**TITLE**

# Ethical Justification for Gender Reassignment Surgery Without Parental Consent for Transgender Youth aged 16 years and older in South Africa.

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Submitted to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree Master of Science in Medicine (Bioethics and Health Law).

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Position: Lecturer

Date: 19/09/2025

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I [Faaiza Gangat] declare that this Thesis/Dissertation/Research Report is my own, unaided work. It is being submitted for the Degree of [Master of Science in Medicine (bioethics and health law)] at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

_____

(Signature of candidate)

19th day of September 2025 in Johannesburg

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| |

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## iii. Acknowledgements

***"umuntu ngumuntu ngabantu"*** – A Zulu Proverb

First and foremost, all praise be to God, the most high

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Finally, I would like to thank myself for staying determined.

## Abstract

This dissertation examines the ethical justification for permitting transgender youth aged 16 and older in South Africa (SA) to consent independently to gender-affirming surgery, provided they undergo a mental health assessment and receive ongoing support. The thesis contends that such youth may possess the competence to make informed decisions regarding their gender identity and, consequently, their healthcare choices. This argument is supported by three premises grounded in theoretical frameworks and empirical literature. First, it is argued that transgender youth aged 16 and older, when supplemented with mental health assessment, are capable of making informed decisions that align with their gender identity, underscoring respect for their autonomy. Second, gender-affirming surgery is viewed as crucial for facilitating social transitioning and enhancing well-being by alleviating gender dysphoria, a stance supported by utilitarianism. The ability to consent independently to surgery is posited to mitigate harm by addressing the psychosocial distress that delays in transition may cause. Third, the requirement of parental consent is identified as a barrier to healthcare access for transgender youth aged 16 - 18, especially when parents are unaccepting or lack understanding of gender identity issues, which can exacerbate gender dysphoria. Where parents are assistive or supportive, they should be involved, however, their involvement and consent should not be a requirement. This position is grounded on well-being theories. This study applies ethical principles and theories, specifically respect for autonomy and utilitarianism to argue that respecting the self-determined decisions of transgender youth aged 16 - 18 aligns with broader social imperatives to promote well-being and minimise harm. The justifications aim to contribute to the discourse on the autonomy of transgender youth aged 16 – 18 and gender-affirming surgery in SA.

**Key words:** normative ethics, transgender youth aged 16 and older, gender-affirming surgery, informed consent, social transitioning, instrumental, respect for autonomy, self-determination, competence, utilitarianism, well-being theories.

Word count: 16 478

## List of abbreviations and acronyms

BMA – British Medical Association

HIV – Human Immunodeficiency Virus

IEP – internet encyclopaedia of philosophy

LGBTIQA+ - lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other terms

NICHQ - The National Institute for Children's Health Quality

OLT – objective list theories

SAHIVCS - Southern African HIV Clinicians Society

WHO – World Health Organisation

WPATH – World Professional

GnRH - gonadotropin-releasing hormone

LH - luteinizing hormone

FSH - follicle-stimulating hormone

DHEA – dehydroepiandrosterone

## Definition of terms

| | |
|---|---|
| Gender dysphoria | Gender dysphoria refers to the distress or discomfort that arises when an individual's biological sex does not align with their gender identity. This distress can be severe enough to cause depression, anxiety, and significantly interfere with daily functioning (NHS, 2023). |
| LGBTIQA+, (Each community) | LGBTQIA+ is an acronym that encompasses a wide range of gender and sexual identities that are often marginalized in society. It stands for lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual, while the "+" represents additional and evolving understandings of diverse gender and sexual identities (Princeton University, 2025). |
| Transfeminine | A transfeminine person is an individual assigned male at birth whose gender identity, expression, or behaviour aligns with femininity (de Villiers, 2023), |
| Transmasculine | Refers to someone who was assigned female at birth but identifies more strongly with being male than with being female (Oxford, 2025).. |
| Transphobia | Transphobia refers to negative attitudes and stigma toward transgender individuals, including prejudice and discriminatory actions, which can contribute to mental health challenges, psychological distress, and an increased risk of suicidality among gender-diverse populations. It includes both stigma experienced from others and internalised negative feelings about one's own gender identity (Science Direct, 2017). |

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# Research Report

## Chapter 1: Introduction and literature overview

### Background

Gender-affirming surgery, also known as sex reassignment surgery, is performed to transition individuals with gender dysphoria to their desired gender. Gender dysphoria is characterized by a profound sense of incongruence between one's assigned gender at birth and their gender identity. Gender-affirming surgery is a treatment option for individuals experiencing gender dysphoria (Tomson et al., 2021).

Gender-affirming surgery involves surgical procedures to modify physical characteristics to align with an individual's gender identity, including genital reconstruction, breast augmentation or reduction, and facial surgeries. Gender-affirming treatment (non-surgical) includes hormone therapy, psychotherapy, voice training, and other interventions (Laungani & Brassard, 2017). This research focuses solely on informed consent for gender-affirming surgery, specifically for minors or children at or above the age of 16 years old. For the purposes of this research, the terms gender-affirming and gender-reassignment will be used interchangeably, while noting that “gender-affirming” is generally regarded as the preferred terminology.

The Children's Act No. 38 of 2005 allows children aged 12 and older, who are deemed mature and mentally capable, to consent to surgeries with parental assistance (Children’s Act No 38, 2005 section 129(3a-c)). However, exceptions are made when parental consent is not in the child's best interest. The first exception is when the parent is unavailable or unfit, this includes situations where the parent(s) are; mentally ill and unable to make sound decisions; missing or cannot be located after a

reasonable effort; have abandoned the child; have a history of neglecting or abusing the child; have failed to fulfil parental duties for a significant period (typically a year); have a court order prohibiting them from consenting to surgical treatment for the child. Secondly, emergency situations when a delay in treatment due to obtaining parental consent could endanger the child's life or health. Thirdly, court order if a Children's Court judges that withholding parental consent is unreasonable and the surgery is in the child's best interest, they can issue a court order allowing the procedure to proceed without parental consent (Children's Act No 38, 2005 section 236(1a-f)). This legal framework prioritises the child's well-being and evolving capacities, enabling healthcare professionals to assess each situation individually.

In SA, the Southern African HIV Clinicians Society (SAHIVCS) guidelines recommend parental consent for gender reassignment surgery for transgender children aged 12 to 18 (Tomson et al., 2021: 5-6). "A child who is older than 12 years can consent to a surgical operation on him or her – or the surgery of his or her child – if the child passes the maturity test" (Tomson et al., 2021: 5-6). As of 2025, no updated or revised version specifically regarding gender-affirming healthcare has been published by SAHIVCS. The 2021 guidelines remain the latest and active reference. These clinical guidelines are aimed to advise and guide clinicians and are not legally binding. The guidelines do operationalise provisions stipulated under the Children's Act Section 129 related to consent for medical and surgical interventions.

For surgery, a child between the ages of 12 and 18 must be properly supported by their parent or guardian(Tomson et al., 2021: 5-6). Written consent is required from both the person performing the surgery or a representative of the institution where the surgery will take place, as well as from the child undergoing the procedure (Tomson

et al., 2021: 5-6). Additionally, a parent or guardian must also provide written consent on the specified form (Tomson et al., 2021: 5-6). The maturity test entails that, maturity is determined by a health professionals judgment of a child's ability to understand and participate in the decision-making process. This assessment goes beyond simply reaching a certain age and evaluates the child's grasp of the surgery itself, including its purpose, steps involved, and potential risks and benefits (McQuoid-Mason, 2010). They will also discuss alternative treatment options and the consequences of refusing surgery. Additionally, the health professional will assess the child's decision-making capacity, ensuring they can weigh the information independently, and their emotional maturity to handle the surgery's emotional aspects (McQuoid-Mason, 2010).

Requiring parental consent can create significant barriers, particularly for those with unsupportive parents, leading to treatment delays and worsening mental health. Critics question if children aged 16 and older can provide informed consent without parental involvement. Although not contextually sensitive, a relevant foreign case law from the United Kingdom for addressing these concerns is the concept of Gillick competence.The 1985 Gillick v West Norfolk case, which assesses if individuals under 16 years old can consent to medical, surgical, and dental treatment by demonstrating sufficient maturity and understanding (Griffith, 2016). Gillick's competence framework, influencing legal standards in several countries, supports the argument that sufficiently mature transgender youth aged 16 and older should ethically consent to gender-affirming surgery without parental involvement (Griffith, 2016). However, in the context of this case it is important to note that not all 16- 18 year olds are considered competent to make complex decisions, such as those related to gender-affirming surgery. Decision-making capacity varies among individuals, and such medical decisions often require a comprehensive understanding of implications, risks, and

personal readiness. Therefore, assessments of competence and informed consent are crucial considerations in medical and legal contexts involving minors (Vrouenraets et al., 2023).

## Literature Overview

### Informed consent

In SA, the binding legal framework regulating consent for medical treatment and surgical operations by children is contained in section 129 of the Children's Act 38 of 2005. Section 129(3) regulates surgical operations. It provides that a child may consent to the performance of a surgical operation on himself or herself, or on his or her child, if three cumulative requirements are satisfied: in subsection (3)(a), the child must be over the age of twelve years; in subsection (3)(b), the child must be of sufficient maturity and must have the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and in subsection (3)(c), the child must be duly assisted by his or her parent or guardian (Children's Act No 38 of 2005, section 129 (3 a-c)). In the context of gender reassignment surgery, the SAHIVCS gender-affirming healthcare guideline recommends obtaining informed consent from parents or legal guardians for transgender children aged 12 to 18 years. The competence of young people to consent to gender-affirming surgery is complex and controversial, with debates about whether minors can fully understand the intricacies of such procedures. However, a recent South African study by Kruger et al. (2020) suggests that children aged 12 and older generally exhibit competence in understanding treatment choices, with improved reasoning abilities observed in those over 14 years (Kruger et al., 2020). Although, being mindful of the fact that this is not a blanket statement for children of all demographics.

## International Clinical Guidelines on Surgery

International clinical guidelines on surgery for gender-affirming treatment include procedures like chest, vaginoplasty, and phalloplasty. World Professional Association for Transgender Health (WPATH) Standards of Care (8th version) advise deferring genital surgery until adulthood but emphasise that age alone is not a reliable indicator of informed consent capacity (WPATH SOC 8, 2022). Minors should not be categorically barred from genital surgery; decisions should prioritise their best interests with transparent data sharing. Genital surgery post-hormone treatment, with gonadectomy and hysterectomy after 18 years; breast surgery is case-dependent (WPATH SOC 8, 2022). Emphasis on case-dependent approach is crucial as older children from ages 17 – 18 may also lack sufficient maturity thus requiring special support. While the WPATH SOC 8 guidelines provide a strong international framework, their direct applicability to the South African context is complex. Legal capacity is tied to age 18 for gender-affirming surgery, which may restrict the approach WPATH recommends regarding minors and informed consent.

Both organizations stress mental health assessments and report positive outcomes. WPATH's guidelines for adolescents focus on diagnostic criteria, sustained gender identity, emotional maturity, informed consent, mental health, fertility, pubertal stage, and hormone therapy, aiming for a comprehensive, individualized approach (WPATH SOC 8, 2022).

## Teenage presentation of gender dysphoria

Since 2005, adolescent transgender clinics in Toronto, London, and Finland have noted shifts in referral patterns and an increase in psychiatric disorders among referred children (Olson et., 2016). Transgender children supported in their gender

identity had normative levels of depression and anxiety, indicating the importance of early support for mental well-being (Olson et al., 2016).

Ashley (2019) critiques earlier work on gender dysphoria, emphasizing the benefits of early social transition and societal acceptance for transgender youth's mental health. The article suggests that previous studies may have underestimated these benefits (Ashley, 2019). Research by De Vries et al. (2014) follows adolescents who underwent puberty suppression and gender-affirming surgery, showing improved psychological outcomes and reduced gender dysphoria. This study supports early medical intervention for transgender youth, highlighting the positive impact on mental health and quality of life, justifying early access to gender-affirming surgery (De Vries et al., 2014).

**Justifications for gender-affirming surgery availability for minors**

Gender-affirming surgery for minors is ethically justified, as argued by Loveday et al., (2022). They advocate for allowing minors aged 16 and above to consent to sex change surgeries independently, emphasizing the importance of minimizing harm and promoting well-being. The TransYouth Project led by Olson et al. (2016) found that supported transgender minors had normal levels of depression and anxiety, suggesting that access to gender-affirming surgery can improve mental health.

Turban et al. (2020) found that gender-affirming care, including surgery, reduces suicidal ideation and attempts among transgender youth. Early medical interventions, including surgery, also lead to higher life satisfaction and improved quality of life, according to Green et al. (2021). Milrod (2014) highlights the importance of congruent genitalia for social and romantic engagement, emphasizing the necessity of gender-affirming surgery for adolescent well-being.

**Justification for age of consent**

In SA, the legal age of consent for sexual activity is 16 years old, as established by the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007). This acknowledges the fact thatindividuals aged 16 and older possess the cognitive and emotional maturity necessary to make informed decisions about their bodies and sexual activities (Sexual Offences and Related Matters Amendment Act No. 32 of 2007). Although, the Act itself does not provide reasoning for selecting age 16 as the consent threshold. Extending this reasoning to the context of gender-affirming surgery, it is consistent and logical to recognise that transgender youth aged 16 and older have the capability to make informed decisions about their gender identity (Rodriguez-Dominguez et al., 2023). This study found that the majority of adolescents (74.9%) and a significant proportion of parents (60%) believe that minors aged 16 and older are sufficiently competent to make their own health-related decisions (Rodriguez-Dominguez et al., 2023). This supports the recognition that maturity and decision-making capacity are often present well before the legal threshold of 18 years in SA.

