The rights and interests of trans and intersex children: considerations, conflicts and implications in relation to the UNCRC

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Abstract

In this paper I consider the contradictions in majority Western treatment of trans and intersex children, in relation to the United Nations Convention on the Rights of the Child (UNCRC). I argue that how each group is treated is underpinned by contrasting assumptions about what constitutes the child's best interest, which are a primary consideration under the Convention. In the case of intersex children, it is assumed that it is in the child's best interest to have an assigned binary gender and a body that matches it as well as possible; in the case of trans children, it is assumed that it is in the child's best interest to be prevented from making irrevocable decisions that they do not fully understand. I then outline and discuss Kirsten Sandberg's approach to trans and intersex children with respect to the UNCRC, and explore the implications of this in practice. I conclude that what follows from

Sandberg's approach would benefit all children, not just those who are trans or intersex.

Keywords

Trans; intersex; UNCRC; children; bodies; rights

Introduction

In this paper I focus on the contradictions in usual Western approaches to trans and intersex children in relation to their interests and rights; contradictions that have been exacerbated by an English High Court judgement concerning the ability of trans children under the age of 16 to consent to treatment (Victoria Sharp P et al., 2020). Following a discussion of how these two groups are approached socially and medically, I argue that the treatment of trans children in relation to their rights under the United Nations Convention on the Rights of the Child (UNCRC) is diametrically opposed to the treatment of intersex children, and that there are, therefore, contradictions in the application of children's rights to different groups of children. I consider how the Norwegian jurist and former Chair of the United Nations Committee on the Rights of the Child, Kirsten Sandberg (Sandberg, 2015) approaches these issues. Sandberg's proposals for legal solutions result in greater fairness and consistency between the two broad groups, and I explore the implications for how they, and other children, should be raised. Although the importance of Sandberg's work has been recognised by previous authors (Frödén & Quennerstedt, 2019), its specific implications have not been explored, or conclusions drawn about how society should treat gender in childhood. This is a crucial gap in the literature in this area, and addressing it is the central purpose of this paper.

Contradictions in current practice regarding trans and intersex children

I will first briefly outline who belongs to each group. Trans children are those whose experienced gender does not conform to the gender they were assigned at birth on the basis of their body morphology. Some experience themselves as being of the opposite binary gender; others (mainly older children and teenagers) as some form of non-binary gender, or agender (Pullen Sansfaçon et al., 2019). In this paper I focus on binary trans children, though that is not to deny the existence of those whose experienced gender is not binary. Intersex children include those for whom it is more difficult to assign a binary gender at birth, due to variations from typical physical development. This might involve an outwardly female appearance but typically male internal anatomy, or genitals between the usual binary types (for example with a large, penis-like clitoris). Some may also have cells with different chromosomal composition, e.g. some XX, others XY (Dickens, 2018).

Current practice in approaching the treatment of these two groups is contradictory. This is particularly the case in relation to what is considered to be the child's best interests. That the best interests of the child should be of primary importance in all decisions is fundamental to the UNCRC:

> 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 (United Nations, 1989: Article 3).

This is developed in the UN's General Comment 14 (GC14), where it is pointed out that the child's best interest will vary according to the child themself, and their circumstances. It explains that:

> The concept of the child's best interests is complex and its content must be determined on a case-by-case basis…Accordingly, the concept of a child's best interests is flexible and adaptable. It should be adjusted and defined on an individual basis, according to the specific situation of the child or children concerned, taking into account their personal context, situation and needs (United Nations Convention on the Rights of the Child: Committee on the Rights of the Children, 2013: para 32).

The combination of these two paragraphs has two clear implications: first, that in considering children's other rights, focusing on the best interests of the child is a cross-cutting underpinning principle (Sandberg, 2015); and, second, that in considering the best interests of the child, their specific situation and context should be assessed and taken into account. This is important because it means that we should not formulate hard-and-fast rules about particular approaches or treatments. Instead, we must focus flexibly on the individual child, their views, and their circumstances.

