, this also explains why corrective or reparative treatment is no longer considered ethical. Clinicians and parents must therefore support a child’s expression of gender diversity and not attempt to correct or frown at their self-expression. Medical support may be beneficial for children and adolescents in understanding or even affirming an identity. One of the aims of this thesis is to justify the need for support and to provide an understanding regarding the provision of any interventions relevant for trans and gender diverse children and adolescents.

Throughout the thesis, I have argued for the recognition of the right of trans and gender diverse children and adolescents to make autonomous decisions on issues relating to health care, particularly, regarding their own bodies. This right is fundamental to their basic rights to equality, privacy, and bodily integrity. I have argued that, although modern medical ethics considers a patient’s autonomy as a key principle in making decisions about their health, this may not be true in some cases. In some instances, medical decision-making may regress into the extremes of a paternalistic model, where parents and doctors makes decisions for a gender diverse child and adolescent without his or her participation. The paternalistic model may also ignore the wishes or choices of a child who possesses proper decision-making capacity and restrict him or her from accessing treatments for gender dysphoria. This is because minor children are believed to have limited understanding, as such, they would need protection from potential harm. This thesis has demonstrated, based on a review of literature, that not all parental protections, albeit well-intended, are in the best interests of trans children and may even cause some children harm, including increasing the risk of depression and suicide among these children.

Chapter 4 has highlighted some differences in the legal ages of majority in Australia, the United Kingdom and Canada. Australia has set the age of maturity at 18, but a person younger than 16 years may be capable of independent decision-making upon an assessment by the physician. In this instance, the child’s consent will be considered valid, provided that his or her capacity is confirmed in writing by another doctor who has examined the patient prior to treatment.[1294] In Canada, the age of maturity is set at 18 years,[1295] with some deviation in provinces that have set the age at 19 years.[1296]

In England, the legal age for children to consent to their own medical treatment is fixed at 16 years. A child younger than 16 may, however, consent to treatment, and his or her consent will be considered valid if his or her capacity is confirmed. These children must prove to be mature and be able to give consent to treatment according to the *Gillick* ruling.

Despite the specified the legal age for informed consent to medical decision-making in the jurisdictions above, legislative measures were put in place to safeguard the right to medical decision-making regarding those individuals who have not yet attained the age of maturity but possess the decisional capacity. Health personnel, particularly, physicians are charged with the responsibility of ascertaining this capacity in minor children. In South Africa, the age of independent medical decision-making is 18, which corresponds with the age of maturity. However, children from the age of 12 years and older can provide informed consent for surgical treatment together with their parents. These differences regarding the age at which children are deemed competent to consent to health care interventions, makes it clear that there is no international consensus on an exact age limit. Lord Scarman correctly observes that a judicially fixed age limits will fail to recognise and understand children's individuality and natural development:

> The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificial and a lack of realism in an area where the law must be sensitive to human development and social change.[1297]

It is generally assumed that people of a certain age, including adults, are competent, whereas others are not. However, in the clinical context, the exact age of consent is largely irrelevant in determining whether a child of a certain age is sufficiently

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[1294] Consent to Medical Treatment and Palliative Care Act 1995. See also Sara Bird, 'Consent to medical treatment: the mature minor' (2011) 40 Australian Family Physician 159-60.

[1295] Alberta; Manitoba; Ontario; Prince Edward Island; Quebec and Saskatchewan.

[1296] British Columbia; New Brunswick; Newfoundland and Labrador; Northwest Territories; Nova Scotia; Nunavut and Yukon.

[1297] *Gillick* case at 196 per Lord Scarman.

competent for medical decision-making. Accordingly, issues of decisional capacity are approached differently, with evidence of a higher degree of maturity being more determinative. Therefore, children of the same age may have different levels of maturity. Carstens and Pearmain note that:

> [i]t is the circumstances and capacity of the individual minor concerned, as opposed to minors as an amorphous group that must be considered by those rendering health care services. Broad generalisation when dealing with specific patients on the basis of factors such as age etc are not only inadvisable, they may also be unconstitutional in a number of different aspects not least of which is unfair discrimination.[1298]

It has been mentioned that consent is not only a legal requirement, but also fundamental to good medical practice. In chapters 2 and 4, I have placed emphasis on the importance of the views of the child regarding his or her medical treatment, including consideration of his or her best interests. Although there is no simple test to determine the decision-making capacities of an adolescent, children should be afforded participatory rights, as there are many benefits associated with participation. In situations where they do not meet the legal standard of competency, consent can be provided by a parent or legal guardian. Parental involvement should, however, not be a barrier to a child’s gender affirming health care. The overall approach argued in this thesis is that independent medical interventions should only be allowed for competent minors. It is further argued that best interests of the child should always be at the forefront and an assessment of such interests should be based on the needs of the individual child. Consequently, surgical interventions are recommended for competent transgender adolescents.

