

VIEWPOINT

Denying Pediatric Gender-Affirming Health Care Is a Human Rights Violation

SWARUPA DEB

This viewpoint critically analyzes contemporary global opposition to pediatric gender-affirming care (GAC) as a regulatory ideology that justifies human rights violations against transgender children. Pediatric GAC is a developmentally appropriate support for children undergoing gender transition that includes interventions such as puberty blockers and hormone replacement therapy.¹ However, recent medico-political shifts have invoked statutory restrictions, institutional retrenchment, and the reorientation of clinical guidelines to limit or withdraw access to pediatric GAC, citing uncertain medical outcomes and child protection concerns.

The Cass Review, for instance, argues against pediatric GAC, emphasizing the limited quality and longitudinal depth of evidence supporting puberty suppression and hormonal interventions, as well as uncertainty regarding long-term outcomes.² The American Society of Plastic Surgeons invokes insufficient risk-benefit data, procedural irreversibility, and minors' limited capacity to provide informed consent.³ Queensland's suspension of puberty blockers for minors emphasizes risk assessment and highlights potential threats to children's health.⁴ Similarly, Alberta's most recent legislative restrictions on pediatric GAC insist on harm to minors' well-being.⁵

Resonant precautionary logics are emerging within Indian medico-juridical-public discourse as well. They problematically frame the expansion of pediatric GAC as a "mistake," appealing to medical caution and aligning with international trends.⁶ Read symptomatically, these oppositions reveal how protectionist language and institutionalized medical hesitation are consolidated as regulatory rationality to justify the denial of equal health care for trans and gender-diverse children.

Such extraordinary medical scrutiny around pediatric GAC reveals symbolic weight attached to the concept of gender itself. Scholarship, both seminal and recent, has demonstrated that gender identity, unlike other aspects of psycho-physiological development, continues to be treated as a foundational principle of social order. It operates as a structuring logic that organizes power, status, and intelligibility.⁷ Consequently, interventions that appear to destabilize binary gender norms are experienced not merely as a

SWARUPA DEB, PhD, is a human rights lawyer and sociologist based in India.

Please address correspondence to the author. Email: swarupa.deb@gmail.com.

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biomedical risk but as a civilizational threat. From this perspective, engaging directly with counterarguments that invoke “documented risk” and “systemic evidence reviews” to justify restrictions or deferral of GAC is important.⁸

Historically, transgender encounters with medicine have been organized less around care than around classification, risk assessment, and the management of gender variance as a problem to be solved.⁹ Within this history, assessments of harm have been unevenly distributed, and evidentiary standards concerning GAC have been subjected to heightened scrutiny. Medical scholarship continues to remain internally differentiated in this context, with one body of research evidencing significant psychosocial and mental health benefits for trans youth, and another body of medical epistemology emphasizing evidentiary uncertainty, potential long-term risks, and caution.¹⁰ The irony here thus lies in the inversion of medical reasoning: “Uncertainty” and “documented risk,” which should typically function as a catalyst for clinical refinement and innovation, are instead mobilized in GAC as a justificatory basis for denying rights. Ergo, the core disagreement concerning GAC is not over the necessity of caution itself but over how caution is unevenly applied and whose interests such applications ultimately serve.

Against this backdrop, I argue that the contemporary opposition around pediatric GAC cannot be understood as a narrow medical dispute. Rather, it is a convergence of multiple regimes of power, including biomedical authority, juridical paternalism, developmental psychology, and deeply sedimented cultural anxieties around gender non-conformity. Within this convergence, structural discrimination against transgender children is (re)produced in ways that systematically generate and sustain disadvantage. This discrimination operates not only through the denial of services but through the unequal distribution of risk and recognition within health care regimes. It is in this precise context that human rights commitments to the best interests of gender-diverse children are critically strained, through the epistemic-moral disqualification of the “child” as a knowing subject.

Childhood, incapacity, and the politics of protection

Across regulatory and clinical contexts, children's self-reports are frequently approached with caution and presumptions of diminished capacity and are often filtered through adult interpretations of risk and protection. This dynamic becomes especially pronounced in the case of gender-diverse children, resulting in the systematic invalidation of their capability and right to articulate gendered experiences, distress, and needs.

Human rights jurisprudence in this context offers a nuanced account of childhood and agency. The Convention on the Rights of the Child explicitly rejects the idea that children are merely passive recipients of protection.¹¹ Rather, it advances a model of *evolving capacities* (article 5), according to which children's ability to participate in decisions affecting them increases over time. Importantly, this framework dismisses the binary distinction between complete autonomy and total incapacity, instead acknowledging that children's capacity to participate meaningfully in decisions that affect them develops relationally and contextually.

The Committee on the Rights of the Child further elaborates this principle in its General Comment 20 on the implementation of the rights of the child during adolescence.¹² It highlights adolescents' entitlement to participate meaningfully in decisions concerning their health, bodily integrity, and medical treatment, emphasizing that states must move beyond protectionist paternalism and ensure access to appropriate, rights-respecting health care services. Read together, these provisions underline the *best interests of the child* principle that mandates all decisions concerning children to prioritize their well-being and development—not as an exception to protection, but as integral to it.

In juxtaposition, anti-GAC arguments represent a selective application of the principle, repeatedly treating it as a risk-management tool, devaluing present and ongoing harm. This approach departs from the fundamental principles of human rights jurisprudence, which emphasize children's lived experience, psychological well-being, social belonging, and sense of self above all else. This is

crucial in the case of gender-diverse children, who are continually required to justify their entitlement to care and credibility—entitlements that are contingent on conformity to dominant gender norms and imagined futures of normalization.