Alongside this principle lies another: the right of the child to be heard in any proceedings that affect them. While the child's views may not always be completely followed, children do have a right to express their opinions, and to have them listened to:

> 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 (United Nations, 1989: Article 12)

This right is so important that GC14 makes it clear that extreme youth, disability, vulnerability or minority status should not prevent such consultation with children about decisions that matter to them. While children of different ages and levels of maturity will be more or less able to understand the issues involved and express their views:

> The fact that the child is very young or in a vulnerable position (e.g. has a disability, belongs to a minority group, is a migrant, etc.) does not deprive him or her of the right to express his or her views, nor reduces the weight given to the child's views in determining his or her best interests (United Nations Convention on the Rights of the Child: Committee on the Rights of the Children, 2013: Para 54).

It is not clear how this would be enacted in the case of very young children. However, given that most children's capacities evolve over time, one implication is that when children are too young to understand decisions that are made about them and their best interests, adults should, where possible, defer such decisions until the child is able to participate fully (Sandberg, 2015). This key point underpins my argument in this paper.

Treatment protocols for trans and intersex children contain implicit, but different, assumptions about the best interests of the child. These assumptions refer to such children as a group, but appear to be applied in particular cases.

Intersex children

For intersex children, the implicit assumptions about best interests in current majority treatment protocols are focused around a belief in the importance of a child having a definite assigned gender and a body that matches it as well as possible. To achieve this, the child is assigned a binary gender and (in addition to medically necessary interventions for specific, life-threatening conditions such as congenital adrenal hyperplasia (Dickens, 2018)) there is then consideration, and frequently enactment, of surgery that makes the child's genitals, and in some cases their internal organs, conform more closely to this assigned gender. For example, surgeons might perform clitoral reduction in a child assigned female, or the removal of a uterus and Fallopian tubes in a child with a fully formed penis and assigned male (Dickens, 2018; Fraser, 2016; Meoded Danon, 2019). Partly because a fully-formed penis is seen as an essential component of normative physical masculinity (Kessler, 1998; Kessler & McKenna, 1978), intersex babies are overwhelmingly more likely to be assigned female than male (Fraser, 2016).

Parents and professionals who decide to carry out these 'normalising' operations on intersex children do so on the basis of two assumptions. One is that a child's gender identity will develop to match the assignment they are given at birth (Dickens, 2018). In some intersex variations this can be fairly reliably predicted on the basis of past cases; in others it is at least partially arbitrary or socially determined, including according to (in some cases culturally-influenced) preferences of the parents (Meoded Danon, 2019). However, while many intersex people grow up with a gender identity consonant with this initial assignment, not all do, and some later identify as intersex (Viloria, 2017). Furthermore, Newbould (2017) points out that, given the state of shock many parents are in following an intersex birth, it may be difficult to separate the best interests of the child from those of the parents and family, who may want a speedy resolution to the question of the child's gender.

Second, it is assumed that the best interests of the child require that their gender identity and body match in a normalised bodily way from as early in life as possible, even though, according to activist groups, intersex adults are usually unhappy about surgery that was performed on them as children (Fraser, 2016). Indeed, intersex adults argue that they should have been consulted before any surgeries took place; that they would have liked to retain tissue that has been removed in case they require it for different surgery later (for example, for gender reassignment); that they regret the loss of sexual sensation or pleasure resulting from clitoral reduction or clitoridectomy; and that many procedures carried out on intersex babies and children, and the general management of intersex, cause psychological harm (Accord Alliance, 2020; Organization Intersex International, 2020).

These operations are irreversible, and some also have effects on future fertility, because functioning testes or internal reproductive organs may be removed (Dickens, 2018; Fraser, 2016). Indeed, fertility loss seems in some cases to be treated almost as a 'natural' outcome of some forms of intersex. Wisniewski and Mazur (2009), for example, state that, for people with partial androgen insensitivity syndrome (PAS),

> fertility is challenging, but not impossible, for individuals with PAS raised male…In contrast, fertility is impossible for individuals raised female (no page numbers).