5.9.1 Implications of the Bell case for Gender Diverse Minors

The case of *Bell* is important for this study as it has considered the issue of whether a *Gillick* competent minor experiencing gender dysphoria could give informed consent to hormone treatment. The English High Court in the case of *Bell*[1299] raised some difficult issues relating to the decisions to provide medical interventions for gender diverse adolescents, particularly issues relating to access to genital surgery. The High Court ruled that the clinicians should obtain permission from the court before

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[1298] Carstens and Pearmain, *Foundational Principles of South African Medical Law* 108.

[1299] *Bell* case [151]-[152].

prescribing puberty blockers. However, the Court of Appeal reversed the decision,[1300] and accorded the responsibility to determine whether a child has capacity to consent to medical treatment, to the doctors. The Appeal court thus clarified the interpretation of the *Gillick* test. Accordingly, an oversight legacy to determine the best interests of the child remains with the courts.[1301] Gender-affirming genital surgery for competent transgender adolescents, particularly where clinicians are of the view that it is in their best interest to do so, should be permitted.

5.9.2 The Impact of Gillick case

The case of *Gillick* allowed English courts to lay down the test for capacity of a minor in relation to medical and health care practice. In terms of this test, a child can give an autonomous valid consent to medical procedures if he or she is deemed sufficiently mature and intelligent to understand the nature and implications of the proposed procedure. Again, parents cannot overturn the decision of a child who has been found to be Gillick competent. Lord Scarman's judgement in Gillick asserted that the rights of parents are not absolute, they only exist to enable parents in discharging their duties towards their children until such time they reach sufficient level of understanding and intelligence to look after themselves. The approach that was applied in *Gillick* was followed in *R (Axon)*. The judgement handed down by Silbur J in *R (Axon)* was quoted with approval in the case of *PD v SD and Others*.[1302] His Honour said that:

> Parental right to family life does not continue after the time when the child is able to make his own decisions. So parents do not have Article 8 rights to be notified of any advice of the medical profession after the young person is able to look after himself or herself and make his or her own decisions.[1303]

It is clear that the court in *Gillick* emphasises that a minor's capacity to make a decision "is not to be determined by reference to any judicially fixed age limit".[1304] Accordingly, Gillick competence became an important precedent in comparable jurisdictions such as Australia, and a threshold in medical care and medical decision-making cases. It has also influenced the way in which children and adolescents are treated in matters relating to health care, particularly within clinical decision-making. Understandably, the

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[1300] *Bell* case [93]

[1301] *Bell* case.

[1302] [2015] EWHC 4103 (Fam).

[1303] *PD v SD and Others* case [28]-[29].

[1304] *Gillick* 188

application of the *Gillick* case in the context of gender transition means that a minor, who is presumed sufficiently mature, may provide independent informed consent and is afforded an opportunity to consent to any medical treatment that he or she wishes to undergo as part of the transition. Consequently, health care professionals may not refuse to treat those children, as it is in their best interests to have access to the relevant medical treatment.

5.10 Legal Protections to trans and gender diverse individuals

Currently, no international human rights treaty focuses on the protection of the rights of LGBTQIA+ persons. While this is true, the absence of a specialised convention does not mean that their rights are not protected under existing international human rights law. The Human Rights Treaty Bodies have documented a wide range of claims concerning exclusions and the violation of the rights of LGBTQIA+ persons.[1305] Although they have not uniformly addressed all the human rights of LGBTQIA+ persons across the world, progress toward the goal of equality has been remarkable in recent decades, particularly in South Africa. The protection afforded to every human being has been wholly extended to sexual minorities. The Constitution obliges the state to "respect, protect, promote and fulfill"[1306] the rights enshrined in the Bill of Rights. On the other hand, the equality clause prohibits any form of unfair discrimination against any person based on, among other grounds, their sex, gender, or sexual orientation.[1307] There is therefore, a need for a progressive position in the area of health and patient care for sexual and gender minorities.

The New Zealand Report of the Inquiry into Discrimination Experienced by Transgender People has captured the summary of transgender individuals' health care experiences, including those relating to gender reassignment as follows:

> Trans people and health professionals consistently raised the difficulties trans people have in obtaining general health services and being treated with dignity and respect when they did use them. The Inquiry has identified major gaps in availability, accessibility, acceptability and quality of medical services required by

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[1305] United Nations. Office of the Human Rights Commission (2019). Born Free and Equal: Sexual Orientation and Gender Identity in International Human Rights Law 9 <https://www.ohchr.org/sites/default/files/Documents/Publications/Born_Free_and_Equal_WEB.pdf.> accessed on 10 August 2023. See also para 2.2 above.

[1306] Section 7(2) of the Constitution of the Republic of South Africa.

[1307] Para 2.5.7 above.

> a trans person seeking to transition. The provision of public health services is patchy and inconsistent. Trans people and health professionals need to work together to address these issues.[1308]

This thesis has highlighted that South Africa still has a lot of work to do in comparison to jurisdictions such as Australia, UK and Canada, in realising the rights of trans children and promoting access to gender affirming care for children and adolescents.