**Lack of parental involvement**

Transgender youth without or limited parental involvement or support are particularly vulnerable (Seibel et al., 2018). They face significant barriers to accessing healthcare, which can lead to negative mental health outcomes and increased risk of harm. In this case, requiring parental consent for gender-affirming surgery can create obstacles for these youth, especially if their parents are absent. (Seibel et al., 2018).

Although, Travers et al. (2012) reported that minors under the age of 18, face challenges in making significant decisions like gender-affirming surgery without

parental involvement. Parental guidance and involvement are typically crucial due to the legal and ethical complexities involved, ensuring that minors receive appropriate support, information, and counselling. The study suggested that in cases where parental support is lacking or absent, legal frameworks often require alternative mechanisms to safeguard minors' interests and ensure that decisions are made in their best interests, taking into account their maturity and ability to understand the implications of such decisions (Travis et al., 2012).

In SA, laws require parental consent for surgical procedures involving minors due to their age and legal status as dependents. Thus, for transgender youth aged 16 and older to consent to their own gender-affirming surgery in SA, it's important to consider the complexities regarding minors without parents (Tomson et al., 2021).

**Consequence for taking parents out of the equation**

When transgender youth make autonomous medical decisions, the consequences can be profound for family dynamics (Arthun et al., 2019). Psychologically, it can strain family relations due to misunderstandings, conflicts over acceptance, and the emotional burden placed on both the youth and their parents (Arthun et al., 2019). Research suggests that parental rejection or lack of support contributes to higher rates of depression, anxiety, and even homelessness among transgender youth. Without parental support, transgender youth experience feelings of isolation and rejection, significantly affecting their mental health and well-being (Trevor Project, 2022). The strain on family relations can manifest in various ways, including breakdowns in communication, heightened conflict, and challenges in maintaining a supportive family environment. However, for transgender minors who are homeless or lack parental

figures, the inability to access gender-affirming surgery due to parental barriers can exacerbate these challenges (Thoma et al., 2021).

**Vulnerabilities and homelessness amongst transgender youth**

Studies have shown that transgender youth who are rejected by their families face significantly higher risks of mental health issues, substance abuse, and suicide attempts (Ryan et al., 2009). In SA, where societal and cultural stigmatization of transgender individuals is prevalent, the situation can be even more dire. A study by Scheim et al. (2020) highlights that transgender youth in sub-Saharan Africa often experience, familial neglect, violence, discrimination, and lack of access to healthcare, which exacerbates their vulnerabilities.

The 2021 National Survey on Youth Mental Health found that transgender teenagers without parental support often find themselves in precarious living situations and are disproportionately represented among homeless populations, with many citing family rejections as a primary cause (Trevor Project, 2022). Approximately 40% of homeless teenagers identify as LGBTIQA+, despite LGBTIQA+ individuals only comprising about 10% of the general youth population. Moreover, 16% of LGBTIQA+ youth have experienced homelessness, having slept away from their parents or caregivers, with over half (55%) indicating they did so due to mistreatment or the fear of mistreatment related to their LGBTIQA+ identity. Additionally, about 14% of LGBTIQA+ youth have slept away from home because they were kicked out or abandoned, with 40% of them attributing their displacement to their LGBTIQA+ identity (Trevor Project, 2022). The experiences of transgender teenagers, especially those without parental support or

who are homeless, further underscore the need for autonomous medical decision-making.

### Regrets after gender-affirmation surgery

A 2021 systematic review and meta-analysis of 27 studies involving 7,928 transgender patients aged 13 and older who underwent gender-affirming surgery found a regret prevalence of 1%. This rate was consistent across both transfeminine (1%) and transmasculine surgeries (<1%) (Bustos et al., 2021). Historical studies reported similar regret rates: Pfäfflin in 1993 (1%–1.5%) and Kuiper et al in 1998 (0.9%). The primary reason for regret was psychosocial issues, such as difficulties reintegrating into society, leading some to revert to their original gender role for social acceptance, financial benefits, or relationship preservation. Other contributing factors included poor surgical outcomes, like loss of clitoral sensation, chronic abdominal pain, and concerns about aesthetic results (Bustos et al., 2021).

### Afro-communitarian values

Traditional beliefs in African societies significantly influence attitudes towards gender and sexuality, often leading to resistance or lack of acceptance of transgender youth (Kruger, 2018). When transgender youth disclose their gender identity to their parents, challenges arise such as fear of negative community reactions, concerns about social standing within community or religious institutions, and worries about their child's ability to establish a family. These socio-cultural barriers make it difficult for parents to support their transgender children in environments deeply rooted in traditional gender and sexuality beliefs (Kruger, 2018).

### Developmental and cognitive considerations

By age 16, most adolescents reach the formal operational stage (Piaget), allowing them to think abstractly, logically, and systematically, which is essential for informed consent (Carpendale, 2000).

Steinberg and Cauffman (1996) found that many adolescents aged 16 and above exhibit maturity and autonomy, supporting their capability to make informed health decisions. They note that while adolescents can make reasoned decisions, their risk assessment and impulse control are still developing (Steinberg & Cauffman, 1996).

Tordoff et al. (2022) emphasised the importance of informed consent and thorough psychological evaluation for adolescents undergoing gender-affirming treatments. The review highlighted the need to assess an adolescent's maturity and readiness, given the significant implications for mental health and well-being (Tordoff et al., 2022). This study highlights the role of supported autonomy where informed consent must be coupled with mental health evaluation.

The ethical dilemma surrounding gender-affirming surgery for transgender youth aged 16 and older in SA centers on the tension between autonomy, beneficence, and parental authority. While research supports that youth aged 16+ possess sufficient cognitive and emotional maturity for informed consent, there is also a great amount of literature suggesting that not all youth aged 16+ may possess sufficient maturity. Thus, existing legal frameworks in SA require parental consent for surgical procedures involving minors under the age of 18 years. This can create barriers to accessing healthcare, particularly for youth without supportive or absent parents, increasing their vulnerability to gender dysphoria and mental health risks. Conversely, removing parental involvement raises concerns about family dynamics, developmental maturity, and the permanence of surgical decisions for minors under 18 years. The challenge is

ensuring ethical justification for independent consent while addressing potential consequences such as regret, social reintegration struggles, and the influence of cultural and communal values (Tordoff et al., 2022).

**Puberty and secondary sexual hormones**

Puberty represents the period of physical maturation during which an adolescent becomes capable of sexual reproduction. Onset usually occurs between 8–13 years in females and 9–14 years in males, though timing varies with genetic and environmental factors. It involves hormonal, physical, and psychosocial changes such as breast development, pubic hair, genital maturation, voice changes, height increase, and in girls, the onset of menstruation (Breehl & Caban, 2018).

Puberty is initiated by pulsatile secretion of gonadotropin-releasing hormone (GnRH) at the hypothalamic level. This stimulates pituitary release of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), which act on the gonads to drive gametogenesis and sex steroid production. In females, estrogen promotes follicle growth, uterine development, fat redistribution, and menarche; in males, testosterone drives testicular and penile growth, spermatogenesis, hair growth, and voice deepening. Adrenarche contributes to early pubic and axillary hair through secretion of DHEA (Breehl & Caban, 2018).

In girls, thelarche is typically the first sign, followed by pubic hair and later menarche. In boys, testicular enlargement occurs first, followed by genital growth, hair development, and eventually first ejaculation (Breehl & Caban, 2018).

Beyond reproduction, sex steroids influence skeletal growth, muscle development, and neural circuits, contributing to emotional sensitivity and impulsivity. Abnormal pubertal timing, delayed, or contrasexual may result from HPG axis disruption,

gonadal dysfunction, adrenal disorders, or exogenous hormones. Careful evaluation through history, Tanner staging, and hormone testing remains essential (Breehl & Caban, 2018).

### Research Question

Is it ethically justified for transgender youth aged 16 years and older to consent to gender reassignment surgery without parental consent in South Africa?

### Rationale

The research aims to examine the ethical justifiability of allowing transgender youth aged 16 and older in South Africa to consent to gender-affirming surgery without parental consent. It seeks to balance the right to autonomy for these youth with potential cultural, social, and legal barriers. De Vries et al. (2014) emphasize the importance of timely access to gender-affirming surgery, highlighting the need for research on autonomous consent for transgender youth aged 16 and older in SA without being duly supported by parental consent. While existing studies address gender-affirming for transgender youth, there is limited literature on the ethical considerations of consent without parental approval in SA. Müller (2017) identifies specific cultural and legal challenges faced by transgender children in the country. This research aims to contribute to discussions on autonomy and cultural competence in healthcare decision-making, particularly for vulnerable populations like transgender youth aged 16 years and older.

### Thesis statement

I will defend the thesis that it is ethically justified for transgender youth aged 16 and older to consent to gender reassignment surgery without parental consent in South Africa if they receive adequate mental health assessment and support.

## Research Aim

The aim is to defend the thesis that it is ethically justified for transgender youth aged 16 and older to consent to gender reassignment surgery without parental consent in South Africa if they receive adequate mental health assessment and support.

## Research Objectives

1. To provide a thematic overview of the literature focussing on different positions on the central normative issue.
2. To argue that transgender youth aged 16 and older have the ability/can be competent to make informed decisions about their gender identity, supplemented with mental health assessment and support.
3. To argue that gender reassignment surgery is instrumental in enabling social transitioning and overall has well-being benefits and the ability to consent to surgery independently for youth 16 and older prevents harm.
4. To argue that requiring parental consent for gender-reassignment surgery can create barriers to healthcare access for transgender youth, especially if parents are unsupportive or uneducated about gender identity issues.

## Research Design

A Type 1 normative project involves arguing in support of a specific claim. Normative ethics, a domain within philosophy and theology, seeks to address fundamental moral questions such as: What actions are morally required? What should be avoided? What kind of character should individuals develop? This field systematically and critically examines these issues, providing reasoned justifications for the ethical conclusions it presents (Wits, Centre Guidelines).

As a Type 1 normative project, this research involves defending a specific ethical claim rather than collecting or analysing new empirical data. Normative ethics, as a branch of moral philosophy, is concerned with identifying what actions are morally required or impermissible, and what values should guide human conduct. The project therefore relies on critical reasoning, conceptual analysis, and ethical theory to evaluate whether youth aged 16–18 in SA should be permitted to consent independently to gender-affirming surgery, in light of the Children's Act and broader moral considerations. The conclusions are drawn from argumentation and ethical analysis of existing scholarship, not from empirical data.

### Research Methods

Type 1 projects are based on desktop and library-based research; no new data is collected or analysed; and the research does not involve human participants. The typical research methods and standards applicable to philosophical research are employed. This includes discussing findings from the literature that is ethically analysed (Wits, Centre Guidelines).

Academic literature was selected using a purposive strategy, with inclusion criteria focused on (a) literature and ethical theories relevant to children, autonomy, well-being, and informed consent; (b) analysis of legal and policy frameworks related to children and informed consent for surgical procedures both local and international and (c) peer-reviewed psychological and medical studies on the outcomes of gender-affirming care in adolescents. Sources were excluded if they were outdated, lacked credibility (e.g., non-peer-reviewed), or fell outside the scope of ethics and law. Search strategies involved databases such as: Cochrane, JSTOR, PubMed, Google Scholar, Law Library and SAFLII online.

To strengthen credibility and avoid confirmation bias, the research engages with counterarguments including concerns about decision-making capacity of 16 – 18-year-olds, potential regret, and the role of parental involvement and weighs them systematically against arguments for autonomy and well-being. For each premise there are objections acknowledged to avoid bias. Relational autonomy and Ubuntu are applied to assess the competing claims, these are also contextually relevant theories. By critically evaluating both supportive and opposing positions, the project ensures that conclusions are the result of balanced ethical analysis rather than selective use of evidence.

### Argumentative Strategy

1. **Defence of premise 1-** To critically justify that transgender youth aged 16 and older have the ability/can be competent to make informed decisions about their gender identity, supplemented with mental health assessment and support.

In this premise, I will review existing literature on capacity, maturity, and consent for children aged 16 and older. Review evidence on the application of the Gillick principle in SA (Kruger, Delport & Van Heerden, 2020: 25-29), Fraser Guidelines (Scout Association, 2024) as well as the Adolescent Autonomy Checklist (NICHQ, 2024).

Premise 1 will be grounded in the principle of respect for autonomy, to support the thesis that transgender youth aged 16 and older in SA should consent to gender-affirming surgery without parental approval. Respect for autonomy emphasises individuals' right to make informed decisions about their own lives. If allowing such consent respects their autonomy and improves their mental health by alleviating gender dysphoria, it can be ethically justified (Parsapoor et al., 2014). The Respect for autonomy principle supports transgender youth by prioritizing their right to self-

determination, especially when it leads to significant improvements in well-being by valuing individual autonomy. In the absence of local case law, there are landmark foreign case laws from UK & USA (Bell v. Tavistock and Portman NHS Foundation Trust (2020), Ritchie Herron v. The Tavistock and Portman NHS Foundation Trust (2022) and Walter Heyer Detransitioning Case (United States) that support the decisional capacity and maturity that youth at and older than 16 years old possess that will also be considered to advance the position. Fair to acknowledge that the socio demographics from the United States may not be scalable to the South African context given the culture and concept of relational autonomy.