Given that a major difference between those raised male and those raised female involves the removal of the testes in those assigned female (due to the high risk of developing germ cell tumours in testes not located in a scrotum, a risk that rises with age), such a claim is, at best, misleading. While fertility treatments for this group are at a relatively early stage, Slowikowska-Hilczer et al (2017) note that microsurgical testicular sperm extraction is a promising way in which people with partial androgen insensitivity syndrome can have biological children, and suggest that ‘prophylactic gonadectomy may deprive some patients with DSD [disorders of sex development, or intersex] their chance for fertility’ (829).

As these children are usually in the first year of life when these interventions take place, there is no possibility of them understanding the decisions being made about their attributed identities and bodies; I will discuss this later when outlining Sandberg’s (2015) position. However, there is an additional concern that applies specifically to intersex children who are assigned as girls, who are in an anomalous position regarding their rights as female children.

Frödén and Quennerstedt (2019) note that, in both the UNCRC and the UN Convention on the Elimination of All Forms of Discrimination Against Women, the focus is on the female gender, with the gendered rights holder in respect of children being a cis[i] girl. Girls are generally expected to be protected from female genital mutilation (FGM), which means that it is banned in most jurisdictions. Intersex operations on babies assigned female, however, while similar in character, involving such treatment as partial or entire excision of the clitoris, are not usually considered to be FGM, and are not usually covered by anti-FGM legislation. As Fraser (2016) points out, ‘intersex bodies are constructed as female – literally – on the operating table, but not as female for the purposes of FGM law’. Fraser further notes that in deciding that ‘gender normalisation surgery’ should be carried out on a female-assigned baby because the clitoris is considered abnormally large, doctors are in practice admitting that it is being undertaken for cultural reasons, ‘and as such is just the sort of harm that FGM law was intended to prevent’ (Fraser, 2016: 69).

It therefore appears that, even as many intersex children are assigned female, they are at the same time refused the health protections that should be afforded to them **as** females. Such contradictions are clearly problematic, and parallel those arising from claims that full recognition as female should only be accorded to trans women who have undergone complete genital reconstruction, something that is not permitted to trans girls.[ii]

Trans children

For trans children, arguments around their implicit best interests focus around them being prevented from making irrevocable decisions that they do not fully understand. This is particular clear from the recent English and Welsh High Court judgement (Victoria Sharp P et al., 2020), about the ability of children and young people under the age of 16 to give fully informed consent to treatment with medication to pause puberty. Although the effects of this treatment are generally considered reversible, with puberty recommencing if it is stopped (Kim & Lee, 2012; Kuper, 2014), the court also took into consideration the fact that most children who have consistently maintained a cross-gender identity into early adolescence, and who therefore qualify for puberty blockers, tend then to go straight on to take cross-sex hormones, usually from age 16, followed by surgery from age 18 (Brik et al., 2020; Giordano & Holm, 2020; Kuper, 2014), the effects of which cannot be reversed.

The judgement argues that, in respect of puberty blockers:

> …to achieve *Gillick* competence[iii] the child or young person would have to understand not simply the implications of taking PBs [puberty blockers] but those of progressing to cross-sex hormones. The relevant information that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH [cross-sex hormones] and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain. (Victoria Sharp P et al., 2020: para 138)

At time of writing this is a highly controversial judgement that is likely to be appealed, and I will not discuss it in detail further, except to note that some of the statements quoted here are themselves strongly contested (de Vries & Cohen-

Kettenis, 2012; Giordano & Holm, 2020). It is clear, however, that the judgement is focused around the idea that puberty suppression, which is the first non-psychological treatment given to trans children, is something that has such serious potential consequences, including loss of fertility, that 'it is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences' (Victoria Sharp P et al., 2020: para 151). Furthermore, such decisions were considered by the court to be so significant that parental consent on behalf of the child would be insufficient. The implication is that the best interests of the trans child, in all cases, are best served by withholding treatment for as long as possible, without reference to any child's specific circumstances, and even when the child's own strongly expressed wishes are to have treatment.