Thus, what appears as an appeal to medical caution is in reality a structural failure of rights realization. The failure arises from a clinical structure so rigidly organized around standardization and normative assumptions about gender and childhood that it actively disables the forms of knowledge most necessary for caring for gender-diverse children. When health care, a fundamental human right, is structured in this manner, access to care is no longer realized as a right but rendered conditional. For gender-diverse children, this results in continued invalidation of their dignity, suffering, and aspirations, which are treated as illegible and unworthy of medical care. The vulnerabilities, anxiety, and depression of gender-diverse children, therefore, actually arise from regulatory and social constraints and not from their embodied identity, as commonly presumed.

Against protective harm

Engaging critically with pediatric GAC is not merely a debate over clinical protocols. It is about medical decision-making that differentially recognizes and restricts fundamental rights to health, bodily integrity, and dignity, thereby effectively violating them under the guise of ethical health care regulation. The harm intensifies when these regulations presume that clinical objectivity, risk assessment, and evidence standards operate independently of social contexts.

This presumption is analytically untenable given that health care has always been socially and culturally embedded. Medical knowledge is produced within institutional norms, regulatory regimes, and moral frameworks. These structures shape how risk is defined, whose experiences are considered credible, and which lives are recognized as legitimate subjects of care.¹³ They not only influence care practice but also significantly structure its ethical and legal boundaries. Appeals that India

too should align with “international consensus” on pediatric GAC thus presume that scientific evidence is context-free and universally transferable; they obscure how local legal frameworks, institutional capacities, and social norms shape risk, eligibility, and access to care.

When discrimination-free health care is withheld in the name of ethical regulation, the outcome is not mere medical caution or risk assessment but an immediate violation of the universal human rights to life, equality, and freedom of expression. Such regulations redistribute harm into the lives of young children, impacting their everyday realities as they concern access to education, social adjustment, peer pressure, and self-image. This viewpoint thus calls for the recognition of gender-diverse children as present rights holders, entitled to dignity and participation in decision-making concerning their health care, rather than as future contingencies to be governed.

References

1. L. Ha, “Further Defining Gender Affirming Care December,” *AAP Journals Blog* (December 22, 2023), <https://publications.aap.org/journal-blogs/blog/27752/Further-Defining-Gender-Affirming-Care>.
2. H. Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* (2024), <https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143933/https://cass.independent-review.uk/home/publications/final-report/>.
3. S. Christy, “US Plastic Surgeons Group Advises Delaying Gender Surgery Until Age 19 Due to Insufficient Evidence,” *Reuters* (February 3, 2026), <https://www.reuters.com/business/healthcare-pharmaceuticals/us-plastic-surgeons-group-advises-delaying-gender-surgery-until-age-19-due-2026-02-03/>.
4. D. Melissa, “Queensland Ban on Puberty Blockers for Gender Dysphoria to Continue Until at Least 2031, LNP Announces,” *Guardian* (December 19, 2025), <https://www.theguardian.com/australia-news/2025/dec/19/queensland-ban-puberty-blockers-gender-dysphoria-2031>.
5. T. Laura, “Alberta Has Restricted Access to Gender Based Medical Care for Trans Youth. Will the Rest of Canada Soon Follow?,” *Healthy Debate* (January 21, 2026), <https://healthydebate.ca/2026/01/topic/alberta-gender-based-medical-care/>.
6. “Gender Reassignment Surgery on Children Is an Invasion of Rights Enshrined in Constitution: Kerala

HC,” ANI (August 8, 2023), <https://www.aninews.in/news/national/general-news/gender-reassignment-surgery-on-children-is-an-invasion-of-rights-enshrined-in-constitution-kerala-hc20230808213114/>; J. Nilekani, “Many countries are rethinking gender treatment for kids. India should too,” *Times of India* (January 3, 2026), <https://timesofindia.indiatimes.com/blogs/toi-edit-page/many-countries-are-rethinking-gender-treatment-for-kids-india-should-too/>.

7. K. K. Means and T. Morgenroth, “The Ubiquity of the Gender/Sex Binary: Power and Status in Social Psychology,” *Frontiers in Social Psychology* 2 (2024); C. West and D. H. Zimmerman, “Doing Gender,” *Gender and Society* 1/2 (1987).

8. Cass (see note 2); Nilekani (see note 6).

9. S. Stryker, *Transgender History: The Roots of Today's Revolution*, 2nd edition (Seal Press, 2017).

10. L. Crabtree, K. J. Connelly, J. T. Guerriero, et al., “A More Nuanced Story: Paediatric Gender-Affirming Healthcare Is Associated with Satisfaction and Confidence,” *Journal of Adolescent Health* 75/5 (2024); K. McDeavitt, J. Cohn, and C. Kulatunga-Moruzi, “Paediatric Gender Affirming Care Is Not Evidence-based,” *Current Sexual Health Reports* 17 (2025).

11. Convention on the Rights of the Child, G.A. Res. 44/25 (1989).

12. Committee on the Rights of the Child, *General Comment No. 20, UN Doc. CRC/C/GC/20* (2016).

13. A. B. Sideman and N. Razon, “Extra/ordinary Medicine: Toward an Anthropology of Primary Care,” *Social Science and Medicine* 346 (2024).