Critics may object that adolescents, even at age 16, may not fully grasp the long-term consequences of irreversible medical interventions such as gender-affirming surgery. They contend that the decision-making capacity of adolescents can be compromised by developmental immaturity, peer pressure, and a lack of life experience (Giordano, 2023). This objection challenges the premise by emphasizing that, despite the principle of respect for autonomy, the unique vulnerabilities of adolescents may necessitate additional protective measures, such as parental involvement or extended psychological evaluation periods, to ensure truly informed and mature consent (Giordano, 2023).

2. **Defence of premise 2** – To argue that gender-affirming surgery is instrumental in enabling social transitioning and overall has well-being benefits and the ability to consent to surgery independently for youth 16 and older prevents harm.

In this premise, I will review existing literature that acknowledges that gender-affirmation surgery is instrumental in enabling social transitioning. This will include

research documenting the benefits of social transitions, such as improved self-esteem, reduced depression and anxiety, and enhanced overall well-being (Graham, 2023).

Secondly, I will review studies showing that the satisfaction rates among individuals who undergo gender-affirming surgeries, especially when initiated during adolescence, are generally high (Bustos et al., 2021). This satisfaction contributes to long-term well-being and a sense of congruence between one's gender identity and physical presentation. Literature review will be conducted on the established link between delay in gender-affirming surgery and heightened mental health risks and self-harm among transgender youth (Bustos et al., 2021).

Premise 2 will be grounded in Utilitarianism and the theories of well-being. This Utilitarianism evaluates the moral rightness of an action based on its ability to maximise overall happiness or well-being. In this case, allowing transgender youth to consent to gender-affirming surgery independently is seen as ethically justified if it leads to greater happiness and minimises harm. The premise will also draw on well-being theories, such as: hedonism which emphasise the pursuit of pleasure and avoidance of pain; desire-fulfilment theory- which focus on the satisfaction of personal desires; and objective list theories (OLT), which assert that certain universal goods—like health, autonomy, and personal development—contribute to well-being.

Deontologists may object to premise 2 by emphasizing the importance of adhering to moral duties and rules regardless of the consequences (O’Neill, 2002). Critics argue that allowing adolescents aged 16 and older to consent to gender-affirming surgery without parental approval violates the duty of care that parents have to minors. Deontology stresses the importance of respecting established moral rules and duties, such as the duty to protect vulnerable individuals from making potentially harmful

irreversible decisions (O'Neill, 2002). Deontologists would argue that the duty to ensure that adolescents are fully mature and capable of understanding the long-term consequences of such decisions outweighs the potential benefits of increased well-being through social transitioning. Consequently, they would contend that parental involvement is a necessary safeguard (assuming that the 16-year-old minor is not fully mature and capable) to fulfil this moral obligation, ensuring that decisions of this magnitude are made with the utmost care and responsibility (O'Neill, 2002).

3. **Defence of premise 3 –** To argue that requiring parental consent for gender-affirming surgery can create barriers to healthcare access for transgender youth, especially if parents are unsupportive or uneducated about gender identity issues.

In this premise, I will review studies documenting the presence of social stigma or discrimination against LGBTIQA+ individuals in certain South African societies which contributes to a lack of open dialogue and awareness about gender identity issues among parents. Some of the studies which will be used are Kruger et al. (2018); Loveday (2022); Muller and Dasckilewicz (2019); Kruger, Delport and Van Heerden (2020); Muller (2017); De Vries et al. (2014); Steensma et al. (2011). Premise 3 will be grounded because it argues that requiring parental consent for gender-affirming surgery creates barriers to healthcare access for transgender youth, particularly when parents are unsupportive or uneducated about gender identity. From a utilitarian perspective, the moral focus is on minimising harm and maximising well-being. Denying or delaying access to gender-affirming care due to parental consent requirements can cause significant psychological distress, leading to negative outcomes.

Support for premise 3 can be found in existing qualitative research studies that report that allowing youth aged 16 and older to consent on their own empowers them to seek gender-affirming surgery without undue hindrances (De Vries et al., 2014). Premise 3 will be supported by well-being theories, such as: hedonism which emphasise the pursuit of pleasure and avoidance of pain; desire-fulfilment theory- which focus on the satisfaction of personal desires; and OLT which assert that certain universal goods—like health, autonomy, and personal development—contribute to well-being.

In the African context, the objection to adolescents' autonomous consent (aged 16 – 18 years) for gender-affirming surgery stems from relational autonomy, stressing the impact of social dynamics on decision-making (Kruger, Delport & Van Heerden, 2020). In the context of adolescent autonomy, relational autonomy refers to the understanding that children's ability to make autonomous decisions is deeply influenced by their relationships with parents, caregivers, peers, and other significant figures in their lives (Kruger, Delport & Van Heerden, 2020). This perspective acknowledges that adolescents are not fully independent agents but develop their decision-making capacities through interactions and support from those around them (Kruger, Delport & Van Heerden, 2020). Family relationships shape their beliefs and values, making parental involvement crucial for informed decisions. Without it, adolescents may lack the necessary support and alternative perspectives (Brierley et al., 2024).

### Research Outcomes

Disseminating research findings through academic publications, conferences, and workshops could facilitate knowledge exchange and collaboration.

## Limitations

Challenges such as limited empirical evidence and a scarcity of literature within the African context regarding this specific subject could potentially hinder the project's progress. While there is a significant body of Western literature available on the subject, the lack of local data and perspectives may present obstacles in fully addressing the issue.

This limitation can be addressed by leveraging the extensive Western literature on the subject by noting differences with the African context. While direct comparisons may not always be possible, this can help highlight unique challenges and areas needing further exploration. The research thesis will also emphasize the need for more localized research. This can serve as a call to action for future studies and underscore the importance of the contributions from this research study.

## Overview of Sections/Chapters

**Chapter 1:** Introduction and literature overview- provides background, context, and key ethical debates surrounding gender-affirming surgery informed consent for transgender youth aged 16 years and older in SA.

**Chapter 2**: Competence of 16-year-olds in decision making for gender-affirming surgery- examines the cognitive, psychological, and legal foundations supporting the capacity of 16-year-olds to provide informed consent.

**Chapter 3:** Benefits of gender-affirming surgery and transitioning and the harm in delay- explores the psychological, social, and medical benefits of timely gender-affirming care and the negative consequences of delayed access.

**Chapter 4:** Parental consent a barrier to gender-affirming surgery- analyses how parental consent requirements create obstacles.

**Chapter 5:** Conclusion and recommendations- summarises key findings and proposes ethical recommendations to address consent barriers in gender-affirming surgery.

## Chapter 2: Competence of 16-year-olds in decision making for gender-affirming surgery

### Introduction

Chapter 2 provides a comprehensive overview of the literature relevant to Premise 1. This chapter specifically addresses objective 2 that transgender youth aged 16 and older have the ability/can be competent to make informed decisions about their gender identity, supplemented with mental health assessment and support. In exploring this, the chapter draws on the principle of autonomy, which serves as the foundation for understanding the competence of 16-year-olds' decision-making capacity for gender-affirming surgery (IEP, 2024). This chapter also considers mental capacity, competence, maturity and other legal frameworks which recognise the decision-making capacity of 16-year-olds.

Autonomy, derived from the Greek root *autos* (self) and *nomos* (rule), fundamentally refers to self-governance or self-rule (IEP, 2024). It emphasizes an individual's capacity to make independent decisions without external interference or control. The most influential non-consequentialist theory grounding respect for autonomy is deontology, first proposed by Immanuel Kant (1724–1804). Kant's work provided a definitive formulation of autonomy through his emphasis on the individual's capacity for rational decision-making and moral self-governance. The classical origins of this principle are found in Kant's writings, particularly in his *Groundwork of the Metaphysics of Morals* (1785), where he argued that individuals must be treated as ends in themselves, not merely as means to an end (IEP, 2024). Autonomy is considered a key principle that respects an individual's right to self-determination, provided they possess the requisite understanding and cognitive abilities. Autonomy encompasses

two essential conditions: liberty and agency (Beauchamp & Childress 2013, pp. 101 – 108). Liberty refers to independence from controlling influences such as coercion or manipulation, while agency refers to the capacity for intentional action, which includes self-governance through understanding, reasoning, and deliberation (Beauchamp & Childress 2013, pp. 101 – 108). Given these conditions, autonomy is not merely the freedom to choose but also entails the possession of specific capacities that allow for meaningful, intentional, and well-reasoned decisions.

Agency as a key component of autonomy, refers to an individual's capacity to act intentionally, make choices, and pursue goals according to their values and desires. It is a crucial component of autonomy because, without the ability to act intentionally, autonomy cannot be fully realized (Pepe et al., 2024). Agency involves several capacities, including intentionality—the ability to form deliberate plans and act based on those plans—and cognitive and emotional abilities to reflect on choices and understand their consequences. Agency requires more than just the ability to act; it requires the cognitive capacity to understand options, deliberate on them, and make informed decisions. Emotional regulation is also critical, as it allows individuals to manage emotions in ways that support intentional decision-making (Pepe et al., 2024).

Mental capacity is another fundamental concept, referring to the cognitive abilities required for decision-making, such as understanding, reasoning, and evaluating information (Icenogle et al., 2019). It is essential for autonomy because only individuals with sufficient mental capacity can be considered fully autonomous. Mental capacity is also described as the ability to understand relevant information, retain it long enough to make a decision, weigh options, and communicate that decision (Icenogle et al., 2019). Mental capacity is often context-dependent, meaning individuals can have the capacity for certain decisions but not others, depending on

the complexity of the decision in question. In many cases, mental health assessments are used to determine whether an individual possesses the necessary cognitive abilities to make specific decisions (Icenogle et al., 2019).

Legal capacity, distinct from mental capacity, refers to the formal recognition by legal systems of an individual's ability to make binding decisions (Icenogle et al., 2019). While mental capacity is a cognitive construct related to understanding and reasoning, legal capacity is a status granted by law, often based on age or other legal criteria (Icenogle et al., 2019). Legal capacity is typically conferred at a specific age (such as 18), after which individuals are presumed to have the legal authority to make decisions without the need for parental or guardian consent. In SA, before the legal age of 18, 12 year olds can consent to medical treatment unilaterally (Children's Act No. 38 of 2005). However, there are exceptions, such as the mature minor doctrine, which permits minors to make specific legal choices if they can prove adequate maturity and comprehension. It is crucial to distinguish between mental and legal capacity because while an individual may possess the cognitive abilities required for decision-making, they may not yet have the legal recognition to exercise those capacities fully (Icenogle, 2019).

Research suggests that children as young as 11.2 years exhibit decision-making capacity and demonstrate cognitive abilities comparable to adults in understanding and processing information relevant to medical decisions. This forms the basis for legal frameworks such as South Africa's Children's Act 38 of 2005, which grants children aged 12 years and older the right to consent to medical treatment if deemed sufficiently mature, have the necessary capacity and are well informed (Grootens-Wiegers et al., 2017). Globally, similar thresholds exist, emphasising a balance between age-based rules and assessments of individual capacity. By early

adolescence, children possess the cognitive maturity necessary for informed decision-making. These capabilities include understanding, reasoning, and appreciating consequences (Grootens-Wiegers et al., 2017). Although, it is important to note that decision-making capacity for medical treatment and surgery differs significantly in SA, with stricter requirements applied to surgical interventions due to their higher risk and complexity. While children aged 12 and older can consent to medical treatment under South African law, additional safeguards, such as parental consent or court approval, are required for surgical procedures (Grootens-Wiegers et al., 2017).

The principle of respect for autonomy emphasises recognising individuals' rights to hold their own beliefs, make choices, and take actions aligned with their personal values. Respecting autonomy means valuing individuals' capacity to make independent decisions and supporting them in exercising this autonomy. This principle requires both the respectful sharing of information and creating conditions that promote autonomous decision-making. Many autonomous choices rely on the active support of others to ensure a range of options is available (Beauchamp & Childress 2013, pp. 101 – 108).

Autonomy is linked to self-understanding, which encompasses more than just cognitive awareness of medical facts; it includes a deep understanding of oneself. Acknowledging the influences of unconscious determinants is crucial for enhancing autonomy. This means understanding how external pressures (like family or cultural expectations) and internal factors (such as past experiences) can affect decision-making (Lemma & Savulescu, 2023). The interplay between conscious and unconscious aspects of the mind is essential for understanding one’s decisions and identity. Self-consciousness is a key aspect of human autonomy, emphasizing the need for individuals to be aware of their internal and external influences (Lemma &

Savulescu, 2023). Emotional reactions and decisions can be controlled by unconscious structures, leading to a lack of reflective thought in decision-making processes. This can pose risks to autonomy, particularly in complex situations like medical transitioning, where decisions should reflect a full understanding of personal identity and well-being (Lemma & Savulescu, 2023).

In healthcare, respecting autonomy requires that healthcare professionals provide necessary information, ensure patients understand it, confirm that their decisions are voluntary, and support their capacity for informed decision-making (Lemma & Savulescu, 2023). However, respect for autonomy holds only prima facie value, and other moral considerations may sometimes take precedence. For instance, when an individual's choices pose a risk to public health, potentially harm others, or involve the use of scarce resources that are unavailable, it is justifiable to limit their autonomy. The duty to respect autonomy does not apply to those who are unable to act autonomously or be made autonomous, such as infants, individuals with severe mental impairment, those under coercion, or individuals dependent on substances that alter or limit mental capacity. While these individuals may lack full autonomy, they still deserve moral respect, which includes protection from harm and access to medical benefits (Beauchamp & Childress, 2013, pp. 101-108).