This underlying understanding that the best interests of the child lie in doing as little as possible until the child is mature enough to give informed consent is also reflected in the approach taken by clinicians who prescribe puberty blocking medication, according to what is commonly referred to as the 'Dutch protocol' (de Vries & Cohen-Kettenis, 2012; Kaltiala-Heino et al., 2018; Zucker, 2019). This approach is used widely in the global North, but takes the opposite position from the English High Court on the use of puberty suppression, treating it as a reversible intervention. It allows children and young people with gender dysphoria to socially transition, changing names and pronouns. Once they reach Tanner Stage 2 (the start of pubertal development), they can, with medical advice and parental support, opt to take hormone blocking medication to pause puberty in order to relieve their distress at their changing bodies, and give them a chance to mature before making much more life-changing decisions about taking cross-sex hormones.

Proponents of this view argue that, in a time-sensitive context such as this, where a child's body is already starting to undergo irreversible physical changes, doing nothing ('watching and waiting'), as the English High Court suggests, is not a neutral act: it is, rather, a decision to allow puberty (Kuper, 2014). Zucker (2019) also points out that, even when puberty blockers are eventually prescribed, there is in practice, for most children, a period of this kind due to long waiting lists. Consequently, many children have moved beyond Tanner Stage 2, and matured in other ways, before they are offered the opportunity to pause puberty through the use of hormone blocking medication. The use of puberty blockers can thus be seen as providing an extended diagnostic phase in which a young person can be further assessed and supported to take later decisions about whether to proceed to hormone therapy (Brik et al., 2020; Pyne, 2017) It has the immediate benefit of relieving feelings of dysphoria that are likely to increase over time, as pubertal changes continue and become more significant. This both supports the child's mental health (and therefore, their best interests, in the short term, at least), while relieving both children and their parents of the immediate pressure to take longer term decisions about gender and their bodies (Minter, 2012).

Current Western treatment protocols and the judgement of the English High Court share an underpinning assumption about what constitutes the best interests of trans children: that no permanent changes to the child's body should take place until the child is considered old enough to understand fully what the implications of these changes will be. The differences lie in what constitutes 'avoiding permanent changes'. While the High Court judgement argues that commencing puberty blockers is the start of a pathway to permanent bodily alteration, medical practice treats taking puberty blockers as a way of pausing physical change (including the changes that would otherwise take place due to puberty). In both cases, the aim is to wait until the child is better able to understand the implications of cross-sex hormone and surgical treatment. This is in complete contrast to current approaches to intersex children. In much of Western medicine, intersex children are given maximum intervention, as early as possible, while trans children are given minimum intervention, as late as possible.

Legal resolutions: the Kirsten Sandberg approach

In an important 2015 paper (Sandberg, 2015) reflecting on the interpretation of the UNCRC in relation to trans and intersex (and other LGBTI) children, Sandberg considers these significant differences and argues that trans and intersex children should have parallel treatment. In what is in essence a legal opinion, her argument is based not on what is in the child’s best interests (though of course she recognises that this is an important factor) but on their rights to non-discrimination, to identity, and to health, and, especially, on a child’s right to be heard in any proceedings that affect them.

Sandberg argues that, while gender identity is not explicitly mentioned in either the UNCRC or GC14, it is part of the child’s identity more generally, and must be taken into account in deciding a child’s best interests. Trans children, therefore, ‘have the same right to this aspect of their identity as children who have the traditional identity of male or female’ (343). The state is obliged to ‘respect’ this right, and this should include the child’s experienced gender identity being officially registered. While the UNCRC does not give children a general right to self-determination, it does give them the right to participate in decisions ‘by expressing views and having them given due weight’ (344). Sandberg points out that decisions about gender identity are private, and are therefore protected under Article 16 of the UNCRC. This, she suggests, would probably mean that, once a child is old enough to understand the consequences of a decision, they should have the final say in that decision.