5.11 Recommendations

5.11.1 The government must adopt policies that make the implementation of the health care interventions, particularly for trans and gender diverse children and adolescents, including the LGBTQIA+ individuals, actionable and reality based.

5.11.2 The government to ensure that the gender affirming care is included in the Prescribed Minimum Benefits list and that medical aid providers explicitly cover such health care services.

5.11.3 Trans and gender diverse health care programmes should be included in the curricula content of all health care professionals. This will assist in sensitising health care professionals regarding the challenges that trans and gender diverse individuals' experience.

5.11.4 The need to ensure that health care professionals are adequately trained on how to communicate with both parents and children, particularly as an aspect of shared decision-making in the health care setting, should be recognised and addressed. One important benefit of such training will be that health care decisions will be made collaborately, in consideration of the trans and gender diverse adolescents' knowledge and preferences. Further, the decision making between the medical health practitioners, child and parents, will ensure that children's interests are not neglected in favour of the parents' preferences or wishes. Where there is a conflict between the child and his or her parents regarding the proposed medical treatment or

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[1308] United Nations. Office of the Human Rights Commission (2008). To be who I am: Report of the inquiry into discrimination experienced by transgender people. Retrieved from Auckland, New Zealand: Human Rights Commission 50 <https://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/15-Jan-2008_14-56-48_HRC_Transgender_FINAL.pdf.> accessed on 10 August 2023.

intervention, the medical health professional must observe the best interests of the relevant child.

5.11.5 The WPATH and the SAHCS GAHC guidelines should be prioritised by health care practitioners, as these provide clear and practical guidance relating to the tools or techniques to be used during the assessment process of transgender persons. Failure to provide guidance will likely result in inconsistencies and never-ending criticisms.

5.11.6 South Africa is widely recognising that children are important social actors, and it is crucial for them to participate in health care decision-making processes. Nevertheless, the thesis has argued that there is a need for further reform.

5.11.7 The thesis rejects the use of a fixed age requirement as an appropriate measure to determine a child's maturity. A child's competence does not depend on a set age but is based on the child's level of their understanding.

5.11.8 This thesis has demonstrated that existing legislation regarding children's consent to medical treatment, specifically section 129 of the Children's Act, does not adequately provide for the very nuanced determination of children's maturity, understanding and autonomy. It is advised that this section be revised, or alternatively, that regulations to the Children's Act be promulgated to remove the inconsistencies that this thesis pointed out in its chapter 1[1309] and chapter 2[1310] respectively.

5.11.9 The UNCRC acknowledges that decision-making capacity in children and adolescents in health care requires thorough assessment, as discussed in 4.3.3 above. The government must therefore, support and promote the use of a functional capacity test within the context of consent to medical treatment for children and adolescents.

5.11.10 Immediate government measures need to ensure that children who meet the capacity requirement have access to gender affirming care, including the required

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[1309] Para 1,2 above.

[1310] Paras 2.4.3, 2.5.2 and 2.5.3 above.

surgery. Policy makers should ensure that gender affirming care guidelines are updated to reflect the adolescent consent approach, articulated in 4.5 above. It is envisaged that these efforts will enable transgender children and adolescents to access the much-needed gender affirming care interventions.

5.11.11 The implementation of the compatible and tailored strategies to respond to issues of insufficient resources and infrastructure in relation to the provision of gender affirming heath care, particularly the public health systems, should be prioritised.

5.11.12 Section 2 of the Alteration of Sex Description and Sex Status Act should be amended to allow minors to amend their birth documents to accurately reflect their lived identity. However, these minor children should be required to go through a careful professional assessment prior to transitioning.

5.11.13 The SAHCS GAHC guidelines should be amended to align with internationally agreed WPATH SOC 8 guidelines, particularly on the lifting of minimum age requirements for gender affirming surgery.

5.12 Final conclusion

In recent years, South Africa has advanced substantially regarding the legal regulation of consent to medical treatment of children. This advancement can potentially pave a way for access to gender affirming health care for children and adolescents in the country. The thesis has identified gaps in the national legal framework that must be addressed to enable children and adolescents to have adequate access to gender affirming health care that is in their best interests. Law reform is a necessary intervention that should address the situation of these vulnerable children, their families, and their health care professionals, particularly in accessing these necessary and therapeutic medical treatment.

This thesis provides a foundation for future legal and multidisciplinary research, particularly pertaining to access to gender affirming health care for transgender children and adolescents, including their mental health and well-being. A comprehensive exploration of the current age threshold for decision-making capacity may be an effective tool towards legal reform in this area. This thesis has engaged in a comparative legal study involving the jurisdictions of the United Kingdom, Australia, Canada, Denmark and New Zealand. The value of this comparative is that it has provided a transparent benchmark against which the recommendations in this final chapter have been suggested. It has also contributed to an informed and comprehensive understanding of the gaps in knowledge of gender-affirming health care in South Africa.

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