Competence is understood as the ability to perform a task or make a decision, and in the context of autonomy, it refers to an individual's capacity to understand, deliberate, and make informed decisions about their own lives. In this context, competence is crucial because it underpins the ethical and legal acceptability of allowing individuals to make choices regarding their healthcare, finances, or other personal matters (Ladwig et al., 2024). Competence is not fixed and can vary depending on the complexity of the decision or the individual's situation. This variability means that an

individual can be competent to make simple decisions but not complex ones, and their competence can fluctuate over time, especially if influenced by health conditions, stress, or medication. It is closely tied to the capacity for making informed decisions, particularly in scenarios involving consent (Ladwig et al., 2024). Two prominent models for understanding and assessing competence are the MacArthur Competence Model for Consent and the Assessment of Mental Capacity developed by the British Medical Association (BMA) .

The MacArthur Competence Model for Consent was developed in the United States as part of the MacArthur Research Network on Mental Health and the Law. The Assessment of Mental Capacity developed by the BMA have been selected due to their comprehensive and widely respected approaches to assessing decision-making capacity in healthcare contexts (Hein et al. 2014). The MacArthur model is particularly focused on competence related to informed consent, addressing key components such as understanding, appreciation, reasoning, and expressing a choice. It is well-suited for evaluating decision-making in situations where medical treatment consent is required (Hein et al., 2014). In contrast, the BMA Assessment of Mental Capacity offers a broader framework, applicable to a variety of decisions beyond healthcare, including financial and personal welfare decisions. This model emphasizes the importance of retention (BMA, 2024 )the ability to retain information long enough to make an informed decision which complements the MacArthur model's focus on reasoning and understanding (BMA, 2024). While both models aim to assess decision-making capacity, their primary distinction lies in their scope. The MacArthur model is specifically tailored to medical consent, whereas the BMA model provides a wider, more general tool for evaluating capacity in different decision-making contexts.

The MacArthur Competence Model for Consent is one of the most widely recognized frameworks for evaluating competence, especially in medical and legal settings where individuals must give informed consent (Hein et al., 2014). This model evaluates competence based on four key capacities: understanding, appreciation, reasoning, and expressing a choice. Understanding refers to the individual's ability to grasp the nature and purpose of the decision, as well as the relevant information. This includes comprehending risks, benefits, and the broader implications of a decision (Hein et al., 2014). Appreciation involves recognizing how the information applies to one's own situation. It requires not just factual understanding but also the ability to internalize and acknowledge how the decision will personally impact one's life. Reasoning is the capacity to compare alternatives and weigh potential outcomes, while expressing a choice means being able to communicate a clear and consistent decision (Hein et al., 2014). Communication of this choice does not necessarily need to be verbal; it could involve non-verbal cues, depending on the individual's ability. Importantly, the MacArthur model emphasizes that competence is decision-specific, meaning individuals can be competent to make certain decisions but not others, depending on the complexity and the individual's cognitive abilities (Hein et al., 2014). This decision-specific nature allows for a nuanced assessment of competence, avoiding overly broad judgments that might prevent individuals from exercising autonomy in decisions they are capable of making (Hein et al., 2014).

Similarly, the Assessment of Mental Capacity provided by the BMA offers a practical framework for assessing competence. Like the MacArthur model, it focuses on an individual's ability to understand, retain, and use relevant information to make decisions. Retention of information is especially important in this model, as it recognizes that individuals may need to hold onto and work with information for a

period before reaching a decision. This framework also considers the ability to communicate decisions, even through non-verbal means if necessary (BMA, 2024). A key principle of the BMA's approach is that competence should be assessed based on the process through which a decision is made, not just the outcome. This principle ensures that individuals are judged by their ability to engage in decision-making processes rather than the perceived "correctness" of their choices, which protects their right to make autonomous decisions even when those decisions seem unconventional or risky. For example, an individual may make a decision that seems unwise or irrational to an outsider, but if the person went through a logical decision-making process, they would still be considered competent. This protects against paternalism, where external parties might unjustly restrict an individual's autonomy based on subjective views of what constitutes a 'good' decision (BMA, 2024). Both the MacArthur and BMA models highlight that competence is context-dependent and can vary based on the type of decision being made.

In addition to competence, the concept of maturity plays a significant role in evaluating decision-making capacity, particularly for adolescents. While competence relates more to the cognitive ability to process information and make decisions, maturity includes the integration of emotional and social factors that affect decision-making (Grootens-Wiegers et al., 2017). Maturity is a more complex concept than competence because it includes cognitive, emotional, and social development. While competence focuses primarily on the cognitive ability to reason and make decisions, maturity involves a broader range of factors, such as impulse control, emotional regulation, and the ability to consider long-term consequences (Grootens-Wiegers et al., 2017). For instance, adolescents can have the cognitive skills to understand information but may still lack the emotional and social maturity needed to weigh future consequences fully

or resist peer pressure (Grootens-Wiegers et al., 2017). From a psychological perspective, maturity involves cognitive development, emotional stability, and social understanding. Adolescents develop cognitive maturity first but emotional and social maturity can continue to evolve into early adulthood (Grootens-Wiegers et al., 2017). This distinction is crucial when assessing younger individuals, as they may demonstrate competence in specific areas while lacking overall maturity to consistently make sound decisions in emotionally charged or complex situations (Grootens-Wiegers et al., 2017).

Having described the principle of respect for autonomy and elements which are applicable in the context of my research, I will now proceed with application of the theoretical framework to support premise 1. The elements from the principle of respect for autonomy which I will focus on are: mental capacity, competence and maturity.

The respect for autonomy principle provides a solid foundation for supporting the thesis that transgender youth aged 16 and older are ethically justified in consenting to gender-affirming surgery without parental consent in SA, provided they receive adequate mental health assessment and support. By applying key concepts- respect for autonomy, mental capacity, competence, and maturity— this principle grounds first premise that transgender youth aged 16 and older can be competent decision-makers regarding their gender identity.

The principle of respect for autonomy is central to the argument, as it asserts the ethical importance of respecting individuals' rights to self-determination. Autonomy involves both liberty and agency, where liberty refers to the absence of controlling influences and agency refers to the capacity for intentional action. In the context of transgender youth aged 16 and older, this principle supports their right to make

decisions about their gender identity without parental interference, provided they demonstrate the necessary agency (IEP, 2024).

The framework suggests that respecting the autonomy of transgender youth involves allowing them to make choices about gender-affirming surgery if and only if they possess the requisite mental capacity to do so. Moreover, autonomy is not only about making decisions but also ensuring that those decisions are informed, free from coercion, and reflective of the individual's identity (IEP, 2024). Transgender youth aged 16 and older, as developing individuals, may face external pressures from family or society, and promoting autonomy involves safeguarding their ability to make decisions that align with their self-understanding, particularly through mental health support (IEP, 2024).

**Mental capacity:**

The concept of mental capacity—the ability to understand, reason, and evaluate information—is key here. Transgender youth aged 16 and older can be assessed for their mental capacity through a mental health evaluation. This evaluation would determine whether they can grasp the implications of gender-affirming surgery, including its benefits and risks, and make an informed, autonomous choice (Pepe et al., 2024). In support of premise 1, mental health assessments can help ensure that youth aged 16 years and older possess sufficient mental capacity to process complex information about surgery, consider alternatives, and weigh potential outcomes. By meeting the mental capacity criteria, these youth can be considered autonomous decision-makers in matters of their own gender identity (Pepe et al., 2024).

Research indicates that adolescents, particularly those in the late stages of development (16 years and older), demonstrate the cognitive abilities necessary for

complex decision-making, including the ability to understand and evaluate the risks and benefits of medical procedures (Levine, Harrison & Sprague, 2022). The development of executive functions, such as reasoning, problem-solving, and evaluating long-term consequences, is typically well-established by this age. Moreover, studies show that transgender youth often possess a clear understanding of their gender identity, making them more likely to be capable of making decisions that align with their authentic self (Paechter, 2021). Furthermore, the process of gender exploration and transitioning is often a lengthy one, allowing adolescents ample time to reflect on their gender identity. Many youth who seek gender-affirmation surgery have undergone significant social and psychological preparation, including therapy, which provides additional support for their decision-making process (Dominguez et al., 2023). These considerations suggest that youth aged 16 and older are likely to have the mental capacity to make autonomous decisions regarding gender-affirming surgery.

**Competence:**

Competence, closely related to mental capacity, refers to an individual's ability to perform tasks or make decisions, particularly complex ones. According to the MacArthur Competence Model for Consent, decision-making competence involves understanding, appreciation, reasoning, and expressing a choice. Transgender youth aged 16 and older, when provided with adequate mental health support, may be able to demonstrate these capacities, especially if they have a clear understanding of their gender identity and its personal significance (Icenogle et al., 2019).

The MacArthur Competence Model for Consent supports the argument that competence is decision specific. While some youth aged 16 and older may lack

competence in other areas, they could still possess the competence necessary to make decisions about gender-affirming surgery (Hein et al., 2014). Application of this model could further clarify whether youth aged 16 and older can apply the information they've received to their personal circumstances and make a well-reasoned decision that aligns with their long-term well-being (Hein et al., 2014).

The Assessment of Mental Capacity provided by the BMA offers a practical framework for evaluating decision-making competence, which is directly relevant to the autonomy of transgender youth aged 16 and older. Similar to the MacArthur Competence Assessment Model, the BMA framework emphasizes an individual's ability to understand, retain, and use relevant information to make informed decisions (BMA, 2024). In the context of transgender youth aged 16 and older, retention of information is particularly critical, as it acknowledges that these individuals may need time to process and hold onto complex information regarding their gender identity and medical options before making a decision. The framework further asserts that competence should be judged on the basis of the decision-making process, rather than the perceived correctness of the outcome. This safeguards against paternalism, where external authorities might restrict autonomy based on subjective judgments of what constitutes a 'good' decision. For instance, even if a transgender youth's decision to undergo gender-affirming surgery might appear risky or unconventional to an outsider, the BMA model ensures that their competence is recognised as long as their decision is reached through a logical and informed process (BMA, 2024). This aligns with the ethical principle of respect for autonomy, supporting the notion that youth aged 16 and older are capable of making informed decisions about their gender identity, provided they receive appropriate mental health support. This reasoning supports the first premise of the thesis: that transgender youth, having undergone the necessary

assessment, are competent to make decisions about gender-affirming surgery independently from parental consent. The BMA's model of competence assessment asserts that decision-making in the context of gender-affirming is highly individual and should be evaluated through a thorough, context-specific process. This ensures that young people's right to autonomous decision-making is preserved, regardless of societal or parental biases, thereby preventing unnecessary barriers to accessing healthcare.

**Maturity:**

Maturity, as discussed in the previous frameworks, extends beyond cognitive competence to include emotional and social factors. Adolescents aged 16 and older can have sufficient cognitive maturity to understand the implications of gender-affirming surgery but could still lack full emotional and social maturity (Grootens-Wiegers et al., 2017). This potential gap is where mental health support becomes crucial. The concept of maturity highlights the role of emotional regulation, impulse control, and the ability to consider long-term consequences (Grootens-Wiegers et al., 2017). Mental health assessments would provide an opportunity to evaluate whether the youth has developed the emotional maturity necessary to make a sound decision about surgery. Additionally, mental health assessments conducted by clinical psychologists, psychiatrists, or child and adolescent specialists can offer support in navigating the complex emotional and social dynamics that often accompany gender identity issues (Grootens-Wiegers et al., 2017). This contends that transgender youth, when supplemented with mental health support, can achieve the necessary emotional and social stability to make informed, autonomous decisions about their healthcare. This consideration of maturity reinforces premise 1 that these youth are capable of exercising informed consent without parental involvement.

Transgender youth aged 16 and older can be competent to make informed decisions about their gender identity, and thus when they are competent, they should be allowed to consent to gender-affirming surgery without parental approval, provided they receive adequate mental health assessment and support. This argument is grounded in the principle of respect for autonomy, which upholds an individual's right to make decisions about their own life, particularly when those decisions lead to improved well-being and mental health. Furthermore, legal precedents in SA and other countries recognize the capacity of 16-year-olds to make significant decisions independently.

Research on adolescent decision-making has consistently challenged the assumption that minors are incapable of giving informed consent (Van Heerden, Delport & Kruger, 2020). For instance, Van Heerden, Delport and Kruger, (2020) conducted an empirical study with participants aged 10–17, assessing their ability to make healthcare choices through interactive case scenarios. The findings showed that adolescents between 12 and 17 were able to understand medical information, weigh options, and provide reasoned explanations for their decisions at a level comparable to adults. While younger adolescents (12–13) demonstrated some limitations in abstract reasoning, the study concluded that by mid-adolescence, young people are generally capable of making informed medical decisions, particularly in relation to treatments that require understanding risks, benefits, and consequences (Van Heerden, Delport & Kruger, 2020). This is significant in the South African context, where children as young as 12 may already consent to the initiation of puberty blockers without parental approval. These blockers represent the first phase of transition and require a comparable level of medical comprehension to other treatments adolescents are legally empowered to consent to. By 16, young people have typically reached the stage of cognitive development where their decision-making abilities can be equivalent to adults, aligning

with Piaget's framework that abstract reasoning stabilises around 14 (Strode, Essack & Slack, 2023). The assessment of a child's maturity should be centred on the specific decision at hand, including the type of information required and the level of understanding needed. While adolescents between 12 and 14 may have difficulty fully grasping abstract concepts, their capacity should not be dismissed outright. Instead, practitioners are encouraged to consider the young person's age, personal circumstances, and ability to weigh competing factors when evaluating their decision-making competence (Strode, Essack & Slack, 2023). The importance of developing supportive tools for younger children, such as age-appropriate explanations of risks and benefits, ideally designed in consultation with adolescents themselves. Finally, while some children may require the involvement of parents or guardians in complex decisions, this should depend on the child's demonstrated capacity and personal preference (Strode, Essack & Slack, 2023).