A right to participate in decisions about one’s treatment, however, does not constitute a right to have that treatment, as states are only expected to provide medical treatment commensurate with the resources available to that state. However, if treatment is available in the public health system of a particular state, children would have a general right to this treatment. Actually obtaining it, she suggests, would require a combination of consent from the child, in most cases consent from the parent(s), and a medical judgement, preferably carried out by a multidisciplinary assessment team, that the treatment is in the best interest of this particular child (Sandberg, 2015).

Regarding intersex children, Sandberg argues that current medical practice is problematic because

> It constitutes an intervention into the physical integrity of the child, from which the child has a right to be protected unless such intervention is medically necessary. Since it has been established that this treatment is not medically necessary, at least at the early stages of a child’s life, the parents have no right to consent to it. (349)

She suggests that any unnecessary medical intervention should be postponed at least until the child understands what it entails and is able to have a say about whether it should take place. Furthermore, she argues, the treatment is so personal and serious that it should not be carried out without the child's informed consent. Sandberg also points out that earlier interventions impose a gender identity on the child, which breaches UNCRC Article 8, the right of the child to uphold their identity.

In her concluding remarks, Sandberg (2015) argues that there is a need to have a children's perspective on LGBTI children generally, including with regard to violations of trans and intersex children's rights to self-determination. She also recommends greater consistency in dealing with these issues, including between states, and, by implication, between different groups. She concludes that:

> Concerning intersex children, in addition to recommendations [about avoiding the unnecessary treatment of intersex children] the Committee may include the training of professionals as well as the need for investigation of violations and redress for the victims. As for transgender children's rights to self-determination and a possible right to medical treatment, more could be done by the Committee in raising the issue with civil society actors and the states. (352)

In the remainder of this paper I will consider the implications of Sandberg's work for how we approach gender issues with respect to children.

Implications of Sandberg's recommendations for approaches to gender and childhood

If we take Sandberg's intervention seriously, there are important implications for how we as a society should approach gender in childhood. In this section I will explore three main areas: attribution of gender at birth; gender exploration and social transition; and health education for trans and intersex children and young people.

Attribution of gender at birth

A major implication of the requirement to respect a child's identity is that, for all children, attribution at birth should have some level of provisionality. Even for non-intersex children, basing a gender label on the child's bodily form is still only really a best-guess attribution, as we do not know at this point for which children that will turn out to be inappropriate. Currently, initial attribution is expected to be reflected in identity throughout life. A better recognition of the identity rights of trans children would lead to some undermining of this expectation, and potentially also a lessening of the gendered expectations that go along with sex-based identity labelling (Paechter, 2007).

For intersex children, this best-guess attribution would need to be much more explicitly provisional, with parents educated to be alert to the possibility that they and the doctors have got this wrong. In most cases, this attribution can be backed by statistical evidence from previous cases which suggest that babies with a particular condition and attribution maintain the gender identity associated with that attribution (Meoded Danon, 2019). Children with conditions for which there are no reliable statistics could be raised as intersex, with ongoing support for both parents and child: Meoded Danon (2019) reports that this is beginning to happen in Germany, where there is the option (not widely taken up, however) to have an X on the birth certificate instead of the usual M or F and where guidelines prohibit irreversible surgeries except where a baby's life is in danger. In such cases it would be important to be aware that a child may still develop a binary gender identity, or they may identify as intersex in the longer term.

In the meantime, we should not carry out any interventions on intersex children, whether surgical or endocrinal, that are not focused solely on addressing medical rather than social needs. As discussed above, many intersex adults are unhappy about surgery that was performed on them as children (Fraser, 2016; Newbould, 2017). Furthermore, surgery carried out on an infant on the basis of a 'best guess' about their likely gender identity removes tissue that may be later required if, as an older child or adult, that person decides that they would like to have a body that aligns more stereotypically with their identity. Early surgical intervention forecloses such decisions by removing the flesh that could be used to make them happen, as well as preventing the child from exploring and understanding their body as it is.