Adolescence is a period of significant cognitive and emotional development, and by the age of 16, many young people possess the maturity and competence required to make informed decisions, especially when supported by mental health professionals. The Gillick competence test, established in the UK, provides a legal standard for determining whether a minor is capable of making their own medical decisions. While general adolescent maturity and Gillick competence are not synonymous, they are conceptually related in that both address a young person's ability to understand and weigh decisions with significant consequences. This principle is applicable to transgender youth aged 16 and older, provided they demonstrate sufficient understanding of the nature, risks, and consequences of their decisions (Griffith, 2016). By extending this reasoning, 16-year-olds should similarly be recognized as

capable of consenting to gender-affirming surgery. This is in line with research that suggests that adolescents, particularly those who are transgender, often have a clear and persistent sense of their gender identity by the age of 16 (Rodriguez-Dominguez et al., 2023).

Furthermore, the World Health Organisation (WHO, 2024) outlines that adolescence is a critical period for the development of self-identity, including gender identity. The WHO emphasises the importance of providing young people with autonomy over their health decisions, especially when these decisions can significantly improve mental and emotional well-being (WHO, 2024).

The claim can be further supported by developmental and cognitive research provided by Piaget, Steinberg, and Cauffman, while integrating additional contemporary studies. This combination of cognitive science and ethics strengthens the argument that 16-year-olds possess the necessary maturity for independent consent, especially when supported by mental health assessments. According to Piaget, by the age of 16, adolescents typically reach the formal operational stage of cognitive development. At this stage, they are capable of thinking abstractly, logically, and systematically, which is a critical foundation for making complex decisions, such as those related to health care and identity. This capacity for abstract reasoning allows them to understand the long-term consequences of gender-affirming surgery, making them suitable candidates for informed consent (Carpendale, 2000).

Similarly, research by Steinberg and Cauffman shows that adolescents aged 16 and older generally exhibit sufficient maturity and autonomy to make informed decisions about their health. While their ability to assess risks and control impulses is still maturing, their cognitive and emotional development at this age allows them to engage

in reasoned decision-making. This suggests that transgender adolescents at this age can make informed decisions about gender-affirming treatments when guided by mental health professionals (Steinberg & Cauffman, 1996).

A recent review by Tordoff and colleagues emphasises the importance of psychological evaluations in ensuring that adolescents seeking gender-affirming treatments are mature enough to make such decisions. The study highlights that, with proper mental health support and assessment, adolescents aged 16 and older can demonstrate the readiness and informed understanding necessary for decisions related to their gender identity (Tordoff et al., 2022). This readiness justifies their capacity for informed consent, provided they undergo a thorough evaluation process to mitigate any potential risks (Tordoff et al., 2022).

Reyna and colleagues' research further supports the argument that by age 16, adolescents possess decision-making capacities similar to adults in contexts involving health care. Their research draws on data from multiple countries, notably the United States and several European nations, to illustrate cross-cultural variations in adolescent risk behaviors (Reyna et al., 2006). Their findings indicate that adolescents are capable of weighing risks and benefits, understanding complex health information, and making choices aligned with their personal values (Reyna et al., 2006). In various health contexts, including reproductive health and mental health treatments, adolescents aged 16 and older are often granted autonomy to make decisions without parental involvement.

In SA, the Choice on Termination of Pregnancy Act (No. 92 of 1996) allows girls of any age to consent to an abortion without parental involvement (CTOPA, 1996). Additionally, the Children's Act (No. 38 of 2005) grants adolescents aged 12 and older

the right to consent to medical treatment (Children's Act, 2005). In other words, while the Children's Act recognises adolescent autonomy from the age of 12 in relation to healthcare, the CTOPA creates a specific exception that enables even younger adolescents to make decisions regarding abortion independently. Additionally, the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 in South Africa further supports the notion that individuals aged 16 and older possess the emotional and cognitive maturity to consent to activities such as sexual relations (Sexual Offences and Related Matters Amendment Act No. 32 of 2007). Taken together, these provisions illustrate that South African law acknowledges the evolving autonomy of adolescents to make significant healthcare decisions.

Rodriguez-Dominguez et al. argue that extending this autonomy to gender-affirming surgery aligns with legal and ethical norms in other areas of adolescent healthcare. Given the irreversible and life-changing nature of these decisions, they stress the importance of mental health assessments to ensure the adolescent's emotional and cognitive readiness, but not the necessity of parental consent (Rodriquez-Dominguez et al., 2023). Additionally, Turban et al. (2020) conducted a large-scale study examining the mental health outcomes of transgender individuals who underwent gender-affirming surgery. The results indicated that those who had access to surgery reported significantly lower levels of psychological distress, highlighting the importance of this intervention in improving overall well-being. The study also demonstrated that delaying access to such care can exacerbate mental health challenges, including increased suicidality (Turban et al., 2020).

Furthermore, taking into consideration foreign law , many legal systems recognise the decision-making abilities of individuals aged 16 and older. Several countries, including Argentina, Austria, and Scotland, have lowered the voting age to 16, acknowledging

the cognitive maturity of young people to participate in important social decisions (World Atlas, 2017). This legal recognition of 16-year-olds' ability to make informed decisions extends to medical contexts in many regions.

The legal system in SA also acknowledges that 16-year-olds have the ability to make important decisions and take independent actions (Mahery & Proudlock, 2008). These include opening and managing a bank account, drafting a valid will, legally driving a motorcycle, registering to vote, consenting to sexual activity, undergoing circumcision or virginity testing, applying for a Child Support Grant, and being recognised as the head of a household (Mahery & Proudlock, 2008) . This indicates that South African law recognises the capacity of young individuals to make informed decisions about their bodies and health.

At the age of 16, adolescents in SA are expected to make significant decisions regarding their future, including selecting subjects that align with their intended career paths, exploring degree options, and choosing potential universities. While some may later revise their choices, this expectation acknowledges their capacity for informed decision-making (Mahery & Proudlock, 2008) . Consenting to sexual activity, losing your virginity or getting an abortion is irreversible and carry profound lifelong consequences, yet the law allows children of any age to make them without parental oversight. This demonstrates a clear legal and ethical recognition that adolescents of this age can possess not only cognitive maturity but also the moral agency to take responsibility for life-altering decisions. Given this it would be inconsistent to deny transgender youth aged 16 and older the ability to consent to gender-affirming surgery, especially when such decisions are deeply connected to bodily integrity, dignity, and psychological well-being rights which are already constitutionally protected in SA (Constitution of Republic of SA, 1996).Recent foreign case law from the UK has

grappled with the issue of minors consenting to gender-affirming treatment. In Bell v. Tavistock and Portman NHS Foundation Trust (2020), the High Court initially held that it was “highly unlikely” that children under 16 could fully understand and consent to the long-term consequences of puberty blockers. However, this position was overturned by the Court of Appeal, which clarified that the decision should rest with medical practitioners assessing competence on a case-by-case basis rather than courts imposing blanket age restrictions. Later, in Ritchie Herron v. The Tavistock and Portman NHS Foundation Trust (2022), the High Court emphasised the importance of adequate mental health assessment and informed consent processes, recognising that youth who receive appropriate psychological support are capable of making informed medical decisions.

While these judgments arise from the UK and thus are not binding in SA, they are persuasive comparative authority that highlight international recognition of adolescent decision-making capacity in the context of gender-affirming care. Importantly, there is currently no South African case law directly addressing whether transgender adolescents may consent to puberty blockers or gender-affirming surgery. Nevertheless, the principles from the UK cases resonate with SA’s constitutional and legislative framework, which already affirms adolescent autonomy in healthcare (see CTOPA, Children’s Act, and Section 12(2) of the Constitution protecting bodily and psychological integrity). This suggests that, if confronted with such a case, South African courts may similarly favour an approach that prioritises individual assessments of competence, guided by healthcare professionals, rather than blanket age prohibitions .Allowing such autonomy aligns with their cognitive capabilities and acknowledges their right to self-determination, provided they receive appropriate mental health support to ensure informed decision-making. This approach respects

their autonomy, minimises harm by addressing gender dysphoria, and enhances their well-being through affirming care. These studies reinforce the thesis that transgender youth aged 16 and older, with adequate mental health assessment and support, are competent to make informed decisions about their gender identity and medical care. Having presented justifications to support my thesis, I will now outline the objections raised by critics. My intention here is not to refute these objections, but simply to acknowledge them.

Critics argue that while adolescents aged 16 may possess some cognitive abilities for decision-making, their emotional and psychological maturity is still developing, which may undermine their ability to fully comprehend the long-term consequences of irreversible medical interventions like gender-affirming surgery. The brain, particularly the prefrontal cortex responsible for impulse control and long-term planning, is not fully developed until the mid-20s (Giordano, 2023). This ongoing development raises concerns that adolescents may be more prone to impulsive decisions or external influences, such as peer pressure and societal trends, rather than making decisions based on long-term self-awareness (Giordano, 2023).

Adolescents around the age of 16 are undergoing profound physical and neurobiological changes associated with puberty, which have notable implications for decision-making competence (Backes & Bonnie, 2019). Puberty entails hormonal activation that drives both primary (e.g., reproductive organs) and secondary sexual characteristics (e.g., growth spurts, facial hair in boys, breast development in girls), with girls typically completing this process between ages 15–17, and boys between 16–17 (Backes & Bonnie, 2019). Concurrently, the dual systems model of adolescent neurocognitive development explains that while the socio-emotional brain systems (reward sensitivity, emotional processing) mature early, the cognitive control systems

(prefrontal cortex which is responsible for impulse control, planning, and moral judgment) mature later, often into the mid-twenties (Backes & Bonnie 2019). This maturational imbalance means that although 16-year-olds may possess the core components of decision-making capacity such as understanding, reasoning, expressing a choice, and appreciation, these can be modulated by still-developing impulse control capacities and heightened vulnerability to emotions or peer influences (Backes & Bonnie, 2019). Studies do support that by ages 12–14 and above, youth demonstrate adult-like responses in structured measures of decision-making competence (McDougall et al., 2018). Nevertheless, these competencies are context-dependent and there remains a need for environmental supports, especially in emotionally charged or socially influenced contexts such as consent to medical or surgical interventions (McDougall et al., 2018). In essence, while 16-year-olds may be cognitively equipped to consent, their physical and emotional maturation still introduces complexity, reinforcing the importance of a supported, multidisciplinary consent process especially given the irreversible nature of gender-affirming surgeries (McDougall et al., 2018).

In a similar vein, Steensma et al. (2018) highlight that while many transgender adolescents experience persistent gender dysphoria, a small subset may experience regret after transitioning. This potential for regret underlines the argument for extended psychological evaluations, and some critics suggest that parental involvement could act as an additional safeguard to ensure that the adolescent's decision is well-considered and mature. In other words, some clinicians and critics argue that because there is a possibility, however small, of post-transition regret, adolescents should undergo longer or more intensive psychological assessments to confirm the persistence and stability of their gender identity before proceeding with treatment

(Steensma et al., 2018). Critics also stress the irreversible nature of gender-affirming surgery, cautioning that adolescents might not fully grasp the permanence of such interventions, particularly if their emotional and identity development is still in flux (Steensma et al., 2018).

Another concern raised by opponents is the complexity of informed consent in medical decisions for adolescents (Giordano, 2023). Informed consent requires not just the understanding of the immediate procedure but also the capacity to foresee and evaluate long-term risks, benefits, and alternative treatment options as entailed in sections 6 to 8 of the SA National Health Act (National Health Act No 61 of 2003). . While adolescents reach cognitive milestones like Piaget's formal operational stage, critics argue that this is not equivalent to the emotional and experiential understanding required to evaluate life-altering medical procedures like surgery. Giordano (2023) argues that while adolescents are able to process factual information, their ability to appreciate how their current emotional state and identity may evolve is less certain (Giordano, 2023). Moreover, according to Levine et al. (2022), one challenge is that gender dysphoria itself may complicate an adolescent's ability to make fully informed and objective decisions, as it can be accompanied by significant psychological distress. This distress may cloud their judgment or lead them to make decisions based on alleviating short-term discomfort rather than long-term well-being. Therefore, critics emphasize that more extended mental health assessments, potentially involving multiple experts over time, may be needed to ensure that adolescents are genuinely ready to undergo irreversible procedures (Levine et al., 2022).

Additionally, some legal scholars caution against allowing adolescents to make these decisions entirely on their own, pointing to other areas of law where parental consent is required for significant medical interventions. Bizic et al. (2018) notes that while legal

standards like the *Gillick* competence test do allow minors to make some health decisions independently, these cases often involve less permanent or less invasive procedures than gender-affirming surgery. Therefore, the irreversible nature of such surgery, combined with the potential emotional and psychological volatility of adolescence, may justify the involvement of parents or legal guardians in the decision-making process (Bizic et al., 2018).

Another core objection is rooted in the potential for long-term psychological consequences. Critics argue that undergoing irreversible medical interventions like gender-affirming surgery at a young age could lead to future regret or mental health complications if the individual later experiences changes in their gender identity. Steensma et al. (2018) discuss cases where adolescents who transition may later detransition, and they emphasise the importance of ensuring that youth fully understand the permanence of their choices. While instances of regret occurrence are common, the possibility raises ethical questions about whether the state or medical professionals should allow minors to consent to such life-altering decisions without parental oversight (Steensma et al., 2018). This concern is echoed in studies examining cases of regret following medical transitions. While regret is not common, it does occur, and some adolescents who detransition report that they felt pressured to make decisions quickly due to the psychological distress associated with gender dysphoria (Giordano, 2023). These cases have led some scholars to suggest that the decision-making process should be extended, with more comprehensive mental health evaluations and parental involvement required to reduce the likelihood of regret (Giordano, 2023). Having acknowledged the objections raised by critics, I will now provide alternative perspectives, drawing on literature to offer responses to these concerns.

While the objections raise valid concerns about the potential vulnerabilities of adolescents, existing protocols for gender-affirming care already provide robust safeguards to ensure informed decision-making. A common objection is the developing/evolving psychological and emotional maturity of 16-year-olds. While adolescence is a period of ongoing cognitive and emotional growth, it is well-established that by age 16, individuals can have sufficient decision-making capacity for complex and impactful choices. Mental health professionals conduct rigorous psychological assessments before approving gender-affirming interventions. These assessments evaluate emotional stability, understanding of long-term implications, and consistency of gender identity over time. Therefore, while psychological maturity continues to evolve, safeguards exist to ensure informed and considered decision-making, meaning autonomy is not diminished but rather supported through professional evaluation (Paraspoor et al., 2014). Transgender youth are not allowed to undergo gender-affirming surgery without undergoing comprehensive psychological evaluations, which assess their mental capacity, competence, and maturity (Paraspoor et al., 2014). The Children's Act (No. 38 of 2005) provides the overarching legal framework for medical treatment of adolescents. Under the Act, children aged 12 and older may consent to medical treatment if they are deemed to have sufficient maturity and mental capacity to understand the benefits, risks, and consequences of the procedure (Children's Act No 38 of 2005). These evaluations are designed to determine whether the adolescent has a persistent and well-founded understanding of their gender identity and the consequences of medical interventions.

Furthermore, research has shown that transgender adolescents often have a clear and consistent understanding of their gender identity by the age of 16. A study by Park et al. (2022) demonstrates that the vast majority of transgender youth who seek

gender-affirming care continue to identify as transgender in adulthood, with only a small percentage experiencing regret. This finding suggests that concerns about developmental immaturity are often overstated (Park et al., 2022). In addition to the existing safeguards, recent research highlights the critical role that timely access to gender-affirming care plays in improving the well-being of transgender adolescents. For example, Turban et al. (2022) emphasises that withholding or delaying access to such care can lead to increased psychological distress, with higher rates of depression and suicidality among transgender youth who are unable to undergo desired medical interventions (Turban et al., 2022). Regret can occur in any medical decision, yet this does not justify restricting access to care. Including comprehensive mental health evaluations before surgery acts as a safeguard, reducing the likelihood of regret (Turban et al., 2022).

Furthermore, recent findings suggest that the permanence of medical decisions, such as gender-affirming surgery, should not be the sole criterion for denying adolescents the right to make informed choices about their own bodies. De Vries et al. (2021) demonstrate that transgender youth who receive gender-affirming treatments, including surgery, report significantly improved quality of life and mental health outcomes over time (De Vries et al., 2021). Another important consideration is the principle of harm reduction. Denying or delaying access to gender-affirming care can result in a range of negative outcomes, including self-harm and substance abuse, as transgender youth struggle to cope with untreated dysphoria (Bustos et al., 2021). Critics object that gender dysphoria may limit an adolescent's ability to fully appreciate their situation and make an informed decision. However, the presence of gender dysphoria does not inherently impair decision-making capacity (Bustos et al., 2021). WPATH 2022 professional guidelines emphasise that before surgery is approved,

adolescents undergo a thorough evaluation to ensure their decision is based on long-term and persistent gender identity rather than transient feelings. In this way, their appreciation of the decision is enhanced, not diminished (WPATH, 2022).

Finally, studies exploring regret among individuals who have undergone gender-affirming surgery consistently show low rates of regret, particularly among those who had access to mental health support during the decision-making process. For instance, Bustos et al. (2021) found that less than 1% of individuals who underwent surgery expressed significant regret, suggesting that the risks of inappropriate decision-making are often exaggerated (Bustos et al., 2021).

Parents are welcome to be involved to minimise the risk of regret. Parental involvement can be beneficial, particularly when parents are supportive. Adolescents should always have the option to involve their parents in the decision-making process if they find it helpful. Parental involvement in this context refers to parents providing emotional support, participating in counselling sessions, and helping adolescents navigate the decision-making process without overriding their autonomy (Olson et al., 2016). Research indicates that supportive parental engagement can improve psychological outcomes, enhance adherence to treatment plans, and reduce decisional conflict, particularly when adolescents are facing complex, irreversible medical procedures (Olson et al., 2016). Importantly, parental involvement does not necessarily mean parental consent is required; rather, it can serve as an additional layer of support to ensure the adolescent's decision is well-informed and emotionally grounded (Olson et al., 2016). The decision to undergo gender-affirming surgery should be based on the adolescent's best interests as determined through medical and psychological assessments, rather than parental approval. The child's best interest is paramount as outlined in Section 28 (2) of the Constitution of the Republic

of South Africa (Constitution of Republic of South Africa, 1996). The Children's Act (No. 38 of 2005) sections 7, 8 and 9 establishes that in all matters concerning children, the child's best interests are paramount, requiring consideration of factors such as the child's age, maturity, emotional and physical well-being, family relationships, and overall development (Childrens Act No 38 of 2003). Therefore, parental involvement should be encouraged when it is supportive, but it should not be a mandatory requirement that can prevent access to care. When it comes to unreasonable refusal or withholding consent, the Childrens Act Section 241 provides that if a parent or guardian unreasonably withholds consent for a matter affecting a child, the children's court may override that refusal if doing so is in the best interests of the child. In assessing whether consent has been unreasonably withheld, the court considers the nature of the relationship between the child and the person withholding consent, as well as the prospects for a healthy relationship in the future (Childrens Act No 38 of 2003). This further strengthens the case for allowing transgender youth aged 16 and older to consent to gender-affirming surgery, as the potential benefits far outweigh the minimal risks of regret when proper safeguards are in place.

**Conclusion**

The principle of respect for autonomy, and evidence supporting the benefits of gender-affirming care, justifies allowing transgender youth aged 16 and older in SA to consent to gender-affirming surgery without parental approval. This justification is grounded in the recognition that adolescents of this age are capable of possessing the necessary decision-making capacity and emotional maturity to make informed healthcare choices. While concerns about developmental immaturity are valid, these are sufficiently addressed by the mental health assessments that are required before surgery. Given the significant improvements in well-being and mental health that result

from gender-affirming care, respecting the autonomy of transgender youth by allowing them to make decisions about their own bodies is both ethical and necessary.

## Chapter 3: Benefits of gender-affirming surgery and transitioning and the harm in delay

### Introduction

In this chapter, I will first draw on literature to support objective 3, which is my second premise that gender-affirming surgery is instrumental in enabling social transitioning and overall well-being and preventing harm. The chapter will draw on Utilitarian ethics and theories of well-being to support the moral justification for independent consent based on maximising happiness and minimising harm. Finally, the chapter engages with deontological objections.

Consequentialism refers to ethical theories that judge actions as right or wrong based on their outcomes (Beauchamp & Childress, 2013, pp. 354–360). The correct action in any given situation is the one that produces the most favourable overall consequences (Beauchamp & Childress, 2013, pp. 354–360). The most well-known consequentialist theory, utilitarianism, focuses on well-being, often defined in terms such as pleasure, happiness, welfare, preferences, and satisfaction (Beauchamp & Childress, 2013, pp. 354–360).

Utilitarianism, the most influential consequentialist theory, was initially introduced by David Hume (1711–1776) and later fully developed by Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873). The classical roots of this theory are found in the works of Bentham and Mill (Beauchamp & Childress, 2013, pp. 354–360). Mill, in particular, contributed significantly to the formulation of utilitarianism, which is consequentialist, welfarist, aggregative, maximizing, and impartial. It is consequentialist because the morality of actions depends on their outcomes (specifically, their impact on welfare). It is aggregative and impartial because

determining the right or required action involves an unbiased assessment of how different actions affect the welfare of all individuals, with the total positive and negative effects being summed across all those impacted (Beauchamp & Childress, 2013, pp. 354–360).

The 4 key features of utilitarianism are that it is consequentialist, welfarist, impartial, and aggregative. At its core, utilitarianism adheres to the principle of utility, which posits that we should aim to achieve the greatest positive balance of value over disvalue or minimize disvalue when only negative outcomes are possible. This principle is often framed as doing the greatest good for the greatest number, taking an impartial approach that considers the interests of all affected parties equally (Beauchamp & Childress, 2013, pp. 354–360).

One of the central debates within utilitarianism concerns how well-being is defined and measured, with different schools of thought proposing distinct approaches. Classical utilitarians, such as Bentham and Mill, often embrace a hedonistic view of well-being, equating it with the maximisation of pleasure and the minimisation of pain. Contemporary discourse recognises that well-being is linked to the satisfaction of personal desires or grounded in objective factors that contribute to human flourishing. As such, well-being theories are generally classified into three main categories: hedonistic, desire-fulfilment, and objective list theories (OLT), all of which are relevant to this research (IEP, 2024). .

Together, these three theories provide a comprehensive framework for understanding well-being, combining subjective experiences, personal desires, and universally recognized goods.

I will now describe and define the 3 well-being theories applicable to my thesis.

**Well-being theories**

Hedonistic theories of well-being assert that the good life is one filled with pleasure and devoid of pain. Under this framework, well-being is measured by the amount of net pleasure an individual experiences, where happiness is considered the ultimate good (IEP, 2024). Rooted in classical utilitarianism, especially in the works of Jeremy Bentham and John Stuart Mill, hedonism suggests that the morally correct action is one that maximizes overall happiness for the greatest number of people. Bentham, for example, famously developed the "felicific calculus," a method to quantify happiness based on factors such as intensity, duration, certainty, and proximity of pleasure (IEP, 2024).

In the context of an individual's well-being, hedonism focuses on subjective experiences—how happy or content a person feels at any given time. This approach is often linked to the idea of life satisfaction and positive affect, emphasizing momentary pleasures or long-term states of happiness (IEP, 2024). For instance, people who report frequent feelings of pleasure and minimal discomfort are considered to have high levels of well-being. However, hedonism has limitations. Critics contend that an exclusive focus on pursuing pleasure may overlook other essential elements of human well-being, such as moral virtues, self-actualization, or meaning (IEP, 2024). Additionally, pleasure alone may not be a sufficient measure of well-being—activities that are initially pleasurable may lead to long-term harm (e.g., substance abuse), while experiences that are initially painful (e.g., hard work or self-sacrifice) can contribute to deeper fulfilment or lasting happiness. This critique led to the development of more

comprehensive theories of well-being, including desire-fulfilment and objective list theories (IEP, 2024).

Desire-fulfilment theories propose that a person's well-being is determined by the extent to which their desires or preferences are satisfied. Unlike hedonistic theories, which emphasise pleasure, desire-fulfilment theories focus on the achievement of goals, wishes, and personal ambitions (Russel, 2023). According to this framework, individuals are best positioned to determine what is good for them, and their well-being improves when they achieve the things they want in life. Philosophically, desire-fulfilment theories are tied to preference utilitarianism, who argue that what matters morally is the satisfaction of preferences, not just pleasure. There are different versions of this theory (Russel, 2023). Simple desire theory holds that well-being increases whenever any desire is fulfilled, regardless of its content. In contrast, informed desire theory adds a layer of sophistication by suggesting that only desires based on full information and rational deliberation should count toward well-being, filtering out irrational or harmful desires (e.g., wanting something out of misinformation or self-destructive tendencies) (Russel, 2023).

The flexibility of desire-fulfilment theories allows for greater individual autonomy since people's desires vary significantly based on their personal values, goals, and circumstances. For example, someone might value artistic achievement over financial success and fulfilling that desire would enhance their well-being. However, this theory is not without critique. Some desires, when fulfilled, may not necessarily make a person's life better (e.g., a desire to engage in risky or harmful behaviour), and desires can be influenced by external factors like social pressure, which may not align with true well-being. Additionally, desire satisfaction may lead to fleeting happiness, with

individuals often moving quickly from one fulfilled desire to the next, without sustained contentment (Russel, 2023).

Another theory of well-being is OLT which presents a more structured and universal approach to well-being by asserting that certain goods or achievements are intrinsically valuable, regardless of an individual's desires or subjective preferences (Lemma & Savulescu, 2021). According to OLT, well-being is determined by an objective list of factors that contribute to human flourishing. These may include elements such as health, personal relationships, knowledge, achievement, autonomy, and personal development. The theory holds that these goods are universally beneficial and that living a good life involves attaining them, whether or not one desires them at a given moment. OLT has roots in the Aristotelian concept of "eudaimonia," which focuses on human flourishing and virtue as essential to well-being (Rice, 2013).