It would also be important to make it easy for intersex children who turn out to have been wrongly assigned to have a social and probably also a legal transition once this became clear. This is not always currently the case: in the UK, for example, intersex people who identify other than their initial assignment are treated as trans and have to go through a convoluted and lengthy set of diagnostic procedures to have their birth certificates changed, rather than the birth registration being treated simply as an error (King et al., 2020).

Gender exploration and social transition

Treating attribution of gender at birth as at least partly provisional for all children should go alongside an encouragement for all children to explore their gender and challenge gender stereotypes. For intersex children in particular, Sandberg's approach suggests that it is important for them to be enabled to try out different ways of thinking about themselves, in order to support the development of a clear sense of identity as male, female, intersex or something else. This is the diametric opposite of the currently widely used Johns Hopkins protocol, which encourages parents to promote strong gender stereotyping in their children and discourage cross-stereotype appearance and play (Fausto-Sterling, 2000; Kessler, 1998; Meoded Danon, 2019).

It is also important to encourage gender exploration in all children, providing play opportunities and ways of being that encompass all genders. One reason for this is to separate gendered behaviour from identity in children's minds. Children frequently have very stereotypical views about gendered behaviour (Blaise, 2005; Paechter, 2007). These are often attributed to developmental processes (Ruble & Martin, 1998), on the assumption that an understanding of gender identity as a constant attribute is the long-term goal. We might want to consider a more fluid approach, however, in which gender identity is seen as only non-immutable for some or most people (Paechter, 2020) and fully separate from behaviour. This would be a considerable social change, but one we might want to aim for. Greater facilitation of gender exploration in children would make it easier for those who do not conform to stereotypes to go through life being the way they want to be.

Non-intersex children who persistently say that they are or strongly desire to be the other gender should be allowed to transition socially, in accordance with the right of a child to have their identity respected (Sandberg, 2015). Social transition is fully reversible and allows a child to explore fully the social implications of living in the other binary gender. For those children who persist in their desire to transition and who are also dysphoric, Sandberg's arguments suggest that it would be appropriate to follow the Dutch protocol from Tanner Stage 2, the beginnings of puberty. This would mean that, in countries where they are available, puberty blockers would be considered as a means to fulfilling the child's right to appropriate medical treatment.

Such children would need considerable support, both during the decision making process, so that they understand the implications of these medications and their side-effects, and throughout the period they are taking them. This would need to include psychological support for them to continue to explore their gender and the possibilities for their identities and bodies; to do this is part of recognising the child's rights both to identity and to participation in decisions about their welfare. In accordance with the UNCRC, which recognises that, as children mature, their capacity to understand and participate in decisions evolves, prescribing puberty blockers allows time for this to happen while preventing the unwanted and irreversible bodily changes that would usually arise from puberty. It is also arguable (though Sandberg (2015) does not argue this) that such an approach further supports the child's right to health, as it leaves them with less need for later surgical and other intervention to reverse the effects of pubertal masculinisation or feminisation.

Health education

Both trans and intersex children should be given specific and detailed heath education, so that they can develop, as they mature, a full understanding of the implications for health of being trans or intersex. This is part of fulfilling the requirement that children should have access to the highest standard of health possible where they live. Such education will have to be tailored to the child's age, but should commence well before key decision points, so that it does not get mixed up, any more than is inevitable, with a child's feelings of urgency about an intervention.

Intersex children should have access to knowledge, from their earliest years, about their condition and its implications, which might include an explicit acknowledgement that little is known about that specific form of intersex. This would be a significant move away from practices that are still prevalent in some countries, which involve hiding a child's intersex status from them, and/or encouraging secrecy with respect to others (Meoded Danon, 2019). It is arguable, in any case, that not telling a child that they are intersex violates their right to identity; it also denies them the opportunity to take into account any health implications of their specific condition when thinking about their future lives.