Aristotle argued that a good life is achieved by fulfilling human potential, engaging in rational activity, and cultivating virtues. Modern proponents of OLT, defend the idea that certain elements—like developing meaningful relationships, acquiring knowledge, or maintaining physical and mental health—are intrinsically good for all individuals (Rice, 2013). The objective list framework offers a more holistic understanding of well-being, as it considers a range of factors that contribute to a fulfilling and meaningful life (Rice, 2013). For example, even if an individual does not actively desire good health, being healthy inherently improves their quality of life (Rice, 2013). Similarly, gaining knowledge or achieving personal growth may lead to long-term well-being, even if these pursuits are not immediately gratifying. However, OLT faces criticism for potentially imposing a rigid, external standard on individuals' lives, which can overlook personal autonomy and subjective experiences. What constitutes "objective goods"

can be debated, and critics argue that the theory may disregards individual differences in what contributes to well-being. Nevertheless, OLT provides a valuable framework for understanding well-being in a broader, more universal context, integrating intrinsic values that benefit human life across cultural and personal variations (Rice, 2013).

Each of these frameworks offers a unique lens for evaluating well-being. Hedonistic theories focus on subjective pleasure, desire-fulfilment theories emphasize personal autonomy and the satisfaction of wants (IEP, 2024), while OLT outline a set of universally recognised goods that contribute to human flourishing (Lemma & Savulescu, 2023). Together, they provide a comprehensive understanding of well-being by balancing subjective experiences, personal desires, and objective values. Utilitarianism, with its goal of maximising well-being, integrates these theories by determining which aspects of well-being—pleasure, desire satisfaction, or objective goods—should be prioritised to achieve the greatest good for the greatest number.

The ethical justification for allowing transgender youth aged 16 and older to consent to gender-affirming surgery without parental consent is grounded in the principles of utilitarianism and the associated theories of well-being. Utilitarianism contends that the moral rightness of an action is determined by its consequences, specifically its ability to promote the greatest overall happiness or well-being. This perspective aligns with the assertion in premise 2 that gender-affirming surgery is instrumental in enabling social transitioning and enhancing overall well-being for these youth.

**Utilitarianism**

Firstly, the core doctrine of utilitarianism—that actions are right if they lead to the best overall consequences—supports the notion that allowing transgender youth 16 and older to make autonomous decisions about their bodies can lead to positive outcomes

(Rachels & Rachels 2019, pp. 101 -112). By recognising their capacity to provide informed consent, we respect their autonomy and empower them to seek the gender-affirming surgery they deem necessary for their well-being. This aligns with the principle of utility, which asserts that we should maximise positive outcomes, thereby ensuring that these individuals can lead happier, more fulfilling lives. However, critics object that in a resource constrained country like SA**,** this might not be the greatest good for the greatest number of people.

Secondly, the welfarist component of utilitarianism emphasises that the value of outcomes is assessed based on the well-being of individuals involved (Rachels & Rachels 2019, pp. 101 -112). In the context of gender-affirming surgery, the well-being of transgender youth significantly improves when they receive the appropriate medical interventions, allowing them to align their physical bodies with their gender identity. This process not only alleviates psychological distress but also enhances social integration and acceptance, contributing to overall life satisfaction. Thus, the ability to consent independently serves to maximise their welfare and happiness.

Thirdly, utilitarianism mandates impartial consideration of all individuals' interests. In this context, the rights and well-being of transgender youth must be prioritised equally with societal norms and parental concerns (Rachels & Rachels 2019, pp. 101 -112). Gender-affirming surgery, when supported by adequate mental health assessment and care, does not only benefit the individual but also enables greater societal acceptance of diverse gender identities, promoting a more inclusive environment for all. Lastly, the aggregated benefits of allowing these youths to make autonomous health decisions contribute to a more compassionate society that values and respect’s individual identity.

From a hedonistic perspective, the pursuit of pleasure and avoidance of pain are essential to well-being (IEP, 2024). Transgender youth often experience significant distress and dysphoria, which can be alleviated through gender-affirming surgery. By allowing them to undergo this procedure, we can significantly enhance their happiness and reduce their psychological suffering.

The desire fulfilment theory asserts that the ability for transgender youth who are 16 and older to fulfil their desires related to their gender identity is crucial (Russel, 2023). When these individuals are empowered to pursue their goals—such as achieving a body that reflects their gender identity—they experience a profound increase in their sense of well-being, leading to a more satisfying life overall.

OLT contends that certain intrinsic goods contribute to well-being, regardless of individual desires. Gender-affirming surgery can be seen as a pathway to achieving several objective goods, including improved mental health, social relationships, and overall life satisfaction (Rice, 2013). These factors are universally recognised as contributing to human flourishing, thus supporting the argument for independent consent. Gender-affirming surgery is instrumental in enabling physical and social transitioning in relation to improving overall well-being; allowing youth aged 16 and older to consent independently to such surgery prevents harm and promotes their mental health and social integration.

Gender-affirming surgery is instrumental in enabling physical and social transitioning in relation to improving overall well-being. Allowing youth aged 16 and older to consent to such surgery independently prevents harm, promotes their mental health and social integration. Research overwhelmingly supports the need for transgender minors to access gender-affirming surgeries as a means to improve their mental health and

overall quality of life. Loveday et al. (2022) advocate for allowing minors aged 16 and above to independently consent to gender-affirming surgeries, emphasising a fundamental ethical principle: the minimisation of harm. The rationale is rooted in the recognition that access to gender-affirming care can significantly reduce mental health issues commonly faced by transgender youth (Loveday et al., 2022). This reasoning is further supported by utilitarianism as the morally right action is the one that produces the greatest good for the greatest number, with the goal of maximising well-being (IEP, 2024). In this context, the well-being of transgender youth is enhanced by allowing them to undergo gender reassignment surgery, which aligns their physical bodies with their gender identity, contributing to long-term mental health and social satisfaction.

In SA, recent reporting from the University of Cape Town highlights a marked increase in demand for gender-affirming care among transgender youth. At the Red Cross War Memorial Children's Hospital Gender Identity Development Service, referrals have risen dramatically, from approximately two patients per year in 2012 to more than three referrals per week in 2023. This exponential growth highlights both the increasing visibility of transgender youth and the pressing need for accessible gender-affirming surgery (UCT, 2023). A landmark study, the TransYouth Project led by Olson et al. (2016) conducted in the United States, using a national, community-based sample of socially transitioned, prepubescent transgender children (ages 3 – 12), found that transgender minors who receive support, including access to gender-affirming care, experience mental health outcomes comparable to their cisgender peers. This supports the claim that when these individuals are given the autonomy to pursue gender-affirming surgeries, they can help reduce depression and anxiety levels (Olson et al., 2016). This contrasts sharply with the distress experienced by those who face barriers to such care (Olson et al., 2016). Parents may refuse to consent to gender-

affirming surgery for their transgender children due to various factors, including religious or cultural beliefs, lack of understanding of gender identity, fear of social stigma, and concerns about the permanence of the procedure. Some may perceive gender dysphoria as a temporary phase or believe that delaying medical transition is in their child's best interest. Others may worry about legal and financial implications (Olson et al., 2016). When it comes to refusal of treatment by parents on the basis of religion, In the case of Hay v B, the High Court of SA considered a situation where parents refused to allow a blood transfusion for their infant child on religious grounds. The court held that such a refusal was unconstitutional and unlawful, emphasizing that a child's best interests are of paramount importance. Thus, any medical decision including gender-affirming surgery must prioritise the child's best interests (Van Coller, 2021)

The principle of utility asserts that preventing harm and promoting well-being for transgender youth justifies their ability to consent independently. Studies have shown that gender dysphoria can lead to significant psychological distress, including anxiety, depression, and even suicidal ideation (de Vries et al., 2014). Allowing transgender youth to access gender-affirming surgery without parental approval helps prevent these harms, thereby producing better overall outcomes (de Vries et al., 2014). Turban et al. (2020) further echo's this argument, their research highlights that immediate access to necessary medical interventions—like sex exchange surgical procedures—can save lives by alleviating the psychological distress that many transgender individuals endure. Similarly, Green et al. (2021) reinforces this idea, highlighting that autonomous decision-making can help transgender homeless children higher life satisfaction and improved quality of life, reinforcing the critical role of gender-affirming surgeries in enhancing well-being (Green et al., 2021). This idea can be supported by

desire fulfilment theories which emphasise that well-being is achieved when individuals satisfy their personal desires and aspirations.

For transgender youth, the desire to transition is central to their sense of self and their overall well-being. The fulfilment of their desire to transition leads to improved psychological and emotional well-being, reducing the harm that results from being trapped in a body that does not match their gender identity (Russel, 2023). In contrast, denying them the ability to make this decision for themselves could perpetuate feelings of frustration, distress, and helplessness, which would negatively impact their overall well-being (Russel, 2023).

Milrod (2014) brings another perspective to the discussion by emphasising the social implications of congruent genitalia for adolescents. The capacity for social and romantic engagement is foundational to adolescent development, and gender-affirming surgeries play a vital role in helping individuals feel aligned with their gender identity. This congruence is essential not just for personal satisfaction but also for meaningful social interactions, which can positively influence mental health (Milrod, 2014). These findings draw upon the aggregate and impartial principles of utilitarianism which maintain that the well-being of transgender youth is given equal weight to that of other members of society (IEP, 2024). In this case, the happiness gained by allowing transgender youth to transition outweighs any potential objections from unsupportive parents or societal concerns.

By allowing these individuals to act in accordance with their deeply held identity, society maximises their overall happiness, thereby achieving the greatest good for the affected population. Although, mindful of the fact that access to care is subject to availability of resources. Furthermore, the consequences of denying transgender

youth access to gender-affirming surgeries can be dire, particularly for those facing familial rejection. Muller and Daskilewicz. (2019) elucidate how parental rejection can lead to elevated rates of depression, anxiety, and even homelessness among transgender youth (Muller & Daskilewicz, 2019).

In SA, where cultural stigmatisation against transgender individuals persists, access to gender-affirming care becomes even more crucial. Kruger et al. (2020) highlight that transgender youth in sub-Saharan Africa often confront familial neglect, discrimination, and violence, further exacerbating their vulnerabilities (Kruger et al., 2020). These insights extend the concepts established in hedonism which claims that subjective experiences of happiness are central to well-being (IEP, 2024). By preventing the pain of gender dysphoria and providing transgender youth with the opportunity to experience pleasure from being more in tune with their identity, this framework supports the argument that independent consent to surgery at age 16 promotes well-being.

The 2021 National Survey on Youth Mental Health by the Trevor Project (2022) conducted in the United Sates indicates that approximately 40% of homeless teenagers identify as LGBTQ+, with family rejection being a significant contributor to their precarious living conditions. By allowing transgender minors to make independent decisions about their healthcare, society recognises their rights and addresses the pressing need for support during critical developmental years (Trevor project, 2022). Results from this survey can be validated by the theoretical framework of OLT, certain goods, such as health, desire fulfillment and meaningful relationships, are inherently valuable and contribute to human flourishing, regardless of an individual's specific desires (Lemma & Savulescu, 2021). The ability to make independent decisions about one's body is tied to autonomy, and transitioning

promotes health, which are key components of OLT. Having presented justifications to support my thesis, I will now outline the objections raised by critics. My intention here is not to refute these objections, but simply to acknowledge them.

Critics of independent consent for gender-affirming surgery among minors often emerge from a deontological ethical framework, which emphasises adherence to moral duties and rules over the potential outcomes of actions. Alexander et al. argues that allowing adolescents aged 16 and older to consent to gender-affirming surgery without parental approval could violate the duty of care that parents have toward their children (Alexander et al., 2021). The objection centres on the belief that parents are obligated to protect their children from making irreversible decisions that they may not fully understand (Alexander et al., 2021). Critics contend that adolescents, regardless of age, may lack the maturity and foresight necessary to comprehend the long-term consequences of such significant medical interventions. From this perspective, parental involvement is seen as a crucial safeguard that ensures decisions are made with careful consideration, emphasizing the importance of moral obligations in the care and guidance of minors (Alexander et al., 2021). The deontological viewpoint posits that failing to involve parents in the decision-making process can lead to negative outcomes and regrettable choices that could have been avoided through parental guidance.

While the deontological perspective raises valid concerns regarding the potential for harm, it overlooks critical empirical evidence supporting the mental health benefits of gender-affirming surgery and the serious repercussions of denying such care. Parents who support their transgender children in accessing gender-affirming surgery also act in the best interests of their child, prioritizing their well-being and affirming their identity. The best interests of the child is a foundational principle in South African law,

enshrined in both the Constitution and the Children's Act (38 of 2005). Their support aligns with the principle of Welfarism—a cornerstone of Utilitarianism—which holds that the moral value of an action is determined by its capacity to enhance overall well-being and happiness. Recognizing the agency of transgender youth in making informed healthcare decisions does not diminish the role of supportive parents but rather ensures that access to necessary medical care is not contingent on parental approval, particularly in cases where consent is withheld for reasons unrelated to the child's best interests.

This philosophical approach aligns with the argument for transgender youth to have the right to make informed decisions regarding their treatment, particularly when such decisions can lead to improved mental health outcomes (Rachels & Rachels 2019, pp. 101 -112). Deontologists' insistence on parental involvement, while grounded in concern for the child's welfare, fails to recognise the acute distress faced by transgender youth when access to necessary medical interventions is impeded. The high rates of mental health issues, self-harm, and homelessness among unsupported transgender youth underscore the urgent need for policies that facilitate independent medical decision-making (Paechter, 2021).

**Conclusion**

In conclusion, the ethical justification for permitting transgender youth aged 16 and older to consent to gender reassignment surgery independently rests on compelling evidence indicating significant mental, physical and social well-being, alongside the recognition of their autonomy and capacity for informed decision-making. Balancing parental involvement with the immediate needs of transgender minors requires a nuanced approach that prioritises the well-being of these vulnerable individuals while

ensuring that their rights and dignity are upheld in the face of societal and familial challenges.

## Chapter 4: Parental consent a barrier to gender-affirming surgery

### Introduction

In this chapter, I will first draw on literature to support premise 3, arguing that parental consent requirements for gender-affirming surgery can hinder healthcare access for transgender youth, especially when parents are unsupportive or uninformed about gender identity issues. Second, I will apply the well-being theories discussed in chapter 3 to defend premise 3.

To argue that requiring parental consent for gender-affirming surgery can create barriers to healthcare access for transgender youth especially when parents can be unsupportive or lack understanding about gender identity issues it is essential to consider the role of social stigma and discrimination against LGBTQ+ individuals within specific South African communities. This stigma often limits open dialogue and awareness about gender identity, impacting parents' ability to make informed decisions about their child's gender-affirming healthcare needs (Mavhandu-Mudzusi, 2017). Studies have shown that LGBTQ+ individuals in SA frequently experience discrimination and social stigma, which can be especially pronounced in rural or conservative communities (Van Heerden,2023).

LGBTQ+ stigma often leads to a lack of awareness or negative perceptions about gender identity, particularly among parents, who may view gender non-conformity as socially unacceptable or as a mental health issue rather than a legitimate aspect of identity (Mavhandu-Mudzusi, 2017; Van Heerden, 2023). This lack of acceptance and understanding significantly impacts transgender youth's ability to access gender-affirming healthcare when parental consent is required.

Research also highlights that many parents lack accurate knowledge about gender identity and transgender issues, which hinders informed consent. For instance, South African study exploring attitudes of parents regarding gender diversity in high school found that they often misunderstand transgender youth's experiences, equating them with sexual orientation or viewing them as a "phase" (Chaka, 2024) This lack of understanding, compounded by social stigma, can result in parents rejecting their child's gender identity and refusing to provide consent for necessary medical interventions. Consequently, transgender youth are left unable to access healthcare. Additionally, transgender youth face numerous barriers in accessing healthcare, including limited resources, societal discrimination, and parental restrictions (Chaka 2024).

South African healthcare guidelines do not adequately address the specific needs of transgender individuals, as children aged 12 and above can access gender-affirming treatment without parental consent however for gender-affirming surgery, parental consent is a requirement (Chaka, 2024). When parental consent is required, these barriers are exacerbated for youth whose parents hold stigmatising views.

Riggs et al. (2023) study highlights that parents of trans children experience significant public scrutiny and are often judged based on their support for their child's gender identity. This judgment can lead to negative perceptions and exclusionary experiences, impacting parents' willingness to support or consent to gender-affirming healthcare including surgery. The study found that individuals with more traditional views on motherhood and fatherhood rated parents of trans children more negatively. Individuals with positive attitudes toward trans rights rated the parents of trans children more favourably, indicating that societal acceptance of transgender rights can improve support systems for trans youth. However, in SA, where stigma and limited

understanding of LGBTQ+ issues persist, the lack of positive attitudes toward trans rights might contribute to parents being unsupportive or reluctant to understand the healthcare needs of transgender youth. South African parents may feel pressured by social expectations, especially in conservative communities, which can create an environment where parental support is less likely if it conflicts with traditional values (Mavhandu-Mudzusi, 2017). Moreover, where certain communities may hold traditional views about gender and family roles, parents may also internalise societal expectations and norms, potentially leading to resistance or refusal. Such traditional beliefs, compounded by social stigma, create barriers for transgender youth (Mavhandu-Mudzusi, 2017).

## Discussion

Requiring parental consent for gender-affirming surgery can pose significant barriers to healthcare access for transgender youth, particularly in cases where parents are unsupportive or lack education about gender identity issues. Examining this through various well-being theories reinforces the argument that youth aged 16 and older should have the autonomy to make this decision independently. Firstly, from a hedonistic perspective, well-being is understood as the maximization of pleasure and the minimisation of pain (IEP, 2024). Transgender youth frequently experience acute distress and gender dysphoria due to the incongruity between their gender identity and assigned physical characteristics. Gender-affirming surgery provides an effective means of alleviating this suffering, thus facilitating greater happiness and reducing psychological discomfort. By permitting youth to pursue this option without the barrier of parental consent, their capacity for pleasure is enhanced, and their exposure to mental anguish is minimised.

Secondly, the desire fulfilment theory further supports this argument by emphasising the role of achieving one's personal goals in promoting well-being. For transgender youth, the desire to live authentically according to their gender identity is paramount. Enabling individuals aged 16 and older to act on this desire through gender-affirming surgery respects their autonomy and allows them to attain a body that aligns with their self-concept. This alignment results in a substantial improvement in their quality of life, fulfilling a core desire essential to their identity and well-being (Russel, 2023). Lastly, the objective list theory contends that certain intrinsic goods contribute to well-being, independent of individual desires. For transgender youth aged 16 and older, gender-affirming surgery facilitates access to objective goods such as enhanced mental health, deeper social integration, and greater life satisfaction. These elements, which are widely recognised as conducive to human flourishing, substantiate the ethical justification for independent consent. When transgender youth are allowed to make healthcare decisions in line with their identity, their potential for well-being is maximised (Rice, 2013).

On the contrary, in the African context, the concept of relational autonomy challenges the justification for adolescents' independent consent to gender-affirming surgery. Relational autonomy asserts that an individual's decision-making capabilities are not entirely isolated but are shaped and supported by their relationships, particularly those with family members. Adolescents, especially those aged 16-18, are still developing the capacity to make deeply impactful decisions (Kruger, Delport & Van Heerden, 2020).

Parental involvement, and in relational autonomy, more relatives and community may be involved, ensures access to essential support and diverse perspectives, which can

help them consider long-term implications and possible alternatives (Kruger, Delport & Van Heerden, 2020). By allowing them to make decisions without parental consent, we risk undermining the holistic social support structure that influences their identity formation and emotional well-being. Allowing adolescents aged 16 - 18 to make such significant decisions without parental consent could limit their access to a broader range of perspectives, reducing the likelihood of fully informed decision-making. Parents and guardians can offer an alternative viewpoint that should help these adolescents consider aspects of the decision they might overlook, particularly given that adolescence is marked by a tendency toward immediate gratification rather than long-term planning. Relational autonomy suggests that a collaborative approach, with parents providing alternative viewpoints, can enrich the decision-making process and help adolescents make choices that are better suited to their current and future well-being (Kruger, Delport & Van Heerden, 2020).

**Conclusion**

Although, while relational autonomy emphasises the role of relationships in shaping youth aged 16 – 18 years decision-making, it is crucial to recognise that not all familial relationships provide support or understanding regarding gender identity. This does not mean that the provisions related to consent in the Children's Act be violated, rather alternatives should be proposed in such sensitive cases involving minors. In cases where parents are unsupportive or lack education on gender identity issues, requiring their consent can lead to significant delays in or outright denial of gender-affirming surgery, exacerbating the youth's distress and dysphoria. In such instances, the autonomy of the adolescent can be respected by empowering them to access healthcare without parental barriers, recognising that autonomy in decision-making is

not necessarily hindered but rather supported by a broader societal structure, including healthcare providers who can offer guidance and emotional support. However, it is also important to consider the parents' position, particularly when that position is positive, as this can facilitate the decision-making process. In the maturity assessment, it is essential to evaluate the adolescent's understanding of the reasons behind parental refusal and determine whether those reasons are justified, ensuring that all aspects of the decision are carefully considered.

This question matters ethically because it addresses the conflict between safeguarding youth aged 16 - 18 and respecting their right to self-determination in decisions that profoundly affect their identity, dignity, and long-term wellbeing. Gender-affirming surgery can be critical to their mental, physical and social health. In the South African context, cultural norms around family authority and community values mean that decisions about gender identity often extend beyond the individual, making autonomy relational. A maturity-based autonomy model should be considered in cases of transgender 16 – 18 year old seeking gender affirming surgical interventions. This approach holds that the permissibility of independent consent should depend less on chronological age alone and more on the young person's demonstrated capacity to understand risks, benefits, and long-term implications. This principle of proportionality balancing potential harm against potential benefit ensures that recommendations remain sensitive both to the vulnerabilities of transgender youth and to the South African cultural and legal context in which they live.

This research report demonstrates that it is ethically justified to permit transgender youth aged 16-18 in SA to consent independently, without parental consent to gender-affirming surgery, provided they have adequate mental health assessment and support.

This argument is grounded in the recognition of the youth's ability to make informed decisions about their gender identity, supported by mental health assessments, as outlined in the first premise. Rooted in respect for autonomy and utilitarian principles, this stance further aligns with the second premise, which asserts that gender-affirming surgery is essential for enabling social transitioning and promoting well-being, with independent consent helping to prevent the harm caused by delayed transitioning.

However, this justification must be considered in light of the current legal framework. At present, the Children's Act 38 of 2005 restricts independent consent by minors under 18 for surgical interventions, unless parental or guardian consent is obtained. This creates a tension, while the argument supports autonomy for mature adolescents, the legal position does not yet reflect this. The requirement of parental consent can restrict access to necessary care, particularly when parents are unaccepting, uninformed, or homeless and abandoned, as highlighted in the third premise, which argues that parental consent, in such cases, creates significant barriers to healthcare access. Therefore, affirming the right of transgender youth to self-determination in this regard respects their autonomy and acknowledges the ethical imperative to mitigate harm. Where parents are assistive or supportive, they should be involved, however, their involvement and consent should not be a requirement. In summary, the premises presented demonstrate coherence in supporting the ethically defensible stance that transgender youth aged 16 and older should be allowed to make independent decisions regarding gender-affirming surgery, underpinned by mental health assessments and the reduction of harm through timely access to care.

The WPATH-SOC 8 guidelines are explicitly framed as evidence-based guidance to be adapted to country contexts and resource realities, not as hard rules. That gives South African clinicians and policymakers cover to operationalise adolescent-appropriate, individualised care while complying with the Children's Act. Compared with SOC-7, SOC-8 removes blanket minimum ages but raises the emphasis on multidisciplinary assessment; demonstrated emotional/cognitive maturity to give informed consent; addressing co-occurring mental-health needs; and parental/caregiver involvement where possible. This aligns with Sections 7 – 10 of the Children's Act focussing on the application of the child's best interest principle. Hence,

SAHIVCS Guidelines should be context accommodating and not rigid. WPATH SOC-8 states that candidates should generally have reached the age of adulthood for gender-affirming surgery, tying the appropriateness of surgery to the local age of majority. That clarifies that SOC-8 does not purport to override provisions in the Childrens' Act.

The SAHIVCS guideline endorses non-gatekeeping, informed-consent-based, multidisciplinary care, and recommends parental/guardian involvement for adolescents when feasible and this approach corresponds with WPATH SOC-8's ethos. The SAHIVCS guidelines should be revised to allow transgender youth aged 16 and older to consent independently to gender-affirming surgery, provided they undergo a mental health assessment and receive ongoing support. However, such a recommendation would not override the provisions of the Children's Act, which currently requires parental consent for minors under 18 to undergo surgery. SOC-8 cannot solve this legal barrier but can guide clinical readiness and consideration of alternatives. SOC-8's call for multidisciplinary assessment and access to specialised surgeons is difficult to implement uniformly in SA, with sparse services and long waitlists, issues not directly addressed by the WPATH.

Parental consent should not be a legal requirement for transgender youth aged 16–18 to access gender-affirming surgery, as many adolescents in this age group demonstrate sufficient maturity and capacity to make informed decisions about their bodies and identities. However, the line should be drawn at ensuring that consent is not automatic, but contingent upon rigorous safeguards namely, a comprehensive mental health assessment, confirmation of the adolescent's decision-making capacity, and ongoing psychosocial support. While parental support is undoubtedly beneficial in helping transgender youth navigate the medical, psychological, and social aspects of

gender-affirmation, it should be encouraged rather than mandated. Mandating parental consent risks excluding adolescents whose parents are unsupportive, potentially exposing them to further harm, stigma, or delay in accessing gender-affirming surgery. At the same time, parental involvement can provide stability, emotional support, and practical assistance. Therefore, a holistic approach is required where parental support should be actively facilitated wherever possible, but the absence of such support should not constitute a legal barrier to accessing care when the adolescent demonstrates sufficient decision-making capacity and is supported by a multidisciplinary healthcare team.

The SAHIVCS guidelines should promote family involvement where possible but ensure that a lack of parental consent does not prevent accessing gender-affirming surgery. Even though the Children's Act provides alternatives (High Court/Childrens' Court/ Minister of Health) for informed consent in absentia of parents/guardians, this can be procedurally heavy and difficult to operationalise given real world barriers. To safeguard the well-being of transgender youth aged 16 and older, the guidelines should also consider the mature minor doctrine and a robust informed consent process.

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# Appendices

## Appendix 1: approval of title letter

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
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Reference: Ms Sandra Munesar
E-mail: Sandra.munesar@wits.ac.za

11 September 2024
Person No: 2604558
PAG

Miss F Gangat
135 Belladonna street, Roodekrans
Roodekrans
1724
South Africa

Dear Miss Faaiza Gangat

**Master of Science in Medicine: Approval of Title**

We have pleasure in advising that your proposal entitled *Ethical Justification for Gender Reassignment Surgery Without Parental Consent for Transgender Youth aged 16 years and older in South Africa* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Ms Sandra Munesar
Faculty Registrar
Faculty of Health Sciences

## Appendix 2: Turnitin report

Turnitin report shared as a separate attachment.