Both trans and intersex children are likely to need a considerable amount of education in fertility and fertility preservation, and the effects of different interventions on this. For example, most children who have a sufficiently strong and persistent cross-sex identity to be prescribed puberty blockers go on to take cross-sex hormones from around age 16-18 (Brik et al., 2020; Giordano & Holm, 2020; Kuper, 2014; Meoded Danon, 2019; Pyne, 2017). If a trans male adolescent does not undergo puberty in the gender he was assigned at birth, he will be unable to conceive children without intervention (Giordano & Holm, 2020). Although trans men with intact ovaries can have ova collected and, if necessary, stored (Brik et al., 2020), if a trans woman wants to become fertile after taking puberty suppression medication she will need to cease therapy for approximately a year in order to undergo some level of her initially assigned gender puberty (Hudson et al., 2018). If a trans woman has taken puberty blockers followed by cross-sex hormones, fertility may not be regained, even if she later ceases to take HRT (Kuper, 2014).

This suggests that trans children and young people who want to take puberty suppression medication should have considerable fertility education and counselling before it takes place. They need to be given the fullest possible information about the implications of moving directly from puberty blockers to transition hormones, and to be supported to understand the implications of potential decisions at all decision making points. This is particularly key for older adolescents at the point at which they might move from puberty suppression to experienced-gender puberty, as this is the point at which irreversible effects on fertility are most likely to occur.

Conclusion

Being trans and being intersex are different, but both need to be taken seriously in relation to the UNCRC. However, examining current practices in relation to children's rights we find that they are underpinned by vastly different assumptions about what constitutes their best interests. In trans children, there is considerable caution about intervention, particularly from medical staff, and intermittent public concern about possible consequences for children in later life, as exemplified by the discussions around the 2020 English High Court judgement (Victoria Sharp P et al., 2020). In these cases, there is a frequently used policy (if only due to long waiting list times) of 'watching and waiting' to see how the child's identity develops. This is not a neutral act: the child's body may change irreversibly while we do so (Zucker, 2019). In the case of intersex children, while watching and waiting is, by contrast, entirely neutral in its effects, at least up until puberty, it is still relatively rare. However, for both trans and intersex children, what is commonly done, even though what this is in one case is the diametric opposite of what it is in the other, can restrict the child's right to an open future.

In both cases, taking Sandberg's (2015) interpretation of the UNCRC seriously means maintaining that open future and giving children as much say in what happens to them as possible. This requires us to delay irreversible decisions until a child is old enough to understand their implications. It means prescribing puberty blockers if a well-supported trans child wishes it, and doing nothing to an intersex child that is not medically necessary. In both cases, this means that nothing irreversible happens to the child's body before they are competent to decide what that should be, with full information about the consequences. At that point, steps should be taken to ensure that the young person is able to come to as complete as possible understanding of the issues involved, including the implications for their future fertility, possible surgical outcomes, and medical risks. Only in this way can we preserve and support children's rights to health, identity, and protection from harm and, above all, to self-determination.

While I have focused here on trans and intersex children, and on Sandberg's (2015) comments about their rights, Sandberg's conclusions have implications for children's rights more broadly. In particular, she treats children's rights to participate in personal decisions, and to have the final say in those that are especially significant for them, as overriding. The case of intersex children, especially, demonstrates how easily such rights are ignored. States should learn from this, and work harder to ensure that this right is enshrined in both their laws and their practices, so that children generally gain greater access to informed self-determination.

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[i] Cis people are those whose gender identity is congruent with the gender they were assigned at birth.

[ii] This is also a problematic requirement in relation to trans female adults, not all of whom have full reconstructive surgery. Some trans women are not sufficiently dysphoric to feel the need to undergo a serious and risky procedure; others are unable to for independent health reasons; in other cases there may be significant financial barriers.

[iii] This refers to a 1986 UK House of Lords judgement that ‘a doctor could lawfully give contraceptive advice and treatment to a girl aged under 16 if she had sufficient maturity and intelligence to understand that nature and implications of the proposed treatment and provided that certain conditions were satisfied’ (Victoria Sharp P et al., 2020: 104).